HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: PIP and ESA assessments, HC 355

Wednesday 22 November 2017

Ordered by the House of Commons to be published on 22 November 2017.

Watch the meeting

Members present: Frank Field (Chair); Heidi Allen; Andrew Bowie; Jack Brereton; Alex Burghart; Neil Coyle; Emma Dent Coad; Ruth George; Chris Green; Steve McCabe; Chris Stephens.

Questions 1-106

Witnesses

I: Yolanda Barker, PIP applicant, Amanda Browning, PIP and ESA applicant, Denise Martin, PIP and ESA applicant, Natalie McMinn, PIP and ESA applicant, and Thomas O'Dell, PIP and ESA applicant.

II: David Bryceland, Project Manager, Oxfordshire Mind, Gary Edwards, Manager, Southampton Advice and Representation Centre, Kayleigh Nor-Val, Team Leader and Specialist Welfare Benefit Caseworker, Citizens Advice, and Martin Richards, Lead Welfare Advisor, Involve Northwest.

Examination of witnesses

Witnesses: Yolanda Barker, Amanda Browning, Denise Martin, Natalie McMinn and Thomas O'Dell.

Q1 **Chair:** A huge welcome to you and thank you very much for coming. We would like to start our hearing—starting with you, Thomas—with each of you saying who you are and, if possible, if you can remember when you were assessed. Then we are going to go around the Committee and introduce ourselves, so that people who need it will have our voices. Thomas?

Thomas O'Dell: My name is Thomas O'Dell. I am 30 years old, from Southampton. I was originally assessed back in 2015. I got run over by a Humvee, and I have got major nerve damage in my left leg and it has caused me a disability. I got refused PIP. I went to the tribunal with it, was only scored seven points there and then I got reassessed within three weeks and was granted PIP. I had ESA, which they disallowed me. One of the assessors scored me zero points and wrote down things that did not even happen. I then approached SARC, a charity in Southampton that helps people deal with these kinds of cases. They helped me with my PIP appeal as well and represented me. They represented me for my ESA as well, and we won that at the tribunal and went from zero points to 21 points straightaway.

Q2 **Chair:** Because we would love to ask you questions, Thomas, the key thing for us was from zero to how many points?

Thomas O'Dell: Twenty-one.

Q3 **Chair:** Yes. That is a key stage. Thomas, thanks. Amanda, brief introduction please?

Amanda Browning: I am Amanda. I am 46 and I have chronic fatigue syndrome. I was first diagnosed in 2008. I first applied for benefits in 2009, and over the years I have had about half a dozen-plus assessments. My last two have been very difficult. For the ESA assessment I had in 2016, initially I was taken off benefits, and I won my appeal in 2017 and was put back on. With regard to my PIP, I was on DLA and reassessed every two years. At my last DLA assessment earlier this year I was awarded zero points and I am now at the appeal stage, waiting to hear at the moment.

Q4 **Chair:** Thank you, Amanda. Yolanda?

Yolanda Barker: Hello. I am Yolanda Barker. I am from Ashford in Kent. I have multiple sclerosis, which I have had since 1993. I was receiving disability living allowance at the high rate for both on an indefinite award. My assessment came through for PIP, and that was in January 2016 that I had my assessment. I received high rate mobility but standard rate care.

Q5 **Chair:** Very good, Yolanda. Thank you. Denise?

Denise Martin: Hello. I am Denise Martin. I am 49 years old. I first started claiming ESA in 2011. I haven't worked in any real capacity since 2011, and on many different occasions I have been found fit for work, placed in the WRAG group and currently am in a support group, and just three weeks ago I had a more recent work capability assessment, which I am waiting the outcome of. I also, like my colleague here, moved over from DLA to PIP last year and lost my mobility element. Sorry, I should also have said that I have got bipolar, fibromyalgia, Crohn's disease and spinal issues. I lost the mobility element, although I am in receipt of the care element of PIP. So I have various different outcomes.

Q6 **Chair:** Natalie?

Natalie McMinn: My name is Natalie McMinn. I am 32 and I am currently living in Birmingham. I am a childhood cancer survivor with dual sensory loss. I previously lived in Northern Ireland for many years and I didn't have any difficulties with my benefits there. I received DLA and ESA. When I moved over to Birmingham I applied for ESA and PIPs, and I applied for both of those in January of this year and the process for both of them was extremely frustrating and very disappointing—a lot of problems. There were different problems with both of them.

With the ESA it took about six months before I got a response as to whether or not I was going to receive it. I had to constantly chase the helpline. It was very frustrating because I use Text Relay, which is operator assisted phone calls, and I was being kept on hold each time for approximately 45 to 50 minutes. A couple of times when we did get through to someone on the helpline for ESA, they hung up on us as soon as the Text Relay operator introduced themselves. Eventually, after having been told that I would receive a response each time from the helpline within two weeks, and not hearing anything, I sent letters of complaint to the Department for Work and Pensions here in London, and to the district manager of the jobcentre in Birmingham. It was only at that stage that things started progressing.

With PIPs it was very frustrating because I had previously been on the middle rate of care and the higher rate mobility on DLA, and when I switched over to PIPs I felt the assessment was very poor. I felt that the lady who was assessing me was very unprofessional, had very poor disability awareness, and the award letter was full of mistakes that contradicted itself. I was given no award for the care component, and I did receive the enhanced mobility and I had to go down the mandatory reconsideration route. I received a letter only two weeks ago saying that I was now being awarded the standard rate of care.

Q7 **Chair:** Natalie, thank you very much. We are now going to go around our side of the room. We will just say who we are, because that is enough, and what constituency we are proud to represent. Chris.

Chris Green: I am Chris Green, the Member for Bolton West.

Jack Brereton: I am Jack Brereton, the Member of Parliament for Stoke-

on-Trent South.

Andrew Bowie: I am Andrew Bowie, the Member of Parliament for West Aberdeenshire and Kincardine.

Alex Burghart: I am Alex Burghart, from Brentwood and Ongar.

Chair: I am Frank Field, the Member of Parliament for Birkenhead.

Heidi Allen: I am Heidi Allen, the MP for South Cambridgeshire, and I am really sorry for being late—the train was late.

Emma Dent Coad: I am Emma Dent Coad, the MP for Kensington.

Ruth George: I am Ruth George, the MP for High Peak.

Chris Stephens: I am Chris Stephens, the MP for Glasgow South West.

Neil Coyle: I am Neil Coyle, for Bermondsey and Old Southwark.

Steve McCabe: I am Steve McCabe. I am the MP for Selly Oak and Birmingham. I also apologise for being late.

Q8 **Chair:** Could we accept Heidi's apology, because if she was being sent to a jobcentre with a time, she would have been sanctioned?

Heidi Allen: Yes, you are right.

Chair: Because the poor staff have no discretion; they have to apply these rules, whatever case you put forward. Andrew, we are going to begin with one Member sanctioned already.

Q9 **Andrew Bowie:** Good morning. This question is to all of you or any of you. Before you applied for either ESA or PIP, did you understand the application process and did you know what the assessment would look at?

Amanda Browning: When I initially applied, I had to get help from a local charity because I was overwhelmed by it. Although I applied a number of times over the years, and had health assessments, it is still very confusing to understand exactly what medical evidence to get, and the health assessment doesn't help. It does not ask the relevant questions and so, yes, each time—even now—I am struggling to get the right information to provide the DWP.

Thomas O'Dell: I had come straight out of work and I didn't claim for a while because I thought I was going to be going back to work. My health did not improve. I went down and got all the forms to fill in for ESA. I was awarded it—I think it was contribution based I got first. Then that stopped and then I applied for ESA and applied for PIP. From what I worked out with working with the charities after getting refused on these occasions, that the paperwork had to be—it was an exercise that if you didn't write what they needed to hear, the correct wording, it would seem they would just throw the case out completely. I also had a lot of problems with the Wolverhampton mailing centre. I had to fill out an ESA50 about four times because it got lost in the mail and they didn't receive it, and then being told that, "You're not allowed to send it

recorded because there will be no one there to sign for it," so you have no receipt of it being received.

Q10 **Chair:** Thomas, when you were in these early stages, did a work coach ask to see you and start discussing, "If we were starting again, Thomas, where you are now, what are the sorts of jobs that you would like to be trained for?" Did you have those sorts of conversations?

Thomas O'Dell: Yes. I had a meeting with a careers adviser. I used to get a phone call every six months from the jobcentre and I would have to go in for a meeting with them. They would ask how my health was and whether I was fit for work yet. My health has deteriorated over the years. I also have mental health problems due to this. After three years of doing hardly anything because of pain levels and restrictions, I have gone back into studying so that I can apply my skills and my trade into further advancement and be able to get my career back again, because I feel that I should be working and earning more money so that I can provide for myself and a family in the future.

Q11 **Chair:** Good. Can we go down and ask Andrew's question to all of you? How many of you found it easy to fill the forms in, and how many of you sought help and what sort of help did you get? Yolanda?

Yolanda Barker: I sought help. I looked at it and I just cried basically. It was just so daunting to be frightened about what to put down and how to put it down. How do you explain your day in a way that someone else is going to understand? It is really hard, and to put it on the form was really challenging. I spent quite a long time—my days are quite short, in terms of what I can actually get done—and I spent a lot of days doing that and then thought, "No, I can't do this," so I sought some help. But you only have two weeks—is it two weeks?

Amanda Browning: Four weeks.

Yolanda Barker: You have four weeks.

Q12 **Heidi Allen:** Can I check, is it ESA or PIP that you are talking about or both?

Yolanda Barker: I am talking about PIP. I do have ESA; I have had it for quite some time and I haven't been reassessed on that yet. I say "yet" because I am sure it will come round the corner tomorrow. But, yes, PIP for me was the case where I have had to fill the form in. I got help to fill the form in because there was just no way I could do it by myself.

