



Burden of Proof

The role of medical evidence in the benefits system

May 2017



Contents

Executive summary	1
About the Citizens Advice service in Scotland	8
Introduction	9
The current system	11
Policy context	15
Methodology	24
Findings	29
Conclusions	78
Policy Implications	81
Appendix 1	83
Appendix 2	90
Appendix 3	98
Appendix 4	103

CAS Policy Series: 2017/18.01

Executive Summary



Medical evidence and benefits

Our 'Burden of Proof' report explores the role that medical evidence plays in assessing ill health and disability benefits, from the perspective of Citizens Advice Bureaux clients, advisers and some of the professionals involved.

The report is based on evidence gathered by Citizens Advice Scotland during 2016 and 2017 exploring the use of medical evidence to assess ill health and disability benefits.

It includes findings from an analysis of existing qualitative and quantitative data held by the Citizens Advice service in Scotland and, in addition, data gathered via a survey of Citizens Advice Bureaux (CAB) advisers, an online mapping exercise, and a survey of GPs and other health professionals.

Eighteen Citizens Advice Bureaux from across Scotland participated in the project by undertaking surveys in their local areas, and gathering longitudinal case histories and documentary evidence.

The findings reveal a complex picture, but suggest that in many cases, not enough information is available at initial claim stage, or at Mandatory Reconsideration stage, to make fully informed and accurate decisions.

The case analysis showed a pattern in which clients received few points at initial claim stage and are disallowed the benefit, then requested a reconsideration of the decision, at which point the decision remained unchanged, and then appealed the decision and were awarded the benefit in many cases.

Advice and Appeals statistics from the Scottish CAB Service

Employment and Support Allowance (ESA) is the most common single issue that Scottish citizens advice bureaux provide advice on, with Personal Independence Payment (PIP) Daily Living component the second most common.

Following general advice regarding benefit entitlement and the claiming process, the most common issues advised upon in relation to these benefits are reconsideration and appeals, which together make up over one fifth of all advice regarding ESA and PIP.

Advice need in relation to disability benefits has tripled in the last three years, and has increased by six percentage points as a proportion of all benefits advice. Data from the first six months of 2016/17 suggests that ESA issues are also on the rise again,

with CAB advising on over 19,000 issues during this six month period (3,600 more issues than were advised upon during the same period of the previous year).

During 2015/16, CAB in Scotland supported clients to complete 2,731 appeal forms (SSCS1 forms) to appeal against a decision made by the DWP. Of the 2,295 cases heard at Tribunal (not including those which were adjourned), 59% had the decision changed, and a further 4% had the decision partially changed, compared to 38% where the decision remained the same.

Analysis of advice codes shows that 77% of appeals advice and representation is in relation to ill health and disability benefits.



FINDINGS BY STAGE:

Initial claim stage

Clients rarely gather further medical evidence at initial claim stage. This is likely to be due to a number of factors:

- The DWP advise claimants not to gather additional evidence at this stage;
- GP practices sometimes refuse to provide supporting medical evidence direct to claimants, or may charge fees which can act as a financial barrier for claimants;
- The one month timescale within which to return the self-assessment form can be too tight a timescale to gather additional evidence.

Respondents to the CAB adviser survey indicated that it is 'difficult' or 'very difficult' for claimants to obtain supporting evidence from GPs at initial claim stage.

The survey results suggest that GPs and other health professionals spend a significant proportion of their time providing evidence to the DWP or assessment provider at the initial claim stage, filling in ESA113 or PIP forms.

CAB advisers, however, presented a different picture. When asked "what further evidence does Atos request from healthcare professionals, in addition to the PIP2 and consultation," 69% of respondents said Atos 'rarely' or 'never' seeks additional evidence.

Assessment forms and face-to-face assessments

Responses to the CAB adviser survey, as well as case evidence from bureaux, suggests that the application process is currently difficult to navigate for many claimants.

The manner of healthcare professionals during assessments is an issue for bureau clients, which may affect their ability to express themselves during the consultation and could impinge upon the quality of information gathered.

Regarding the accuracy of the healthcare professional's report, 59% of CAB adviser survey respondents said that clients 'rarely' agreed that the healthcare professional's report accurately reflected the discussion that took place.

Some comments made in response to the GP survey also raised concerns regarding the assessment process.

Appraisal of evidence at initial claim stage

The CAB adviser survey results showed that almost half (48%) of survey respondents said that, in their experience, DWP decision makers 'rarely' or 'never' make decisions regarding PIP claims based on all the available evidence.

Some respondents to the GP and health professionals' survey also raised concerns around the appraisal of evidence at initial claim stage.

Mandatory Reconsideration

Many clients experience barriers when obtaining evidence at Mandatory reconsideration stage, including tight timescales, physical and mental health conditions, as well as financial barriers.

Respondents to the CAB adviser survey raised concerns about there being no proper reconsideration of the original decision, and decision maker bias.

Appeals

It is much more common for supporting medical evidence to be provided at appeal stage, and for advisers and representatives to be involved in gathering this evidence.

Appellants can, however, experience barriers at appeal stage too. The case studies showed evidence of GPs refusing to provide evidence because they have a policy to only provide this to the DWP. In fact, it is possible for the claimant to go through the whole claiming and appeal process without ever having had medical evidence considered as part of their claim. For example, if the DWP/Atos did not request it at initial claim stage or Mandatory Reconsideration stage, and the GP has a policy of not providing evidence directly to the claimant.

Impact on clients

Receiving an inaccurate decision when first assessed has been shown, in some cases, to have detrimental financial and health impacts on CAB clients.

- Sixteen of the clients represented in the 45 case studies were without benefit entitlement prior to having the decision changed on appeal. This meant they had to manage on less despite incurring the same costs related to their health condition or disability, such as having to travel by taxi.
- This and previous CAS research¹ has found that clients can experience a period of acute income deprivation due to benefits not being payable pending a Mandatory Reconsideration decision.
- The analysis of the case studies showed some evidence of the impact of the assessment and appeals process on clients' mental and physical health. In two cases, clients mentioned suicidal thoughts.

Information available to clients

Limited information is available to clients regarding what support they can expect from health professionals in relation to benefit claims.

- The results from the online mapping exercise showed that at least 25 (31%) of the 81 GP practices for which data was gathered had no information on their website in relation to medical evidence, while 64 GP practices (79%) provided information about certification of fitness for work.
- Very few practices provided a list of fees charged for providing letters, and they tended not to detail whether these referred to letters related to benefit claims.

¹ Citizens Advice Scotland, Living at the Sharp End: CAB clients in crisis, July 2016. Available from: www.cas.org.uk/publications/living-sharp-end

“Our research has shown that accuracy of decisions could be improved by more evidence being gathered at an earlier stage of the claim. This could also include taking better account of evidence provided through the individual’s self-assessment, and the evidence provided by friends, family and carers who see how an individual’s condition affects their ability to carry out everyday activities.”

Full report, ‘Burden of Proof’, Citizens Advice Scotland, May 2017

Conclusions

The research has found that – while the system works for the majority of claimants – improvements could be made to how incapacity and disability benefits are assessed, and the role that medical evidence plays.

Different Government departments and public sector services have different responsibilities in relation to assessment of ill health and disability benefits, which are not always clearly aligned. For example, DWP decision makers and assessment providers have an interest in gathering as much evidence as possible at an early stage so that they can get the decision right first time.

GPs are primarily concerned with the health of their patients, and the resources at their disposal. They experience demands from the DWP, patients, advice and advocacy organisations to provide details of patients' conditions and how these conditions impact on their everyday lives. GPs, however, may not have frequent contact with the patients in question, and do not always feel qualified to make a judgement regarding how conditions are experienced by the individual.

These responsibilities and interests are equally valid and important, but make for a system in which the claimant can receive mixed messages, and means that there is not always the same degree of evidence available at the initial claim stage as there is at the appeal stage.

If the decision maker has inadequate evidence to make an accurate decision, and the decision is appealed, the onus and financial burden of gathering this medical evidence then transfers to the claimant.

Opportunities for change

There are a number of upcoming opportunities to improve and refine the way in which medical evidence is gathered and treated within the benefits system, including:

- The UK Government's Work and Health agenda represents an opportunity to revisit the way in which Work Capability Assessments are carried out, and to improve data sharing between the NHS and the DWP

- The new digital platform for Universal Credit may present opportunities for sharing documentation such as Fit Notes in a more timely and straightforward manner
- The UK Government's consideration of the recently published Second Independent Review of Personal Independence Payment presents an opportunity to rethink the way evidence is gathered and assessed
- The devolution of disability benefits to Scotland presents an important opportunity to design a disability benefits system that considers new ways of assessing eligibility for the new Scottish benefits.

Solutions to the issues raised in this report are not straightforward, and can only be reached with careful consideration and joint working between each relevant government department and agency involved in the process.

Citizens Advice Scotland sees the impacts of decision making and the appeals process on CAB clients, and although we do not have all the answers, we hope that we can be part of an ongoing conversation around improvements that benefit the DWP, GPs, the NHS, HM Courts and Tribunals Service, and most importantly, those in need of benefits.



Full report



Acknowledgements

Citizens Advice Scotland (CAS) would like to acknowledge all the time and effort provided by Citizens Advice Bureau staff and volunteers that went into the writing of this report.

Particular thanks to the following bureaux who participated in the research project: Airdrie CAB, Citizens Advice and Rights Fife, Central Borders CAB, Clackmannanshire CAB, Dumfries and Galloway Citizens Advice, Dalkeith CAB, Glasgow Drumchapel CAB, East and Central Sutherland CAB, East Ayrshire CAB, East Kilbride CAB, Grangemouth CAB, Inverness CAB, Motherwell and Wishaw CAB, Nairn CAB, Glasgow Parkhead CAB, Peebles CAB, Rutherglen and Cambuslang CAB and South West Aberdeenshire CAB.

Citizens Advice Scotland would also like to thank all the GPs, practice staff and other health professionals who took the time to fill in surveys, and the funding provided by Scottish Government that allowed bureaux to participate in the research.

About the Citizens Advice service in Scotland

The Citizens Advice service in Scotland is the largest independent advice service in the country. The service is made up of: the national umbrella organisation, Citizens Advice Scotland; 61 Citizens Advice Bureaux; the Citizens Advice Consumer Service, and the Extra Help Unit. Our service has a footprint across every community in Scotland.

In total, more than 300,000 people receive advice on over one million issues each year, with our self-help website receiving over four million unique page views in Scotland alone helping people to address their own issues and queries. Almost 1 in 6 people in Scotland have sought advice from the service in the last three years, with 96% of consumers agreeing that Citizens Advice Bureaux are an important community asset.

Introduction

Deciding eligibility for ill health and disability benefits requires carrying out an assessment of somebody's needs or capacity. This involves gathering evidence through an individual's self-assessment of their own needs, through functional and needs-based assessments carried out by independent assessment providers, and through the gathering of medical evidence from health professionals which provides details of the individual's condition. The extent to which the system relies on the latter two types of evidence depends on the degree to which the individual (and their friends, family and advocates) is capable of, and trusted to, provide an accurate account of how their health condition or disability affects their everyday lives.

Relying on assessment by independent providers, and evidence gathered from health professionals, however, has its drawbacks. Firstly, it is difficult for an assessor to gain a full picture of how an individual's condition affects their daily lives in the brief consultation they have with a claimant. In order for there to be consistency in how these consultations are carried out, there must be a uniform schedule of questions, the consequence of which is that the interaction can seem impersonal from the point of view of the claimant, and at times they will be asked questions that are not relevant to them or their condition. To rely on reports from GPs and other health professionals also has limitations, however, because health professionals do not necessarily know the details of how a patient's condition affects their day-to-day activities, or their capacity to work. Furthermore, involving health professionals in assessment of eligibility can put a strain on the therapeutic relationship a doctor has with his/her patient.

This is the dilemma of benefits assessment, and is an ongoing focus of debate amongst policy makers, disability rights campaigners, advice organisations and parliamentarians. The system currently in place for assessing eligibility for incapacity benefits and disability benefits works for the majority of claims. However, evidence from citizens advice bureaux (CAB) in Scotland has shown that there are design flaws and administrative errors within the system which mean that CAB clients often do not receive the correct decision first time. There are a number of agencies involved in the design and delivery of this system, including the UK and Scottish Governments, the Department for Work and Pensions, private assessment providers including Atos Healthcare and the Centre for Health and Disability Assessments, General Practitioners, the National Health Service, the British Medical Association, Allied Health Professionals, HM Courts and Tribunals Service, and independent advice and advocacy organisations. This is a complex policy area, and improvements require input from all of the agencies listed above.

This report presents findings from research carried out by Citizens Advice Scotland (CAS) during 2016 and 2017, exploring the use of medical evidence to assess ill health and disability benefits. The research focuses particularly on the financial and health impacts on CAB clients when they do not receive the right decision first time, and what information is available to them regarding the type of support their GP is able to provide. The findings reveal a complex picture, but suggest that in many cases, not enough information is available at initial claim stage – or at Mandatory Reconsideration stage – to allow DWP decision makers to make fully informed and accurate decisions. The evidence suggests that this is due to both design flaws in the system, and the fact that different government departments and public sector services have differing responsibilities and interests in relation to assessment of ill health and disability benefits, which are not always clearly aligned.

CAS does not have all the solutions, but hope that we can be part of an ongoing conversation around how improvements might be made, and work constructively with the UK and Scottish Governments to design and improve systems to ensure people have access to financial support when they need it, and that decisions are right first time.

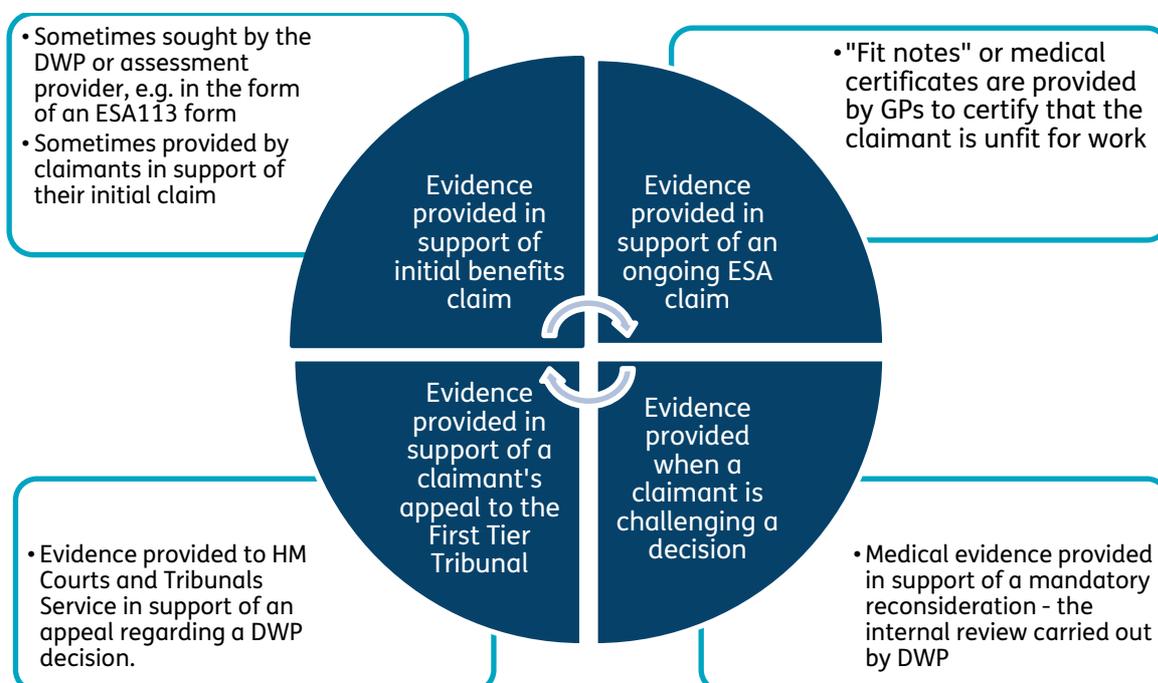
The current system

Evidence from health and social care professionals plays an important part in the existing benefits system, particularly in assessing eligibility for ill health and disability benefits including:

- Employment and Support Allowance (ESA) and Universal Credit (UC)
- Disability Living Allowance (DLA)
- Attendance Allowance (AA)
- Personal Independence Payment (PIP)

There are several points at which evidence from health professionals may be sought, including: at the initial claim stage; when someone is challenging a decision either by mandatory reconsideration or independent appeal; and when someone is required to provide medical certificates or 'fit notes' from GPs in support of an ESA or UC claim (see Figure 1).

Figure 1: Circumstances in which medical evidence is provided in support of a benefits claim



Evidence in support of initial claims

It is the responsibility of the DWP and assessment provider to gather medical evidence regarding a claim. GPs have a statutory obligation to provide evidence when requested to do so by the DWP or an assessment provider such as Maximus or Atos Healthcare, as specified in the contractual arrangements between a GP practice and the relevant Primary Care Trust². NHS trusts are also required to provide hospital case notes and medical reports without charge.³

For ESA and Universal Credit, Further Medical Evidence (FME) will not be sought in all cases. It should be obtained in those cases where there is a strong probability that such evidence will confirm a level of claimed disability. In these cases, a Health Care Professional (HCP) from the Centre for Health and Disability Assessments (CHDA) may request GPs to fill in a form detailing the patient's conditions and how they affect the individual's ability to work.^{4 5} If information from the GP is needed, usually an UC/ESA113 form will be sent. However, there may be occasions when a specific issue needs to be addressed and form FRR2 is more appropriate (e.g., when information about the frequency of epileptic fits is required). The DWP requires GPs to return these forms within five working days of receipt. Where, in the HCP's judgement, there is a clear possibility that a face-to-face assessment may be avoided the HCP should make reasonable attempts to seek further evidence.

Similarly, guidance on the PIP claimant journey advises claimants 'Don't ask for other documents which might slow down your claim... If we need this we'll ask for it ourselves'⁶. However, as with ESA, the assessment provider does not always gather medical evidence at this stage.

² BMA Guidance to GPs on their statutory obligations:
www.bma.org.uk/advice/employment/fees/benefits-and-work-for-atos

³ DWP Medical Reports Completion Guidance:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/524047/medical-reports-completion-guidance.pdf

⁴ ESA113 form:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/251339/esa113-interactive.pdf

⁵ DWP Medical Reports Completion Guidance

⁶ Paragraph 2.3.4 of Department for Work and Pensions PIP Assessment Guide
www.gov.uk/government/uploads/system/uploads/attachment_data/file/547146/pip-assessment-guide.pdf

Patients may ask GPs to complete form DS1500 if they are terminally ill. The form can be used for UC, ESA, PIP, DLA or AA claims and ensures that they are dealt with rapidly under special provisions.

The DWP guidance states that it is acceptable for GPs to delegate completion of the ESA113, FRR2, PIP or DLA/AA factual report to a practice nurse.⁷

Individuals can provide evidence in support of their initial claims, which may be called ‘further evidence’ or ‘supporting evidence’, but they must gather this themselves. Further evidence can improve the accuracy of the decision regarding the claimant’s entitlement to the benefit, but claimants can experience barriers in accessing supporting evidence. The number one barrier is that GPs and other health professionals are not required to provide supporting evidence and so may refuse to do so, or charge a fee. In explaining why GPs charge fees for non-NHS work, the British Medical Association says:

‘It is important to understand that many GPs are not employed by the NHS. They are self-employed and they have to cover their costs - staff, buildings, heating, lighting, etc. - in the same way as any small business. The NHS covers these costs for NHS work, but for non-NHS work, the fees charged by GPs contribute towards their costs.’⁸

The BMA provides guidance to GPs in setting their own fees for non-NHS work.⁹

Medical Certificates in support of an ESA or UC claim

For the first seven days of a claim, the DWP should accept a self-certificate as evidence of limited capability for work. After those seven days, the claimant is required to provide a medical certificate from their doctor. The claimant must be ‘signed off’ as unfit for work until they receive a Work Capability Assessment, but the medical certificate (otherwise known as ‘Med 3’, ‘fit note’, or ‘sick line’) will provide evidence that the individual is unfit to work for a finite period of time.

⁷ DWP Medical Reports Completion Guidance

⁸ British Medical Association website – [Why GPs sometimes charge fees](#), February 2017

⁹ British Medical Association website – [What to consider when setting your own fees](#), February 2017

Therefore, they may be required to acquire an updated medical certificate from their doctor several times during the assessment phase.

