

Citizens Advice Scotland Response to the Second Independent Review of Personal Independence Payment



September 2016

The CAB Service in Scotland

Citizens Advice Scotland (CAS), our 61 member Citizen Advice Bureaux (CAB), the Citizen Advice consumer helpline, and the Extra Help Unit, form Scotland's largest independent advice network. Advice provided by our service is free, independent, confidential, impartial and available to everyone. Our self-help website Adviceguide provides information on rights and helps people solve their problems.

In 2014/15 the Citizens Advice Service network helped over 323,000 clients in Scotland alone and dealt with over one million advice issues. With support from the network clients had financial gains of over £124 million and the Scottish zone of our self-help website Adviceguide received over 4 million unique page views.

Issues relating to benefits and tax credits are the most common area of advice provided by citizens advice bureaux in Scotland, with 220,000 new issues in 2014/15, representing 37% of their work.

Executive summary

Despite improvements having been made to waiting times and other aspects of benefit delivery, fundamental problems remain with respect to the design of Personal Independence Payment (PIP), specifically around assessments, medical evidence, length of awards, accuracy of decision making and mandatory reconsideration. These are all issues that CAS raised in our response to the first independent review, and it is now crucial that solutions to these issues are found before more people experience similar problems as they undergo the transition from DLA to PIP.

This response covers the four topic areas requested in the call for evidence, namely:

- 1) Further evidence
- 2) Data sharing
- 3) Claimant experience
- 4) Progress since the first review.

In order to improve the design and delivery of Personal Independence Payment, CAS recommends that:

- The timescale for returning the PIP2 form should be re-examined, particularly where clients need support to complete the form. DWP should establish a maximum timescale for issuing these forms following the claimant's initial call.
- The DWP and the assessment provider should ensure that they routinely gather medical evidence from a wide range of relevant health and social care professionals (not solely GPs) as is clearly stated in the guidance.
- Medical evidence should be gathered at the initial assessment phase to inform the decision regarding the claimant's eligibility. This would improve accuracy of decisions and therefore avoid the administrative costs associated with reconsiderations and appeals.
- Claimants are provided with more information about the claim process, including an overview of the process, and information about what will be required of them at each stage.
- The timescale during which claimants are expected to make an initial claim following receipt of a letter regarding the closure of their DLA claim should be extended to two months, allowing claimants enough time to seek advice and support.
- Assessment providers increase the use of paper-based assessments, thereby increasing the availability of assessment centres and ensuring that claimants are assessed at a centre that is familiar, geographically close and easily accessible.
- Home visits should always be available for those who need them.
- The DWP introduce a tiered approach to assessment in order to reduce the number of face-to-face assessments carried out.
- The standard rate for the mobility component is increased to reflect the costs associated with limited mobility.
- PIP awards are lengthened for those with long-term disabilities or health conditions that are unlikely to change.
- There should be independent scrutiny of decision making to ensure that decisions are based on an unbiased and fair appraisal of all available evidence.

- The timescales within which clients are expected to submit a mandatory reconsideration request are lengthened to reflect the time it takes to gather supporting evidence.
- A statutory time limit should be introduced within which a Mandatory Reconsideration decision must be returned to the claimant.
- The DWP continue to work to reduce waiting times, not just for receiving a medical assessment but also the time taken to make a decision and notify the claimant.

Introduction

One of the policy intentions behind PIP was to ensure that the benefit focused on disabled people with the greatest need. Instead of using ‘care’ and ‘mobility’ needs as proxies of extra costs, PIP determines need based on the impact of a person’s disability or condition on their ability to carry out a range of activities key to everyday life. It is worth stating at the outset that, on the whole, CAB clients and advisers are positive about these policy intentions. Many feel that the introduction of PIP was a ‘step in the right direction’, but that there are problems with its implementation, which this response will explore in more detail.

This response is based on various forms of quantitative and qualitative data already held by the CAB Service including: statistics on advice provided by Scottish CAB Service; client profile data; findings from consultation with CAB clients; and client case notes. In addition to this, CAS conducted an adviser survey which was carried out in August 2016 and received a total of 61 responses from 40 CAB offices. This represents 65% of the bureaux across Scotland.

Respondents to the survey were from both urban, rural and island CABs, including CABs on Orkney and the Outer Hebrides and our most remote CAB in Kinlochberrie. The survey also received responses from bureaux who 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.

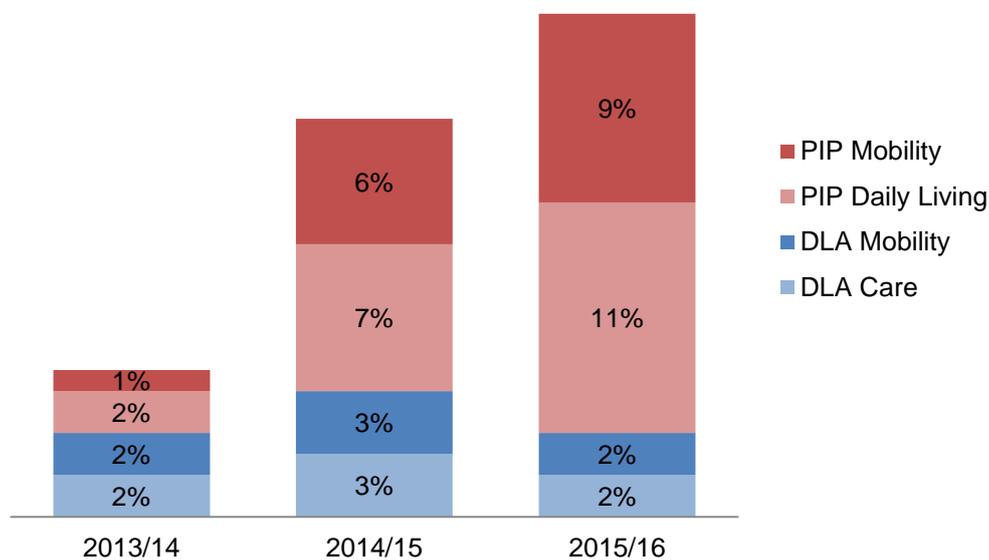
In 2014, CAS carried out a similar adviser survey on Personal Independence Payment, which received 52 responses. Reference will be made to the 2014 survey throughout this response where comparisons can be made.