Q13 **Chair:** Yolanda, do you think it would be a good exercise for us to do, to try to explain our day on the forms?

Yolanda Barker: Yes.

Chair: That is really helpful. Thanks. Denise?

Denise Martin: Hi. I sought help from a mental health charity to try and fill in the forms, but just reading the questions was quite upsetting, because they are quite intrusive and I have to describe my worst days, and there are a lot of misconceptions about what you are supposed to put. You can be led to believe that you are supposed to put things in a certain way. It is all very cloudy and I want to do the form to the best of my ability, send it off with medical evidence, which I hope we are going to come on to because it is a massive issue. It is very hard and if you were to try to fill in one of the forms you would probably get your benefits refused, because it doesn't give a true reflection of how awful our lives can be at times.

Chair: Natalie?

Natalie McMinn: I would say, first off, just getting the forms was very difficult for me, because having an application process where you have to phone up is not really accessible for people who are deaf and hard of hearing. As I mentioned, I would make calls with a Text Relay operator. We were on hold for 45 to 50 minutes before being able to speak to someone just to get the forms.

In terms of completing the application forms, it is something that I would be quite confident about and I am quite experienced in that. However, I do need a lot of extra time because my sight does slow me down. I do get very tired. Something else that I would also add is that I think, particularly with regard to the ESA forms, there was quite a lot of information that I had to put down and that required me to do quite a lot of research in terms of, for example, getting bank statements and so on. Those are things that I do need help with and I have to seek help in that respect. I did not enjoy filling in the ESA form at all.

Q14 **Chair:** Natalie, when you are waiting 50 minutes for the call to go through, what happens to your screen? How are you told to just keep holding on?

Natalie McMinn: The operator is typing what they are hearing, and when it is a queue situation, when you are on hold, they just write, "You are in a queue". What I found quite frustrating is that, particularly recently, I have noticed the Text Relay operators in that situation will say, quite frequently, "You are in a queue; do you wish to hold or try again later?" If you are being asked that repeatedly over a 50-minute period, it can be quite frustrating, so I have had to say, every time I have made that call to the operator, "We are going to be on hold for quite a long time. Please, don't ask me if I want to hold. I want you to stay on the line. I want to continue with this call until someone actually answers." Usually during that time there has been a change of operator as well, which has been quite difficult.

Q15 **Chair:** Do you think the Department should have special lines, Natalie?

Natalie McMinn: In my experience of other situations, with other helplines, generally when I have found a minicom number that you can

call and that does not require a Text Relay operator's support, generally it is not answered. I have had a lot of difficulties with that where people in the office don't know how it works. If there was something like that, if there was that facility put in place, if it was manned for the full office hours or the full hours that the main helpline would receive calls, and if it was answered by people who were trained and experienced in the use of minicoms and Text Relay and communicating with deaf and hard-of-hearing people, then I think that would be an improvement. But I think generally you will find if you talk to deaf and hard-of-hearing people about these sorts of issues, they always prefer to have communication by email or by text message and that would be preferred over a minicom line.

Chair: Very good. Thank you.

Q16 **Andrew Bowie:** I presume from what we have just heard that you would all agree that the information that you receive prior to the assessment could be improved.

Thomas O'Dell: Could I just make a point?

Andrew Bowie: Yes.

Thomas O'Dell: Multiple times I have phoned up the DWP. You are given one number to phone and then you have to listen to all the options, you are on the phone for maybe five to 10 minutes for them just to give you another number to ring. Then you have to listen to it all over again, to then be on hold for anything up to an hour and a half. Also, these phone lines are not free, so they are charging you from the minute you are connected.

Q17 **Andrew Bowie:** Is that a common experience?

Denise Martin: I have no landline so I have to use my mobile. I live in a really rural area and I did not realise. I phoned the ESA department about a month ago and my phone bill was £10 for that call. I know it is being changed but you go on to Google and type, "ESA helpline," and it is exactly as Tom said, they will only deal with new claims. I had real trouble finding a number for an existing claim to speak to somebody, because the way I work I prefer to speak to somebody to get it clear in my own mind what I need to do. I can make notes and things. I know it is changing, but £10 for a phone call. I didn't realise until I got my phone bill.

Chair: Can Chris come in on that, because it is one of his campaigns?

Q18 **Chris Stephens:** I have been campaigning on this, but I want to ask Natalie specifically about how much it costs you to phone any helplines in relation to PIP and ESA. I would imagine that the experience that you have outlined today would be very expensive for you, with the phone bill.

Natalie McMinn: I will have to check, because I don't have that specific information with me at the moment, but it would have cost a lot because

having a Text Relay operator means that the call takes that bit longer—it takes a lot longer usually. For example, as I said, one time when we did eventually get through to the helpline the adviser immediately hung up as soon as the Text Relay operator introduced themselves, meaning that potentially that call could have been made and could have been completed in perhaps an hour or so but, because we had to start the whole process all over again, so it took about an hour 45 minutes.

Q19 **Chair:** I will just ask Yolanda about that point on cost that Denise raised. What has been happening to all of your phone bills, please, in this respect?

Yolanda Barker: I am not sure whether any of the calls have cost anything. It is not just about the cost; it is about the time. If you only have a very short space of time that you are feeling up to making a phone call, if it is taking an hour you have lost it by then, hanging on waiting, it is too long.

Q20 **Chair:** That is a good point, Yolanda. Amanda?

Amanda Browning: I am fortunate in that I have a landline and I have a plan, so those numbers don't cost me anything. But I think I spent—unfortunately, with my memory; I have it written down—dozens of hours.

Q21 **Chair:** Would you send the hours into us, Amanda?

Amanda Browning: Yes, absolutely.

Q22 **Chair:** It is a really good way. You have changed our questioning. Okay. Back to Andrew.

Q23 **Andrew Bowie:** This is my last question. Were you aware of the flexibilities that are available in the application process? For example, did you know there were home visits available and was this ever made clear to you?

Thomas O'Dell: No, they didn't.

Yolanda Barker: I was aware. However, I was also aware that that would delay how long it would take for the assessment.

Q24 **Andrew Bowie:** Were you put off from asking for that because you knew it would delay the assessment?

Yolanda Barker: Yes.

Denise Martin: Can you repeat your question, please?

Q25 **Andrew Bowie:** Yes. I was asking if you were aware of the flexibilities that were available as part of the assessment procedure and, for example, if you knew that home assessments were available.

Denise Martin: Yes. I did apply for a home visit for ESA once, and the rigmarole I had to go through. I had to get a letter from my doctor to say that, due to spinal issues, I couldn't travel two hours on the bus, and it

was again such a huge, complex procedure to request this. It looks like a good idea but to get it done and to get somebody come and visit you at home is almost impossible, so I don't think that is an option for a lot of people because it is too difficult. You have to get all this evidence and prove that you are not able to get to the jobcentre or whatever.

Q26 **Ruth George:** Can I ask if you were allowed a home visit?

Denise Martin: No. I was allowed transport to the assessment.

Q27 **Chair:** Did anybody have a home visit?

Thomas O'Dell: No.

Q28 **Neil Coyle:** When you say you knew it would take longer, was it the assessment provider, or was it a welfare or charity organisation, or was it a jobcentre that told you it would take longer, or someone else?

Yolanda Barker: I am not actually sure. No, I am not sure who it was that said about it.

Q29 **Chair:** Yolanda, was it the jobcentre?

Yolanda Barker: No, it wasn't the jobcentre itself. I hadn't had really any contact with the jobcentre. I think it may have been over the phone when speaking to the DWP about actually getting it and when you fill the form in, because I was aware that I didn't want somewhere with steps, and things like that, if I was going to an assessment place, which—that is another story. But yes, on the home visit part, I do know people who have had home visits but I haven't had one personally.

Q30 **Chair:** Has anyone got a different experience? Amanda?

Amanda Browning: I wasn't even aware that that was an option until I read this question, and I thought it would be good because a number of times my appointments have been cancelled at the last minute. Sometimes I have actually travelled to the town, and for my last ESA I had to wait for two hours to see someone, by which time I was unable really to participate in the health assessment.

Q31 **Chair:** Amanda, just tell us a little bit more about that, because the staff are given no discretion, if you fail in any of your requirements about turning up.

Amanda Browning: Yes.

Chair: However much they might feel for you, they cannot act as human beings. There is no discretion. Are you saying that you turn up and appointments are then cancelled?

Amanda Browning: Yes. I have never actually got into the building when that has happened, but it has happened two or three times. This is back when I had a car. If I had been on the bus, which is very difficult for me to do, I would have already been on the bus. I have been driving to the town when it has been cancelled, and it is not even just, "Oh this is a

cancelled appointment in my day," which we have all experienced; for me, my week would have been planned around that. When I got there this last time, I was initially told I might not be seen because so many people had turned up. They obviously double book or treble book.

Q32 **Neil Coyle:** Were you told why the appointment was cancelled? Was it because of the lack of availability of an assessor or was it because they had double booked appointments?

Amanda Browning: I don't think they said they had double booked it. They said, "We don't know whether you will be seen because of a lack of assessors," and the room was quite full compared to normal. I don't know if that is an assumption I have made or somebody at some point in the last 10 years has said to me that is what they do.

Q33 **Alex Burghart:** Did they apologise for that or try to accommodate you in any way?

Amanda Browning: It was very matter of fact, and then I had to sit in a very cold waiting room without access to a cup of tea. I know it sounds like I am being a bit of a drama queen but just something to keep me going for two hours. Yes, I had no idea when I would be seen, so I just had to wait and hope.

Chair: Neil, do you have a quick question?