The DWP contacts the individual when they are due to provide an up-to-date medical certificate. The claimant then has to obtain the medical certificate from the doctor within a given period of time, and send the medical certificate to the relevant department in the DWP.

If the DWP does not receive an up-to-date medical certificate within the required timeframe, then their payments may be stopped altogether. Given that ESA and Universal Credit are income replacement benefits, this leaves the individual with no income.

Medical evidence provided when challenging a decision

A final circumstance in which benefit claimants are likely to provide medical evidence is when they are challenging a decision regarding their eligibility. If the claimant has been told they have been found ineligible for the benefit, and they wish to appeal, they are required to first request a Mandatory Reconsideration (the DWP's internal review process) and then, if the decision remains unchanged, an appeal to the First Tier Tribunal.

At this stage, the onus to collect evidence in order to challenge that decision falls on the claimant and the GP is under no obligation to provide a letter of support. The British Medical Association's guidance regarding appeals is that:

'NHS GPs are under no obligation to provide such evidence to their patients or to provide it free of charge. If a GP does not agree to provide additional evidence for their patient then it is a private matter to be resolved between the GP and their patient.'¹⁰

There is a timescale of one month within which to return a Mandatory Reconsideration request, with any supporting evidence, but there are longer timescales involved when making an appeal to the First Tier Tribunal, which can be weeks or months after receiving the initial decision.

¹⁰ British Medical Association website – Benefits and work for Atos, September 2016: www.bma.org.uk/advice/employment/fees/benefits-and-work-for-atos

Policy context

There are a number of planned changes to ill health and disability benefits, which may present opportunities to make improvements to the way in which medical evidence is used in assessing eligibility for benefits. Some of these changes are outlined below, and more information about the benefits listed above has been provided in Appendix 3.

Current and future changes to ill health and disability benefits

Incapacity benefits

The 2012 Welfare Reform Act introduced the Coalition Government's flagship social security policy: Universal Credit. This new benefit would see the six working age benefits rolled into one single payment. Universal Credit is paid to a wide variety of claimants, including those with limited capacity for work due to ill health or disability. Universal Credit brings with it other changes for this client group in the form of increased conditionality and a tougher sanctions regime¹¹.

The 2015 Welfare and Work Act introduced a further change to ESA and Universal Credit in that the Limited Capacity for Work group (the equivalent of the existing Work Related Activity Group) will, from April 2017, be paid at the same level as Jobseekers Allowance. This will involve a reduction of £29.05 a week (at 2017-18 rates), for those unable to work due to ill health or a disability¹².

Most recently, the UK Government published its Work and Health Green Paper, which it consulted on during winter 2016/17. This paper proposes a number of changes in the relationship between employment and social security, including improving assessment of capacity for work, Jobcentres providing more support and contact with those in the Support Group, changes to certification of fitness

¹¹ Department for Work and Pensions press release: *Choosing a life on benefits is no longer an option*, 22 October 2012. Available here: www.gov.uk/government/news/choosing-a-life-on-benefits-is-no-longer-an-option

¹² House of Commons Library, *Briefing Paper CBP 7649: Abolition of the ESA Work Related Activity Component*, March 2017, page 14. Available from: <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7649#fullreport>

for work, and greater sharing of health information across public sector agencies.¹³

Disability benefits

In 2010, the UK Government announced that Disability Living Allowance would be replaced with Personal Independence Payment. In April 2013, the first new claims for PIP were made, and from October 2015, the DWP began inviting DLA working age recipients to claim PIP. At the end of January 2017, 543,200 claims in payment were reassessment claims from DLA (44% of the total PIP caseload). ‘Full PIP Rollout’ is now expected to complete by October 2018.¹⁴

Second Independent Review of PIP

In March 2017, Paul Gray published the results of his second independent review of Personal Independence Payment, focussing on the assessment of the benefit. One key conclusion of the review is that “public trust in the fairness and consistency of PIP decisions is not currently being achieved, with high levels of disputed award decisions, many of them overturned at appeal.”¹⁵ He makes a number of recommendations around improvements that can be made to the way in which evidence is gathered and appraised, including that:

- The DWP makes clear that the responsibility to provide Further Evidence lies primarily with the claimant and that they should not assume the Department will contact health care professionals.
- Assessment Providers and the DWP work to implement a system where evidence is followed up after the assessment where useful evidence has been identified and may offer further relevant insight.

¹³ Department for Work and Pensions, *Improving Lives: Work and Health and Disability Green Paper*, October 2016. Available from: www.gov.uk/government/consultations/work-health-and-disability-improving-lives

¹⁴ Department for Work and Pensions, *Personal Independence Payment: Official Statistics*, March 2017. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/598755/pip-statistics-to-january-2017.pdf

¹⁵ Paul Gray, *The Second Independent Review of the Personal Independence Payment Assessment*, March 2017, Page 3. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf

- The Department ensures that evidence of carers is given sufficient weight in the assessment.¹⁶

Devolution of social security powers

New social security powers have been devolved to the Scottish Parliament under the Scotland Act 2016. These include disability benefits, which make up the vast majority of the social security budget to be devolved, and are claimed by 10% of the Scottish population.

The Scottish Government has committed to reforming the way in which disability benefits are assessed, “from application all the way through to final decision”¹⁷ and aims to reduce the number of face-to-face assessments and re-assessments carried out. In a statement to Parliament in April 2017, the Minister for Social Security ruled out private companies providing assessment of disability benefits¹⁸, and Expert Advisory Group and Experience Panels have been established to inform the design of the new system.

Later in 2017, the Scottish Government will introduce a Social Security Bill to the Scottish Parliament, but it is unlikely that disability benefits will be fully delivered and administered by the Scottish Social Security Agency until at least 2020.

Co-location of advice and primary care services

Several pilots in Scotland have explored co-location of advice services with GP practices, allowing Welfare Rights Advisers access to medical records to support benefit claims. NHS Lothian has evaluated this co-location model in Edinburgh and Dundee, with positive results¹⁹. The key element of this co-location model is the advisers’ direct access to patients’ medical records, which enables easy access to clients’ medical information as required. The Improvement Service has recommended that: “On a national level, [this model] should also be given due

¹⁶ Paul Gray, The Second Independent Review of the Personal Independence Payment Assessment, March 2017, Pages 11-12.

¹⁷ Scottish Government, A New Future for Social Security Scottish Government Response to the Consultation on Social Security in Scotland, February 2017, page 14. Available from: www.gov.scot/Topics/People/fairerscotland/Social-Security/SG-Response

¹⁸ Ministerial announcement on the new social security system, 27th April 2017. Scottish Government press release available here: <https://news.gov.scot/news/new-social-security-agency-puts-people-first>

¹⁹ Improvement Service, Forecast Social Return on Investment Analysis on the Co-location of Advice Workers with Consensual Access to Individual Medical Records in Medical Practices, 2017. Available here: www.improvementservice.org.uk/documents/money_advice/SROI-co-location-advice-workers.pdf

consideration by the Scottish Government in reference to the new Social Security powers”²⁰.

Decision making, reconsideration and appeals

Introduction of Mandatory Reconsideration

In October 2013 the Department for Work and Pensions (DWP) made it a requirement that all benefit claimants who wanted to take a case to appeal would have to get a DWP decision maker to reconsider the decision first. This is known as a ‘Mandatory Reconsideration’. According to previous UK Government ministers, “these measures aim to ensure timely, proportionate and more efficient dispute resolution”²¹ and “mandatory reconsideration will improve the disputes process and effectively shorten the journey for all DWP administered benefits, not just those referred to, by making sure that as many disputes as possible are resolved without the need to appeal.”²²

Under the regulations, a claimant must request a reconsideration within one month of the date of notification of the original decision, except in exceptional circumstances²³. A claimant can ask for a decision to be revised either orally or in writing, but there is no application form. After a claimant has requested a mandatory reconsideration, there is no time limit within which the DWP must consider whether it will revise its decision, and disputed benefit entitlement is not payable pending a Mandatory Reconsideration notice.

Various organisations and agencies have raised concerns about Mandatory Reconsideration²⁴, in particular highlighting the barrier it may present for people to have decisions considered by an independent Tribunal. This concern arose in

²⁰ Improvement Service and The Money Advice Service, Case Study: Co-location of Advice Workers in Medical Practices in Dundee and Edinburgh, 2017, page 4. Available here: www.improvementservice.org.uk/documents/money_advice/ma-case-study-colocation-advice-medical.pdf

²¹ HC Deb, 30 April 2012, c1334W

²² HC Deb, 11 June 2013, c307W

²³ Regs 3, 4 SSCS(DA) Regs 1999; regs 5, 6 UC,PIP,JSA&ESA(DA) Regs 2013

²⁴ See, for example, The Alliance: www.alliance-scotland.org.uk/news-and-events/news/2014/06/mandatory-reconsideration-its-time-to-reconsider/#.WPYboPnyuUk; Child Poverty Action Group: www.cpag.org.uk/sites/default/files/CPAG-SSAC-consultation-decision-making-mandatory-reconsideration-Mar-2016.pdf; Benefits and Work: www.benefitsandwork.co.uk/news/3521-massive-fall-in-success-rates-for-esa-mandatory-reconsideration

response to the drop in appeals following the introduction of Mandatory Reconsideration.

Tribunal Statistics

Tribunal receipts were lowest during the period between January to March 2014 (the year following the introduction of Mandatory Reconsideration), and 67% lower than the same period of 2013. Social Security and Child Support (SSCS) accounted for 38% of these receipts and drove the overall downward trend. The official report from this quarter suggests that “this could be due to ... the introduction of mandatory reconsideration across DWP benefits.”²⁵

However, the most recent official statistics from the HM Courts and Tribunals Service shows that social security appeals have been increasing since April-June 2014. For the October to December 2016 quarter, when compared to the same quarter in 2015, overall receipts for all tribunals increased by 4% while Social Security and Child Support (SSCS) tribunal receipts increased by 47%. The official report recognises that “this increase is driven by two types of benefit – Personal Independence Payment and Employment Support Allowance, up 71% and 58% respectively”²⁶.

Another possible explanation for the rise in appeals is that, since the MR process was introduced, there has been a decreasing trend in the number of ESA decisions being revised at reconsideration each month²⁷. The most recent available data²⁸ shows that, of those ESA claimants who receive a decision following a Work Capability Assessment (WCA), 14% challenged the decision via a Mandatory Reconsideration. Of those reconsiderations, only 10% of decisions

²⁵ Official Statistics, *Tribunals and Gender Recognition Statistics Quarterly, January to March 2016*, June 2016, page 31. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/597905/tribunal-grc-statistics-q3-2016-2017.pdf

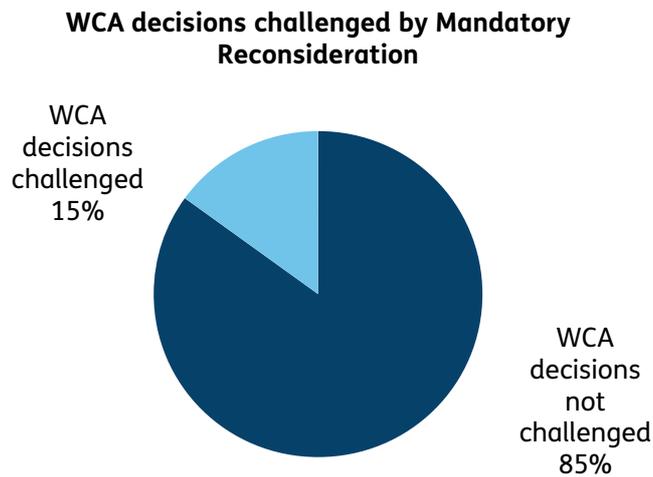
²⁶ Official Statistics, *Tribunals and Gender Recognition Statistics Quarterly, October to December 2016 (provisional)*, March 2017, page 7. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/597905/tribunal-grc-statistics-q3-2016-2017.pdf

²⁷ DWP Official statistics, *Employment and Support Allowance: Work Capability Assessments, Mandatory Reconsiderations and Appeal*, March 2017, page 8. Available from: www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-march-2017

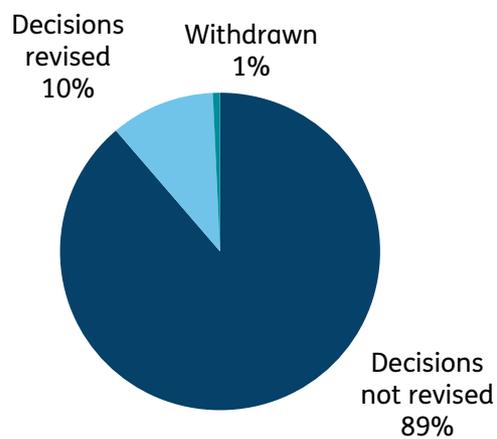
²⁸ DWP Official statistics, *Employment and Support Allowance: Work Capability Assessments, Mandatory Reconsiderations and Appeal*, March 2017. Available from: www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-march-2017

were revised. Following this, 23% continue to appeal, and at appeal stage 58% of decisions are overturned. These percentages are represented in Figure 2.

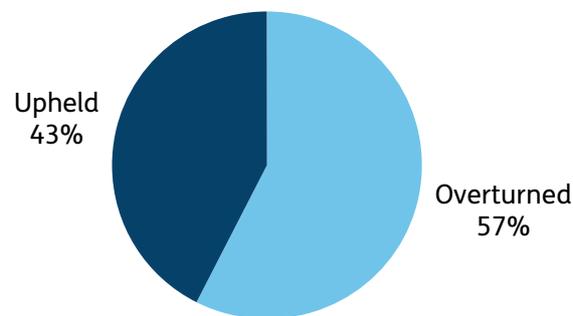
Figure 2: Comparison of percentage of ESA decisions revised at Mandatory Reconsideration and percentage overturned on appeal



Decisions revised at Mandatory Reconsideration



Decisions overturned at appeal



Source: Official statistics on Employment and Support Allowance: Work Capability Assessments, Mandatory Reconsiderations and Appeal, March 2017

In response to the recent increase in appeals, the HM Courts and Tribunals Service has issued a letter to all representative organisations, making them aware that they expect to see an increase of 60% over the coming year, and encouraging them to consider how they will meet this demand.

Data from HM Courts and Tribunals Service shows how many decisions are overturned on appeal. Data from 2015/16, presented in Table 1 shows PIP and ESA to be the two benefits with the highest percentage of decisions overturned on appeal. In Quarter 4 of 2015/16, 63% of PIP decisions were overturned on appeal, and 58% of ESA decisions.

Table 1: Official statistics showing percentage of benefit entitlement decisions overturned on appeal

Benefit	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4
AA	31%	29%	33%	27%
TC	52%	48%	46%	44%
ESA	58%	58%	58%	58%
IS	42%	43%	44%	45%
JSA	47%	40%	43%	43%
PIP	57%	60%	61%	63%
UC	32%	47%	47%	45%

Source: *Decision Making and Mandatory Reconsideration: A study by the Social Security Advisory Committee, Occasional Paper No. 18*²⁹. Based on official statistics: Tribunals and gender recognition certificate statistics quarterly: January to March 2016³⁰

It should be noted that these statistics reflect a small proportion of the overall decisions made by the DWP, as less than one per cent of decisions are appealed. These statistics cannot be used to reflect the quality of decisions made in cases which have not been brought to Tribunal, although it is probable that there are other challengeable decisions that go undetected.

Due to limited publication of statistics around quality assurance and audit of internal decision making by DWP, quality of decision making for decisions that are not brought to the First Tier Tribunal are simply unknown.³¹

What we do know, however, is the cost of appeals. In 2013-14, just over 300,000 Employment and Support Allowance decisions were appealed, which cost the Treasury almost £70 million and took an average of 25 weeks.³²

²⁹ Social Security Advisory Committee, *Decision Making and Mandatory Reconsideration: A study by the Social Security Advisory Committee, Occasional Paper No. 18*, July 2016, page 13. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/538836/decision-making-and-mandatory-reconsideration-ssac-op18.pdf

³⁰ Official statistics, *Tribunals and gender recognition certificate statistics quarterly: January to March 2016*, June 2016. Available from: www.gov.uk/government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-january-to-march-2016

³¹ For a more comprehensive analysis of HM Courts and Tribunals statistics and what we can infer from them, see the Social Security Advisory Committee's study on Decision Making and Mandatory Reconsideration.

Committee recommendations regarding Decision Making

In 2014, the Work and Pensions Committee considered Mandatory Reconsideration as part of its inquiry into Benefit Delivery. The final report recommended that:

- Assessment rate ESA be paid to claimants throughout reassessment of their claim, not only once an appeal is lodged.
- The DWP publish Mandatory Reconsideration clearance time statistics and that the DWP introduce a seven day clearance time target for all Mandatory Reconsiderations.³³

In its official response, the DWP did not commit to making any substantial changes to policy in response to these recommendations³⁴.

The Social Security Advisory Committee, as part of its independent work programme, last year published a paper on decision making and Mandatory Reconsideration. This study concluded that Mandatory Reconsideration “could be an efficient process that provides opportunity for timely review” but that “the process does not work as well as it should.” The report makes a total of 37 recommendations around how decision making and Mandatory Reconsideration could be improved, which have been provided in Appendix 4.

³² Thomas, R. *Administrative Justice, Better Decisions, and Organisational Learning*, Public Law, 2015. Available from: papers.ssrn.com/sol3/papers.cfm?abstract_id=2477969

³³ House of Commons Work and Pensions Select Committee, *Benefit Delivery, Fourth Report of Session 2015–16*, December 2015, pages 32-3. Available from: www.publications.parliament.uk/pa/cm201516/cmselect/cmworpen/372/372.pdf

³⁴ DWP, *Benefit delivery: Government Response to the Committee's Fourth Report of Session 2015–16*, 2016. Available from: www.publications.parliament.uk/pa/cm201617/cmselect/cmworpen/522/52204.htm

Methodology

This report is based on evidence gathered by Citizens Advice Scotland during 2016 and 2017. It includes analysis of existing qualitative and quantitative data held by the CAB service in Scotland and, in addition, data gathered via a survey of CAB advisers, an online mapping exercise, and a survey of GPs and other health professionals. In addition to this, CAS gathered longitudinal case histories and documentary evidence relating to these.

Eighteen Citizens Advice Bureaux from across Scotland participated in the project (see Table 2), and project leads for each site were recruited from existing staff and volunteers. The project leads were provided with a research toolkit with detailed instructions, and were responsible for co-ordinating the research locally, including gathering survey responses, extracting case histories from the case management system, and providing anonymised documents.

The Research Tools Annex, published alongside this report, provides full details of the surveys and instructions provided to bureaux.

Table 2: Participating citizens advice bureaux and data collected by each

Citizens Advice Bureau	GP and Health Professionals survey	Collection of case histories
Airdrie CAB	✓	✓
Citizens Advice and Rights Fife	✓	✓
Central Borders CAB	✓	✗
Clackmannanshire CAB	✓	✓
Dumfries and Galloway Citizens Advice	✓	✓
Dalkeith CAB	✓	✓
Drumchapel CAB	✓	✓
East and Central Sutherland CAB	✗	✓
East Ayrshire CAB	✓	✗
East Kilbride CAB	✓	✓
Grangemouth CAB	✓	✓
Inverness CAB	✓	✗
Motherwell and Wishaw CAB	✓	✓
Nairn CAB	✓	✓
Parkhead CAB	✗	✓
Peebles CAB	✓	✓
Rutherglen and Cambuslang CAB	✓	✓
South West Aberdeenshire CAB	✓	✓

‘Citizen Alerts’

The majority of Citizens Advice Bureaux in Scotland use a real-time electronic case recording system, and send case notes from client enquiries which demonstrate services or policies which they feel are failing to meet clients’ needs to the Policy Team at Citizens Advice Scotland. These case notes, known as ‘Citizen Alerts’, are typically between 100 and 500 words, and are written up by the CAB adviser directly following a client interview. Ongoing analysis of this existing data helped to inform the drafting of the research questions, the surveys and the research toolkit.

Adviser survey

In addition, CAS conducted an adviser survey on medical evidence in support of Personal Independence Payment claims in August 2016 which received a total of 61 responses from 40 CAB offices. This represents 65% of the bureaux across Scotland.