PIP advice need in Scotland

Since PIP was introduced, CAB across Scotland have seen a steady increase in advice regarding the new benefit, as the caseload in Scotland has increased. However, as Figure 1 shows, the increase in advice need in relation to disability benefits has increased even when advice regarding DLA is included in the figures. We would expect to see an increase in demand for advice regarding any new benefit, but analysis of client case notes suggests that some of this increase may be a result of policy and administrative issues associated with PIP, not least of which has been the assessments delays (though evidence suggests that these delays have decreased more recently).

When advice regarding PIP Daily Living and Mobility are combined, advice in relation to PIP issues is the single biggest issue that bureaux provide advice on, and in 2015/16 it made up 20% of the total benefits advice given. CAS expects that advice in relation to PIP will continue to grow over the coming months and years.

Figure 1: Percentage of new advice issues relating to PIP and DLA as a proportion of total benefits advice - 2013/14 to 2015/16



Part 1 - Further Evidence

Under current guidance to both health professionals and claimants it is clear that, during the assessment phase, claimants should not be approaching their GP to gather further evidence.

Guidance on the PIP claimant journey states that, at the stage the claimant is sending in their 'How your disability affects you' form they should also send any supporting evidence, but that should only be things that the claimant already has available. It advises claimants: 'Don't ask for other documents which might slow down your claim or for which you might be charged a fee – for example, from your GP. If we need this we'll ask for it ourselves using the contact details you provide on your form'.¹

However, when asked what further evidence Atos/Capita request on claimants' behalf, 19 survey respondents, unprompted, 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). This reflects a similar picture to the one provided by advisers in 2014, when 56% of survey respondents said that assessment providers were not requesting evidence. Only two respondents said that Atos do sometimes obtain further evidence, and both mentioned GPs. The comment from a bureau tribunal representative below summarises the difficult position this puts clients in:

“Less than 1 in 10 set of appeal papers contains medical evidence that ATOS has sought themselves. Clients are often very upset or frustrated by this as they have given the details 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.”

A North of Scotland CAB reports of a client who had a face-to-face assessment for PIP carried out as a home visit. The health care professional did not have with her the additional medical evidence that had been sent in to support his claim. On this occasion the client was pro-active and checked, and was able to provide his own copies of the medical evidence for the HCP. Another client might not know to check, and might be disadvantaged because the HCP was unaware of all the evidence.

¹ 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

Even if the claimant ignores the DWP guidance and attempts to gather supporting evidence, there are numerous barriers associated with trying to obtain evidence in support of a benefits claim from healthcare professionals, which are explored below.

When asked who clients tend to obtain evidence from in support of a benefits claim, survey respondents answered with the following, in order of most common:

GPs	44
Specialist Doctors	35
Community Psychiatric Nurses	31
Mental Health Service providers (both NHS and other)	30
Physiotherapists	17
Occupational Therapists	14
Social Workers	7
Other Allied Health Professionals	5
Carers	2
Friends and family	2

We also asked advisers how easy it is to gather supporting evidence 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.

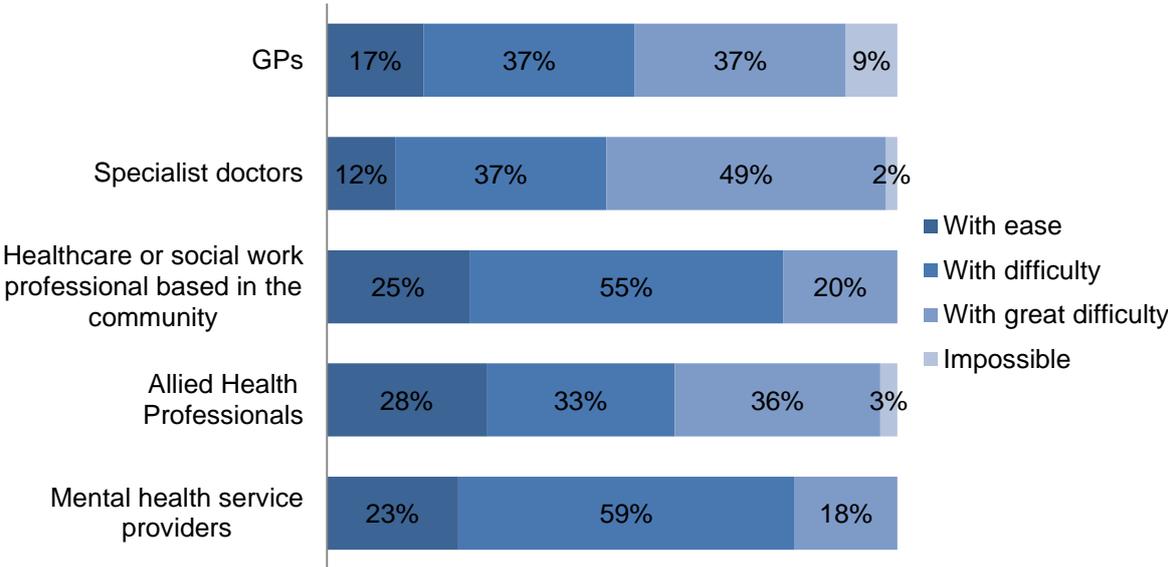
Respondents also indicated that GPs are not always easy to obtain evidence from, and four respondents said it was 'impossible' to obtain evidence from GPs.

As Figures 2 and 3 show, for each of the health and social care professionals included in the question, respondents indicated that it is on the most part difficult, very difficult or impossible to acquire supporting evidence from them.