Neil Coyle: No, I was going to say that if you kept a lot of us away from caffeine for two hours you would soon see drama queens.

Q34 **Heidi Allen:** The difficulty is this is such a massive system, isn't it?

Denise Martin: Yes.

Q35 **Heidi Allen:** I am interested in perhaps just one thing from each of you. What would make it better? I appreciate that home visits for everybody who claims the ESA or PIP is not going to be possible. With telephone calls, would that take forever? Is that better or worse? If you could all list me one thing that would make either the ESA or PIP process better, what would it be? Do you want to start, Thomas?

Thomas O'Dell: Yes. Personally, I would think using proper doctors instead of—

Heidi Allen: I am thinking about the initial form filling.

Thomas O'Dell: Oh for the actual form?

Heidi Allen: We are going to come on to the assessment in the next set of questions, so just getting going with the system, I suppose.

Thomas O'Dell: To be told that you can find a website that will tell you the descriptors that need to be listed, if it tells you that you could go to there, and that was what you needed to write and what they are looking for basically for the form to actually go through the system, for them to

see you and know what is wrong with you because, even in the descriptors, they are so brief that it is hard to try to correlate with them.

Q36 **Heidi Allen:** Is it not enough information on the form?

Thomas O'Dell: Yes. The questions are quite bland and you have to try to work out what they mean by them.

Q37 **Chair:** If we could get just sentences from you now because we have almost not started questioning—and we have been going for half an hour—that would be good. Amanda?

Amanda Browning: For me, the questions on the form are not thorough enough. They need to ask not just what we can do but, "How frequently can you do it? What impact does that have on you? Could you do it safely?" etc.

Q38 **Heidi Allen:** Again, is that for PIP now?

Amanda Browning: Both PIP and the ESA.

Yolanda Barker: I would say for PIP—I would be working on PIP—that centres for the assessments need to be closer, and safe to get in and out of.

Denise Martin: I think possibly the questions for ESA and PIP could be more streamlined to the individual's illness, because when you first make a claim you do have to disclose what is wrong. Maybe the forms could be streamlined slightly more.

Q39 **Heidi Allen:** Or perhaps a variety of half a dozen; if you have musculoskeletal or mental health, but it is something like that.

Yolanda Barker: Yes, although it is difficult if you have all of them.

Q40 **Heidi Allen:** Yes, I know. This is the difficulty. We are trying to find quick, good ideas.

Natalie McMinn: I think that there needs to be an alternative method of both initiating the application process and communicating during that time other than by phone. There should be a dedicated email address and ideally a text messaging number.

Q41 **Chair:** Great. One brief thing before Emma. Thomas, I grew up in a world where there was the 11-plus and we spent all of our last year doing papers, but we also had books that gave us the sorts of answers that we were expected to aim at. Are you suggesting if they showed you people similar to you—if there are people ever similar to any of us—and how they would fill in the form, would that help, because it would give you an idea of the answers?

Thomas O'Dell: Yes, that would give guidelines, basically.

Q42 **Emma Dent Coad:** This subject has come up in some of your answers, but perhaps you can explain: did you have confidence in the person who

was assessing you that they would understand whether or not you were eligible? If you provided medical evidence or any other evidence, how did they use it? What was their kind of relationship? Did they understand, did you trust them and did they understand the evidence you gave them?

Chair: Natalie, could we begin with you, so we do not keep picking on Thomas?

Natalie McMinn: To be honest, I was absolutely appalled by my PIP assessor, because to begin with, when I had initially contacted the helpline, I was very clear with them that if the assessor needed to contact me, they needed to do so either by calling through Text Relay—and I gave my full Text Relay number—or by sending a text message. On the day of the assessment, they were coming to do a home visit and it was supposed to be, I believe, about 9 o'clock in the morning. I was living in an apartment building at that time and I came downstairs, because I cannot hear the intercom or the buzzer, and I was waiting in the reception area and nobody arrived.

I did not receive any communications until around half-past 10 or a quarter to 11. At that stage, my phone rang twice. It was not a Text Relay call, so after the caller had stopped trying to get through I called them back with Text Relay and it was the assessor. She said she could not find any parking, so she would come back in a couple of hours. Now, particularly at that time, I had a very busy schedule and I had other appointments in the afternoon. It really threw my whole day's plans out the window.

I went back up to my room for a while. I came down a couple of hours later. I asked the receptionist if they had seen the assessor and they said then that she had come back in at around half 12 and said to tell me that she had gone the other direction to try to find somewhere to park; she was still having parking difficulties. Eventually she came back in about another half hour after that. She came in and we went upstairs. We only talked for about 15 or 20 minutes at the most. It was very obvious to me that the assessor had no deaf awareness. She did not strike me as being very professional or having very good disability awareness. She did not seem to be very understanding or experienced of the difficulties that I have. I felt that—

Q43 **Chair:** She could not even park her car, could she, let alone deal with the really complicated things in your life, Natalie?

Natalie McMinn: Yes, that is very true. I was just really shocked. I noticed that a lot of the information that I had given her as well as putting on the forms was not reflected or was wrongly recorded in the award letter after her visit. I just felt that this assessor did not understand me or the difficulties. I felt like she did not listen to me. She just did not understand at all.

Chair: Thank you very much. Denise.

Denise Martin: I have not found any of these services over the years to really be anything other than—they have been pleasant, but they seem to just be going through a tick-box exercise in their mind, asking the questions; there is no kind of human warmth there. You are asked some quite painful questions, especially to do with mental illness, and you are also asked about things like incontinence and stuff like that. It is really difficult and I just do not think they take it on board; they just go, "Tick, tick, tick." I have had various different views from various different assessors, but they all seem to be just completing a task. There is no kind of human interaction there, and certainly no awareness of the difficulties that I face.

Yolanda Barker: I agree with all of that. I had a paramedic for mine and he said that he did not really have experience with multiple sclerosis other than the people he takes to hospital when they are in a really bad situation. It almost made me feel, "Well, okay, I am not like those people, so he does not think I am ill enough," which was very disheartening. He referred to the paperwork, saying, "You said such and such on your application. How did that affect you?" But they are not looking at you; they are just typing while they are doing it. They are facing away from you and you are trying to say something that is quite—you feel quite vulnerable, don't you?

Chair: Yolanda, thank you. Amanda.

Amanda Browning: My last ESA assessor did not seem very thorough and the report had 21 inaccuracies in it. At my appeal, the tribunal noted that the assessor had been selective in reporting my capabilities and awarded in my favour. Similarly, at my last PIP assessment they did not seem very thorough, but this particular assessor was unprofessional and rude and made the whole experience very distressing.

Chair: Thomas.

Thomas O'Dell: I agree with the ladies to my left, having had similar experiences. I have had paramedics assess me. I receive an industrial injuries disablement benefit as well and the assessment for that is carried out by a proper doctor at the hospital. I have never had any problem with that. The problems I have had with ESA—she was almost like a smiling assassin. She was telling me, "Yes, I am here to help you to do this and to do that". My father pushed me into the examination room in a wheelchair. I took three steps holding on to the table. She then said I could walk 50 metres from that. She said she had done an examination, when all she had literally done was touch my leg and then said, "Oh, we are not going to carry on, because I can see you are in a lot of pain," which I was not that day. Then she just fabricated this whole assessment after that.

Also, with my PIP assessment, I was assessed and the paramedic said that she had done all these different things and she had not done them. The charity that works with me wrote to a musculoskeletal doctor and

asked his opinion on this and he said, "You cannot carry out these examinations by doing what is said in the actual form, in the report." That happened.

Q44 **Chair:** By looking at you, in fact?

Thomas O'Dell: Yes, pretty much.

Q45 **Emma Dent Coad:** Do you think from what we have been hearing that a face-to-face assessment was the right way of assessing you?

Yolanda Barker: No, I just think it is not appropriate. It does not prove that you can do something. Some of the tests they do, one of them is squeezing fingers. From squeezing fingers they have decided that I can cook a meal, which I can't. They said if I sat on a perching stool that would be fine. You cannot cook a dinner from a perching stool, and if you have fatigue as well, you really can't.

Also, I notice one of the assumptions was made that because I am overweight that I have no difficulties taking in food. That is not true. I have a problem where I get food stuck because the MS affects how messages get sent to the brain and I have problems with that. Again, that is an assumption that is not true.

Q46 **Chair:** Yolanda, good food costs money though, doesn't it?

Yolanda Barker: Yes, unfortunately.

Q47 **Chris Stephens:** I was just going to ask all of you—I think Thomas has answered this, because he was accompanied—whether you were all accompanied with someone. Did you know you could bring someone with you?

Yolanda Barker: I took my husband, because he drove me.

Denise Martin: I live alone. I do not have any family.

Amanda Browning: I am the same; I went alone. I have nobody that I could have taken.

Natalie McMinn: I did not know that you could have anybody with you, so I was by myself.

Yolanda Barker: I could not have gone if I did not have my husband, because I was sent to one that was an hour away, so there is no way I could have driven that far. I only drive locally. Then when I got there, I would have had kittens anyway because the parking was atrocious, and there were steps to get in. If you wanted to use somewhere that did not have steps, you had to walk all the way around the back, which again was extra distance I could not do. It was just atrocious and there was no public transport nearby either.

Q48 **Andrew Bowie:** Just to clarify, you said that you were not aware that you could have anybody with you, and that nobody had made that clear

to you before you went to the assessment. Is that true?

Natalie McMinn: It was not made clear to me.

Amanda Browning: Once you have gone through all this, the assessments really are a waste of everybody's time and money. As I said earlier, about the small things they ask you to do, and when they observe you, they do not ask you whether you can do them repeatedly or what the impact of doing them has on you. They spend so much time looking at the screen that they cannot focus on you and delve deeper into those questions. The very basic movements they ask you to do, like touching your shoulders, does not demonstrate your ability to do something like stack shelves for four hours. They just are not fit.