Respondents to the survey were from urban, rural and island CABs, including CABs on Orkney and the Outer Hebrides and our most remote CAB in Kinlochbervie. The survey also received responses from bureaux that serve some of the most deprived areas of Scotland including Renfrewshire and Drumchapel CABs.

One fifth of respondents were specialist advisers, and a further 18% were generalist advisers, though the survey was also filled in by managers, session supervisors and others with specialist roles. More than a quarter of respondents reported that they had advised more than 50 clients regarding a PIP claim in the six months prior to completing the survey. The full questionnaire is provided in Appendix 1.

Online mapping and data collection

Participating bureaux gathered data on local GP surgeries and other local healthcare departments. They were asked to focus on services that were a) those that were commonly used by clients; and b) those that were most local to the bureau. Project leads gathered data on what information is provided online to clients about access to medical evidence and medical certificates in support of benefit claims. The URLs of relevant web pages were provided to CAS for analysis.

GP and Health Professionals’ survey

Participating bureaux conducted a survey of local GP surgeries and other Health Professionals during January and February 2017. These were two slightly

different surveys, with some identical questions. The surveys were designed by Citizens Advice Scotland and distributed and collated by project leads at 16 participating bureaux. The surveys received 62 responses from 42 GPs practices across Scotland, and 21 responses from health professionals, including:

- Consultant Clinical Neuropsychologist
- Clinical Nurse Specialist
- Community Psychiatric Nurse
- Consultant in Anaesthesia & Pain Management
- Physiotherapist
- Addiction Service

Case histories

CAS provided instructions to the project leads of participating bureaux in order that they could extract longitudinal case histories of clients who had undergone ill health or disability benefits appeals.

The project leads were presented with instructions on how to download these case histories from the electronic case management system used by the Scottish CAB Service. For the purposes of this report, case histories were analysed, the shortest of which spanned 14 days, and consisted of case notes from two instances of contact with the client; the longest of which spanned 6 years, 8 months, and consisted of case notes from 25 contacts with the client. Five of the case histories provided were discarded during analysis due to lack of detail or clarity, leaving 45. The mean length of the case studies was 616 days (approximately 1 year 8 months), and the mean number of instances of client contact was 11.

The case studies were analysed using a framework analysis, in which a number of indicators were developed to capture information relevant to the research questions. These indicators were developed separately by each of the researchers, and compared for consistency. Following this process, each case study was analysed for the presence of these indicators and coded accordingly.

Documentary evidence

To supplement the case histories, participating bureaux provided anonymised documentary evidence relating to the cases. These included benefit claim forms, benefit decision letters, Mandatory Reconsideration notices, First Tier Tribunal Appeal papers, and medical evidence provided in support of claims. Participating bureaux provided in excess of 100 documents relating to the case files, which were read and analysed in conjunction with the case notes. Appendix 2 provides a full list of the documents included in the analysis.

Findings

Statistics from the Scottish CAB Service

Advice related to Benefits and Tax Credits makes up the largest proportion of advice provided by the CAB network in Scotland. In 2015/16, Scottish bureaux advised on over 227,000 benefits-related issues, making up 39% of the overall advice given.

Employment and Support Allowance (ESA) is the most common single issue that Scottish citizens advice bureaux provide advice on, with Personal Independence Payment (PIP) Daily Living component the second most common. During 2015/16, Scottish bureaux advised on over 32,000 issues related to ESA, 14% of all benefits advice provided. During the same period, Scottish bureaux advised on 24,000 issues related to PIP Daily Living component (11% of all benefits advice), and 20,400 issues related to PIP Mobility (9% of all benefits advice provided).

Table 3 shows the top ten most common issues related to ESA during 2015/16. Following general advice regarding benefit entitlement and the claiming process, the most common advice provided is in relation to reconsideration and appeals, which together make up over 15% of all advice regarding ESA. The next most common advice given is in relation to the Work Capability Assessment, which represents 12% of all ESA advice provided.

In April 2016, a new advice code was introduced to capture advice related to issues around medical evidence for ESA claims. During the first two quarters of 2016/17, Scottish CAB recorded 947 pieces of advice relating to medical evidence, which represents 5% of all ESA related advice provided during this period.

Table 4 shows the top ten most common issues related to PIP during 2015/16. Again, following general advice regarding benefit entitlement and the claiming process, the most common advice provided is in relation to reconsideration and appeals, which together make up 16% of all advice regarding the PIP Daily Living component, and 17% for the Mobility component. Following the introduction of the 'medical evidence' code, data from the first six months of 2016/17 showed that 3% of PIP advice provided was in relation to issues around medical evidence.

Table 3: Top ten most common ESA issues Scottish CAB provided advice on during 2015/16

Issues	Number	%
Claiming process / backdating	10,954	29%
Entitlement (benefit check)	9,325	24%
Work capability assessment	4,567	12%
Payment	3,772	10%
Reconsideration	3,464	9%
Appeals	3,143	8%
Revisions / supersessions	1,093	3%
Work Related Activity	798	2%
Transfer from statutory sick pay	640	2%
Poor administration / complaints	401	1%
Total ESA issues	38,157	

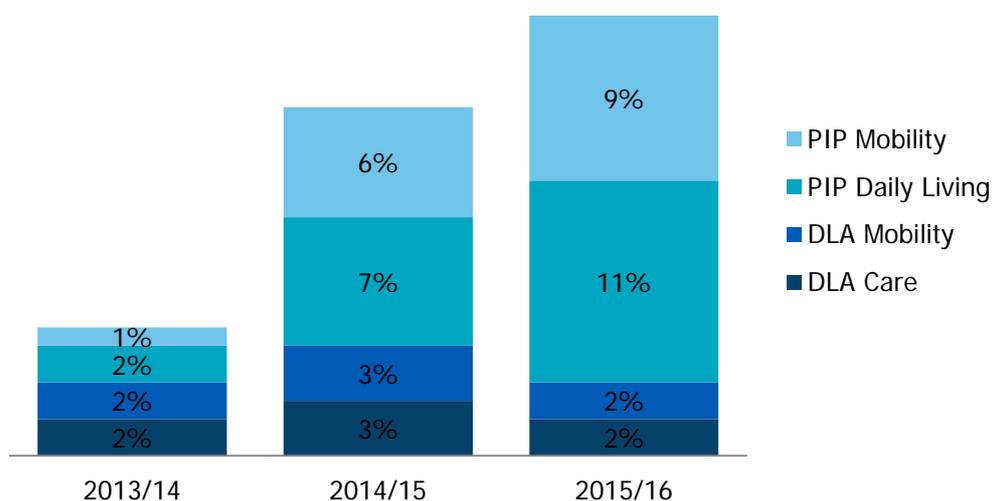
Table 4: Top ten most common PIP issues Scottish CAB provided advice on during 2015/16

PIP	Daily Living		Mobility	
	Number	%	Number	%
Claiming process / backdating	13,966	46%	11,632	46%
Entitlement (benefit check)	6,717	22%	5,793	23%
Reconsideration	2,434	8%	2,253	9%
Appeals	2,409	8%	2,049	8%
Payment	1,357	4%	1,033	4%
Medical examinations	961	3%	772	3%
Renewals	723	2%	604	2%
Revisions / supersessions	409	1%	412	2%
Civil penalty	140	0%	134	1%
Poor administration / complaints	126	0%	96	0%
Total PIP issues	30,301		25,557	

Increases and decreases in advice in relation to ESA and PIP

Since PIP was introduced, CAB across Scotland have seen a steady increase in advice regarding PIP as the caseload has increased, as we would expect to see with the introduction of any new benefit. However, as Figure 3 shows, the increase in advice need in relation to disability benefits has increased overall, as can be seen when DLA and PIP advice is considered together. We would expect to see issues related to DLA fall as PIP issues increase, but what Figure 3 shows is that advice need in relation to disability benefits has tripled in the last three years.

Figure 3: Percentage of new advice issues relating to PIP and DLA as a proportion of total benefits advice - 2013/14 to 2015/16



Whilst advice in relation to PIP has been increasing, advice in relation to ESA has been decreasing since its peak in 2013/14. Figure 4 shows that advice in relation to ESA has steadily decreased from 38,600 issues in 2013/14, to just over 32,200 issues in 2015/16. Figure 5 shows that advice in relation to ESA has also been decreasing as a proportion of all benefits-related advice.

Data from the first six months of 2016/17, however, suggests that ESA issues are on the rise again, with CAB advising on over 19,000 issues during this six month period (3,600 more issues than were advised upon during the same period of the previous year). This increase has been driven by an increase in advice provided in relation to the Work Capability Assessment, which saw an 81% increase, an increase in relation to Reconsiderations, which saw a 50% increase, and an increase in relation to appeals, which saw a 30% increase.

However, despite the recent increase in numbers, ESA issues have only increased by one percentage point when taken as a proportion of all benefits advice, which is likely to be due to the increase in advice provided in relation to disability benefits, as shown above.

Figure 4: Number of new pieces of advice provided in relation to ESA from 2012/13 to 2015/16 (in thousands)

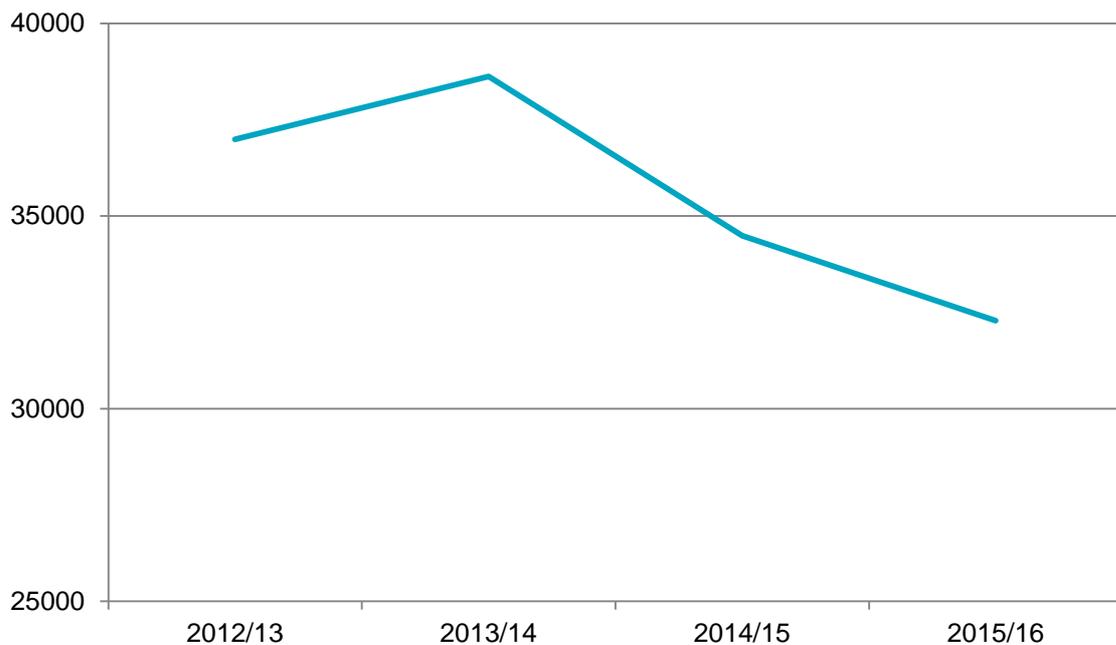
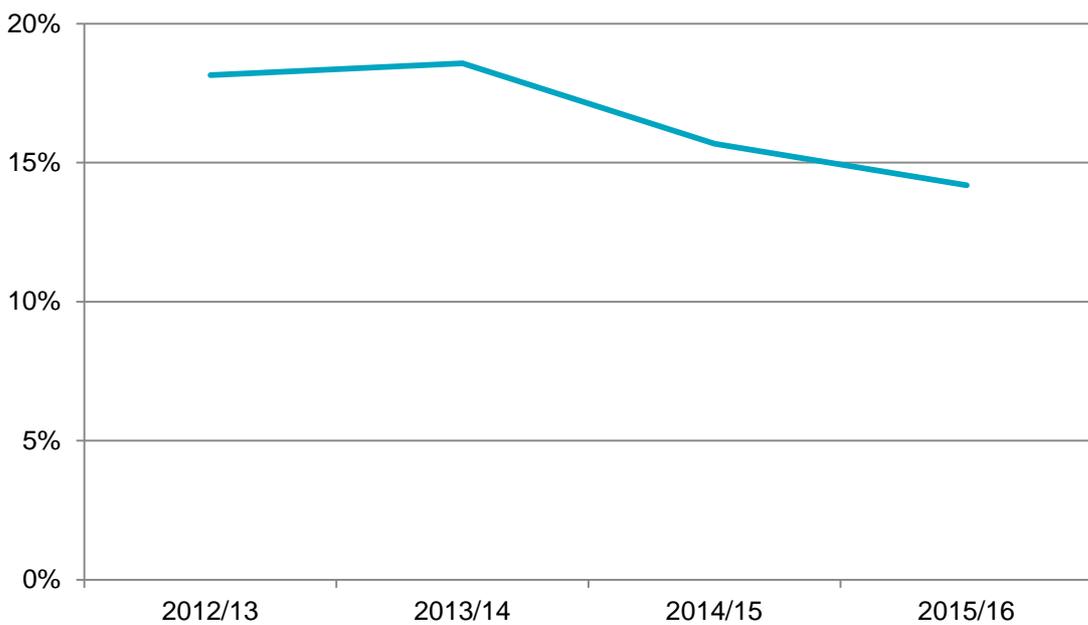


Figure 5: New pieces of advice provided in relation to ESA as a percentage of all benefits advice



Appeals statistics

During 2015/16, CAB in Scotland supported clients to complete 2,731 appeal forms (SSCS1 forms) to appeal against a decision made by the DWP. Of these cases, CAB represented clients at 2,561 appeals to the First Tier Tribunals (94%). Of the 2,295 cases heard at Tribunal (not including those which were adjourned), 59% had the decision changed, and a further 4% had the decision partially changed, compared to 38% where the decision remained the same (see Figure 6). However, some CAB have reported that their appeal success rate is as high as 70%. Analysis of advice codes shows that 77% of appeals advice and representation is in relation to ill health and disability benefits.

CAB advice code statistics also show that advice related to Mandatory Reconsideration and advice related to appeals is flattening out. Assuming that, at Mandatory Reconsideration stage, a proportion of decisions will be overturned in the claimant's favour, we would expect to see advice in relation to Mandatory Reconsideration as slightly higher than advice in relation to appeals, as it is only unfavourable decisions that go to appeal. What the statistics in Figures 7, 8 and 9 show is that, between 2014/15 and 2015/16, the difference between the number of Mandatory Reconsiderations (the blue columns), and the number of Appeals (the red columns) *decreased*, for most benefits. It is difficult to draw conclusions from this data; one possible explanation for this is that DWP initial decisions are increasing in accuracy, but the 59% success rate at appeal does not substantiate this explanation. Another possible explanation is that fewer decisions were changed in the client's favour at reconsideration stage in 2015/16 than in 2014/15.

Figure 6: Percentage of successful appeals to the First Tier Tribunal

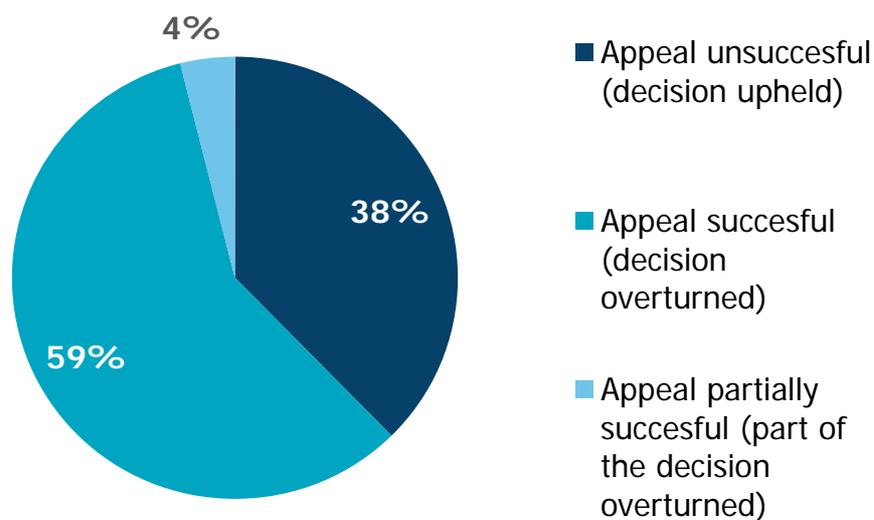


Figure 7: The difference between Mandatory Reconsideration advice and Appeals advice for DLA, 2014/15 to 2015/16

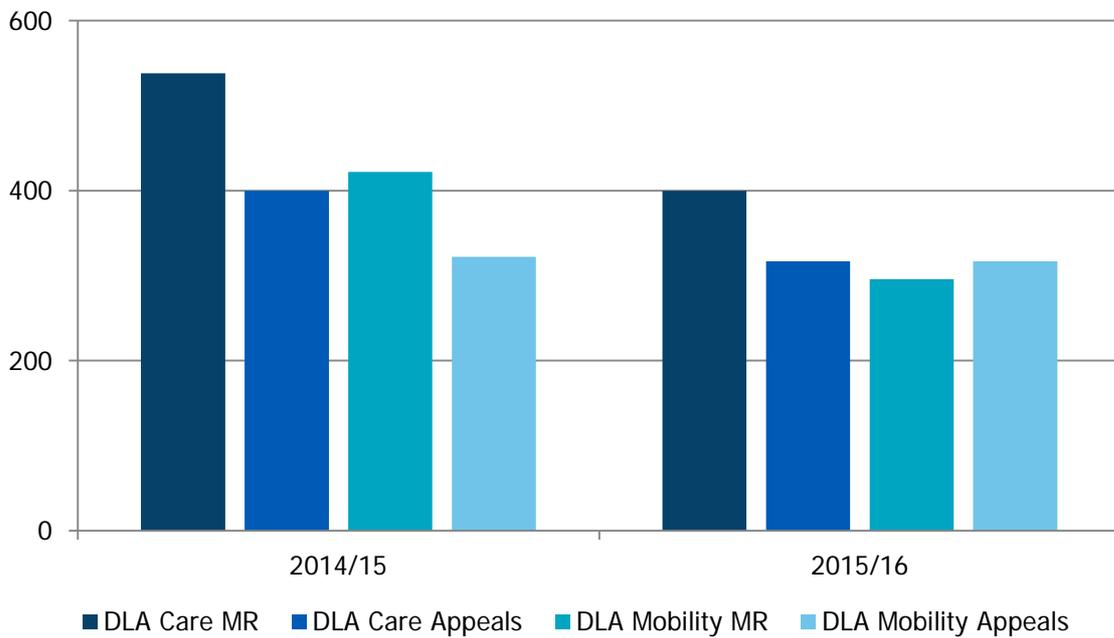


Figure 8: The difference between Mandatory Reconsideration advice and Appeals advice for PIP, 2014/15 to 2015/16