Figure 2: Ease of obtaining supporting evidence from health and social care professionals – based on adviser survey

	Supporting evidence can be obtained with ease	Supporting evidence can be obtained with difficulty	Supporting evidence can be obtained with great difficulty	It is not at all possible for clients to obtain supporting evidence	Don't know	Total
From their GP	17%	35%	35%	8%	4%	48
From specialist doctors	10%	33%	44%	3%	10%	48
From healthcare or social work professional based in the community	22%	48%	17%	0%	13%	46
From Allied Health Professionals	23%	28%	30%	2%	17%	47
From mental health service providers	21%	54%	17%	0%	8%	48

Figure 3: Ease of obtaining supporting evidence from health and social care professionals – based on adviser survey



Another problem with providing supporting evidence is the tight timescales involved. When asked whether one month was enough time to gather relevant medical evidence in support of their initial claim, 80% of survey respondents said that one month was ‘rarely’ or ‘never’ enough time. As one adviser put it:

“Clients don’t often have reports [supporting evidence] to go with the PIP form. The month starts from the date that the phone call for the claim is made. It does not leave enough time for clients to get reports. Most of the PIP forms we assist with are sent away with what the client has available during the visit. The bureau only seeks further information if the award has to be appealed.”

CAS recommends that the timescale for returning the PIP2 form should be re-examined, particularly where clients need support to complete the form. DWP should establish a maximum timescale for issuing these forms following the claimant’s initial call.

One of the biggest barriers clients experience in obtaining medical evidence is that healthcare professionals are not contracted to provide this information unless the DWP or Atos requests it. The British Medical Association provides guidance to GPs advising 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.”²

This means that GPs and other healthcare professionals are in a difficult position of being asked by patients to provide evidence that they are not contracted to provide or being paid to provide. To cover the costs, GP surgeries will sometimes charge for medical evidence, but this means that the cost is transferred to the claimant, and can be prohibitive. It also means there is not a consistency of approach geographically: a PIP claimant registered at one GP surgery may be expected to pay £50 for a letter detailing how their disabilities affect them, whilst a claimant registered at a different surgery might have access to this for free.

“[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.”

Another barrier for PIP clients is that for some who are long-term disabled, they may have gone a long time without consulting medical professionals because their condition is unlikely to change, there is no cure or treatment, or it is a disability as opposed to a medical condition (e.g. for somebody blind or partially sighted they may have a condition that affects their ability to carry out daily tasks but they do not have an illness). This makes it more difficult for them to gather further evidence from health professionals.

The various barriers outlined above may be part of the reason why claimants do not always provide medical evidence in support of their initial claim, but if they are being supported by an adviser to appeal a decision they are much more likely to provide further evidence at this stage. Advisers know that appeals are much more likely to be successful when additional evidence is provided, and although a number of the barriers above still exist, the longer timescales involved in appeals gives claimants longer to gather the evidence. It is also possible that health professionals place more importance on appeals, and prioritise provision of evidence in support of these.

However, there are still tight timescales within which to return a mandatory reconsideration, meaning that some of these problems persist at this stage, undermining the purpose of having an internal review process.

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

“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

² <https://www.bma.org.uk/advice/employment/fees/benefits-and-work-for-atos>

feel they are not believed so need to get medical evidence but are unable to do so.”

CAS recommends that it should be the responsibility of DWP and the assessment provider to routinely gather medical evidence from a wide range of relevant health and social care professionals (not solely GPs).

Medical evidence should be gathered at the initial assessment phase to inform the decision regarding the claimant’s eligibility. This would improve accuracy of decisions and therefore avoid the administrative costs associated with reconsiderations and appeals.

Part two: Data Sharing

CAS has limited evidence on ways in which DWP could improve its IT systems or data sharing practices. However, our consultation during 2015 showed that most clients and advisers thought that there could be improvements to information sharing between services which would reduce the need for claimants to provide the same information more than once.

For example, links with GPs and hospitals could be improved. Some suggested a central system which would hold information on claimants from a variety of sources – e.g. GPs, social workers and occupational health – which could then be accessed by the agency making a decision on disability benefits. Participants emphasised that obtaining client consent for information sharing was essential.

CAS is of the view that there is a lot of potential for improving the assessment of eligibility for disability benefits through data sharing, although it is necessary to proceed with caution and ensure that data sharing practices yield improved outcomes for clients as well as government departments.

Part three: Claimant experience

Transferring from DLA to PIP

Survey respondents were asked: 'In your experience, are there any administrative issues that clients experience in transferring from DLA to PIP?' 26 respondents raised issues in response to this question, which can be grouped around the following themes:

- DLA claimants having a lower award when in receipt of PIP than they had when on DLA;
- Lack of understanding around what is required of them when sent a letter inviting them to apply for PIP;
- Difficulties faced by clients in making the claim due to mental and physical limitations;
- Clients struggling with the limited time given for them to complete the claim form;
- Administrative failures, particularly letters not being sent on time;
- Fear and uncertainty.

A number of respondents raised concerns that the limited time given to clients to make a claim for PIP means that they struggle to access advice during that period:

“Clients struggle with the limited time given to complete the form - it is often 10 days into the one month timescale before they receive the form and we have a three week waiting list for appointments so they struggle to get help in time - most require extensions to return the form.”

An East of Scotland CAB reports of a client who is 68 years old, has a long term heart condition, is a type 1 diabetic, and suffers from arthritis. The client has been on DLA long term and received a letter from DWP asking him to apply for PIP. The client made a claim over the phone but then received a further letter from DWP stating that his DLA payment had been suspended as he had not made an initial claim within the time limit. The client has now received a PIP1 form to be completed, and as he cannot read or write, wanted help to complete the form.

CAS recommends that when DLA claimants receive the initial letter inviting them to claim PIP, they are provided with clear and accessible information about the claim process, including an overview of the process, and information about what will be required of them at each stage.