Thomas O'Dell: Can I just make another quick point? I had one of my assessments re-edited by a member of staff on a different date who was not even in the examination room. We have also taken this to the upper tribunal and have been told that there is a year's worth of backlog of complaints to deal with, so we are just basically at the bottom of the pile.

Q49 **Chair:** We have had that with other people's notebooks, haven't we, Thomas?

Thomas O'Dell: Yes.

Q50 **Jack Brereton:** My question leads on from that. A number of organisations have raised concerns about the accuracy of some of the statements, so would you welcome the opportunity to have your face-to-face assessment recorded?

Yolanda Barker: Yes, definitely. It should be mandatory.

Q51 **Jack Brereton:** Also, would you welcome, when you receive the outcome of your assessment, having a copy of that recording?

Denise Martin: Absolutely; I think it goes without saying.

Yolanda Barker: Because you have to phone up to request a copy of it, which is another day wasted, if you know what I mean. If you think that you have only got so many spoons to give yourself—there is this thing called the spoon theory, which allows you say 10 spoons in a day—if you are using your spoons up on making phone calls, you do not have the energy to do anything else. Making just a simple phone call to get that back is another thing that you do not need to do.

Amanda Browning: Not just to keep them honest, but also having conducted research interviews myself, I understand how difficult it is to conduct the interview and take the notes exactly verbatim of what somebody is saying. It really takes away from the quality of the interview, so if the assessor could use a recording to then fill in the notes, they could give you a better quality assessment.

Denise Martin: Can I just add that I think the assessors are really under pressure and stressed, because they have targets to meet, and that is felt by us when we go. For me, I was asked about hospital admissions and it was like the hospital admission was a reflection of how unwell I was, but it does not work like that in my life.

Q52 **Chair:** Might I ask you a question, please, because you are taking an exact record for Natalie?

Susie Lithman-Romeo: Yes, I am.

Chair: Could you combine that with questioning what Natalie meant and the meanings and keep the record to the verbatim standard that you are doing?

Susie Lithman-Romeo: Absolutely not.

Chair: Thank you very much. Very good. A quick one from Steve.

Q53 **Steve McCabe:** I just wanted to ask quickly this point you were making about keeping a record. I think Natalie said it would be better if you could communicate by text or online. I was wondering, would it be better if there was a video record of the assessment and your application was accompanied by a video diary of what you said was your day? I am asking this because I am conscious that there are quite a lot of online forums where people with different conditions exchange information quite often about their conditions and different things they are doing. I do not know if that applies for—

Chair: Steve, can you slow down?

Steve McCabe: Am I going too fast?

Chair: I am sure you are not.

Steve McCabe: I would never pass the assessment.

Chair: But it is quite important for that to go on to another screen, you see? Sorry, Steve. Yes, slowly.

Steve McCabe: I was asking because it seems to me there are a number of online forums. I am not saying it suits everyone, but there are examples of people who exchange information. I am wondering if what is needed here is a change in the culture of the Department employees. Filling in a form is very old hat—it is very standard. I am not saying this will work, but I wondered what your experience would be if you could use a different medium. If there was a video recording, it would give a slightly more accurate impression of what happened in the interview.

Yolanda Barker: I do not think it would.

Amanda Browning: No, I think more fundamentally it is about asking the more appropriate questions and getting—

Q54 **Steve McCabe:** How could they be asked more appropriately?

Amanda Browning: Again, rather than saying, "Can you walk to the shops? How far are the shops away? Yes, you can do that. Thank you very much, it is okay," they should ask, "How often can you walk to the shops? If you were to walk that short distance three times in one day, could you walk there? What would happen to you? Could you do it the next day?" Those are the things. No, I could not do that the next day.

Q55 **Chair:** That is brilliant, Steve, because what I hope we are going to do is try to fill in the forms ourselves, but might you all, the five of you, change the forms in a way that you think would make them more meaningful for you so that you could express yourself more accurately? Amanda, that was a brilliant suggestion.

Yolanda Barker: I think the video part would not work, because to be honest I do not think anyone would want to watch a video of me sleeping the whole time, because that is ultimately what happens a lot of the time; a lot of my day is taken up sleeping.

Denise Martin: I think it would be misinterpreted because what one assessor might feel to be serious, another assessor might not. There is no consistency. I think all the assessors have to tick, but it does not seem to be adaptable. It is fairly rigid.

Yolanda Barker: Yes, nothing fits in, does it?

Denise Martin: I think the recording is a fantastic idea.

Thomas O'Dell: On the recording, at the end of the day we have nothing to hide. We are applying for these benefits because we are in this state and we do need this kind of help. It does feel like the assessors are trying to meet quotas, basically, as was mentioned earlier. But in a video recording, we have nothing to hide. We are being assessed for genuine cases, so if you have nothing to hide you have nothing to worry about being videoed for it.

Chair: Natalie.

Natalie McMinn: What was the question, sorry?

Q56 **Chair:** What about being videoed, or do you think we might just start with a better questionnaire?

Natalie McMinn: I think that you do need to tailor the process to the individual. For example, if you are assessing someone who is profoundly deaf and a sign language user, filling in a form is not their primary means of communication, so it is very difficult for them. They will need a lot of support with that. For someone like myself, written communication is my preferred format so, thinking purely of my own needs, I would prefer to have a new and updated questionnaire, perhaps with more open-ended questions, for example asking, "What difficulties would you have with doing your shopping?" and just allowing you, as the applicant, to explain a bit more in your own words in the way that you feel comfortable with,

explaining the whole difficulty and not just one particular aspect of the task.

Chair: When you look at the form for us to revise, might all five of you bear that in mind? If you were designing the form so that you could tell your story properly, what sort of questions should they be, please? Is that all right? We will have Ruth and then Chris.

Q57 **Ruth George:** Some of you have said that you felt the assessors were under a lot of stress, and they did not have time to look at you because they were so busy typing. Do you feel that is part of the problem; that they are not given enough time to make a proper assessment and to ask the more detailed questions that you feel they should be doing? Is it just, as you say, very much a tick-box exercise?

Yolanda Barker: It is tick-box, isn't it? They have, "Yes/no". There is not much option to say a lot.

Amanda Browning: They just ask exactly the same questions that the form asks, as if they have not even read the form. It is almost like they are asking exactly the same sort of questions again.

Q58 **Ruth George:** I think you all disagreed with at least one of the decisions that were made on your applications and you have taken them to mandatory reconsideration and appeal in some cases. Did you feel you had enough information when you received your decision to enable you to understand the process for asking for a reconsideration and then appealing it?

Denise Martin: Not particularly. I would go to charity websites or health lines, but it is not entirely made clear on the forms that you get from the DWP—

Amanda Browning: You do not get a copy of the health assessor's report unless you go through a mandatory reconsideration and then go to appeal. If you had a copy of that report with the initial decision letter or even a mandatory reconsideration—you are entitled to it. I have only recently found this out. As I say, my last ESA had 21 inaccuracies and I had to go through a whole six-month process, at great cost to the DWP, because of this report, yet they did not give me that report so it could be flagged.

Q59 **Chair:** I am conscious of time. We are learning so much, but we are well over time. Does anyone have anything different to say on that question?

Thomas O'Dell: Just about the sanctions, you get sanctioned before you get the letter. You think that you have your money going in and as you go to check your bank, the money is not there and you wonder why. You then have to make a phone call—45 minutes to an hour—to be told that there is a letter in the post that you will receive about three weeks later after the assessment.

Q60 **Chris Green:** Something that consistently comes through throughout this

session is the data side of things, so whether it is the paperwork that has to be filled in, whether it is your ability to put that information into the system or to the paperwork and the assessor's ability to understand and interpret and then use that data. I was on the Science and Technology Select Committee in the last Parliament, so I know that there is a big concern about how the medical industry could use data that GPs are putting in their notes. If different GPs—professionals—often are inconsistent in their data on those notes for other people to then interpret, you are in a really difficult position. Yolanda, how does that make you feel, if the system seems to be stacked up against you in that way?

Yolanda Barker: It is really hard and you feel that you are being dishonest, even though you are not. You feel that people are not trusting you, that other people are looking at you thinking you are a sponger. You try to do your bit as well. But on your point about giving it to GPs, while I think that, yes, it is partly a good idea, a lot of people with chronic conditions do not visit anybody because a lot of the consultants will only see you if they can do something for you. If they cannot do anything for you, then you are sent off to do your own thing basically and just deal with it.

Q61 **Chris Green:** This must have an impact on your health as well. If you are confronting the system and the system seems to be working against you, it must have an impact on you.

Yolanda Barker: For me, I am dreadfully worried with my PIP, which I was given this time for three years, because it took a year to go through to the appeal. I have a year inbetween, because they contact you a year before it finishes to start the whole process again. You do not get three years with a three-year award. I know that at some point in January that brown envelope will be dropping through my door again to start the whole process all over again. It is just awful.

Amanda Browning: Even if they want to, doctors do not know to help you because they do not know what evidence is being asked for. I agree that it would be really good if there could be a common language between what the DWP are looking for in terms of capability and how doctors record information for people; so not just that they have a heart condition or whatever, but that this heart condition means they cannot walk more than 250 feet, or they cannot do exercise. That way, the information would already be part of your medical record and could be accessed whenever needed.

Q62 **Chris Green:** As a group, do you think that some more research should be carried out on the impact for applying for disability and incapacity benefits so they can really understand the impact it has upon you?

Thomas O'Dell: Yes, it should. To get a doctor's evidence, the doctor's surgery will charge you if you want a letter from the doctor as well, or if

you need your history to send away with your application they will charge you for that.