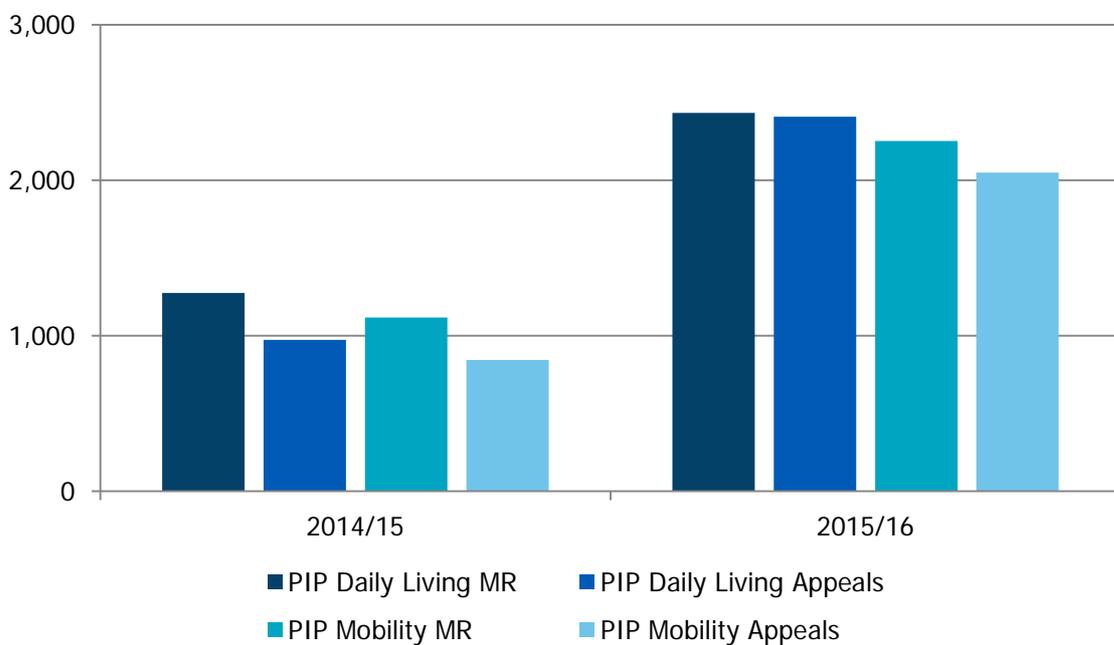
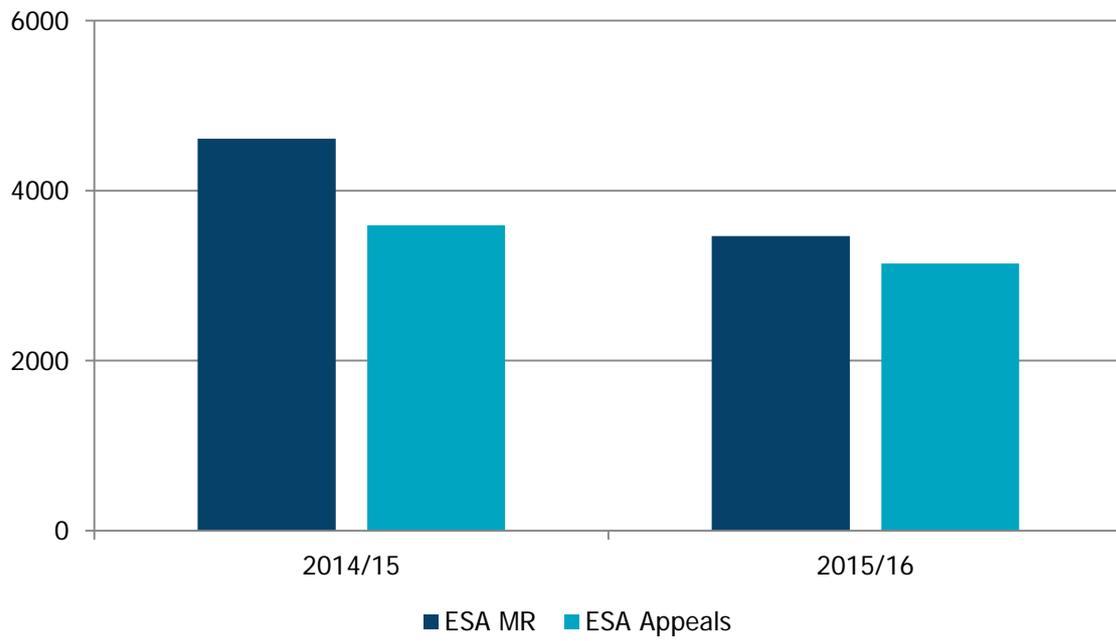


Figure 9: The difference between Mandatory Reconsideration advice and Appeals advice for ESA, 2014/15 to 2015/16



Quality of Decision Making

From the analysis of case studies, the number of clients who have had decisions overturned on appeal suggests that there are problems associated with quality of decision making at the initial claim stage. Sixteen of the 45 cases included in the analysis (35%) showed evidence of the decision regarding the client's eligibility for the benefit being overturned at appeal. Not all cases showed the outcomes of appeals, however, so if only those cases which showed the outcome of the appeal are considered, this increases to 73%, or 16 out of 22 clients who had a decision overturned in their favour on appeal.

Of the 36 clients who challenged a decision through the Mandatory Reconsideration process – which includes all of those clients whose decision was ultimately overturned on appeal as outlined above – 89% of those clients did not have their decisions changed at Mandatory Reconsideration stage (N=32), and only 8% (N=3) did have a decision changed in their favour (the outcome of the decision is unknown for one of the cases).

Below, we explore in detail each stage of the evidence gathering process, in order to better understand the reasons why decision makers may not have adequate information to make a fully informed decision. First, evidence gathered in relation to the initial claim is considered, then the mandatory reconsideration stage, and finally, appeals.

Initial claim stage

There are a number of different types of evidence gathered at the initial claim stage:

1. Medical evidence provided by clients at initial claim stage;
2. Assessment forms (ESA50 and PIP2);
3. Face-to-face assessments carried out by independent assessment providers (for example, Atos Healthcare and the Centre for Health and Disability Assessments);
4. Evidence sought from GPs and other health care professionals by DWP or assessment provider at initial claim stage (for example, via the ESA113, or PIP forms).

Findings related to each of these types of evidence are explored in more detail below.

1. Medical evidence provided by clients at initial claim stage

KEY FINDINGS:

Clients rarely gather further medical evidence at initial claim stage. This is likely to be due to a number of factors:

- The DWP advise claimants not to gather additional evidence at this stage;
- GP practices sometimes refuse to provide supporting medical evidence direct to claimants, or may charge fees which can act as a financial barrier for claimants;
- The one month timescale within which to return the self-assessment form can be too tight a timescale to gather additional evidence.

Respondents to the CAB adviser survey indicated that it is 'difficult' or 'very difficult' for claimants to obtain supporting evidence from GPs at initial claim stage.

It is the responsibility of the DWP or assessment provider to gather medical evidence regarding a claim. GPs have a statutory obligation to provide evidence when requested to do so by the DWP or an assessment provider such as Maximus or Atos Healthcare³⁵.

Claimants are discouraged from gathering further evidence themselves at this stage. Individuals can provide evidence in support of their initial claims, which may be called 'further evidence' or 'supporting evidence', but they must gather this themselves.

35 British Medical Association website – Benefits and work for Atos, September 2016: www.bma.org.uk/advice/employment/fees/benefits-and-work-for-atos

In line with this, the case history analysis suggested that supplementary medical evidence is rarely provided at initial claim stage. From an analysis of 75 case studies, evidence provided with PIP2 or ESA50 claim forms was mentioned on only seven occasions. For example:

Case extract:

Completed ESA50 with client and collected medical evidence.

Case extract:

Medical evidence provided by consultant neuropsychologist for PIP reassessment.

This is likely to be due to the fact that claimants are advised by the DWP not to gather additional evidence at this stage, other than what they already have, but other findings suggest that claimants who do wish to seek further evidence may experience barriers in gathering this.

One barrier clients encounter is fees charged for the provision of medical evidence at any stage of the claims process. These fees can vary widely, from £10 to £75. The analysis of the 45 case studies showed eight cases where the client had been charged a fee or been refused medical evidence. This research also found a small number of cases in which a client was unable to afford the fees, or paid them and experienced financial detriment as a result.

Case extract:

22 November 2016: The client told me he was on his way to GPs to get medical records to support Mandatory Reconsideration. The client called back half an hour later to tell me he had to pay there and then and the medical records will be available to collect on Wednesday. I asked the client to bring them in as soon as possible.

10 January 2017: The client has to pay £15 to get medical records to support his case... The client is low on fuel and does not have enough money to buy food.

He advised he will get medical records on Friday and details of the medical he attended. He advised that he is struggling with money so this has been the reason for the delay in getting the medical records.

24 January 2017: Client advised me he just cannot afford to pay for medical records; he has no money left.

Some respondents to the CAB adviser survey also commented that fees can present a barrier to clients accessing medical evidence:

“If a client requests a GP or consultant report, the client often has to pay for it, and many are unable to do that.” (CAB adviser)

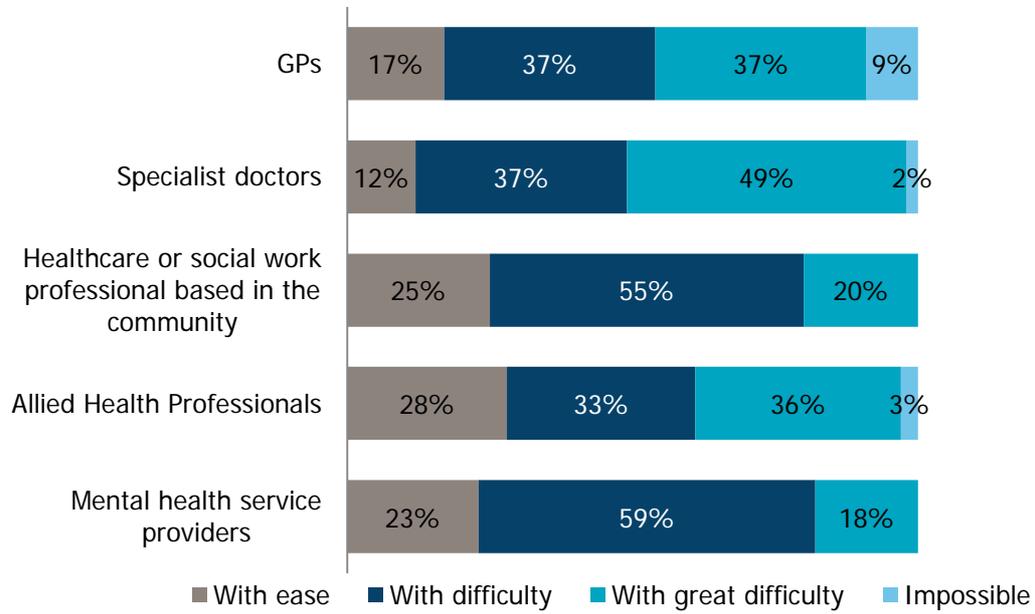
“We struggle to get some medical practices to provide crucial detailed evidence without charging their patients for it.” (CAB adviser)

“Clients face difficulties in accessing good supporting evidence and often the GP can write (for a fee) information that does not help their case.” (CAB adviser)

Another barrier is related to the timescales involved: a client only has one month from receiving their claim form to complete and return it. When asked whether one month was enough time to gather relevant medical evidence in support of their initial claim, 80% of respondents to the CAB adviser survey said that one month was ‘rarely’ or ‘never’ enough time.

Advisers were also asked how easy it is to gather supporting evidence at initial claim stage from various kinds of health and social care professionals. The category which received the highest number of responses indicating that supporting evidence could be obtained with ease was Allied Health Professionals (23%). The survey results showed specialist doctors to be the most difficult category from which to obtain supporting evidence. Three quarters of those who answered the question (74%) also indicated that it is with ‘difficulty’ or ‘great difficulty’ that claimants obtain supporting evidence from GPs at initial claim stage, and a further four respondents said it was ‘impossible’ to obtain evidence from GPs.

Figure 10: Ease of obtaining supporting evidence from health and social care professionals – based on adviser survey



The case notes contained some examples of CAB advisers encouraging clients to send medical evidence with their claim forms.

Case extract:

Took the opportunity to talk the client through the ESA50 to identify what information he would need to bring to his appointment. I stressed that if he had any letters from the hospital etc. or a list of medicines taken he should bring these with him. The client said he did not have a list of medicines, but would bring his medicines with him.

Case extract:

I filled the ESA50 form based on the information given by the client, I advised the client he may be sent for a face to face assessment, I also stressed to the client he should get medical evidence to back up his claim.

This may be because advisers believe that the outcome is more likely to be favourable to clients if further evidence is gathered, as the following comment suggests:

“Often claimants themselves will seek additional medical evidence to support an initial benefit claim, a mandatory reconsideration request or benefit appeal. We know that clients are more likely to receive a favourable decision if this evidence is provided.” (CAB adviser)

Finally, when asked whether their practice had a specific procedure in place in relation to a request for evidence in support of initial claims, 53% (N=33) of the 62 GPs who responded said ‘no’ they did not, compared to 32% (N=20) who said that they did.

2. Assessment forms (ESA50 and PIP2)

KEY FINDINGS:

Responses to the CAB adviser survey, as well as case evidence from bureaux, suggests that the application process is currently difficult to navigate for many claimants.

When asked what proportion of claimants are able to complete the PIP2 'How your disability affects you' form on their own, 63% of CAB survey respondents said 'very few' or fewer than 10% would be able to do this on their own.

The analysis of case studies also showed some evidence of clients' misunderstanding what information needed to be included in claim forms:

Case extract:

Client had written on his ESA50 form that he was experiencing four seizures a month and stated to the HCP that he was having three a month. However, client states that he was only talking about his night time fits as he thought DWP were aware of his day time fits of which he was having approximately three weekly.

Again, advised client that it would be beneficial to his case if could get medical evidence supporting this, as the current supporting letters from the GP only advise as to how frequently the client is experiencing seizures now and not how the client was back in July when the decision was made.

Issues in relation to assessment forms were also raised in response to the health professionals' survey:

"I find that the current forms from DWP are very lengthy and arduous. The questions can be complex and not always appropriate to health issues of the service user" (Addiction Service)

During 2015 CAS carried out a wide-ranging consultation with CAB clients and advisers on the topic of disability benefits³⁶. This yielded a number of

suggestions regarding changes that could be made to application forms which would make them easier for claimants to use. These changes included:

- Ensuring that disabled people and representative organisations are involved in the design of any application form, and that design is kept under review;
- Shortening the form;
- Reducing the number of repetitive questions;
- Form should include descriptions of different scenarios which illustrate how a person's disability or health condition may impact on their daily living or mobility;
- Form should allow people to fully explain their condition and its impact;
- Form should be less rigid and not simply a 'tick box' approach;
- The language of questions needs to be much clearer;
- Form should be more focused on what a person can do, and what support they need to do that.

³⁶ The full methodology and findings of which are presented in CAS's response to the Scottish Government's consultation on the Future of Social Security in Scotland, October 2016. Available here: www.cas.org.uk/system/files/publications/social_security_consultation_-_response_from_citizens_advice_scotland.pdf

3. Face-to-face assessments carried out by independent assessment providers

KEY FINDINGS:

The manner of healthcare professionals during assessments is an issue for bureau clients, which may affect their ability to express themselves during the consultation and could impinge upon the quality of information gathered.

Regarding the accuracy of the healthcare professional's report, 59% of CAB adviser survey respondents said that clients 'rarely' agreed that the healthcare professional's report accurately reflected the discussion that took place.

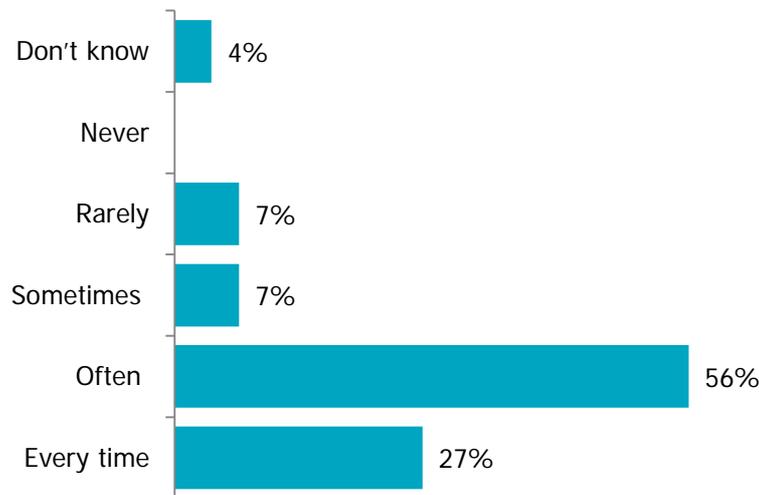
Some comments made in response to the GP survey also raised concerns regarding the assessment process.

CAS has raised concerns about face-to-face assessments for ill health and disability benefits elsewhere. The focus of this report is the quality of evidence used to assess benefit claims. Therefore, the findings presented below avoid going into detail regarding all of the issues associated with face-to-face assessments. However, findings related to the experience of assessments are presented, because someone's experience, comfort and ability to express themselves during the consultation could impinge upon the quality of information gathered.

The manner of healthcare professionals during assessments is an issue for bureau clients: 82% of CAB adviser survey respondents said that issues relating to the manner of healthcare professionals were raised 'often' when advising clients about their PIP claims or 'every time' they advised a client about their PIP claim (see Figure 11). Similarly, when asked about the appropriateness of the questions asked by healthcare professionals, three quarters of CAB adviser survey respondents said that issues around the appropriateness of the questions asked during the consultation came up 'often' or 'every time' they advised a client regarding a PIP claim.

"DWP's guidance states that HCPs should use open ended questions but far too often clients come to see me stating that they are being told to answer yes or no, with no or limited explanation allowed." (CAB adviser)

Figure 11: How frequently do issues around the manner of HCPs arise during advice interviews?



A number of CAB adviser survey respondents were concerned that, for those with mental health issues, medical assessments can be stressful, and anxiety can prevent them from engaging with the process:

“Mental health issues are the biggest problem - those with anxiety who struggle to engage with others” (CAB adviser)

“People with mental health problems find it extremely stressful” (CAB adviser)

“[PIP assessments are] similar to ESA, in that clients with mental health issues 1. find the process very stressful - often to the point of abandoning their claims, and 2. find that their mental health issues are not recognised throughout the assessment process.” (CAB adviser)

“Those with mental health issues may not be able to open the mail notifying of the ATOS medical appointment” (CAB adviser)

The case extract below demonstrates an occasion when a client was so anxious about an assessment that she decided to abandon the claim.

Case extract:

The client attends a GP and a Psychologist and has previously been sectioned twice. The client explained that she had previously, around one year ago, applied for PIP but was not awarded the benefit at that time. The client was advised that she may qualify for PIP as her condition means that she may require help with specific daily activities. It was explained that we could help complete the PIP2 form however I could not

guarantee that she would not be asked to attend a medical assessment. The client became very agitated and anxious and stated that she did not want to apply for PIP as she could not cope mentally with the process and left abruptly asking for the notes to be shredded. I explained to the client that if she would like any further advice in the future she can return and also advised that the notes would be shredded on my return.³⁷

Regarding the accuracy of the healthcare professional's report, 59% of CAB adviser survey respondents said that clients 'rarely' agreed that the healthcare professional's report accurately reflected the discussion that took place (N=27), 20% said it 'sometimes' reflected the discussion that had taken place (N=9), and 13% (N=6) said it 'never' did (see Figure 12).

A West of Scotland CAB reports of a client who was challenging a decision regarding his PIP award. He felt that the difficulties he has taking nutrition, managing his medication and washing due to tremor in both hands had not been recognised. The client advised that statements contained within the decision maker's reasoning regarding mixing with family members and going for walks had been taken out of context. Contrary to the report, he states that he was extremely anxious on the day. Despite referring to the medical evidence the CAB had submitted with the PIP2 form in the decision letter, they do not appear to have taken into account the supporting statements contained within.

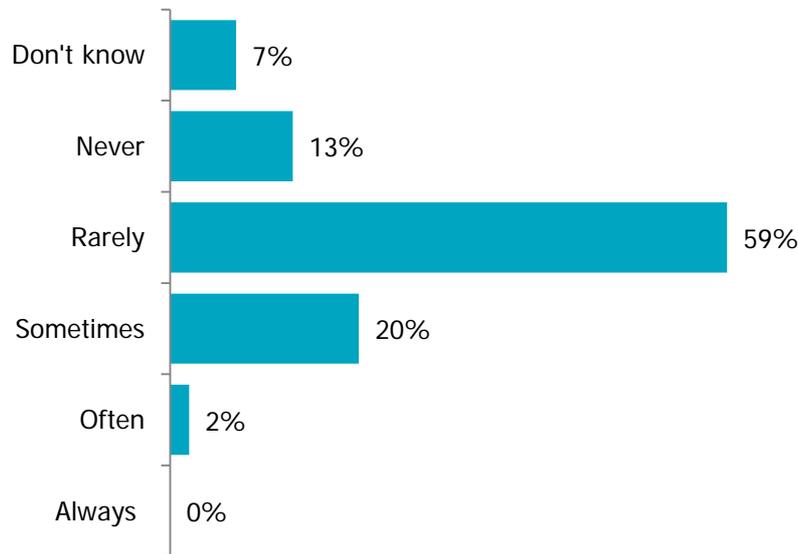
Some comments made in response to the GP survey also raised concerns regarding the assessment process:

"Despite us providing good evidence to the DWP [as is our] statutory duty, a large number of patients have their claim poorly assessed. There is often little or no examination and health problems are frequently ignored." (GP)

"Patients frequently complain about the assessment and appeals process; they tell us we get the blame for benefits being refused. Anxious and depressed patients become more anxious and depressed as a result of the assessment and appeals process, increasing our workload even further." (GP)

³⁷ This case was written up based on the adviser's recollection of the interview with the client. The notes that the client requested to be destroyed were notes in relation to her health and disabilities that would have been included in her PIP2 application form.