CAS recommends that the timescale during which claimants are expected to make an initial claim following receipt of a letter regarding the closure of their DLA claim should be extended to two months, allowing claimants enough time to seek advice and support.

Making a claim

Responses from CAB clients, as well as case evidence from bureaux, has emphasised that the application process is currently difficult to navigate for many claimants. Claimants experience the process as confusing and distressing. Too often, the process leads to the claimant's condition deteriorating and their quality of life suffering. The most significant issue for bureaux and clients has been the introduction of the face-to-face assessment, which is dealt with in more detail below. However, there are a number of problems with the application process itself.

When asked what proportion of claimants are able to complete the PIP2 *'How your disability affects you'* form on their own, 63% of survey respondents said 'very few' or fewer than 10% would be able to do this on their own, and a similar proportion said that fewer than 10% of clients would be able to complete an online claim form on their own.

Two key themes emerged from the evidence around how the application process could be improved so as to be more accessible, and less distressing, for claimants:

1. Claimants should have a choice about how they apply for disability benefits (including online, by telephone, on paper and in person).
2. Support needs to be widely available to help people make a claim for disability benefits

During 2015 CAS carried out a wide-ranging consultation with CAB clients and advisers on the topic of disability benefits. This yielded a number of suggested changes that could be made to the application form which would make it easier for claimants. 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 repetitive questions.
- The 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.
- The form should allow people to fully explain their condition and its impact.
- The form should be less rigid and not simply a 'tick box' approach.
- The language of questions needs to be much clearer.

- The form should be more focused on what a person can do, and what support they need to do that.

Finally, when asked about the number of clients they had seen who had received a paper-based assessment, the majority of respondents (69%) said that fewer than one in 20 PIP clients – or less than 5% - receive a paper-based assessment. There is potential for paper-based assessments to minimise the administrative burden on the DWP, as well as the stressful process of face-to-face assessments for clients.

Access to assessments with healthcare professionals

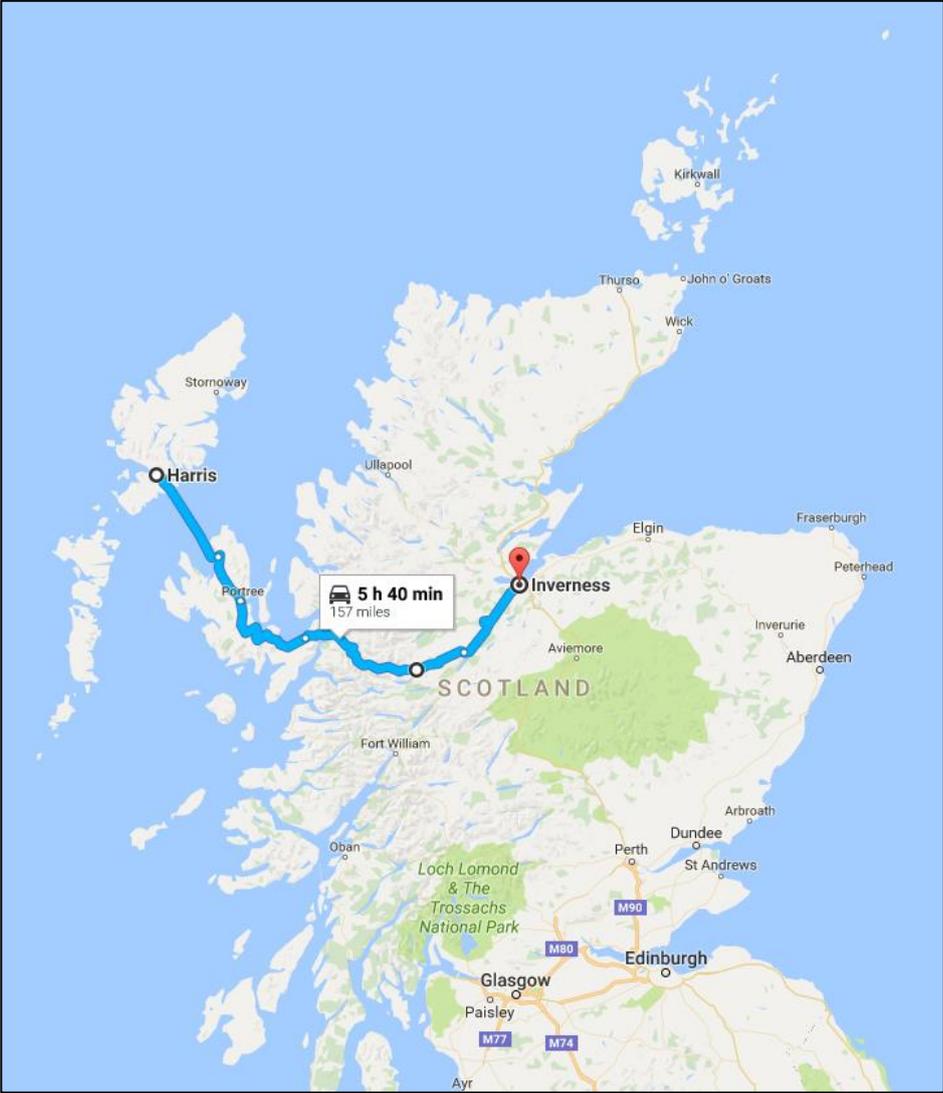
When asked if there are any barriers that clients face when attending an assessment 28 of the 40 comments made (70%) referred to barriers associated with geographical distance and accessibility by public transport.

Citizens Advice Bureau offices are located in 30 of Scotland's 32 Local Authorities and serve some of the country's most rural and remote communities. For clients living in these areas, there can be substantial geographical distances to assessment centres, which are not always easily accessible by public transport. The table below gives an indication of some of the distances clients are required to travel to assessment centres.

Figure 4: distances clients are required to travel to assessment centres.