Q63 **Neil Coyle:** That research should include how much these testing processes cost the NHS, the GP and consultant's appointments, perhaps?

Thomas O'Dell: Yes.

Denise Martin: Can I just say—and I am sure I speak for everybody on this panel—that none of us asked to become ill. I endeavoured to work most of my life and became too unwell to work. This is not a choice we make easily. It is all stacked against us. Predominantly, I have a mental illness that affects me quite severely. It is really, really tough and these assessments are adding to that. I do not think it should be allowed. I do not think anybody has the right to make me go home and cry because I have just had work capability assessment three weeks ago that is still playing on my mind.

Chair: Denise, on that note, we are going to stop. I thank all of you for sharing your experiences. I thank our colleague here as well—in future we will have your name there so I can address you properly, and I apologise in not doing that this morning. We will let you know how we get on in filling the forms in and we will invite our ministerial colleagues to join us to see how they fare as well. A huge thank you for coming this morning.

Examination of witnesses

Witnesses: David Bryceland, Gary Edwards, Kayleigh Nor-Val and Martin Richards.

Q64 **Chair:** Welcome to the second half of our evidence session. Martin, might you identify yourself for the sake of the record? We will go down the line and then Heidi will open the questioning.

Martin Richards: I am Martin Richards. I work for a charity organisation based in Wirral called Involve Northwest. I specialise in disability benefits. I have two other colleagues who do more general benefit work, so we do cover the full spectrum of the benefits system.

Chair: I will give you a bill of health, Martin.

Martin Richards: Thank you.

David Bryceland: My name is David Bryceland. I work for Oxfordshire Mind. As part of Oxfordshire Mind we have a small section that helps people both identify and understand the benefits they are entitled to. We then help them make and maintain those claims and we also represent those clients at appeal when the decisions go wrong.

Kayleigh Nor-Val: Good morning. My name is Kayleigh Nor-Val. I am a specialist welfare benefits adviser for Citizens Advice in Merthyr Tydfil. I

have worked there for five years now. I deal with everything from the initial assessment process, completing the forms, all the way through to tribunal appeals. We have a massive footfall of people who have the exact issues that we are talking about today. Over the past year I have dealt with just short of about 100 clients with these exact issues, so I am looking forward to speaking about this, looking for recommendations and just putting the clients to the forefront.

Gary Edwards: My name is Gary Edwards. I am from Southampton Advice and Representation Centre. We are the specialist advice centre in Southampton that deals with welfare benefits. I have worked there for 22 years. In the past year we have dealt with about 150 appeals of a combination of both PIP and ESA. I came here earlier on in the year and we published on our website—

Chair: I was going to welcome you back, Gary.

Gary Edwards: Thank you. Maybe I can update you when we come on to that, because we met Atos client champions after the last meeting here.

Chair: It is an extraordinary world, isn't it; that we have awards for that? Heidi.

Q65 **Heidi Allen:** I think the overwhelming sentiment from our previous panel was about not understanding, "Is my condition being understood?" and the form, "Did they listen to me properly?" Do you think it would be a good idea for recordings to be made of assessments and for people with their decision notice to get a copy of that form at the same time, just as a default system? Shall we start with Gary?

Gary Edwards: Yes, I do. I think the trust needs to come back into this system. The trust is lost between claimants and the providers, meaning the private contractors that the DWP use. A good example is a tribunal I went to yesterday, on a PIP appeal. The gentleman had multiple mental health issues. He asserted that his assessment lasted for seven minutes. The tribunal issued a direction that the Atos and DWP had to report how long they said the assessment took place. They refused to say how long that was. There was 30 minutes writing-up time. He got two points. We went to the hearing and he got 11 points and 10 points. This man was without benefit from June 2016. If it had been recorded, there would not have been that dispute about brevity.

Q66 **Heidi Allen:** And should people get their report with their decision notice at the same time?

Gary Edwards: I do not see why not. Let us have transparency.

Kayleigh Nor-Val: I agree 100%. The report is such an important part of the whole decision process. It is exactly what DWP uses. The decision makers refer back to that report as the evidence, so it is fundamental to

the actual decision process, so for the client to have that before anything goes any further is 100% fundamental.

Q67 **Heidi Allen:** Would you have recordings of the assessment process as well?

Kayleigh Nor-Val: On request, yes, if that is what the client wanted, because of the inaccuracies, as have been pointed out. There are so many that that would be fantastic.

Q68 **Chair:** Kayleigh, your answer was slightly different from David's—you said you would make it available if the client asks for it. If I was entering this world of claiming a benefit, I would be very trusting and I would not have dreamt of asking for my interviews to be recorded. I thought Gary was saying they should be mandatory.

Kayleigh Nor-Val: Either/or, but if they are done by default, I think the healthcare professional might conduct the actual assessment well, which should be done the way that they should do it. Yes, I suppose by default as well as on request.

David Bryceland: We agree entirely with that. We hope that the client should receive automatically a copy of the report. The one big difficulty with that is that when they see the inaccuracies, it can be extremely distressing, because that information is then recorded and will follow them and can be used for other benefit applications as well. The difficulty then is that when you go to appeal, you are not challenging the content of the report; you are challenging the decision, which is a subtle difference. All that misinformation remains with the client and follows them. As well as having a default setting whereby the client receives a copy of it and there is a recording of it, we also strongly recommend that there should be an easy way to challenge the information.

One of the things that we have started to do, because we see so many inaccuracies, is to request the tribunal judges to direct that the healthcare professional involved appears before the tribunal to explain, for example, why somebody who lives in a one-bedroom downstairs flat has been recorded as having a three-bedroom house. Those are not easy mistakes to make. Those are not slips of the pen.

Q69 **Heidi Allen:** Should that be through a judge or is that a contractual relationship between the DWP and the contractor to say, "You are not running the assessment correctly. You have that wrong"?

David Bryceland: That is both, but what we are fundamentally concerned with is ensuring that the client receives the correct treatment and the correct award. If they are failing to provide that information, then they should be held accountable at the tribunal level, certainly.

Heidi Allen: Or they need to be fired, because they are not doing their job properly.

Q70 **Chair:** David, that is so serious, isn't it; that you have to go up to the

tribunal to get an instruction to get a record check? The world would not go round, given what we have been hearing this morning. We have to find an easier way, don't we? We have to recommend an easier way that records are correct records.

David Bryceland: Yes. Even when the tribunal judge makes a direction, the DWP do not always follow it.

Q71 **Chair:** But that comes back to the recording, David, doesn't it?

David Bryceland: Yes.

Martin Richards: Unemployment support allowance on the ESA50 questionnaire, near the back page they do ask if you want your assessment recorded. We will always advise clients that is the best way and we will always advise them to have someone to go with them. Unfortunately, clients still then have to ring up to ask for the assessment to be recorded, even though it is on the form. They can turn up at the assessment centre and the recording equipment is not available.

We were invited to Bootle Medical Services to discuss a way forward with Maximus. We were taken into a broom cupboard. We were given a cup of water and then we were told that it is our fault that claimants are not being paid, because we are creating a backlog, because we instruct our clients to have their assessments recorded. With PIP that is an issue at the moment. Unless the client provides their own recording equipment that meets the specified standards, it will not be recorded.

Q72 **Chair:** Martin, I have to declare an interest, because your organisation brilliantly helped me with my constituency work. But isn't it right that at one stage we had only two recording machines for the whole of Merseyside?

Martin Richards: That is correct.

Q73 **Chair:** This idea that this was going to be part of the service is moonshine, isn't it?

Martin Richards: We were also told that the machines do not work on a Saturday or a Sunday.

Q74 **Alex Burghart:** Is there a reason why they cannot use mobile phones to record interviews? Have you ever been told a reason why it cannot happen?

Martin Richards: We have not been told the reason why. It is similar equipment to what the police would use at an interview or the fraud team. It is quite simple: it is two buttons pressed, you get a CD, they keep a CD and then we have an accurate recording of what was said.

Q75 **Chris Green:** My understanding of freedom of information when it first came out is fundamentally about the individual's access to data, to information that is held on them, whether it is by business or by Government. Surely you ought to have a system now that has that as a

presumption, to give that information out, rather than it being a challenge to get hold of it. If the Government paid a bit more attention to that legislation for freedom of information, they should take it as a default position to give that information out.

David Bryceland: Agreed.

Martin Richards: Totally.

Chair: I have to agree. What would we want for our families? I always think of this in my constituency. If it is not good enough for us, it is in no way good enough for my constituents. The idea that this sort of service should be offered is—Gary, we have lots to get through. You wanted to finish, Heidi?

Q76 **Heidi Allen:** Yes, I have a very quick follow-up question, mainly for Kayleigh. If we videoed or recorded the assessments, should the assessor b doing that? Is it a question of just what they should be doing, whether it is a seven-minute, speedy assessment and it should be half an hour, or is the actual assessment process not working? Because if the assessment process stays the same, you can record it 20 times a day.

Kayleigh Nor-Val: I say 100%. It is both. Picking up from what David said about inaccuracies, something as small as somebody living in a one-bedroom ground floor flat and saying that they have stairs, there are so many assumptions that can be made from that: they are going up and down stairs and they interact with people on the stairs, when that is 100% not the case. The assessment process is poor, it is flawed, and there are issues with it that 100% need to be changed. The only way to get around those are with recordings.

David Bryceland: Or not to have the assessment at all. There are many instances where the DWP hold substantial records that already allow them to make a decision on someone's eligibility for the benefit without having to call them in for an assessment.

Chair: But only if those records are correct.

David Bryceland: That is certainly true.