Figure 12: In your experience of advising clients who have seen an Atos healthcare professional's report following a consultation, how often do clients tend to agree that the report accurately reflects the discussion that took place?



Below is an account of one client's experience of a medical assessment, at which the CAB adviser was present. This client felt strongly that there was no need to carry out a face-to-face assessment as evidence had already been provided detailing her multiple health conditions. As can be seen from the account of the assessment, the Health Care Professional was also of the view that the assessment was not necessary, but proceeded 'as instructed'.

Case extract:

Assessment conducted by a medical and psychiatric nurse. [The assessor] introduced herself and stated as soon as the client entered the room that the list of her medication was self-explanatory but she needed to complete the assessment nevertheless, as instructed. The client was struggling with pain and side effects of her medication. The client was a bit muddled but coherent mostly, and managed to answer all questions. The client had to take painkillers mid-assessment due to the pain of traveling so early and sitting so long (approximately 20 minutes). The client was in so much pain it took her five minutes to stand to relieve the pain, at which point [the assessor] ended the assessment, stating that she had enough information to complete the assessment, so client was able to leave. The client complained of feeling sick due to her medication throughout the assessment.

Finally, assessment providers have the option of carrying out a paper-based assessment, to minimise the administrative burden, and to avoid clients having to undergo a face-to-face assessment where it is not necessary. When asked about the number of clients they had seen who had received a paper-based assessment, the majority of CAB adviser survey respondents (69%) said that fewer than one in 20 PIP clients – or less than 5% - receive a paper-based assessment.

4. Evidence sought from health care professionals by DWP or assessment provider at initial claim stage

KEY FINDINGS:

The survey results suggest that GPs and other health professionals spend a significant proportion of their time providing evidence to the DWP or assessment provider at the initial claim stage, filling in ESA113 or PIP forms.

CAB advisers, however, presented a different picture. When asked “what further evidence does Atos request from healthcare professionals, in addition to the PIP2 and consultation,” 69% of respondents said Atos ‘rarely’ or ‘never’ seeks additional evidence.

The findings also revealed issues with the details provided by GPs through ESA113 forms.

The survey results suggest that GPs and other health professionals spend a significant proportion of their time providing evidence to the DWP or assessment provider at the initial claim stage, filling in ESA113 or PIP forms.

Of the 61 GPs who responded to the survey, 33% (N=20) said that they received requests from DWP or the assessment provider regarding patients’ benefit claims between one and five times a week, and 28% said that they received 5 to 10 requests per week. A further 7% (N=4) said they received more than 10 requests per week.

Despite the reported frequency of the requests, when asked whether they had a set proportion of time allocated towards providing medical evidence to the assessment provider or DWP, 79% of GPs said that they did not, compared to 13% who said that they did. When presented with the opportunity to provide additional comments, nine respondents to the GP survey said that the provision of medical evidence was time consuming, and some health professionals raised concerns about the time taken away from time spent with patients:

“Personally, I have completed around 12 PIP forms in the last 6 months which eats into my time providing appointments for my patients.”
(Community Psychiatric Nurse)

CAB advisers, however, presented a different picture. When asked “what further evidence does Atos request from healthcare professionals, in addition to the PIP2 and consultation,” 19 survey respondents, said Atos ‘rarely’ seek further evidence in regards to a claim, and six further respondents said that Atos ‘never’ seeks additional evidence (together, they made up 69% of those who answered the question). The following comment from a bureau tribunal representative summarises the difficult position this puts clients in:

“Less than 1 in 10 sets of appeal papers contain medical evidence that Atos has sought themselves. Clients are often very upset or frustrated by this as they have given the details [of their doctors] and are happy for the medical professional to be contacted. Moreover a lot of services that can provide medical evidence are reluctant to give this to the client themselves.” (CAB adviser)

“[Atos] very rarely seeks further medical evidence, but place the onus on the claimant to provide this. In South Lanarkshire this presents a problem as NHS Lanarkshire have advised not to provide their patients with medical reports unless sought by an authorised body.” (CAB adviser)

These seemingly contradictory findings could be due to the fact that assessment providers such as Atos Healthcare (for PIP claims) and the Centre for Health and Disability Assessments (for ESA) only contact medical professionals in relation to a limited number of cases. This is perhaps why CAB advisers feel it is ‘rare’, but a large enough number for GPs and other health professionals to feel that it is time-consuming and contributes to their workload.

The findings also revealed issues with the details provided by GPs through ESA113 forms. These forms can be hastily completed, with limited details of conditions or how these conditions affect the individual. Figure 13 below provides an example of the kinds of cursory notes common on ESA113 forms, and more than one adviser also commented that GPs may be hesitant to complete the forms fully if they do not know how a patient’s condition affects their day-to-day lives:

“Many GP’s are reluctant to complete the tick boxes because they do not know what the person is like on a day to day basis.” (CAB adviser)

“When a GP completes a form stating that there is “no known” problems or leaves a section blank, the DWP will often assume that the claimant does not have any problems in that area. A form may be completed in this way because the GP does not know the claimant particularly well or may not have knowledge of the area being asked about” (CAB adviser)

Figure 13: Example of a completed ESA113 form

DM 1 1 1 1 1 1 1 7p

ESA113

Client Name: Mr [REDACTED]
 Client NINo: [REDACTED] Client Date of Birth: [REDACTED]

Your reply.
 Please answer the following questions from the information which is currently available to you.
 If you need more space for any of your answers, please continue at Part 7.

1 When did your patient last see a GP?
 1 12 16

2 Current conditions affecting ability to work:
 Please give us details of those conditions which may have significant effect on the person's capacity to work. Include:

- Relevant symptoms and signs, including side effects of medication, with dates. For mental health conditions, please provide brief mental state examination findings, if available.
- Past, present and planned investigations and management, including medication, where relevant.

If you are sending a computerised printout of current medication you do not need to list this here.

Please complete **both sides** of this form, and return the completed form in the supplied envelope - with the above address showing in the window

7443948/000347/2

Freepost RTGB-KGKS-AEEZ
 Centre for Health and Disability Assessments
 Glasgow ASC
 Mail Handling Site A
 Wolverhampton
 WV98 1SN
 1 8 APR 2016

Condition and date of diagnosis	Symptoms and signs	Investigations, management & medication
x Chronic issues with mental health	mostly anxiety, medicated for this	x
x See attachments		x

Figure 13 shows an example where the GP or nurse has written 'see attachments'. Usually attachments include details of the consultation between the GP and their patient and details of tests and medications.

5. Appraisal of evidence sought at initial claim stage

KEY FINDINGS:

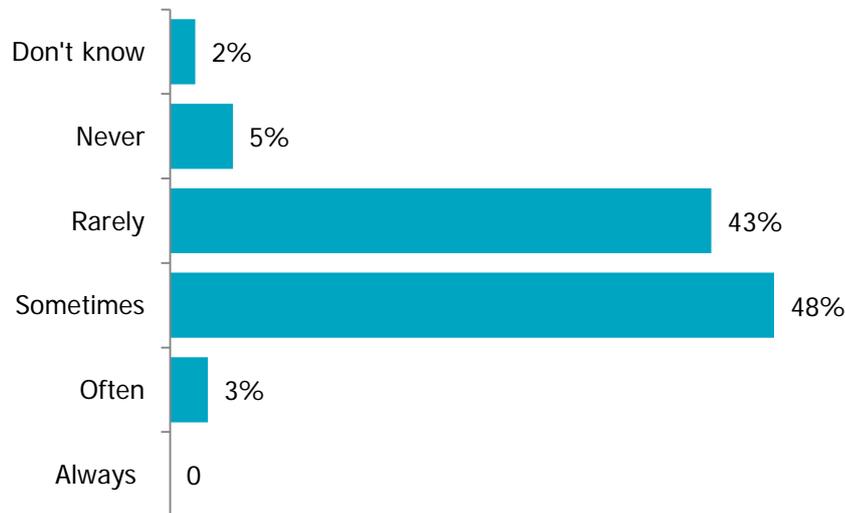
- The case analysis showed a pattern in which clients receive few points at initial claim stage and are disallowed the benefit, then request a reconsideration at which point the decision remains unchanged, and then appeal the decision and are awarded the benefit in the majority of cases.
- The CAB adviser survey results showed that almost half (48%) of survey respondents said that, in their experience, DWP decision makers 'rarely' or 'never' make decisions regarding PIP claims based on an all the available evidence.
- Some respondents to the GP and health professionals' survey also raised concerns around the appraisal of evidence at initial claim stage.

The analysis of the case studies showed that 16 out of 22 clients who appealed the initial decision about their benefit entitlement had the decision overturned on appeal. What emerges from the case analysis is a pattern in which clients receive few points at initial claim stage and are disallowed the benefit, then request a reconsideration at which point the decision remains unchanged, and then appeal the decision and are awarded the benefit in the majority of cases.

The CAB adviser survey results showed that almost half (48%) of survey respondents said that, in their experience, DWP decision makers 'rarely' or 'never' make decisions regarding PIP claims based on an all the available evidence³⁸.

³⁸ The question asked was: "In your experience, do you think DWP decision makers make decisions regarding PIP awards based on a fair appraisal of all the available evidence" and respondents were able to answer: 'always'; 'often'; 'sometimes'; rarely'; 'never'; 'don't know'. However, it was not specified whether this meant an appraisal of all evidence in the decision maker's possession at the time, or whether it meant all the evidence that might have been available from other sources.

Figure 14: In your experience, do you think DWP decision makers make decisions regarding PIP awards based on a fair appraisal of all the available evidence?



The following text, taken from correspondence between a Citizens Advice Bureau and the Tribunals Service, and provided to the researcher to supplement the case studies, shows concerns that evidence is not being appropriately considered at the earliest opportunity:

“Our greatest concern is that clients are not being correctly assessed at Mandatory Reconsideration stage and during medical assessments, which is evidenced by our success rate of between 60-70% at tribunals in favour of the client. We have had cases whereby medical evidence was provided at Mandatory Reconsideration stage and during a medical assessment and was not taken into consideration. The same medical evidence was then produced with a submission and we were successful at tribunal.”
(Correspondence between CAB staff and Tribunals Service)

Some respondents to the GP and health professionals’ survey also raised concerns around the appraisal of evidence at initial claim stage:

“I frequently feel that medical evidence from those who know the patients really well is ignored in initial assessments undertaken by ATOS and considered only at appeal. The stress this causes the patients is immense and in cases it can lead to deterioration in their health. I would say that as much as 5-10% of my time is spent with patients discussing their anxieties regarding benefits and the possibility of losing them.” (Consultant Clinical Neuropsychologist)

“It would be helpful for DWP to clarify that a letter from a GP about someone's disabilities is completely disregarded.” (GP)

“We would welcome details from DWP as to what evidence is accepted by them at each stage to stop unnecessary GP work if not accepted/required. Also clarify this to the patient prior to approaching GP.” (GP)

Mandatory Reconsideration stage

KEY FINDINGS:

- Many clients experience barriers when obtaining evidence at Mandatory reconsideration stage, including tight timescales, physical and mental health conditions, as well as financial barriers.
- Respondents to the CAB adviser survey raised concerns about there being no proper reconsideration of the original decision, and decision maker bias.

The analysis of the case studies suggests that it is more common for clients to send medical evidence at Mandatory Reconsideration stage, but the one month timescale for submitting a Mandatory Reconsideration request can mean it is difficult to gather supporting evidence, especially if the client cannot book a GP appointment within the timeframe. When asked whether one month was enough time to gather relevant medical evidence in support of their initial claim, 80% of CAB adviser survey respondents said that one month was ‘rarely’ or ‘never’ enough time.

“Unfortunately the majority of cases are not successful at mandatory reconsideration without medical evidence (and more than 50% are won at tribunal).” CAB Adviser

“There is not enough time to get supporting evidence [at mandatory reconsideration stage]. The onus is on the client but a lot of health professionals will not supply a letter unless it is requested. Clients are disadvantaged as they feel they are not believed so need to get medical evidence but are unable to do so.” CAB Adviser

Clients can experience other barriers in accessing medical evidence to support Mandatory Reconsiderations, including barriers associated with poor physical or mental health. The case extract below provides an example of where a client has failed to gather medical evidence because he is agoraphobic, has difficulties communicating, and does not have an existing relationship with his GP.

Case extract:

The client has received his mandatory reconsideration notice which indicates that he did not provide further medical evidence. The client was unable to get medical evidence, firstly because he is agoraphobic and has difficulties communicating and he did not feel able to request the evidence and also because he does not engage with medical services as he previously had a bad experience with doctors and has a gap in his medical history of about 22 years.

Medical evidence was requested by the DWP but because of the issues stated above the form was not filled in and instead just stated that the client was not known to the doctor so he could not complete the medical form requested. The client has called his doctor to ask why no information was given and was told that the wrong doctor completed this.

Client has had an occupational therapist report completed and has called to ask them to make some adjustments as the information he received he felt was incorrect. Again, he found this assessment difficult due to communication issues.

The cost of medical evidence can also present a barrier at Mandatory Reconsideration stage, as the following case study extract demonstrates.

Case extract:

Client called the office today to advise he had received contact from the MP's Office and had spoken to a member of staff there. She had advised him that he needed to provide medical supporting evidence for his claim. The client told her that he had already provided a GP letter which had cost him £18 and that he could not financially afford to try to obtain further medical evidence at this time and also that apart from his GP he has no other specialist input. She then advised him that his MR was with a decision maker and they would look at reconsideration and notify him in due course.

GPs and health professionals are also sometimes reluctant to provide patients with evidence to support a Mandatory Reconsideration, believing that it is not their role, and that the DWP will contact them if further evidence is required.

Case extract:

The client called to explain that her doctor would not supply any medical evidence for the client's mandatory reconsideration as 'the DWP would contact the doctor if information is needed'. The client is now worried as the DWP have not contacted the doctors' surgery. I advised her to get a print out of consultation letters and possibly her patient record.

In some cases, the DWP will contact the GP or health professional regarding a reconsideration of the initial decision. However, one health professional commented that they were sometimes approached by DWP regarding conditions that they had not provided information about. This health professional specialises in mental health, but was sometimes asked about the impact of physical conditions.

"I find it very frustrating that I provide supporting evidence, via letter, regarding the mental health of the service user then I sometimes get calls from the DWP requesting information about physical health. Some things I can answer but for the most part not. I don't mind being contacted to clarify things in my letter but not to ask questions that are answered in my letter already." (Community Mental Health Team)

Some case notes suggest that Mandatory Reconsiderations are more likely to be successful if medical evidence is present (see below), and the high success rate at appeal, where medical evidence is much more common, does suggest that presence of medical evidence tends to yield better results for the claimant. If, however, many clients experience the barriers outlined above, including tight timescales, physical and mental health conditions, as well as financial barriers, it raises questions around the accuracy of decision making at Mandatory Reconsideration stage, when the decision makers may not know the full extent of a claimant's conditions.

Case extract:

CAB called the DWP to ask what stage the claim was at, as the client thought he had already asked for the decision to be reconsidered. The reconsideration has begun, but no evidence has been sent, so I agreed I would send this evidence to support the reconsideration with a brief covering letter as client has already started the process. The DWP phone handler took note of this on their system and they will wait for this evidence before making a decision.

I called the client's doctor who was very keen to support the client with medical evidence so I explained to the doctor what may help support his claim... Agreed with client he would hand this evidence in and I would send on to the DWP.

The client called to say that the Mandatory Reconsideration was successful and he has been awarded the mobility component at the enhanced rate.

When CAB adviser survey respondents were asked what experience PIP clients have of the mandatory reconsideration process, 31 provided comments:

- Eight respondents said they thought the mandatory reconsideration process is a 'lengthy process' and one mentioned having waited a year for a decision;
- Seven respondents said that the mandatory reconsideration process is 'stressful' or 'upsetting' for clients;
- Four said they thought the process was 'daunting' or 'difficult' for people to undergo without support and a further two respondents mentioned clients' 'lack of understanding' of the process;
- Five responses included that clients feel that there is no proper reconsideration of the original decision, merely a 'rubber stamping' of the original decision;
- Five respondents mentioned that it is difficult for clients to gather medical evidence in support of a Mandatory Reconsideration request and two mentioned that there is little time for the client to prepare;
- And, finally, two respondents mentioned that they thought the decision makers were biased towards the Atos Healthcare Professional's report, and one respondent used the word 'unfair' to describe the process.

Appeals stage

KEY FINDINGS:

It is much more common for supporting medical evidence to be provided at appeal stage, and for advisers and representatives to be involved in gathering this evidence.

Appellants can, however, experience barriers at appeal stage too. The case studies showed evidence of GPs refusing to provide evidence because they have a policy to only provide this to the DWP.

Analysis of the case studies suggests that it is much more common for supporting medical evidence to be provided at appeal stage. This is likely to be for several reasons: firstly, there is a shared understanding between the DWP, GPs and the BMA, clients and HM Courts and Tribunals Service that the onus at this stage is on the client and the client's representatives to gather any relevant medical evidence. Secondly, there is a much longer timescale during which to gather medical evidence, and clients can have weeks and months to provide their submission; thirdly, if the client is being represented by a third party such as an advice or advocacy organisation, the representative is likely to play a more active role in the gathering of supporting evidence at this stage. The case studies would bear this assertion out, with several cases showing evidence of CAB advisers gathering medical evidence on clients' behalf.

Appellants can, however, experience barriers at appeal stage too. In addition to the financial barriers of paying for supporting evidence, the case studies showed evidence of GPs refusing to provide evidence because they appear to have a policy to only provide this to the DWP.

Case extract:

GP has refused to provide medical evidence in support of her ESA appeal as "the DWP will ask for it if they want it"; request to Occupational Health for additional information was also refused.

Case extract:

Telephone call with Practice Manager at Medical Practice. She advised that [the client's GP] can only provide medical evidence to the DWP when requested in their specific format. Therefore she cannot provide client with supporting evidence [for her appeal].

The GP survey results also reflect this, as 79% of respondents (N=49) said they had established policies, either in principle or in writing, in regards to provision of evidence direct to the DWP, and comments in response to the survey suggested some GPs prefer to provide evidence direct to the DWP rather than the patient.

It should be noted that health professionals provide medical evidence direct to the DWP at the initial claim stage and at Mandatory Reconsideration stage; it is not common at appeal stage. However, GP surgeries are within their rights to refuse to provide any further information to the patient at appeal stage, as is specified in the British Medical Association guidelines. And, indeed, this research has found one GP surgery in Scotland that states quite clearly on its website that it is 'no longer able' to provide letters in support of appeals:

"We wish to advise patients that the practice is no longer able to issue letters of support for appeals for the Department of Work and Pensions. We are sorry for any inconvenience caused."

Analysis of the case studies has shown at least three occasions (out of 23) where the First Tier Tribunal has been adjourned in order for the HM Courts and Tribunals service to gather sufficient medical evidence to make a decision. Despite the low number, this is relevant given that the appeal submission includes *all* evidence that had been available to the DWP Decision Maker, and that the Decision Maker had deemed that evidence sufficient to make a decision on the claimant's eligibility.

On some occasions, the DWP change the decision prior to an appeal being held. This occurs if the submission papers are received by the DWP and the Decision Maker judges there to be adequate evidence to overturn the decision and to not have to go to appeal. This research found evidence of this occurring in at least two of the case studies. Again, this is noteworthy as it suggests that the decision may have been different at an earlier stage if all the medical evidence were available.

Finally, the differences between DWP decision making procedures and the First Tier Tribunal is most striking in cases where the individual has received no points at the initial claim stage, no points at the Mandatory Reconsideration stage, and

then enough points at appeal stage to place them in the support group for Employment and Support Allowance (higher rate of benefit and least conditionality) or judged them eligible to receive the higher rate of Personal Independence Payment. Below is a case extract that provides full details of a client's appeal and subsequent reassessment.