CAB	Nearest assessment centre	Number of miles (by car, as calculated by Google Maps)	Survey respondent's comments
North and West Sutherland CAB – located in Kinlochbervie	Inverness	94 miles	“over 50 miles”
Harris CAB	Unknown	Unknown	“37 miles (74 roundtrip) from bureau but up to 120 miles (roundtrip) from home for some clients.”
Lewis CAB – located in Stornoway	Inverness	111 miles	
Perth	Dundee	22.5 miles	“Dundee, about 30 miles away from the main town in the county but this could involve two long bus journeys for those who live outwith the main town.”

Below is a screenshot taken from Google Maps to give an idea of the geographical distances that clients in Harris would be expected to travel if they had an assessment in Inverness.



In their comments, some bureaux mentioned that clients are being routinely referred to assessment centres in another town or city which can mean long journeys on public transport to places they are unfamiliar with.

“In the Dumfries and Galloway area our clients can be sent to Carlisle or Glasgow for an assessment. This is too far when there is an assessment centre in Dumfries.”

“Appointments are routinely made in Edinburgh. This is 30 miles away and for most people involves two buses and a train. There is an assessment centre in Stirling which is 7 miles away.”

“Clients are often offered appointments outwith Glasgow area, such as Edinburgh, Kilmarnock, Stirling and Ayr. There is also a protracted process to obtain medical evidence to obtain a taxi to the venue, GPs seem to be unaware of their role in this process.”

A West of Scotland CAB reports of a client who has received an appointment for his PIP medical assessment in Carlisle (a 58 miles round trip), even after his serious condition was explained in the PIP application and in the assessment assistance section it clearly stated an appointment in Dumfries (21 miles round trip) or a home visit was required, due to the risk to the client’s health.

CAS recommends that assessment providers increase the use of paper-based assessments, thereby increasing the availability of assessment centres and ensuring that claimants are assessed at a centre that is familiar, geographically close and easily accessible.

Bureaux have drawn attention to the fact that it can be difficult to get a home visit for those who need it: of the 48 who replied to the question, almost a third of survey respondents (28%) said that it is rarely possible to get a home visit for those who need it. However, responses to the survey suggest that there is no discrepancy between waiting times for home visit medical assessments and those which take place at an assessment centre.

“The closest assessment centre is 2.5 - 3 hours by bus for some of my clients, only 2 hours by car, but some people cannot sit this long or travel by public transport. It is more difficult to get a home visit as they require a doctor's letter and supporting information.”

“In a recent request for a home visit, a client was asked if she visited her GP, to which she answered yes. So, she was told she can manage the 55 mile round trip to a place she does not know and will need help to get access, i.e. severely limited mobility problems and not able to use public transport.”

“Clients are often refused the chance to reschedule appointments, and are refused home visits when they cannot travel independently to an appointment and have no-one to travel with them.”

CAS recommends that home visits should always be available for those who need them.

A number of 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”

“People with mental health problems find it extremely stressful”

“Clients cannot always access the assessment centre due to mental health difficulties and being house bound”

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

Other barriers mentioned by the survey respondents included the financial cost to clients of having to travel by public transport to another town or city, language barriers, and inconvenient dates and times of appointments that don't take in to account the client's medical circumstances. One respondent mentioned the accessibility of the facility and the 'intimidating environment':

“Assessment centres are not always easy to reach, find or access. Parking can be difficult near the assessment centre. There is (anecdotally) an intimidating environment in the centres which upsets clients.”

Assessments with healthcare professionals

For the purpose of this consultation, we asked advisers how the PIP process compares to similar assessments (e.g. ESA work capability assessment or an occupational health assessment). Survey respondents gave a mixed response, but the general themes were:

- PIP waiting times are better than waiting times for ESA Work Capability Assessments;
- Clients tend to feel that both ESA and PIP assessments do not accurately reflect their everyday life and illness or disabilities;
- There seems to be a lack of transparency with the decision makers.

Some specific observations include:

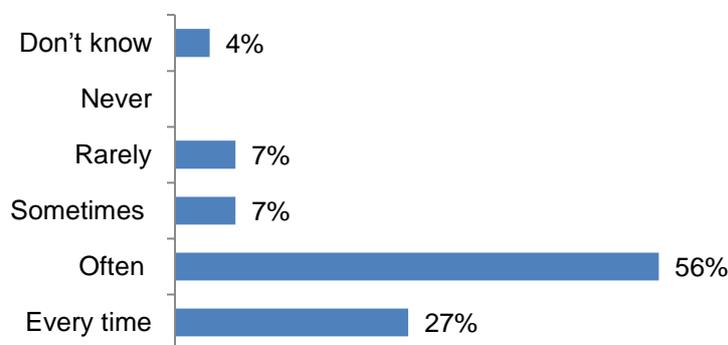
“DWP's guidance states that HCPs should use open ended questions but far too often clients come to see me stating that they are being told to answer yes or no, with no or limited explanation allowed.”

“[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.”

“Generally better than ESA in terms of getting appointments, waiting times and the process etc. The assessment itself seems very rigid, certainly more rigid than DLA and I would say more rigid than the ESA assessment.”

The manner of healthcare professionals during assessments is still an issue for bureau clients: 82% of 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. Similarly, when asked about the appropriateness of the questions asked by healthcare professionals, three quarters of 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.

Figure 5: How frequently do issues around the manner of HCPs arise during advice interviews?



An East of Scotland CAB reports of a client who has mental health issues including personality disorder and is currently being treated for trauma. 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 this 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 to the office.

Regarding the accuracy of the healthcare professionals' report, 59% of respondents said that clients 'rarely' agreed that the healthcare professional's report accurately reflected the discussion that took place, 20% said it 'sometimes' reflected the discussion that had taken place, and 13% said it 'never' did.

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. As regards some statements contained within the decision maker's reasoning, the client advised that statements 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 we had submitted with the PIP2 form in the decision letter, they do not appear to have taken into account the supporting statements contained within.

