

Written evidence from Anonymous (HAB0021)

Suitability of assessments

1. How could DWP improve the quality of assessments for health-related benefits?
 - a. Have you seen any specific improvements in the process since the Committee last reported on PIP and ESA assessments, in 2018?

One of the problems with the assessment is that the assessor is working on their knowledge of the training of the assessment questions and not knowledge of the condition of the person they are assessing. They seem to ignore all medical professional input on the person – those who actually treat and know the claimant. It's therefore inevitable that the assessor is merely managing the bureaucratic process of assessment and the claimant feels they have to prove they are 'ill enough'.

The claimant's health condition seems to be based solely on the one hour health assessment and if the claimant doesn't show in that hour the symptoms or support they claim they need then it's assumed by the assessor that they don't need it. For example, I attended an assessment with my step-daughter who has chronic pain and chronic fatigue and because she wasn't 'prompted' during that hour long assessment to eat something, the assessor commented on this and ignored all other written evidence given that she needs support to eat properly.

This approach is endemic throughout the assessment process – the assumption is that you aren't telling the truth. This is particularly difficult for fluctuating conditions like Chronic Fatigue/ME where a claimant might be able to do a task on one day, but there seems to be little understanding that this isn't replicated across the week or that doing an activity has an impact on being able to function sufficiently the rest of the time.

There is obviously a serious mis-match going on between one assessment strand and another (initial assessment, mandatory reconsideration, tribunal) and assessments over time. For example, a friend who has CFS/ME was awarded PIP after a tribunal decision then 3 years later it was turned down at re-assessment, but nothing in her condition had changed. It feels claimants are 'punished' if they are intelligent and articulate or able to study but this has no bearing on how they have to manage their lives with a health condition. As it is they are limiting their participation in society, have to live daily with a health condition and are then made to feel punished further by having to navigate the assessment process.

2. Are there any international examples of good practice that the Department could draw on to improve the application and assessment processes for health-related benefits?
3. Do the [descriptors for PIP](#) accurately assess functional impairment? If not, how should they be changed?
4. Do the [descriptors for ESA](#) accurately assess claimants' ability to work? If not, how should they be changed?

5. DLA (for children under the age of 16) and Attendance Allowance usually use paper-based rather than face-to-face assessments. How well is this working?

a. Before PIP replaced DLA for adults, DLA was also assessed using a paper-based system. What were the benefits and drawbacks of this approach?

6. How practical would it be for DWP's decision makers to rely on clinician input, without a separate assessment, to make decisions on benefit entitlement? What are the benefits and the drawbacks of such an approach?

There should be more trust in clinician's comments on the claimant's health condition. However, clinicians can understand the condition and how it can impact on someone but they don't see the day-to-day impact it has on the person and have to rely on the claimant/patient's reporting of the impact. How can a GP know how a condition affects their patient when it comes to preparing food or going out, other than what the patient reports to them? But they can know the person's medical history, how their condition has affected them over time and how it's affecting their life now. If a person has an on-going condition and the clinician confirms this, why does the claimant need to be assessed all over again by PIP?

In addition, some claimants have limited input from health professionals as there is nothing more they can do for the claimant/patient. Claimants with long term conditions learn to manage their health condition as that's often all they can do. For example, with CFS/ME there is limited medical input and this is generally at the start of diagnosis – after that there is no regular 'check up' or assessment and the person learns to manage the condition on their own. However, at the PIP assessment it is often commented that the claimant is getting no input from medical professionals so it's not as bad as they say – e.g for brain fog, a well known element in CFS/ME, but the assessor will say that it can't be a significant issue as there is no medical treatment or input being given. When you've had this condition for a number of years there is no medical treatment (and very little at the start).

7. Appeals data shows that, for some health-related benefits, up to 76% of tribunals find in favour of the claimant. Why is that?

a. What could DWP change earlier in the process to ensure that fewer cases go to appeal?

It feels as if the assessor is trying to prove that you can do more than you say and are black and white in their interpretation of the questions and answers, whereas the tribunals question more the impact the health condition has on your daily life. The tribunal seems to understand better the assessment process and what the questions are meant to measure. For example, the assessor asked 'can you read a text?' and wasn't interested in the explanation that 'yes, I can read a text because I can read, but in the morning I struggle to respond to texts and often mis-read them or ignore them due to brain fog and fatigue'. In another example, the assessor constantly referred in their report that the claimant was a Councillor for 2 hours a week and the assumption was that she was therefore intelligent and articulate enough to communicate. This ignored the evidence given that medication and pain meant that on most days communication was difficult and at times impossible.