Case extract:

8 July 2011: The client [who had previously been in receipt of ESA] needed assistance filling out her new Limited capability for work questionnaire (ESA50) form. The client suffers from widespread osteoarthritis, soft tissue rheumatism, fibromyalgia, Raynaud's disease, planter fasciitis, irritable bowel syndrome, spinal stenosis (trapping both sciatic nerves), and hiatus hernia. The client is easily stressed and upset, gets frustrated easily and has very poor concentration; thoughts of suicide.

21 March 2012: The client phoned to say that she has received a phone call from Job Centre Plus on Saturday morning informing her that she will no longer get ESA as she has "been on it too long" and that "she would not be entitled to any other benefit apart from DLA". Client wanted to know what to do.

11 July 2012: The client has received the Mandatory Reconsideration decision notice stating that the client does not fit the support group criteria. The client wishes to appeal.

14 February 2013: ESA appeal successful: the client was placed in support group: schedule 3 descriptor 1.

14 March 2013: Client received an ESA3 10/12 with the words "ESA Maintenance. ESA(C) Exhausted, Customer Won Appeal" hand written on the front. The client contacted Jobcentre Plus regarding this as she did not understand why she was receiving a renewal form, when she has just won her appeal on the 14th Feb 2013 and they stated that client would have to fill in the form and send it back to them this week as her contribution based ESA has stopped due to time limits and that she would have to claim income based ESA in order to continue to receive her benefits. Informed client that she has been issued this form in error.

21 March 2013: Backdated payments of £4,842 due to client will be in her account next Tuesday and that she will be in receipt of ESA - Support group payments as of the 1st April = £213 a fortnight.

1 April 2016: Client requested assistance to complete her ESA50 [reassessment].

Certification of fitness for work

KEY FINDINGS:

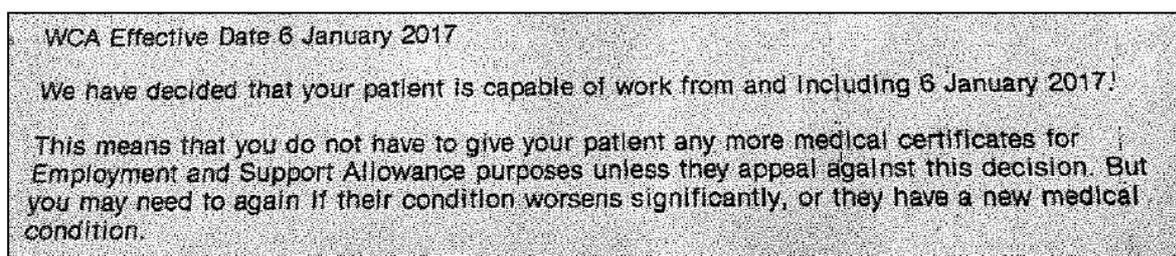
It is not always clear whether it is the GP or the DWP who has the authority to certify that an individual is unfit for work.

CAB case evidence suggests that Fit Notes can sometimes be lost in the Department's own mail handling systems.

The design of the system whereby a GP provides certification that someone is unfit for work also has the potential to lead to a 'revolving-door' scenario of transferring from JSA to ESA.

When a client has undergone a Work Capability Assessment, the DWP will send a 'Work Capability Assessment Outcome Notification' letter to the GP in question, informing the GP of whether the client has been placed in the support group, the Work Related Activity group, or been found capable of work. Through this research CAS saw examples of these letters, and the text has been provided (see figure 15).

Figure 15: Example of Work Capability Outcome Notification



WCA Effective Date 6 January 2017

We have decided that your patient is capable of work from and including 6 January 2017!

This means that you do not have to give your patient any more medical certificates for Employment and Support Allowance purposes unless they appeal against this decision. But you may need to again if their condition worsens significantly, or they have a new medical condition.

As can be seen, the letter to the GP reads “you do not have to give your patient any more medical certificates for Employment and Support Allowances purposes unless they appeal against this decision”. It is clear that the DWP is making efforts to ensure that everyone engaging with the client is aware of the outcome of the assessment, but CAS is concerned that the GP who, up until this point, has been the executive voice regarding the patient's fitness to work, is now being asked to accept the decision made by the DWP, even if they disagree.

The DWP guidance to GPs, however, states that “If you assess that your patient’s health affects their fitness for work, you should give them a fit note indicating whether your patient is not fit for work OR may be fit for work”³⁹ and makes no mention of whether or not GPs should continue to provide Fit Notes following the DWP’s decision. This has been known to cause confusion to clients (and at times, their doctors) who have been used to GPs having the authority to ‘sign them off’ as sick.

Case extract:

17 January 2017: Client broke his wrist in a motorcycle accident in February 2016 which he is still getting surgery for. At his assessment he was judged to be fit for work. For some reason he was told that he could not appeal decision. He then went to his local MP’s office which has put in a Mandatory reconsideration on his behalf.

1 February 2017: The DWP had instructed the client to open a new claim for JSA, despite him still being signed off sick by his Doctor, but when he had tried to do this he had been told that he would not be able to do so, as he was still signed off sick. He had eventually managed to open a new claim for JSA (17th Jan) but, according to the client, had been told at the Jobcentre that he would not receive any payments as he was still signed off sick. The client stated that he had also tried to get another up-to-date sick line from his Doctor, but had been told by the receptionist at his surgery that the DWP had written to the Doctor telling them that he was not to get any further sick lines. The client wanted to know if the DWP had the right to tell his Doctor not to issue anymore sick lines and what his rights were to challenge this.

In some cases, GPs do continue to issue Fit Notes following a work capability assessment decision, and CAS has seen evidence of where the Jobcentre are unwilling to accept these, even when the client has decided to appeal the decision, as the case below demonstrates.

³⁹ DWP, *Getting the Most Out of the Fit Note, Guidance for GPs*, December 2016, page 7. Available here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465918/fit-note-gps-guidance.pdf

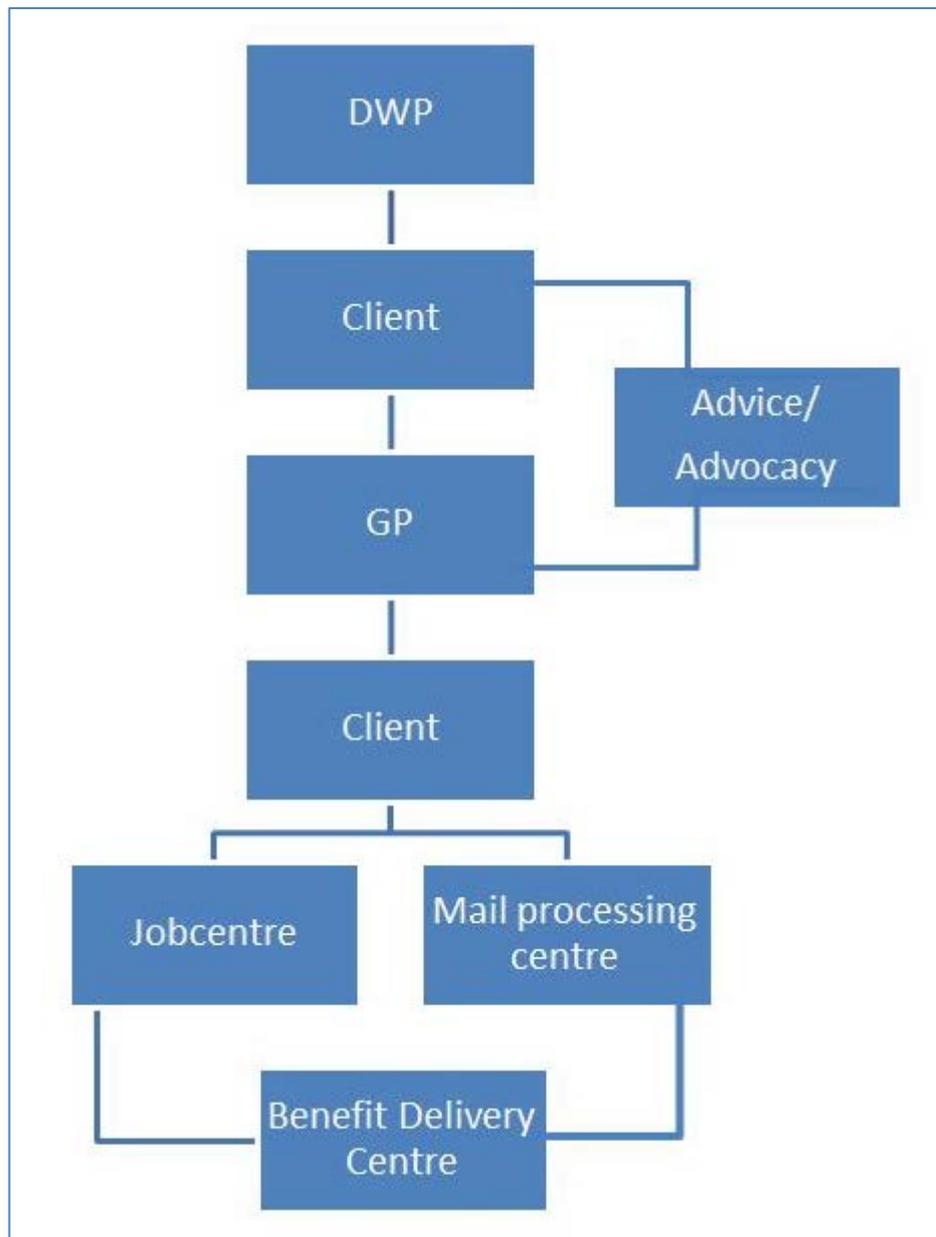
Case extract:

The client is looking for some help to submit the ESA Mandatory Reconsideration - she also has a GP support letter and a sick line.

The client [previously on ESA, but found capable of work following a WCA] has now claimed Jobseekers Allowance (JSA) again and is struggling with the mandatory work search and training. She is very anxious and as stated previously has learning difficulties which makes it very difficult for her to learn new tasks and she is unable to do the auxiliary work she previously did due to mobility problems since she had a hip replacement.

The client had taken her sick line to the Jobcentre Plus adviser when signing on and they stated that this was not sufficient for her to be let off mandatory work activity.

CAB evidence has shown that the processing of Fit Notes can create problems for clients, including gaps in payments. There are a number of steps in the journey that fit notes must take in order to be logged by the DWP and for payment to be made to those on ESA, as Figure 16 demonstrates.

Figure 16: Journey taken by Fit Note

Firstly, the DWP contacts the individual when they are due to provide an up-to-date medical certificate. These letters are generated automatically. However, there are occasions when this message does not reach the claimant – for example, because the claimant has moved house – and occasions when the claimant is unable to act on the information due to literacy, language, physical or mental health barriers.

The claimant then has two more potential barriers to overcome: one is to obtain the medical certificate from the doctor within a given period of time, and the

second is to get the medical certificate to the relevant department within the DWP.

“The letters that request the individual to send in a Fit Note are sent out generically. This causes problems for clients if the client can’t get an appointment easily at the GP practice. It causes clients anxiety if they cannot get an appointment before the Fit Note runs out.” (CAB adviser)

The Fit Note must then go from the client to the correct department within DWP via one of two routes: the client can send the Fit Note to the centralised Mail Handling Site themselves (based in Wolverhampton), or they can bring the Fit Note to the Jobcentre, who will check it and send it to the Mail Processing Centre. The Fit Note then must be sent back from the Mail Processing Centre to the relevant Benefit Delivery Centre (based in Scotland). CAB case evidence suggests that medical evidence can sometimes be lost in the Department’s own mail handling systems.

Case extract:

The client came to the bureau with a fit note (dated 10 June 2016; cover starting from 22 April 2016) - this is for submission to the Jobcentre Plus or Clydebank Benefit Delivery Centre as supporting evidence for the claim. The client advised that he had submitted a fit note to the Jobcentre recently but there was difficulty in this being forwarded by email. This client leads a chaotic lifestyle and is experiencing difficulties engaging with DWP. The client has no income and required a referral for a food parcel.

The concern is that if any of these barriers prevents the DWP from receiving an up-to-date medical certificate from the individual in question, then they may experience a gap in payments. Given that ESA and Universal Credit are income replacement benefits, this leaves the individual with no income whatsoever. CAB across Scotland have seen many clients who have presented at the bureau with their ESA payments having stopped due to an absent medical certificate.

Case extract:

The client has sent off a new sick line for his ESA claim, and was expecting a payment today. However, when he called the DWP, he was advised that his sick line had not been processed and that he would not get a payment until it did. The client sent it at the end of last week. He wanted to know if he could get a food parcel to tide him over until his payment is made. He has a 17 year old son living with him.

While gathering evidence for this report, a number of issues were mentioned by CAB advisers and other professionals as potentially creating difficulties, though it cannot be said how often these occur. These include:

- When a customer is posting a fit note themselves, the fit note will go to a central mail processing site in Wolverhampton, then to the local Benefit Delivery Centre. This can take a considerable amount of time.
- On occasion, inaccurate information is included on a fit note, for example, the address included on the fit note is that which is held by the GP practice. If the patient has moved house since they registered, the GP practice has the wrong address. This does not match the details held by the DWP and the fit note is rejected.
- Where inaccurate information has been provided, some clients try to amend the fit notes themselves, with the consequence that they are invalid, and are rejected by the DWP.
- On some occasions GPs have been known to write down a diagnosis that is not strictly medical, for example “homelessness”, again with the consequence that they are invalid.

Citizens advice bureaux, when the client is vulnerable, will often take a scanned copy of the Fit Note and also post the certificate by recorded delivery.

“Some JCP staff stated that this does not speed up the process whilst others indicated that it does. However, it has proved invaluable as we have been able to prove and provide evidence that certificates have been sent when DWP have closed claims as they state that they have never received them. We can argue that they have been received and can state when it was delivered.” (CAB adviser)

The design of the system whereby a GP provides certification that someone is unfit for work also has the potential to lead to a ‘revolving-door’ scenario of transferring from one benefit to another.

If someone is in receipt of JSA, they are allowed two short term periods of sickness of up to 14 days each and one extended period of sickness up to 13 weeks. If the sickness period extends even a day beyond this amount of time, the individual is no longer entitled to JSA and must instead make a claim for ESA. If a GP misunderstands and assumes ‘13 weeks’ is the equivalent of ‘three months’, he or she may sign-off a patient for three months. But, three months is frequently *longer* than 13 weeks, meaning that even though the intention was to only sign them off for a short period of time, the fit note has had the unintended consequence of making the individual no longer eligible for JSA. Furthermore, when that individual makes a claim for ESA, they are likely to be found fit for work, and must go back to claiming JSA, a process which can cause a disruption in payments.

Under Universal Credit this ‘revolving-door’ between different benefits has largely been designed-out. However, the confusion between 13 weeks and three

months may still remain a problem because a sickness absence that is longer than 13 weeks will, under Universal Credit, still trigger a Work Capability Assessment.

Impacts on clients

KEY FINDINGS:

Receiving an inaccurate decision when first assessed can have detrimental financial and health impacts on CAB clients.

Clients must manage on less, despite incurring the same costs related to their health condition or disability, such as having to travel by taxi.

Disputed benefits not being payable pending the mandatory reconsideration process can lead to acute income deprivation for some clients.

The stress of undergoing the assessment and appeals process can have negative impacts on mental health.

Financial detriment

There are three ways in which clients can experience financial losses as a result of the issues discussed in the previous section on decision making. Firstly, if they appeal a decision and the Tribunal judges the client to be entitled to the benefit, their award will be back-dated to the time of the original DWP decision. This means that, during the period of time that the client was challenging the decision, they should have been entitled to the benefit and receiving payments. The client may have incurred costs related to their illness or disability during this time, for example, if they had to use taxis to access services. As an illustrative example, one client represented in one of the case studies received back-dated benefit of £4,842. This means that the client had to manage on £4,842 less money that she was entitled to during the time that she was appealing the decision.

The second point at which a client can experience financial detriment is during the Mandatory Reconsideration stage. While the DWP reconsiders the decision, the disputed benefit is not payable. This becomes a problem when the benefit being disputed is Employment and Support Allowance, an income-replacement benefit. When ESA payments stop, the claimant may not have access to any other funds to cover living costs. The DWP recommend that clients claim Jobseekers Allowance pending their reconsideration notice, but CAS evidence suggests there can be administrative problems in relation to this.

These include cases where clients are told by DWP staff that they cannot claim JSA because they are 'unfit for work' and should instead be claiming ESA; and cases where there is a delay in processing the JSA claim, meaning that claimants experience a period of no income while they await their reconsideration notice. This is a common experience of CAB clients, and research carried out by CAS in 2016 on the causes and impacts of periods of no income found mandatory reconsideration to be one of the most common causes.⁴⁰ The case extract below provides an example of where the client has experienced difficulty claiming JSA pending the reconsideration of his ESA decision, but also demonstrates the knock-on impact this situation can have on Housing Benefit payments.

Case extract:

3 May 2016: Client attended appointment as agreed. He was refused ESA on the 25th of April 2016 scoring 0 points.

16 May 2016: He has an appointment with the Welfare Rights Officer on Thursday at 10am to request a Mandatory Reconsideration. The client wanders off and appears at times not to follow the conversation to its conclusion. The client has some food in his fridge and his freezer which should last him for four or five days.

Advised client to claim JSA and a crisis grant and advised him that he would need to wait to see a generalist adviser re this.

1 June 2016: Client attended bureau and advised that he had been awarded a crisis grant of £100 as a result of our help last week but that he still had not received any payment of JSA (applied for pending his ESA mandatory reconsideration) and has been without funds since 27th April. He is stressed out about his mounting debts and doesn't know what to do.

The CAB contacted DWP JSA department to determine status of claim and was advised that this was bouncing about between ESA and Jobcentre: ESA claim client is fit for work; Jobcentre claim he is not fit and citing potential for basis of extended period of sickness. The call-handler advised that this should have been subject to clerical/manual processing and has escalated this to the regional centre asking for either same day payment or short term benefit advance.

2 June 2016: Client attended the CAB requesting advice after receipt of letters from the Council. The letters were Terminations of Housing Benefit,

⁴⁰ Citizens Advice Scotland, *Living at the Sharp End: CAB clients in crisis*, July 2016. Available from: www.cas.org.uk/publications/living-sharp-end

Council Tax Reduction and Cancellation of Discretionary Housing Payment. The client had previously been in receipt of ESA but this has been stopped. The CAB is dealing with the Mandatory Reconsideration (see previous entries). The client was previously advised to apply for JSA and received a text message yesterday confirming his award and first payment of £292.40.

The third way in which someone can experience financial losses is in relation to the fees charged for provision of medical evidence when a claimant is challenging a decision. These fees can vary widely, from £10 to £75, but it is also important to note that if clients are unable to obtain supporting letters from GPs then their only option for providing medical evidence may be copies of medical records, at a charge of £40.00.

In addition to the issues already raised, many of the clients undergoing the appeals process are also experiencing financial hardship as a result of other benefits-related issues, debts and rent arrears, low pay or other crises or emergencies. Of the cases analysed, at least eight of them showed evidence of periods of acute income deprivation where the client did not have any food or enough money to pay for fuel.

Case extract:

7 July 2016: Client seemed vulnerable and became very tearful whilst we were chatting, he mentioned that he had not eaten for three days

18 July 2016: The council had not helped at all in regard to his benefits and he still had no money. Lesley had managed to get him £17 as they were conscious of him having no income and would not be able to get in touch with them via his mobile.

Case extract:

The client has no money to live on. At the moment she is not on any benefit, cannot pay rent, council tax, utility bills, food etc. and has no other income.

Physical and mental health

The analysis of the case studies showed some evidence of the impact of the assessment and appeals process on clients' mental and physical health. In two cases, clients mentioned suicidal thoughts. Although there were not enough examples to draw any conclusions, it appeared to be cases where the client had been assessed and reassessed a number of times in the space of a few years that showed the most evidence of a detrimental impact of this process on mental health.

Case extract:

The client requested assistance to complete her ESA50. The client states that the stress of the benefits process has deteriorated her health and she feels suicidal, client has informed her GP, family etc. that if this claim is not successful she will be unable to fight the decision and plans to end her life.

As mentioned previously, some respondents to the GP and health professionals' survey also raised concerns about the impact that the assessment process and appeals have on their patients' health:

"I frequently feel that medical evidence from those who know the patients really well is ignored in initial assessments undertaken by ATOS and considered only at appeal. The stress this causes the patients is immense and in cases it can lead to deterioration in their health. I would say that as much as 5-10% of my time is spent with patients discussing their anxieties regarding benefits and the possibility of losing them." (Consultant Clinical Neuropsychologist)

Information available to claimants

KEY FINDINGS:

Limited information is available to clients regarding what support they can expect from health professionals in relation to benefit claims.