During 2015, CAS gathered and analysed evidence from 10 client focus groups and 10 client interviews on the topic of disability benefits. By far the most common complaint about the current system of disability benefits was the assessment process for PIP. The key message that emerged from participants was that, in assessing people's eligibility for disability benefits, much greater emphasis should be given to evidence from people who know the claimant, particularly GPs but also carers, family and friends, support workers, social workers, occupational therapists, community psychiatric nurses, employers etc. It was widely thought that evidence from such sources gave a much better insight into how a person's disability or health condition affects them than a one-off face-to-face assessment.

An East of Scotland CAB reports of a client who was reassessed for PIP a year in advance of the end date for his award. The client was awarded PIP Care Enhanced Rate and Mobility Standard Rate. Previously the client had Mobility Enhanced Rate, meaning he now faces losing his Motability Car which he needs on a daily basis. The client is very anxious and stressed because of this decision. The client suffers from Hereditary Angioedema (HAE) which is a very rare and potentially life-threatening genetic condition. He was diagnosed when he was 5 years old. HAE symptoms include episodes of edema (swelling) in various body parts including the hands, feet, face and airway. The client has flare-ups every day and this can result in him having to go to the hospital for injections. His

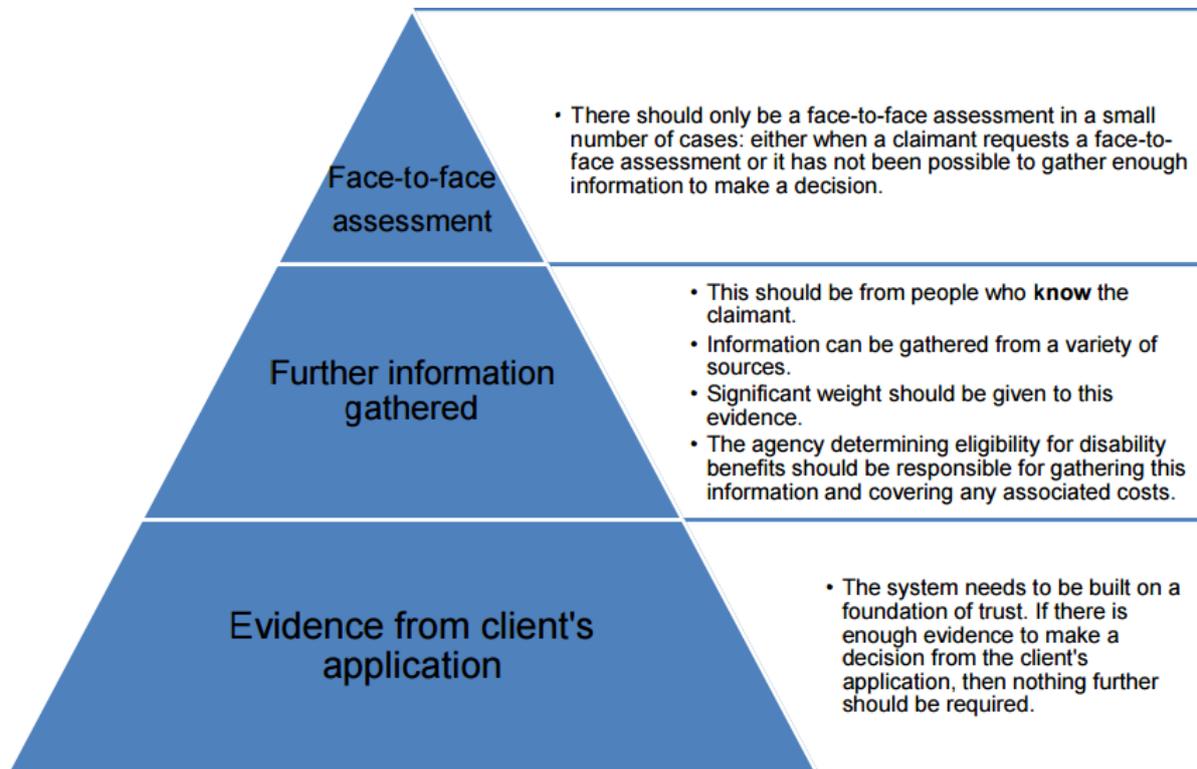
mobility is severely impaired when the flare-up occurs. When he goes to the hospital his notes state what treatment he needs and this means he can get treatment straightaway.

Overall, participants thought there should be a tiered approach to assessment (see figure 6), with a face-to-face assessment only carried out in a small number of cases.

“The starting point should always be the client’s own evidence; you need to accept what people say as prima facie truthful. In some circumstances, there will be a need for further investigation and gathering further evidence. A face-to-face assessment should be rare”.

CAS recommends that the DWP introduce a tiered approach to assessment in order to reduce the number of face-to-face assessments carried out.