8. Is there a case for combining the assessment processes for different benefits? If not, how else could the Department streamline the application processes for people claiming more than one benefit (eg. PIP and ESA)?

9. What are your views on the Department's "Health Transformation Programme"? What changes would you like to see under the programme?

a. (For people claiming) Would you like to be able to manage your benefit claim online?
b. What would be the benefits and drawbacks of DWP bringing assessments "in house", rather than contracting them to external organisations (Capita, Atos and Maximus)? In particular, would this help to increase trust in the process?

b. There is a feeling that by having the assessment external that there is a financial incentive for the company to turn down a certain number of claims. There is no repercussion on the external company if the assessor's decision results in going to tribunal. However, taking it 'in house' could just result in it being even more led by the bureaucratic process and more removed from the reality of claimant's lives. At the end of the day it's the assessment process and lack of trust in the claimants that is the issue, no matter who delivers the programme.

10. What lessons should the Department learn from the way that it handled claims for health-related benefit claims during the pandemic: for example, relying to a greater extent on paper-based assessments, or using remote/telephone assessments?

a. Is there a case for making some of the changes permanent?

This will depend on the claimant and their health condition and should be an option offered to those who want it. For my son who has CFS/ME being able to do the assessment by phone was a better option and it felt he was also not going to be judged on his appearance and how he walked that day. Having to visit an assessment centre for many claimants is frightening and tiring. However, for others they might prefer that the assessor sees this so they can get some understanding of the impact on the claimant.

11. Most assessments for Industrial Injuries Disablement Benefit were suspended during the pandemic. What has been the impact on people trying to claim IIDB?

a. Some IIDB claimants will receive a lower award than they might have, due to the suspension of assessments, because IIDB awards are linked to age. Should the Department compensate these claimants? How?

b. What lessons could the Department learn for how it deals with these claims in future, in the event of further disruption to normal services?

12. DWP believes that applications for some benefits dropped sharply at the start of the pandemic because claimants weren't able to access support (for example, from third sector organisations) to complete their applications. What are the implications of this for how the Department ensures people are able to access health-related benefits consistently?

a. How can the Department best help the third sector to support claimants in their applications?

The impact of assessment/application on claimants

13. DWP recently published research on the impact of applying for PIP or ESA on claimants' mental and physical health. What would be the best way of addressing this?

There seems to be a lack of understanding about how long the initial assessment takes to do. To do the form properly and try and cover everything you need to cover in the paper assessment takes hours and days. Many people with health conditions find this impossible to do without significant support. For example, I spent 5 days over a period of 2 weeks doing the form for my step-daughter's reassessment (even though nothing in her condition had changed, and in fact had got worse). This meant spending long periods of time talking to her about each question, writing answers and examples – all of which was very exhausting and had an impact on her health for the next few weeks (both mental and physical – it's very draining having to write about everything you 'can't do). My son who has CFS/ME would never have even applied for PIP as he would not have had the energy to complete the form or the physical or mental drive to do it. If he didn't have significant support from his parents it would have caused a huge amount of stress, no money and no way of being able to support himself independently. The best way to address this would be to believe people and the medical professionals around them.

The stress and impact of applying for PIP starts at the beginning when you assume you won't get through the first assessment or the mandatory reconsideration and will have to go to tribunal (if you can). And almost the moment you get awarded PIP you worry about the next re-assessment – the thought process goes something like this - 'I've got it for 3 years which means I've got 18 months or 2 years at the most before I'm contacted to be re-assessed, so I can't rely on having this benefit, what am I going to do then?'

Waits for assessments

14. What could the Department do to shorten waits for health-related benefit assessments—especially for ESA/UC?

a. How effectively does the “[assessment rate](#)” for ESA cover disabled peoples' living costs while they wait for an assessment? Is there a case for introducing an assessment rate for other health-related benefits?

Health assessments in the devolved administrations

15. The Scottish Government intends to introduce its own assessment process for the [Adult Disability Payment](#), which will replace PIP in Scotland from 2022. What could DWP learn from the approach of the Scottish Government?

a. PIP started rolling out in [Northern Ireland in 2016](#). Is there evidence that the Department learned from the experience of rolling out PIP in the rest of the UK?

Policy development

16. How effectively does DWP work with stakeholders—including disabled people—to develop policy and monitor operational concerns about health-related benefits?

a. What steps could the Department take to improve its engagement with stakeholders?

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