Gary Edwards: Could I just say something on this, Frank, if I may? We had a client who had been through the mill. It was an ESA claim and we had to go to the upper tribunal and eventually it was all sorted. He then said—as my colleague said—that he ticked the box to say that he wanted to have his ESA assessment with Maximus recorded, which is his right. They forgot about that or they did not notice it. When he got there, he said, "Where is the recording stuff?" and they said, "Oh, okay. If it is being recorded, you cannot see the one who we had assigned you to; you have to see someone else," which we thought was really telling. What happened in reality is that the person they were going to see was changed because they said they wanted it recorded. They got someone who knew about his particular health issues. I think we need it for quality

purposes, we really do, and I think they are more likely to do their job properly.

Q77 **Jack Brereton:** I should probably declare that I visited the assessment centre in my patch last week. There they have fixed recording systems attached in the rooms where people are assessed, but do you think there are differences across the country, in terms of the equipment that is available, the types of assessments being done and the quality of those assessments?

Kayleigh Nor-Val: I am not aware in our area of them being fixed. It is almost like what Martin was saying about having to request it. They will only allow it to be their recording equipment, so the client would not be able to bring their own, but it is clearly different in different areas, because that is not the case.

Gary Edwards: I understood that ESA were there and people had the option, so they could insist on it. It is damn hard to make them do that, but on PIP there is no arrangement. I know Atos were thinking about that and I think they can be pushed to roll that out.

Chair: Good thinking.

David Bryceland: Our clients are called into multiple counties, so we do know that there is a dearth of equipment available, but what is consistent is the poor quality of decision making and the poor quality of questioning and understanding of our clients' difficulties.

Q78 **Jack Brereton:** The decision making is not done by the assessor though.

David Bryceland: No, the decision making is not done by the assessor, although many assessors will imply that. A lot of our clients who have not been to us to have it explained to them will assume that is the case. Also, the quality of information collected is very poor because so many of the assessors simply do not understand either the language or take the time to ask and record the follow-up questioning that is really needed if you are going to understand somebody's mental health.

Chair: Martin, do you have anything to add?

Martin Richards: What concerns me is the motivation for a healthcare professional to record something that has not been said—the untruth. I do not understand the motivation or reason behind that, because if I went to see my consultant and he wrote untruths down, there would be civil actions and things in place, whereas these guys are under the tent of being medical specialists. I have a client from the mental health unit, and when the community mental health nurses attend these PIP and ESA assessments with him they are told to be quiet. They are not allowed to provide extra information and maybe clinical notes, things like that—they refused. When you get the reports through, they are totally inaccurate again and they totally contradict a consultant psychiatrist's report. We have, say, a physiotherapist who has done assessments on someone

with, say, paranoid schizophrenia or schizoaffective disorder. It is just not correct.

Chair: Right, we are going to go on to question 2 now and time is going. Alex.

Q79 **Alex Burghart:** Hi, everyone. What changes do you think the Government need to make in order to improve the accuracy of decision making following initial assessment?

Gary Edwards: Can I start? Right, after I came here last time we got a visit from the Atos customer team—I think they were concerned with some of the things we were saying. They came to our office, which was great, and we showed them the worst decisions that we had and we identified six health professionals that we viewed were not doing their job correctly. One of the things that came very clear to us is that in the Atos quality control system there is no connection between the final outcome, which could be at a tribunal, and what the assessor did originally, so it is never fed back. They asked us to see if they could take copies of the tribunal decisions.

You have a situation where it is not connected and there is not that training, so if they were recorded they could be used for training purposes. We have a crazy situation where I have a guy who went from zero points on both elements to 50 and 22, which is ridiculous and should not happen. It was the highest one we have ever had. He is now two months into the system. He went for his assessment again and he got nil points. This is all about where the assessor is ignoring the DWP guidance, which is reliably, repeatedly and within a reasonable timescale, so they may be able to walk once but, as we heard earlier, they can't do it later.

Q80 **Alex Burghart:** You say that the guidance is all right but some assessors just ignore it?

Gary Edwards: It is ignored; they do not know the law. They do not know the law—that is what I would say. Sorry, the last point was that when he went back for this assessment again, all the assessor would have had would be the form he completed now. He would not have all the information. He offered specialist reports because on the forms it says, "Who do you see? Who are your specialists?" But they never take that up. They have a timescale to turn round decisions, which is so short it is rushed and it is all disconnected.

Q81 **Chair:** Does anybody have anything to add?

Kayleigh Nor-Val: To improve accuracy, there should be consequences for incorrect assessments. There should be fines against healthcare professionals who are making inaccurate statements and DWP should be pulling that more. There should be more of that because, as Martin was saying, there is no reason to put incorrect information on there, apart from unless the assessment has been rushed, which, again, is an issue, so timings. But there should be fines. There should be repercussions for

those healthcare professionals and those contractors that have taken out the contracts.

Q82 **Chair:** There is no line management, is there, tracking and helping people improve?

Kayleigh Nor-Val: Quality control is terrible.

David Bryceland: Yes. We would ask for consistency across the assessments. We would ask for a degree of humanity and dignity if the process has to be like this, because there is none whatsoever and people feel they are being judged. Their basic benefits are under threat from somebody who is not trained in mental health normally in order to be able to make—because while it is supposed to be a functional analysis, in fact it ends up being a clinical analysis and the people who are doing the assessment are not qualified.

Q83 **Chair:** But, David, isn't this part of a much greater problem? We simply don't have the professionals to help people who have mental illness. It is not surprising that there is no one helping in the decision-making system or later on in the tribunal system.

David Bryceland: Our understanding is that almost half of all ESA claims—and I think it is possibly slightly more for PIP claims now—involve mental health as either the primary or secondary health condition. If the Department of Work and Pensions is not prepared to take that level of a single block of health concern seriously enough to train the people who are making these decisions and to involve the clinical professionals who already exist and who may already have contacts and information from then, then I think they are doing an injustice to the whole country.

Q84 **Chair:** We ought to think about the recommendations on bursaries for people who go into universities, whether nurses or other people, so that we waive the outcome of the universities into the skills that we need by making the places free?

David Bryceland: You could start immediately. For example, we run a two-day mental health first-aid course. Most of the people who do these assessments haven't been to anything as basic as that. That would not cost the earth and it would not delay us by years. It would start to improve the content of their questions.

Q85 **Chair:** But I have just had my boiler done, and the idea that somebody who had never done boilers, and so had no knowledge of boilers, would come in and do mine is absurd, isn't it? It is great that you are doing two-day courses, but for God's sake, these are people's lives. I know we can't change it immediately, but we have to lift the spirit in the country, have we not, thinking that we are tackling these issues for the long term?

David Bryceland: Absolutely, and the DWP needs to recognise that and ensure that it is employing sufficiently trained professionals in order to be able to understand the consequences of mental health.

Kayleigh Nor-Val: Or paying more attention to those who are specialists in that role and are giving evidence for those clients, because most of the time it is ignored. We have to utilise what is already available.

David Bryceland: For example, one of our clients took in a letter of support from the head of psychiatry at Oxford University and was told by the assessor that that individual, the head of psychiatry, was not qualified to make a diagnosis.

Q86 **Chair:** We are going to have to move on, but one thing we ought to have, for the decision makers, shouldn't we, is to have a health warning at the front? Nobody of any expertise has contributed to building up this form for you.

David Bryceland: Yes.

Martin Richards: I believe accountability would help to reduce this problem. I believe that the healthcare professionals involved need to be accountable for their opinions. At present they will supply their report and it is left to the Department and the claimant to try to resolve it through the appeals procedure. Just in the last six months I have had two mental health clients who have been sectioned following these assessments, where basically their care packages were reduced because their income had reduced. They couldn't cope. Next thing they went back into hospital and it was purely down to inaccurate recordings. When we help clients to fill in forms, we listen to what the client says. We look at the medical evidence. If we can do it, surely to God they can do it.

Q87 **Chair:** Martin, do you think locally we might try to do some class actions on this?

Martin Richards: Yes.

Chair: Thank you very much.

Q88 **Heidi Allen:** It strikes me that maybe we are trying to put sticky tape around the system; train to put a bit more here, do a bit more of that. Yes, because the system needs sticky tape—I am not saying it doesn't. It seems to me, as a better use of taxpayers' money, that we should just have better connection between GPs' records and the DWP. Just go direct and take the middleman out. Why are we even going through this loop of contractor, assessor, DWP decision maker? Shouldn't we try to integrate the two much more closely?

Kayleigh Nor-Val: I have been saying this for years, because of the number of times I have seen clients go through the process and be refused, based on the healthcare professional reports by a decision maker, but they get some evidence from a GP or consultant psychiatrist and it overturns it. It completely undermines the healthcare professional when the only thing that they are after is evidence from a specialist. Yes, I totally agree.

Q89 **Heidi Allen:** I am not saying that GPs are not under immense pressure and it would need, I am sure, extra funding. With all this money sloshing around in the DWP system, it strikes me we should just put it in at the front end.

Gary Edwards: The issue with this is the connection, because you have these external contractors and the information is not shared. Previously—I have been around a long time doing this job—when we had incapacity benefits we didn't get this level of disparity of awards. We never had appeals that were so disparate with the outcome and the original award. It was doctors who did it; GPs or former GPs. With a contract I think it has down-skilled the medical expertise that they have in the field. Heaven forbid, if you wanted to get great connectivity, why not take it in-house?

Q90 **Chair:** But on that, Gary, disagreeing with Heidi, if I was a doctor—I would not necessarily say in Birkenhead—and if I was asked to give an honest opinion, I might not want that opinion to come out to my client if I was going to do it truthfully. But it will be totally different, would it not, if there were retired doctors for five years or so committing themselves to doing this work?

Gary Edwards: Yes.

Chair: The conversation is going so well but time is so short, so I think we should just fire up the points that we hear and that we want, rather than stick to our questions, but I will make sure everybody comes in.