The results from the online mapping exercise showed that at least 25 (31%) of the 81 GP practices for which data was gathered had no information on their website in relation to medical evidence, while 64 GP practices (79%) provided information about certification of fitness for work.

Very few practices provided a list of fees charged for providing letters, and they tended not to detail whether these referred to letters related to benefit claims.

Citizens advice bureaux who participated in the project carried out an online mapping exercise, which gathered data on what information was available to patients on the websites of just over 100 GP practices and NHS services in the fourteen locations. They looked at whether the websites provided information on policies or processes in relation to:

1. Medical certificates/ 'Statements of Fitness for Work'/ 'Fit Notes' / 'Med 3s'
2. Medical evidence provided to the DWP/assessment provider
3. Additional medical evidence provided direct to benefit claimants
4. Charges for providing medical evidence in support of benefit claims

The results showed that at least 25 (31%) of the 81 GP practices for which data was gathered had no information in relation to any of the four points above. The research found 54 GP practices (79%) that provided information about certification of fitness for work. This, for the most part was standardised text as follows:

“Self-Certificate: If you have been sick for more than four days in a row, but less than seven, you can self-certify your illness using a SC2 form. You can obtain this form from your employer or by visiting the HMRC website [links to GOV.UK website]. If you are unwell for more than four days you are advised to arrange an appointment to see a Doctor to assess your fitness to work.

“Statement of Fitness for Work: The Doctor will provide you with a Statement of Fitness for Work (‘Fit Note’) if you are still not well enough to work. Your employer will most likely request this statement as evidence to support payment of Statutory Sick Pay (SSP). Further information is available at the Direct.Gov website [link provided].”

It was less common for GP practice websites to contain information about letters or reports they could access themselves; 55 (71%) of the 77 websites for which information was provided were found to contain no information about letters or reports that a patient could request themselves. Where websites did contain this information, it tended to be standardised text as follows:

“Non-NHS Services: Some services provided are not covered under our contract with the NHS and therefore attract charges. Examples include the following:

- Medicals for pre-employment, sports and driving requirements (HGV, PSV etc.)
- Insurance claim forms
- Prescriptions for taking medication abroad
- Private sick notes
- Vaccination certificates

The fees charged are based on the British Medical Association (BMA) suggested scales and our reception staff will be happy to advise you about them along with appointment availability.”

However, the research also found two websites that featured an alternative and out of date version of this text, which makes reference to the DSS (Department of Social Security) which no longer exists:

“Non-NHS Services: We are able to offer a range of services not covered under NHS treatment. This includes:

- Completing insurance forms
- Medicals for work, driving and insurance companies
- Reports for lawyers and DSS
- Completing holiday cancellation forms

Many of these services incur a fee - details of these are available at reception.

Please note that these forms will not be completed during a routine consultation with the doctor.”

Very few practices provided a list of fees charged for providing letters, and they tended not to detail whether this referred to letters related to benefit claims. In many cases, where there was information about the charging of fees, reference was also made to British Medical Association guidelines. An example is provided below:

Figure 17: Information provided on GP practice website

Fees Charged		
Some services provided by the practice or requested by patients are not covered by NHS General Practice. We charge a fee as we are recommended to do so by the British Medical Association.		
(Fees are currently being revised)		
Forms	Passport countersignature	£30.00
	Driving Licence signature	£30.00
	Holiday Cancellation Insurance Claim	£35.00
	Private Prescription - Travel or otherwise	£
	Yellow Fever Vaccination	£60.00
Reports	Private Medical Report, (short) or Extract from Records	£55.00-£80.00
	Full report (without examination)	£55.00-£80.00

Source: Medical practice website

Several websites were found to have information about a patient’s statutory right to access their medical records. Again, this tended to be standardised text:

“In accordance with the Data Protection Act 1998 and Access to Health Records Act, patients may request to see their medical records. Such requests should be made through the practice manager and may be subject to an administration charge. No information will be released without the patient consent unless we are legally obliged to do so.”

Finally, it was found to be very rare for a website to provide information about evidence that would be provided directly to DWP or the assessment provider. The research yielded only one result where the website provided information about evidence provided direct to the DWP, and this was in relation to charges payable by the DWP for disability benefit reports.

Figure 18: Information provided on GP practice website

<i>Payable by Government Depts/Agencies (Normally not invoiced) (Set by Statute)</i>		
	Report	Report with Examination
Government Depts. in general (MOD are exempt from certain charges)	£40.00	£117.00
DVLA Reports	£11.50	£37.50
Attendance Allowance (DWP)	£33.50	
Disability Allowance (DWP)	£33.50	

Source: Medical practice website

In summary, some information is available to patients about certification of fitness to work, and non-NHS services such as access to medical records and letters, but there is not consistent access to information, and it is not always clearly communicated to the patient whether or not they can expect their GP to write a letter in relation to their benefit claim or appeal. There is even less information available on what charges this kind of letter might incur.

Comments in response to the GP and health professionals survey which suggest that GPs and other health professionals find this work time consuming and detracts from time spent with patients is perhaps an indication of why this information is not widely accessible. It may be that GP practices are reluctant to advertise these services out of concern that they may receive an increase in requests.

Conclusions

1. Different Government departments and public sector services have different responsibilities and interests in relation to assessment of ill health and disability benefits. At times these are not clearly aligned.

- The DWP has a responsibility to ensure that public money is protected, and benefits provided to those who meet the eligibility criteria. For this reason, the Department requires robust evidence to demonstrate that a claimant meets the eligibility criteria.
- DWP decision makers and Dispute Resolution Teams have an interest in gathering as much evidence as possible at an early stage so that they can get the decision right first time.
- HM Courts and Tribunals Service also has an interest in robust evidence being gathered at initial claim stage or mandatory reconsideration stage, in order to reduce demand for independent appeals. However, if a case does reach appeal stage, HM Courts and Tribunals Service has an interest in there being adequate evidence submitted in order for the Tribunal to make the right decision.
- Independent advice and advocacy organisations have an interest in seeking medical evidence from health professionals in order to best represent their clients.
- Assessment providers, contracted by DWP, have an interest in gathering robust evidence from GPs (ESA113 and PIP forms) in order that they can accurately assess the individual. However, they have limited resources that must be carefully managed, and therefore do not request medical evidence from GPs in every case.
- GPs are primarily concerned with the health of their patients, and the resources at their disposal. They experience demands from the DWP, patients, advice and advocacy organisations to provide details of patients' conditions and how these conditions impact on their everyday lives. GPs, however, may not have frequent contact with the patients in question, and do not always feel qualified to make a judgement regarding how conditions are experienced by the individual.
- The British Medical Association is primarily concerned with protecting the workload of GPs and other health professionals; making sure they are not working for free; and ensuring that GPs are able to focus on medical rather

than non-medical work. In order to do this, they issue guidance about how to respond to requests from the DWP or patients regarding benefit claims.

These responsibilities and interests are equally valid and important, but makes for a system in which the claimant can receive mixed messages, and means that there is not always the same degree of evidence available at the initial claim stage as there is at the appeal stage.

Related to this, it is not always clear whether it is the GP or the DWP who has the authority to certify that an individual is unfit for work. When a client has undergone a Work Capability Assessment, the DWP will send a 'Work Capability Assessment Outcome Notification' letter to the GP in question, which reads "you do not have to give your patient any more medical certificates for Employment and Support Allowances purposes unless they appeal against this decision". The authority for certifying whether someone is fit or unfit for work has thereby transferred from the GP to the DWP and it is of concern that the GP who, up until this point, has been the executive voice regarding the patient's fitness to work, is now asked to accept the decision made by the DWP, even if they disagree.

2. The findings suggest that, in many cases, not enough information is available to decision makers at initial claim stage, or at Mandatory Reconsideration stage to make fully informed, accurate decisions.

The findings of this research suggest that this is due to the following factors:

- The DWP and assessment provider does not always request evidence from GPs or other health professionals at initial claim stage and those claiming benefits are told to only provide information they have to hand, such as prescriptions.
- The forms that the DWP or the assessment provider requests GPs to fill in at the initial claim stage – the ESA113 and PIP forms – can lack detail.
- The timescale at Mandatory Reconsideration stage does not allow enough time to gather supplementary evidence, compared to the much longer timescales at appeal stage.
- GP practices sometimes refuse to provide supporting medical evidence direct to claimants, or may charge fees which can act as a financial barrier for claimants.
- Advice and advocacy organisations are more likely to be involved in gathering further medical evidence at appeal stage than at Mandatory Reconsideration or initial claim stage.

3. Receiving an inaccurate decision when first assessed can have detrimental financial and health impacts on CAB clients.

- Clients must manage on less, despite incurring the same costs related to their health condition or disability, such as having to travel by taxi.
- Disputed benefits not being payable pending the mandatory reconsideration process can lead to acute income deprivation for some clients.
- The stress of undergoing the assessment and appeals process can have negative impacts on mental health.

4. Limited information is available to clients regarding what support they can expect from health professionals in relation to benefit claims.

- The results from the online mapping exercise showed that at least 25 (28%) of the 81 GP practices for which data was gathered had no information on their website in relation to medical evidence, while 64 GP practices (67%) provided information about certification of fitness for work.
- Very few practices provided a list of fees charged for providing letters, and they tended not to detail whether these referred to letters related to benefit claims.

5. The processing of Fit Notes can create problems for clients, including gaps in payments.

- CAB case evidence suggests that Fit Notes can sometimes be lost in the Department's own mail handling systems.
- The design of the system whereby a GP provides certification that someone is unfit for work also has the potential to lead to a 'revolving-door' scenario of transferring from JSA to ESA.

Policy implications

This report has concluded that improvements could be made to how incapacity and disability benefits are assessed, and the role that medical evidence plays in the system. As was stated at the outset of the report, the degree to which a social security agency must rely on independent assessment and medical evidence is dependent upon the degree to which the individual is deemed capable of accurately assessing their own needs. Our research has shown that accuracy of decisions could be improved by more evidence being gathered at an earlier stage of the claim. This could also include taking better account of evidence provided through the individual's self-assessment, and the evidence provided by friends, family and carers who see how an individual's condition affects their ability to carry out everyday activities.

Under the current system, Further Medical Evidence is gathered in some, but not all cases. If this means the decision maker has inadequate evidence to make an accurate decision, and the claimant decides to appeal the decision, the onus and financial burden of gathering this medical evidence then transfers to them.

Furthermore, this creates a tension between the claimant, the claimant's representatives, those in the health profession and the DWP, all of whom view the role and responsibilities of GPs and other health professionals slightly differently. GPs have limited time to provide detailed reports at the initial claim stage, and if they provide supporting evidence at appeal stage, this can impact on their workload, resources, and the time spent with patients.

There are a number of upcoming opportunities to improve and refine the way in which medical evidence is gathered and treated within the benefits system. In relation to Employment and Support Allowance (and Universal Credit), the UK Government's Work and Health agenda poses an opportunity to revisit the way in which Work Capability Assessments are carried out, and to improve data sharing between the NHS and the DWP. In addition to this, the new digital platform for Universal Credit may present opportunities for sharing documentation such as Fit Notes in a more timely and straightforward manner.

With regards to disability benefits, the UK Government's consideration of the recently published Second Independent Review of Personal Independence Payment presents an opportunity to rethink the way evidence is gathered and assessed. And, last but by no means least, the devolution of disability benefits to Scotland presents an important opportunity to design a disability benefits system that considers new ways of assessing eligibility for the new Scottish benefits.

Solutions to the issues raised in this report are not straightforward, and can only be reached with careful consideration and joint working between each relevant government department and agency involved in the process. Citizens Advice Scotland sees the impacts of decision making and the appeals process on CAB clients, and although we do not purport to have all the answers, we hope that we can be part of an ongoing conversation around improvements that benefit the DWP, GPs, the NHS, HM Courts and Tribunals Service, and most importantly, those in need of benefits.

Appendix 1

Personal Independence Payment CAB Survey

The responses to this survey were collected online via SurveyMonkey.

About you and your CAB

1. Name of participating CAB
2. What is your role within the CAB?
3. In the last six months, approximately how many clients have you advised regarding a PIP claim?

Section 1: Processing and administration

Thinking back over the last six months:

4. In your experience, what is the average waiting time for receiving a consultation with Atos after having completed and returned their PIP1 form?
 - a) Less than one month
 - b) Between one and three months
 - c) Between three and six months
 - d) Between six and nine months
 - e) Between nine months and a year
 - f) More than a year
5. In your experience, what is the average waiting time for clients receiving a decision regarding their PIP award following a consultation with Atos?
 - a) Less than two weeks
 - b) Between two and three weeks
 - c) Between three and four weeks
 - d) Between four and six weeks
 - e) Longer than six weeks
6. In your experience, what number of clients do you estimate undergo a paper-based assessment as opposed to a face-to-face consultation?
 - a) Fewer than one in 20 PIP clients receive a paper-based assessment
 - b) Approximately one in 20 PIP clients
 - c) Approximately one in 10 PIP clients
 - d) Approximately one in 5 PIP clients
 - e) Approximately 1 in 2 PIP clients
 - f) The majority of PIP clients receive a paper-based assessment

7. In your experience, are paper-based assessments more or less likely to lead to a successful award?
- a) A paper-based assessment is more likely to lead to a successful award
 - b) A face-to-face consultation is more likely to lead to a successful award
 - c) Neither a paper-based assessment nor a face-to-face consultation is more likely to lead to a successful award
8. In your experience, are there any administrative issues clients experience in transferring from DLA to PIP?
[Text box]

Section 2: Making a claim

9. How do clients find the completion of the PIP form?
[Text box]
10. In your opinion, what proportion of PIP clients are able to complete the PIP1 form on their own?
- a) All PIP clients are able to complete the form on their own
 - b) Most (three in five) PIP clients are able to complete the form on their own
 - c) Some (two in five) PIP clients are able to complete the form on their own
 - d) A few (one in five) PIP clients are able to complete the form on their own
 - e) Very few (one in ten) PIP clients are able to complete the form on their own
11. The government plan to introduce online PIP forms. In your opinion, what proportion of PIP clients have the digital skills required to complete the PIP1 form online on their own?
- a) All PIP clients have the digital skills needed to fill in a PIP1 form online on their own
 - b) Most (three in five) PIP clients have the digital skills needed to fill in a PIP1 form online on their own
 - c) Some (two in five) PIP clients have the digital skills needed to fill in a PIP1 form online on their own
 - d) A few (one in five) PIP clients have the digital skills needed to fill in a PIP1 form online on their own
 - e) Very few (one in ten) PIP clients have the digital skills needed to fill in a PIP1 form online on their own

Section 3: Supporting evidence

12. Who do clients tend to obtain supporting evidence from? (please tick all that apply)

- GP
- Community Psychiatric Nurse
- Social worker
- Occupational Therapist
- Physiotherapist
- Nurse
- Specialist Doctor
- Mental health service providers (both NHS and other)
- Other allied health professionals (includes chiropodists, speech and language therapists, prosthetists)
- Other (please specify)

13. In your experience, what types of supporting evidence do claimants send in as part of their claim?

[Text box]

14. How easy is it for clients to gather evidence in support of their claim (when completing and submitting their PIP1 form)?

	<i>Supporting evidence can be obtained...</i>				
	with ease	with some difficulty	with difficulty	with great difficulty	It is not at all possible
From GP					
From specialist doctors					
From social work					
Allied Health					

Professionals					
Mental health service providers					

15. How do clients find the process of gathering medical evidence?

[Text box]

16. In your experience, is one month enough time for a client to gather relevant medical evidence in support of the PIP1 form?

- a) Yes, in all cases
- b) Yes, in most cases
- c) No, it is rarely enough time
- d) No, it is never enough time
- e) Don't know

17. In your experience what further evidence does Atos request on claimants' behalf, in addition to the PIP1 and consultation? Is this requested on time and used appropriately and fairly?

[Text box]

Section 4: Consultations with healthcare professionals

18. Are there any barriers that PIP clients experience in accessing a consultation with an Atos healthcare professional?

[Text box]

19. Where is the closest assessment centre to your bureau?

[Text box]

20. In your experience, if a client requires a home visit assessment, do they receive a home visit by an Atos healthcare professional?

- a) Yes, in all cases
- b) Yes, in most cases
- c) No, it is rarely possible for a client to get a home visit
- d) No, it is never possible for a client to get a home visit
- e) Don't know

21. In your experience, what is the average waiting time for receiving a home visit consultation with Atos after having requested one?

- a) Less than one month

- b) Between one and three months
- c) Between three and six months
- d) Between six and nine months
- e) Between nine months and a year
- f) More than a year

Section 5: Consultations with Healthcare Professionals

Based on your experience as an adviser, please respond to the following questions about clients' experiences of Atos consultations as part of the PIP assessment process.

22. In your experience of advising clients about their PIP claims, how often do issues relating to the manner of Atos healthcare professionals get mentioned by clients during the advice interview?
- a) Every time I offer advice to clients about their PIP claim
 - b) Often when advising clients about their PIP claim
 - c) Sometimes when advising clients about their PIP claim
 - d) Rarely when advising clients about their PIP claim
 - e) Never when advising clients about their PIP claim
 - f) Don't know
23. In your experience of advising clients about their PIP claims, how often do issues relating to the time taken by Atos healthcare professionals get mentioned by clients during the advice interview?
- a) Every time I offer advice to clients about their PIP claim
 - b) Often when advising clients about their PIP claim
 - c) Sometimes when advising clients about their PIP claim
 - d) Rarely when advising clients about their PIP claim
 - e) Never when advising clients about their PIP claim
 - f) Don't know
24. In your experience of advising clients about their PIP claims, how often do issues relating to the appropriateness of the questions asked by Atos healthcare professionals get mentioned by clients during the advice interview?
- a) Every time I offer advice to clients about their PIP claim
 - b) Often when advising clients about their PIP claim
 - c) Sometimes when advising clients about their PIP claim
 - d) Rarely when advising clients about their PIP claim
 - e) Never when advising clients about their PIP claim
 - f) Don't know
25. In your experience of advising clients who have seen an Atos healthcare professional's report following a consultation, how often do clients tend to agree that the report accurately reflects the discussion that took place:

- a) Always
- b) Often
- c) Sometimes
- d) Rarely
- e) Never
- f) Don't know

26. How does the PIP process compare to similar assessments (e.g. ESA work capability assessment or an occupational health assessment)?

[Text box]

27. Do you have any further comments you would like to make concerning clients experiences of Atos consultations as part of the PIP assessment process?

[Text box]

Section 6: Decisions and awards

28. In your opinion, are the rates of awards available under PIP adequate to meet the extra costs associated with daily living and/or mobility?

Daily living – standard rate	Daily living – enhanced rate	Mobility – standard rate	Mobility – enhanced rate
Yes – rate of awards are adequate			
No – rate of awards are not adequate	No – rate of awards are not adequate	No – rate of awards are not adequate	No – rate of awards are not adequate
Don't know	Don't know	Don't know	Don't know

29. If you said 'no' to the above question, what impact does this have on CAB clients?

[Text box]

30. In your opinion, are the lengths of awards available under PIP adequate?

- a) Length of awards are adequate in all cases
- b) Length of awards are adequate in most cases
- c) Length of awards are adequate in less than half of cases
- d) Length of awards are inadequate in most cases
- e) Length of awards are inadequate in all cases

31. In your experience, do you think DWP decision makers make decisions regarding PIP awards based on a fair appraisal of all the available evidence?

- a) Always
- b) Often
- c) Sometimes
- d) Rarely
- e) Never
- f) Don't know

32. When appealing a decision regarding their PIP claim, are there specific descriptors for which clients are commonly awarded additional points? If so, which descriptors?

[Text box]

33. What experience do PIP clients have of the mandatory reconsideration process?

[Text box]

34. What experience do PIP clients have of the appeals process?

[Text box]

Section 7: General questions:

Do you have any other comments about how the PIP claim process be improved? Please provide examples or suggestions.