Figure 6: A tiered approach to assessment

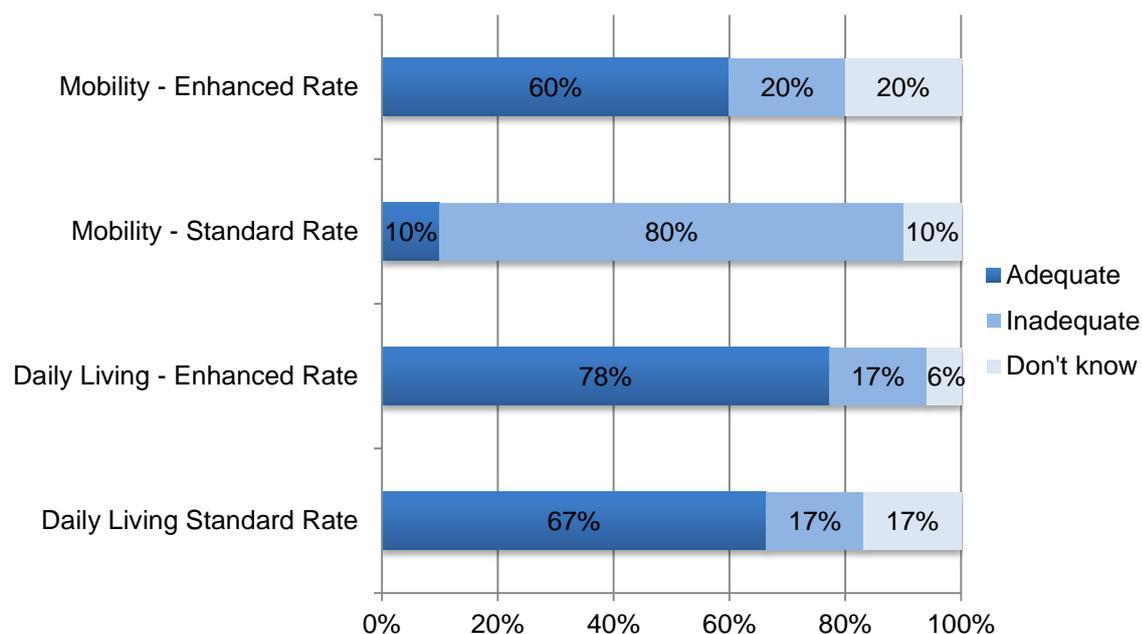


Impact on employment

Based on a sample of over 1,400 clients who sought advice on PIP, 16% are in work (including full time, part time and self-employed), compared to a CAB client average of 34%. Unsurprisingly, the majority of PIP clients are unable to work due to short or long term ill health (64%), and 9% are unemployed, which is a considerably lower proportion than the CAB client average of 17%.

CAS is concerned that the rate of awards, particularly the standard rate mobility component may impact on people's ability to stay in or return to employment. When asked about the rates of awards, the majority – 60% or more – of the 44 respondents said that the awards for Daily Living standard rate and enhanced rate, and Mobility enhanced rate are adequate. However, in stark contrast, 80% of respondents said that the standard rate for the mobility component of PIP is inadequate to meet the extra costs associated with mobility.

Figure 7: Adequacy of awards to meet the costs associated with daily living and mobility



When asked the reason for their answer, respondents made the case that lower-rate mobility is not enough to afford public transport and leaves clients with a financial burden:

“If a client has been assessed as having mobility difficulties, £21 is not enough for them to be able to use other forms of transport. Many clients have severe distress and need to travel in taxis. Having a disability incurs extra costs and the standard rate of mobility, in my opinion, is not enough to cover these costs.”

“I do not think the standard rate mobility is enough. Just because someone can physically walk more than 20 metres does not mean they can walk to shops or stand at bus stops etc.”

Many respondents mentioned that for clients who were previously on DLA, the less generous mobility component rates means that many lose their entitlement to their Motability vehicle. One respondent mentioned the effect that this can have on employment:

“Many clients because of the changes to the mobility test (re. DLA) are totally disadvantaged now. Many people having to give up mobility car and some clients rely on this for getting to work and have had to give up work as a result.”

An East of Scotland CAB reports of a client who has had a Motability car since 1992 due to his DLA award but the transfer to PIP has taken away this entitlement. The loss of the car would have a substantial impact on the client's independence as he needs the car to get to work. The client currently works with the Post Office sorting depot. If he had to use public transport then this would mean he would have to walk at least half a mile to get to work. This would cause him great difficulty.

CAS recommends that the standard rate for the mobility component is increased to reflect the costs associated with limited mobility, and to help people to remain in employment.

Another issue that may have an impact on a claimant's ability to stay in employment is the frequency of reassessment and how stressful and time consuming this is for the client. When asked about the length of PIP awards the parity of the responses to this question was striking; 31 respondents answered the question and there were two dominant themes:

- 1) The short length of awards and frequent reassessment causing stress and anxiety to clients who are in many cases already suffering from serious physical and mental health conditions (mentioned in 18 of the 31 responses);
- 2) The unlikelihood for the many PIP recipients of their condition changing significantly in such a short time frame (mentioned in 9 of the 31 responses).

Many of the comments also mentioned that, when claimants are sent a letter about reassessment a full year before their claim is due to end, it creates a feeling of constant assessment which is unfair and unnecessary.

CAS recommends that PIP awards are lengthened for those with long-term disabilities or health conditions that are unlikely to change.

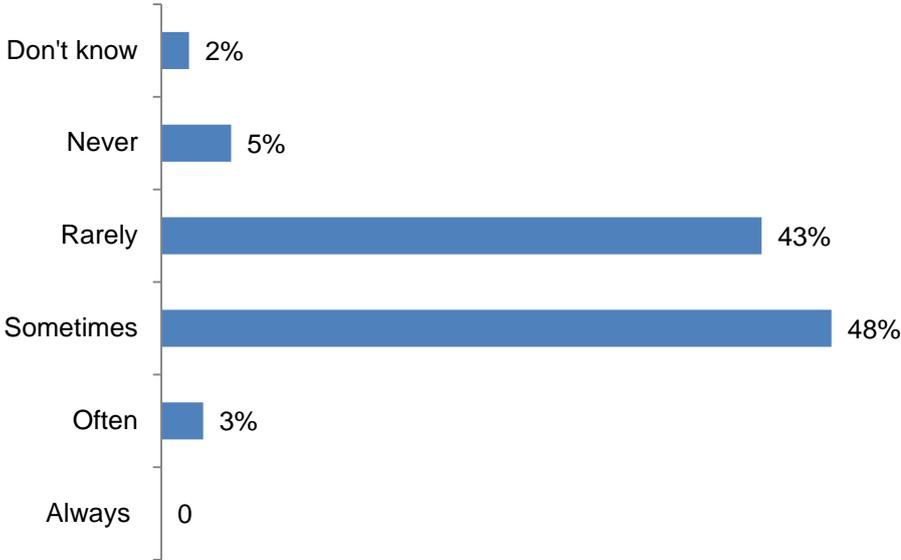
Mandatory Reconsideration and appeals

The call for evidence asks: *‘what are the reasons for people making an appeal to HMCTS and what is their experience of this process?’* The straightforward answer to the first part of the question is that people appeal a decision because they believe the decision is inaccurate, and does not reflect how the claimant’s disability affects their everyday lives. However, if we ask *why* do so many clients feel the decisions are inaccurate, the answer is a complex interaction of factors relating to a) how medical evidence is gathered in support of a claim; b) issues around the ability of a consultation with Atos to accurately assess the needs of a claimant; and c) issues associated with DWP decision making.