Alex Burghart: Sorry, do you want me to follow up?

Chair: Yes, all right and then we will open the field.

Q91 **Alex Burghart:** Everybody has raised concerns about the assessors, but I just want to take a step back from that and think about what is being assessed and the framework that it rests on. What sort of confidence do you have that, at its bones, these categories and these point systems are the best way of setting about these benefits?

Martin Richards: We are mainly talking about PIP and ESA today. With ESA there is what we call regulation 29 and regulation 35, and that is for the Department to look at a client who may not score points on the actual descriptors available but they know that the client has got a condition that is going to prevent them going to work. It is like the joker in the pack; they can say, "Although you don't meet this descriptor, we are going to apply these special—"

With PIP there is none of that and there are a lot of mental health clients who no longer qualify. There may have had a life award to DLA and then all of a sudden it stopped because they don't meet the criteria. In PIP there should be regulations 29 and 35 because we are seeing these people who are genuinely poorly, and who genuinely need help, and the decision maker is saying to us, "But I can't award them points."

Alex Burghart: Yes, computer says no.

Martin Richards: Yes, exactly.

David Bryceland: Aside from the fact that I think there are far too many assessments, and assessments that simply are not required, I agree certainly that there are areas that could be improved, particularly in terms of personal independence payment. In the move from DLA we lost the idea of safety being of a concern and for a lot of people with mental health problems their safety and the safety of others is something that we need to address. As are night time needs; if you are not sleeping, nothing goes right. The other thing, particularly with PIP, is that it needs to be comparable between mental health and physical health and equal, so that you can score the same amount of points for mobility if it is mental health, as well as physical health, which was a change that recently came through to take away that parity.

On the questions, I don't think anybody is ever going to agree that every area is correct and, generally, we work with what we have. When we are helping our clients complete the forms, don't ask me what the questions are because I have no idea. All I know are what the descriptors are and that is what we work from—that and the DWP guidance that we get on what is an acceptable answer to a question. Working with that, and helping clients understand what it is, is almost more important than what the specific nitty-gritty of the questions is.

Gary Edwards: One of the issues here is that effectively the decision-making process has been delegated to the provider, so whatever that assessor says, that is the outcome; that is the points basis that the decision maker is going to give. Sometimes when we speak to them they let it slip: "Yes, that is what Atos have decided," or whatever. There needs to be real ownership back with the DWP. They need to be looking at the whole picture and thinking, "This is a rogue assessment, compared to what we have seen. Is it right?" Because after that half an hour or 40 minutes, if you are lucky, that assessment determines whether you get the benefit or not.

Q92 **Alex Burghart:** I understand that, Gary, but what I am asking is whether we are even starting with the right questions.

Gary Edwards: I think the questions are fine, but one of my lovely colleagues, when they said earlier on, the question—because a big part of this is, can you do something? Yes, you can. But can you do it reliably, repeatedly and within a reasonable timescale? She suggested it should say, "Can you walk? Can you walk later? Can you repeat it again?" Those are the questions that we need to do because the decision makers invariably miss that part of the test. A lot of tribunal cases we go to have to go that way because they have not looked at those three questions afterwards.

Kayleigh Nor-Val: I agree. We need something to work with. There needs to be something available for us to say, "Right, we need to look at your mobility. We need to look at your communication skills." We need to be able to do that, so that needs to be incorporated into it somehow. But, as Martin was saying about regulations 29 and 35, they are not used enough. There needs to be that element of considering risk. They may be able to walk, they may be able to communicate, but does their condition mean that they would be at risk in the workplace or would there be a risk to their daily living? Those types of things need to be used more and regulation 4 is used nowhere near enough with regard to PIP. It is not incorporated into the assessments. It is not used at all.

Clients are not aware of it; it is not on the forms. They don't understand that those things need to be incorporated. Even "majority of the time" is not looked at. The ESA50 has a box that says "It varies". It is such a terrible box because it leaves it so open. The clients don't understand how that would be used. There is just a lack of explanation. Yes, we do need something to work towards but there needs to be that element of risk considered.

Q93 **Jack Brereton:** When I visited the assessment centre in my area, they said that when people are requesting a home visit, they need to have that evidence from the GP to say, "Yes, this person has medical reasons to do that." But often what happens is that the GP has only put that the individual has said that they need an assessment at home, so that is not enough. They need to have that GP's recommendation from the GP to say that. Do you think there needs to be some more information or education for GPs as well about how they put forward that evidence and recommend people for those home visits?

Kayleigh Nor-Val: Yes, ESA require medical evidence for a home visit. PIP are a little bit more lenient, they keep going through their phases, but ESA you have to have medical evidence. I have a case that I am dealing with at the minute where the GP stated, "I agree with the client needing a home visit." Then underneath that because she had originally missed an assessment and it was in Swansea, the GP had explained, "The client would struggle to be able to get to Swansea." Because they use the word "struggle", the HCP picked up on it straightaway and said, "They would only struggle; we will provide a taxi". I had to then go back and take it all the way through complaints and explain that it is not as straightforward as needing a taxi, because this is mental health.

There is so much more; it is about support. It is the mental support, the physical support, it is everything to do with that, with GPs not understanding or not knowing what to say and then the healthcare professionals picking up on it. The only person who is literally dealing with all of this is the client and it just creates such deterioration in their health, it is unbelievable, especially with mental health. Yes, I definitely would agree with that.

David Bryceland: We have a standard letter with the language that the GP needs to put on the letter that we give to the client to take in. If we are asking for supporting evidence from the GP or from another healthcare professional, we don't just say, "Can you do us a letter, please?" What we do is a tick-box form that puts the descriptor that is applicable to the client with "agree", "disagree" and "don't know" and hope they either tick for agreeing or don't know. But, essentially, what we try to do is make it as easy for the client to take it in and for the GP or the other professional to be able to get through, rather than having to spend hours and hours writing.

Q94 **Chair:** Martin, do doctors charge for this?

Martin Richards: Doctors do normally charge. My wife used to work in a GP practice until very recently and I know for a fact that they had to increase their charges because DWP had not been writing for that information, so their income had reduced. They were basically balancing their books now by where they used to charge DWP for information, they now try to counter that by charging the patients.

Q95 **Chair:** But we all, as MPs, sign all sorts of letters for our constituents. The idea we could charge for them—

Martin Richards: Not all of them do but different ones do. What I found about requesting home visits for a PIP, we can even attach the appropriate letter as evidence to the application, then the client will get a call or a message or whatever to say they have to attend. Then you get in touch with them and they hum and haw. The majority of the time we have to then, through our local MP's team, get them to put it through for us and once the MP's team is involved we get a different reaction, and we shouldn't have to do that. The letter is exactly the same but because it has come from, say, Frank's office or Andrew's office or wherever, they stand up and listen to us, and it is not fair.

Q96 **Steve McCabe:** It would be very useful if the Committee could get a copy of the pro forma that Mr Bryceland has just referred to; that he used with GPs. I think it would be good to see that. I also think, Chair, we are going to have to think about our expectation of the assessment and the assessor very clearly in this report. I am not convinced a retired GP is the answer but I think we need to look at what we mean there.

Chair: But, Steve, also in my lifetime here all the people in the DWP and their agencies were delegated the authority of the Secretary of State to act in the welfare of claimants, so everybody was an agent of the Secretary of State and the Secretary of State was responsible for all these actions, who then took it off the statute law because it was unnecessary. From what we are gathering today, nobody seems responsible to anybody above or below; it is just chaos.

Steve McCabe: That was my point; I don't think there is a clear expectation. I want to ask about time and the process. I was worried that, on average, it takes about three months from someone making an

application to get a decision broadly for PIP and for ESA. Apart from the obvious financial consequences of that, I wonder if you could tell me: what is the impact of waiting that length of time and what could you do or what should we do to speed it up and make it a better process?

Martin Richards: If I may just answer this one, I will just say I deal a lot with people in mental health and obviously there are physical issues. I have mental health clients, the CPNs bring the clients to see me; we fill the form in. There's stacks of information with it—clinical notes, reports, discharge letters, everything—and for PIP it will take about two or three weeks, in our region anyway, before they will be taken in for an assessment. But during that time waiting for the medical, because we have had all these horror stories, they are in bits and their treatment does increase. When I have a conversation with the mental health nurses, they tell me how their medication and whatever have to be increased because they are basically on the edge and then they go through the process and it is whatever happens then. Obviously if it goes to appeal, there is great hardship.

Kayleigh Nor-Val: With the ESA I normally tell my clients that the wait for even just the actual face-to-face assessment is about six to nine months, so it is a lot longer than PIP, whereas PIP is about probably three to four months. During that time, as Martin said—especially mental health but it is across the board—the stress, distress, clients are put under it. With PIP there is no payment until they are assessed obviously and a decision is made.

There is that monetary aspect of it as well, and with the ESA it is obviously a lower payment. Going through to monetary reconsideration stages, there is no payment, which just causes—the domino effect of that is unbelievable; it can affect so many things, their rents, their council tax. I am dealing with a client at the minute who had an eviction notice because of that. Timing is everything but also just the process itself is flawed.

Q97 **Chair:** But, Kayleigh, that is better, isn't it, than universal credit? Because if you are on a historic benefit and you are on to PIP, you keep the money you had until a decision is made, whereas in fact once you are put on to universal credit all those previous historical benefits stop and that is one little reform we might also look at.

Kayleigh Nor-Val: Yes. Universal credit is going to have a massive effect on—

Chair: Yes. No, we will not get you on that today.

Gary Edwards: If I can just say, we are in the universal credit area now, so we have gone live in February, and it is horrendous.

Q98 **Chair:** What, this February or last February?

Gary Edwards: This February.

Chair: You are lucky you get through Christmas.