[Text box]

Appendix 2

List of all documentary evidence included in analysis

Type of document	Pages	Benefit	From whom	To whom
Mandatory Reconsideration Notice - no change	5	ESA	DWP	Client
Further Medical Evidence - from GP	1	ESA	Medical Practice	The DWP/HMCTS
Further Medical Evidence - from Adult Community Mental Health Services	1	ESA	NHS - Adult Community Mental Health Services	The DWP/HMCTS
Appeal papers - Grounds for Appeal	1	ESA	Client/CAB	HMCTS
Letter from HMCTS - appeal lapsed, no further action	1	ESA	Client/CAB	HMCTS
ESA decision letter	9	ESA	DWP	Client
Request for a Mandatory Reconsideration	1	ESA	Client/CAB	DWP
Further Medical Evidence - from GP	1	ESA	Medical Practice	Client
Mandatory Reconsideration Notice - no change	3	ESA	DWP	Client
Appeal papers - Grounds for Appeal	1	ESA	Client/CAB	HMCTS
Mandatory Reconsideration Notice - decision changed	4	ESA	DWP	Client
Tribunal Adjournment Notice - requires DWP and client to provide all medical evidence	1	ESA	HMCTS	Client and DWP

Tribunal Decision Notice - decision changed	5	ESA	HMCTS	Client/DWP
Letter to Centre for Health and Disability Assessments re. ESA50 questionnaire wrongly sent	2	ESA	Client/CAB	CHDA (Maximus)
Further Medical Evidence - from GP	1	ESA	Health Centre	DWP
Further Medical Evidence - from GP	1	ESA	Health Centre	CAB
Mandatory Reconsideration request	2	ESA	Client/CAB	DWP
Appeal papers - Grounds for Appeal	3	ESA	Client/CAB	HMCTS
Email to David Mundell's office re. client's ESA	2	ESA	CAB	David Mundell MP's constituency office
Scottish Public Pensions Agency - application form?	9	ESA	Scottish Public Pensions Agency	Unknown
Further Medical Evidence - GP letter	1	ESA	GP	CAB
Further Medical Evidence - GP letter	1	ESA	GP	ATOS
Further Medical Evidence - GP letter	1	ESA	GP	Unknown
ESA decision letter	9	ESA	DWP	Client
Mandatory Reconsideration request	2	ESA	Client	DWP
Mandatory Reconsideration notice - no change	4	ESA	DWP	Client

Appeal papers - Form SSCS1	4	ESA	Client/CAB	DWP
Appeal papers - Grounds for Appeal	2	ESA	CAB	DWP
Further medical evidence - consultant letter	2	ESA	Royal Infirmary	GP
Further medical evidence - list of medications	1	ESA	NHS	GP
Further Medical Evidence - GP letter	2	ESA	GP	CAB
Tribunal Decision Notice - decision changed	2	ESA	HMCTS	Client
Appeal papers - Form SSCS1	6	ESA	Client/CAB	DWP
Tribunal Decision Notice - decision changed	2	ESA	HMCTS	Client
Mandatory Reconsideration request	4	ESA	Client	DWP
Further Medical Evidence - GP letter	1	ESA	GP	Unknown
WCA appointment letter	1	ESA	HAAS	Client
WCA appointment letter	1	ESA	HAAS	Client
ESA decision letter - benefit awarded	1	ESA	DWP	Client
ESA50 - additional information supplied by client	1	ESA	Client	DWP
Further medical evidence - CAB request to GP	2	ESA	CAB	GP
Further medical evidence - GP position on ESA appeal letters	1	ESA	GP	CAB
Mandatory Reconsideration request	2	PIP	Client/CAB	DWP

PIP decision letter	7	PIP	DWP	Client
Mandatory Reconsideration notice - no change	8	PIP	DWP	Client
Appeal papers - Grounds for Appeal	3	PIP	Client/CAB	HMCTS
Further Medical Evidence - Neurology Clinic	3	PIP	NHS, Neurology Clinic	HMCTS
Tribunal Adjournment Notice - to gather further medical evidence	1	PIP	HMCTS	Client/DWP
HMCTS - Further Evidence related to the appeal (client's full medical records)	25	PIP	HMCTS	Client/DWP
Further Medical Evidence - GP letter	1	PIP	Medical Practice	DWP
PIP decision letter - benefit not awarded	6	PIP	DWP	Client
Mandatory Reconsideration request	3	PIP	Client/CAB	DWP
Mandatory Reconsideration notice - no change	5	PIP	DWP	Client
Appeal papers - Grounds for Appeal	2	PIP	Client/CAB	HMCTS
Page from PIP application form detailing documents sent in support of initial claim	1	PIP	Client/CAB	DWP
Further Medical Evidence - GP letter	1	PIP	Medical Practice	DWP
Further Medical Evidence - GP letter	1	PIP	Medical Practice	DWP
PIP decision letter	5	PIP	DWP	Client
Further Medical Evidence -	1	PIP	NHS, Day	DWP

Day Surgery			Surgery	
Mandatory Reconsideration request	2	PIP	Client/CAB	DWP
Mandatory Reconsideration notice - no change	5	PIP	DWP	Client
Appeal papers - Grounds for Appeal	4	PIP	Client/CAB	HMCTS
Revision letter - DWP changed decision prior to appeal	1	PIP	DWP	Client
Referral letter	1	PIP	GP	Neurology department
Tribunal Decision Notice - decision changed	1	PIP	HMCTS	Client/DWP
Letter to request Further Medical Evidence	1	PIP	CAB	GP
Tribunal Decision Notice - decision changed	1	PIP	HMCTS	Client
PIP decision letter - benefit awarded	7	PIP	DWP	Client
Mandatory Reconsideration request	1	PIP		
PIP decision letter - benefit denied	33	PIP	DWP	Client
PIP Assessment - client comment	6	PIP	Client	CAB
Mandatory Reconsideration request	2	PIP	CAB	DWP
Patient summary and medication list	2	PIP	GP	Client
Client daily log and personal statement	7	PIP	Client	Unknown

Further Medical Evidence - GP letter	1		GP	Unknown
Further Medical Evidence - GP letter	1	PIP	GP	CAB
Mandatory Reconsideration notice - no change	4	PIP	DWP	Client
Mandatory Reconsideration notice - no change (annotated with clients comments)	4	PIP	DWP	Client
Appeal papers - Form SSCS1	6	PIP	Client/CAB	DWP
Appeal papers - Grounds for Appeal	2	PIP	CAB	DWP
Tribunal Decision Notice - decision changed	2	PIP	HMCTS	Client/DWP
PIP - Award post appeal	9	PIP	DWP	Client
Mandatory Reconsideration request	2	PIP	CAB	DWP
Mandatory Reconsideration notice - no change	4	PIP	DWP	Client
Appeal papers - Form SSCS1	6	PIP	Client/CAB	DWP
Appeal papers - Grounds for Appeal	2	PIP	CAB	DWP
Appeal papers - client daily log	1	PIP	Client	Unknown
Further medical evidence - optician letter	1	PIP	Optician	Unknown
End of DLA/Start of PIP notification & statement of entitlement	8	PIP	DWP	Client
Medical evidence - proof of provision of medical	1	PIP	Client	DWP

professional's details				
PIP decision letter - reassessment	6	PIP	DWP	Client
Medical consultation report - list of evidence provided	1	PIP	Atos	Unknown
Medical evidence - neuropsychologist letter	1	PIP	NHS	DWP
Appeal papers - Grounds for Appeal	2	PIP	CAB	DWP
Medical evidence - neuropsychologist letter	2	PIP	NHS	Unknown
Appeal - tribunal report	9	PIP	Unknown	Unknown
Tribunal Decision Notice - decision changed	2	PIP	HMCTS	Client
Appeal papers - Grounds for Appeal	1	PIP	Client/CAB	DWP
Medical evidence - GP letter	2	PIP	GP	Unknown
Mandatory Reconsideration - letter of support from CAB	2	PIP	CAB	DWP
Mandatory Reconsideration - letter from CAB requesting late MR	1	PIP	CAB	DWP
Tribunal notice - adjournment for further medical evidence	1	PIP	HMCTS	HMCTS
PIP decision letter - award coming to an end	5	PIP	DWP	Client
Letter from Atos Healthcare regarding PIP assessment report	2	PIP	Atos Healthcare	Client/CAB
Mandatory Reconsideration request	3	PIP	DWP	Client/CAB

Mandatory Reconsideration notice - decision changed	8	PIP	DWP	Client
--	---	-----	-----	--------

Appendix 3

Incapacity benefits – Policy Context

Employment and Support Allowance (ESA) was introduced by the UK Labour Government in 2008 as a new benefit for those unable to work due to ill health or disability. ESA replaced Incapacity Benefit (IB), and in April 2011 the DWP began migrating IB claimants onto ESA through a process of reassessment using the new ‘Work Capability Assessment’. The policy intent behind the new benefit was the principle that “everyone should have the opportunity to work” and that “people with an illness or disability should get the help and support necessary for them to engage in appropriate work, if they are able.”⁴¹

The Work Capability Assessment (WCA) is a face-to-face functional assessment carried out by an independent assessment provider, contracted by the DWP. The WCA was introduced to assess a claimant’s eligibility for the benefit and, if so, the level of support they should be entitled to. There are two groups of ESA, the Support Group – the higher rate of the benefit and no conditionality – and the Work Related Activity Group, which has limited conditionality.

Since its introduction, the Work Capability Assessment has received media attention and criticism from disability rights groups⁴², and was the focus of the first inquiry by the previous Parliament’s Work and Pensions Committee in 2014⁴³. Five independent reviews carried out by Professor Malcolm Harrington

⁴¹ Archived DWP web content. Available from: webarchive.nationalarchives.gov.uk/20100407120701/dwp.gov.uk/healthcare-professional/benefits-and-services/employment-and-support/

⁴² For example, see: The Guardian newspaper, *Disabled charities attack fit-to-work tests after 1m people denied benefit*, 25 January 2014. Available from: www.theguardian.com/society/2014/jan/25/disabled-charities-fit-to-work-tests-benefit; The Independent, *DWP’s fit-to-work tests ‘cause permanent damage to mental health’, study finds*, 13 March 2017. Available from: www.independent.co.uk/news/uk/politics/fit-to-work-wca-tests-mental-health-dwp-work-capability-assessment-benefits-esa-pip-a7623686.html; The Week, *‘Fit to work’ tests not fit for purpose, say MPs*, 24 July 2014. Available from: www.theweek.co.uk/uk-news/59642/fit-to-work-tests-not-fit-for-purpose-say-mps

⁴³ House of Commons, Work and Pensions Select Committee, *First Report: Employment and Support Allowance and Work Capability Assessments*, July 2014. Available from: www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/inquiries/parliament-2010/esa-wca-inq-2014/

CBE⁴⁴ and Dr Paul Litchfield⁴⁵ led to a number of improvements, but the contract with Atos Healthcare was not renewed in 2015 when claimants were experiencing significant delays before receiving an assessment. The Centre for Health and Disability Assessments, run by Maximus, now holds the contract to assess eligibility for ESA.

Disability benefits – Policy Context

Disability benefits are non means-tested benefits which are paid to individuals with disabilities and/or disabling conditions in recognition of the additional costs that their disability may incur. In 2010, the UK Government announced that Disability Living Allowance would be replaced with Personal Independence Payment, partly to reduce the budget spent on disability benefits and to ensure that payment was being made to those who were in most need⁴⁶. The intention behind PIP was to introduce different eligibility criteria which focussed on a needs-based assessment rather than specific conditions and to assess these needs through a more objective assessment process⁴⁷.

In April 2013, the first new claims for PIP were made, with the reassessment of all existing DLA claims originally set for completion by October 2017, although

⁴⁴ Professor Malcolm Harrington, *An Independent Review of the Work Capability Assessment – year one*, November 2010, and the *Government's response to Professor Malcolm Harrington's Independent Review of the Work Capability Assessment*, November 2010; Professor Malcolm Harrington, *An Independent Review of the Work Capability Assessment – year two*, November 2011, and the *Government's Response to Professor Malcolm Harrington's Second Independent Review of the Work Capability Assessment*, November 2011; and Professor Malcolm Harrington, *An Independent Review of the Work Capability Assessment – year three*, November 2012, and the *Government's Response to Professor Malcolm Harrington's Third Independent Review of the Work Capability Assessment*, November 2012

⁴⁵ Dr Paul Litchfield, *An Independent Review of the Work Capability Assessment – year four*, December 2013, and the *Government's response to the year four independent review of the Work Capability Assessment*, March 2014

⁴⁶ Department for Work and Pensions, *Government's Response to the consultation on Disability Living Allowance Reform*, April 2011, page 3. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181637/dla-reform-response.pdf

⁴⁷ Paul Gray, *An Independent Review of the Personal Independence Payment Assessment*, December 2014, pages 19-20. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf

this timetable has now been extended. From October 2015, the DWP began inviting DLA working age recipients to claim PIP and, at the end of January 2017, 543,200 claims in payment were reassessment claims from DLA (44% of the total PIP caseload). ‘Full PIP Rollout’ is now expected to complete by October 2018.⁴⁸

The Welfare Reform Act 2012 mandated two Independent Reviews of PIP. The first of these was carried out by Paul Gray in 2014 in the context of lengthy delays and backlogs in the assessment process. The review made the following recommendations with regards to the gathering of further medical evidence:

- Explore opportunities for improving the collection of further evidence by:
 - a) reviewing external communications so that messages about further evidence are consistent and give greater clarity about the type of evidence required and who is responsible for gathering the information;
 - b) where appropriate and relevant, sharing information and evidence from a Work Capability Assessment or other sources of information held by the Department;
 - c) examining the potential for wider sharing of information and evidence across assessments carried out in other parts of the public sector, for example health and social care reports.⁴⁹

There was also recognition that “there is a tension between the claimants’ view of GPs as their most trusted source of reliable evidence, and GPs’ own view that they are often less well placed than other professionals to comment on functional impact.”⁵⁰

⁴⁸ Department for Work and Pensions, *Personal Independence Payment: Official Statistics*, March 2017. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/598755/pip-statistics-to-january-2017.pdf

⁴⁹ Paul Gray, *An Independent Review of the Personal Independence Payment Assessment*, December 2014, Page 11. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf

⁵⁰ Paul Gray, *An Independent Review of the Personal Independence Payment Assessment*, December 2014, Page 8. Available from:

In March 2017, Paul Gray published the results of his second independent review of Personal Independence Payment, focussing on the assessment of the benefit. One key conclusion of the review is that “public trust in the fairness and consistency of PIP decisions is not currently being achieved, with high levels of disputed award decisions, many of them overturned at appeal.”⁵¹ He makes a number of recommendations around improvements that can be made to the way in which evidence is gathered and appraised, as well as quality auditing of decision making. Of particular relevance to this report, the Review recommended that:

- The DWP makes clear that the responsibility to provide Further Evidence lies primarily with the claimant and that they should not assume the Department will contact health care professionals.
- Assessment Providers and the DWP work to implement a system where evidence is followed up after the assessment where useful evidence has been identified and may offer further relevant insight.
- The Department ensures that evidence of carers is given sufficient weight in the assessment.
- In the longer term, the Department should develop a joined up digital journey which includes an online facility for both claimants and external Health Professionals to upload documentary evidence securely.⁵²

Devolution of disability benefits to Scotland

Resulting from commitments made following the 2014 Scottish Independence Referendum, new social security powers have been devolved to the Scottish Parliament under the Scotland Act 2016. These include disability benefits, which

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf

⁵¹ Paul Gray, *The Second Independent Review of the Personal Independence Payment Assessment*, March 2017, Page 3. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf

⁵² Paul Gray, *The Second Independent Review of the Personal Independence Payment Assessment*, March 2017, Pages 11-12.

make up the vast majority of the social security budget to be devolved, and are claimed by 10% of the Scottish population.

The Scottish Government has so far:

- Published the ‘A New Future for Social Security in Scotland’ vision paper, outlining the Scottish Government’s core principles⁵³;
- Carried out an appraisal of the options for delivering social security in Scotland and decided to deliver this through a new Social Security Agency;
- Carried out a broad and wide-ranging consultation on the future of social security in Scotland which received responses from more than 500 individuals and organisations⁵⁴;
- Published the Government’s response to this analysis in February 2017⁵⁵.

The Scottish Government has committed to reforming the way in which disability benefits are assessed, “from application all the way through to final decision”⁵⁶ and aims to reduce the number of face-to-face assessments and re-assessments carried out, but has not yet outlined how this will be achieved. An Expert Advisory Group and Experience Panels have been established to inform the design of the new system.

Later in 2017, the Scottish Government will introduce a Social Security Bill to the Scottish Parliament, but it is unlikely that disability benefits will be fully delivered and administered by the Scottish Social Security Agency until at least 2020.

⁵³ Scottish Government, *A New Future for Social Security in Scotland*, March 2016. Available from: www.gov.scot/Resource/0049/00496621.pdf

⁵⁴ Scottish Government, *Analysis of Written Responses to the Consultation on Social Security in Scotland*, February 2017. Available from: consult.scotland.gov.uk/social-security/social-security-in-scotland/results/00514346.pdf

⁵⁵ Scottish Government, *A New Future for Social Security Scottish Government Response to the Consultation on Social Security in Scotland*, February 2017. Available from: www.gov.scot/Resource/0051/00514404.pdf

⁵⁶ Scottish Government, *A New Future for Social Security Scottish Government Response to the Consultation on Social Security in Scotland*, February 2017, page 14. Available from: www.gov.scot/Topics/People/fairerscotland/Social-Security/SG-Response

Appendix 4

Decision Making and Mandatory Reconsideration – recommendations from Social Security Advisory Committee

The Social Security Advisory Committee, as part of its independent work programme, last year published a paper on Decision Making and Mandatory Reconsideration. This study concluded that Mandatory Reconsideration “could be an efficient process that provides opportunity for timely review” but that “the process does not work as well as it should.”

The report makes a total of 37 recommendations around how decision making and Mandatory Reconsideration could be improved. The following recommendations⁵⁷ are of particular relevance to this report. Recommendations that:

1. The DWP and HMRC consider whether current time limits for requesting an MR and submitting evidence are conducive to effective evidence gathering.
2. The DWP should provide clarity for claimants under what circumstances it will gather evidence for claimants and what expectations are placed upon them at each stage in the decision making process.
3. A review of the Quality Assurance Framework used by DWP and HMRC is carried out to establish if it is fit for purpose in evaluating whether decisions are of a high quality.
4. The DWP work with the Department of Health and the devolved administrations to establish a consistent approach to the provision of medical evidence.

⁵⁷ Social Security Advisory Committee, *Decision Making and Mandatory Reconsideration: A study by the Social Security Advisory Committee, Occasional Paper No. 18*, July 2016, pages 62-6. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/538836/decision-making-and-mandatory-reconsideration-ssac-op18.pdf

-
5. The DWP seek to further raise awareness with the medical profession about how the benefit system functions and their role within it, and seek to design forms that seek to capture precisely the data required from doctors to determine eligibility.

In response to this report, the DWP have committed to a Decision Making and Appeals improvement plan, which will “be cross-cutting and will concentrate on introducing measures to improve: the accuracy of decision making; the balance struck between robust decision making and managing large volumes of cases and making the MR journey easier for appellants to understand and comply with.”⁵⁸

Of the five recommendations listed above, the first was rejected, on the basis that the Department believes one calendar month for submitting evidence is adequate, and because that timescale can be extended as appropriate. Recommendations numbered 2-5 were accepted by the Department. In response to the recommendations numbered 4 and 5 above, the Department writes:

“The current medical evidence report form (ESA113) was designed in conjunction with GPs. The form already asks GPs to provide functional information about the WCA activities / descriptors if known from their knowledge of the claimant but it is important to note that clinicians (including GPs) very often do not have this information as their primary role is the clinical management of their patient. We meet regularly with representatives of the BMA and RCGP to discuss issues of joint interest and we are currently exploring mechanisms for raising awareness of the benefit system and the role of GPs.”⁵⁹

⁵⁸ Letter from Penny Mordaunt MP, Minister for Disabled People, Health and Work, to Paul Gray, Chair of the Social Security Advisory Committee, January 2017, page 1. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604139/detailed-response-from-the-government-to-the-ssac-mandatory-reconsideration-report.pdf

⁵⁹ DWP, *Response to SSAC Report on Mandatory Reconsideration Processes*, January 2017, page 13. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/604139/detailed-response-from-the-government-to-the-ssac-mandatory-reconsideration-report.pdf



www.cas.org.uk



@CitAdviceScot



CitizensAdviceScotland

The Scottish Association of Citizens Advice Bureaux -
Citizens Advice Scotland. Scottish charity (SC016637) and
company limited by guarantee (89892)