Gary Edwards: Yes. Going back to your point about the assessment and how long they take from the claim, you make an ESA claim and then there is the assessment phase and then after 12 weeks you are supposed to have your assessment and they make a decision to determine whether you are going into the work-related activity group or the support group. We have had clients who have been waiting over a year and in fact what has happened is their benefit has stopped because they have not been assessed before their one-year contribution runs out. We have said, "Hang on a minute, you can't do that."

We have had some clients who we are aware probably would not pass the work-capability assessment test and they have been on it. They have been getting the basic rate because they do not have their act together to do that assessment within 12 weeks. In some ways it is swings and roundabouts, but the providers are not meeting the contractual arrangement they have. The other thing I would say with timescales, what I would not want to do, particularly on PIP, is to squeeze that timescale too much because if Atos have to turn a decision round within 42 days or whatever, then they are even less likely to take the options of getting the specialist details. When we fill the form in we put all the information down about who the specialist is and they don't use it, or very seldom they use it; you might as well save money.

David Bryceland: But it is not beyond reason for them to write and say, "We are currently working on claims that were made in—" and then, "The assessment will be within this time period and to stick to that." Local authorities do that all the time when you are applying for housing benefits and local housing allowance. The one thing I would say with the assessment process is that it feels, from our clients' point of view, they describe it as having the sword of Damocles hanging over their head constantly because it is not one assessment; it is another assessment. ESA and then PIP and then you are back into ESA and then you are back into PIP. There is never a prolonged period of time that allows our clients to be able to focus on their recovery because all they have been doing is being sent from one place of judgment to another place of judgment.

Gary Edwards: We have one client who has been through his sixth assessment on ESA. Every time he has been given nil points and we have had to appeal it, then he gets another assessment through. He has gone through that process six times. How is that affecting his mental health? The money that they think they might be saving is costing the wider community, health services, health and well-being a lot more money.

Q99 **Emma Dent Coad:** I was just going to add to a point that was being made a little bit earlier about GPs' letters. We had somebody who had virtually nothing, had no money or income coming in at all and going through the process. This is Kensington, of course. A doctor's letter was going to cost £30 and take two weeks. There are all these levels of

complexity. We had four people suicidal coming to us last week, in one week, who were going through these horrendous processes and, as you say, it is just costing more because of where they are going to be picked up elsewhere, if they are indeed. Suddenly in the middle of all of this you have to find £30 to get a doctor's letter, which, in an ideal world, would be free.

Q100 **Chair:** Has anyone heard anything worse than £30?

David Bryceland: Yes, £50. *[Interruption.]*

Chair: Right, thank you for the public contributing to our session; that is good. All right. A quick one from Ruth and then Neil.

Q101 **Ruth George:** You were saying it is a problem for clients and claimants on the number of assessments. I wondered how much crossover there is between PIP and ESA assessments and whether it would be worth trying to use some of the information from one assessment in another or combine them, or whether that would make the assessment process too long for a lot of individuals to cope with?

David Bryceland: Strangely enough, they do occasionally use the ESA for a PIP assessment, but the criteria are so very different. If there was a better match between the criteria, that would make it a lot easier.

Kayleigh Nor-Val: They are looking at different things, aren't they? With the ESA it is working and your ability to be able to work and with PIP it is more about your daily living and those things that you need to do around the house. But I do think some of them overlap, like mobility, for example, and those things. Yes, definitely because you will find some PIP awards are given and they award the enhanced rate, which looks at a specific lack of distance of being able to work and ESA will refuse it or vice versa.

Q102 **Chair:** Do you think it should be one of our recommendations to the Government that they look at the two forms, following up Ruth's suggestion, to see to what extent they could perhaps use data from one to the other? But it does come back to having the data accurate, doesn't it?

Gary Edwards: It is different criteria. For example, if we look at walking, that is called mobilising under ESA, so it doesn't matter if you can't walk. If you can propel yourself in a wheelchair you get no points, which is different; in PIP it would be walking.

Q103 **Chair:** Yes, well that would come out, would it not, in the exercise?

Kayleigh Nor-Val: Yes.

Gary Edwards: If he could get rid of that descriptor, yes.

Chair: Yes, all right. How would you see that, if there is an overlap, before we go to the Government?

Q104 **Neil Coyle:** One very quick one and then a slightly longer one, Kayleigh, you made the point earlier about financially penalising the assessors for including inaccurate information. Do you all support that, given that, I think, it is 200,000 disabled people who have only gone on to receive PIP through mandatory reconsideration and tribunals? Do you all support financial penalties on the assessors if they include inaccurate information?

Gary Edwards: There are some conduct issues and I am certainly aware of lots of physiotherapists, nurses and so on being reported to their professional bodies; I think that there are over 1,000 cases of that. But the contractors are the employer here or they are not. Locally we have Atos, they have a supply-chain partner, so they are not even being assessed by Atos, more or less. Any financial penalty should be on the contractor and it is the accuracy.

David Bryceland: Also, that level of accountability needs to go further up. While there might be financial penalties for the contractor and the provider, whoever within the civil service signs off on these also needs to take responsibility.

Martin Richards: I would agree that the contractor should be the one who gets penalised because I believe the healthcare professionals are acting under orders. There is a motivation for them to be recording in such a way.

Q105 **Neil Coyle:** Thank you. The different one is that DWP have announced that they want to reduce the number of reassessments. You have touched on this, David, but you have all touched on it in different ways. Your point was around the information that DWP hold. How else would you reduce the number of pointless assessments or duplicate assessments and are there specific groups that do not require or should not require face-to-face assessments?

Martin Richards: I have a lovely client with Down's syndrome, 48 years of age. He had to go for an assessment for his PIP, face-to-face assessment, although we have pages and pages of evidence. He then had to go for an ESA review. The ESA50 was filled in in February and in October he went for his face-to-face assessment. There were significant changes in his heart disease by that time as well, but I just can't believe that the young man had to go and sit and go through these pressures. His mum and dad are elderly carers for him. There was no need for it. It could have been done on paper, or even a call to his GP. There was no need for it.

David Bryceland: Collecting information can be done through a phone call or it can be information from the family. It can be information reports that may well go back a number of years because there is nothing new to add. But still for people who are making the decisions to be able to understand that certain types of conditions, certain types of medication will incapacitate your client to the point where they are not able to

function and to recognise that in the length of awards and with the number of reassessments.

Kayleigh Nor-Val: Using the forms, the ESA50 and the PIP, sometimes, especially if the client is having assistance to fill in those forms, like from organisations like us, there is so much information that goes into those forms. They are thoroughly completed with everything you could possibly think of. There would be evidence attached to it, not all the time but if there is, and then they still called for an assessment. I don't think any of my applications that I have done for PIP have not had to have a face-to-face assessment, when it just seems so pointless. There is so much information in there. Those application forms, which is the client's evidence, are used nowhere near enough.

Gary Edwards: I don't think a decision maker is looking at the evidence that is there; it is almost, "It is up for renewal, we need to make sure that we do that." Bear in mind that it is in the interests of the contractors to have an assessment, isn't it, because they get paid? They get paid less money if there were less assessments, but the decision maker could have a bigger role in that. We have seen clients—amputees, or double amputees—who go through the process and then two years later they go through another assessment. With all the will in the world, things are not going to change a lot on their ability to walk under PIP.

Kayleigh Nor-Val: Understanding when conditions are either going to stay the same or deteriorate, that is what DWP need to pick up on.

Chair: Chris, will you complete our hearing, please?

Q106 **Chris Stephens:** Thank you. I think it might be helpful if you could write to us in relation to some of the cases that you have mentioned, whether people were accompanied or not, because I think that that is an issue, and also the issue in relation to telephones that we have heard from the claimants earlier. What would you say, if you think about the process and claimants' needs—from the beginning of the process of the application, right through to the decision—is the biggest thing that should be changed and that we could recommend to the DWP?

Martin Richards: The collection of information or the refusal of information. I believe if we are going down the route of using contractors, the contractors should record the information correctly; that way the claim gets dealt with fairly. The DWP can then base their decisions on accurate information because there are people who are well enough to go to work and there are people who shouldn't qualify for PIP; that is a fair comment. But you have to build the foundations; you can't build a house on dodgy foundations. For the majority of cases that I go to tribunal with, the foundations don't even exist.

David Bryceland: To bring it in-house to the DWP, to try to make it local to the people who it is serving and to remember that they are an organisation that serve the public and that the people who are claiming

are claiming because they have a legal entitlement. This is not the largesse of some philanthropist or something; this is their legal entitlement and they should be treated with respect and dignity throughout the whole process.

Kayleigh Nor-Val: Tendering the actual assessor with the condition at hand, for example, if there is a client with mental health, that assessor should understand mental health. They should understand how that particular condition would affect somebody going out on their own, whether they need somebody with them.

The mental state examination across both ESA and PIP is massively flawed. It considers whether somebody is trembling, whether they are sweating, whether they are dressed appropriately, and that in itself is a flaw. There is just a massive lack of understanding. I specifically relate to mental health but I feel as though it is any condition that you can't see, like you can't see pain. So many assumptions are made, so that tailoring of the two—the health condition and the assessor's knowledge—is key.

Gary Edwards: Yes, I would absolutely go along with that. We need to take some steps. We definitely need the option for it to be recorded, which I think would have a massive impact on looking at the quality of the assessors and it would also highlight, would it not, where they didn't have the skills? I cannot believe that a physiotherapist can confidently assess someone on serious mental health issues. I would never be dissuaded of that.

Chair: That was really good. Thank you. Apart from Sir Philip Green, the session today has been our longest, so I think you have gained how important we think that both parts of our evidence today were. They are alarming, are they not? Thank you very much. If I might ask you to leave, so that we can talk about you behind your backs.