An East of Scotland CAB reports of a client whose mother, aged 60 years, took her own life. According to the client her suicide was as a result of a response from DWP to a mandatory reconsideration where she was awarded no points and therefore received no benefit. The client indicated that he had received a letter from his mother stating her intentions. The client, who was accompanied by his wife, wanted to have it recorded that the actions of his mother was as a direct result of the response from DWP over her appeal for PIP.

We have already explored the difficulties clients face in accessing medical evidence in support of claims, the fact that Atos rarely request further evidence associated with a claim, and that, based on advisers’ experience, claimants rarely feel that the healthcare professionals report accurately reflects the discussion that took place during the consultation. However, to add to these factors which impinge upon good quality decision making, almost half (48%) of survey respondents said that DWP decision makers ‘rarely’ or ‘never’ make decisions based on a fair appraisal of all the available evidence (see Figure 6). This may be due to a number of factors, including timeframes within which to make a decision, issues around training, and issues around decision-maker bias.

Figure 8: Do DWP decision makers make decisions based on all the available evidence?



We also asked advisers whether, when appealing a decision regarding a PIP claim, there are specific activities or descriptors for which clients are commonly awarded additional points. The most common activities mentioned were:

- Washing and bathing: 5
- Dressing: 5
- Walking/mobility: 5
- Engaging with others: 5
- Aids and adaptations: 3
- Incontinence: 2

This raises questions about whether there are characteristics inherent in the points-based assessment process based on activities and descriptors that lend themselves to inaccurate decision-making.

In terms of CAB clients' experiences of challenging decisions, CAS has a number of concerns about the mandatory reconsideration process based on extensive evidence provided by bureaux. In particular, the absence of any time limit within which the DWP must make a decision on a mandatory reconsideration has left clients without support for significant lengths of time, causing hardship and distress. We are also concerned that this additional step in challenging decisions, as well as the associated delays, makes it more difficult for claimants to exercise their statutory right to appeal.

A West of Scotland CAB reports of a client who returned to bureau because he has not received any correspondence or decision from DWP regarding his request for a PIP mandatory reconsideration made in January 2016 [four months previously]. Adviser's comments: PIP understaffed and not coping. I phoned PIP, and recorded message said telephony problems and to phone back later in the week if not urgent. Also the person I spoke to was a manager and only helping on phones because of staffing problems.

There is also a particular issue for claimants who are requesting a mandatory reconsideration in cases where they have lost their entitlement to the Motability Scheme. Once a claimant loses that entitlement, they have to return the car within 21 days of their DLA payments stopping. This can often be before a decision on mandatory reconsideration has taken place, which can put the claimant in a difficult position.

A North of Scotland CAB reports of a client who had his mobility component stopped following a review of his PIP. DWP immediately contacted the Motability company who requested the return of the car or that it be purchased for £8,475. The client could not get around without it so he took out a loan for £10,000 over 5 years (16,387.30 in total). DWP then reinstated the mobility component before considering an appeal stating that they had made a mistake. The client is now eligible for the Motability car again but company will not refund him the cost of the car and he is saddled with the loan. The client would prefer to be on the scheme as it includes tax, insurance and repairs. He is out of pocket as a result. A better system would be to delay requesting the return of the car until the outcome of an appeal.

When 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.

A similar question was asked about the appeals process, and 16 respondents said that clients found the appeals processes ‘stressful’ or ‘daunting’; five said that the appeals process often made clients feel they were being ‘judged’, ‘interrogated’ or feel as if they were ‘on trial’; and four respondents said they thought the timescale to take a claim to appeal is ‘excessive’ or ‘lengthy’.

In order to avoid the waiting times and stress associated with an appeal at the first tier tribunal, it is important to have an internal review process that is efficient and consistently makes high quality decisions.

CAS recommends that there should be independent scrutiny of decision making to ensure that decisions are based on an unbiased and fair appraisal of all available evidence.

CAS recommends that the timescales within which clients are expected to submit a mandatory reconsideration request are lengthened to reflect the time it takes to gather supporting evidence.

CAS strongly recommends that a statutory time limit should be introduced within which a Mandatory Reconsideration decision must be returned to the claimant.

Part four: Progress since the last review

Waiting times

It is clear that there have been improvements since the first independent review, especially around waiting times prior to assessment.

When asked, in their experience, what the average waiting time is for receiving a consultation with the assessment provider after having filled in the PIP form, over half (55%) of respondents said it was between one and three months, though 35% said it was between three and six months. Very few – only four respondents – said that the average waiting time was longer than six months.

This is a marked difference from the picture in 2014. When asked about delays, responses varied considerably from a minimum of two to three months, to ten month delays. Several bureau advisers wrote of seeing cases delayed by 13, 14 or 15 months.

However, we also asked advisers about the average waiting time for clients to receive a decision of their award *following* a consultation with a healthcare professional. Almost two fifths (39%) of survey respondents said that clients on average had to wait four to six weeks to receive a decision, and 12% said that clients on average had to wait longer than six weeks. This is still a considerable length of time if a claimant has to wait between one and three months to receive an assessment and then several weeks to receive their decision. Following this, it is likely that there may be a short wait before receiving a payment. Taking all this into consideration, it seems likely that Scottish bureaux are still seeing a significant number of clients that are waiting four or five months before receiving their PIP award.

CAS recommends that the DWP continue to work to reduce waiting times, not just for receiving a medical assessment but also the time taken to make a decision and notify the claimant.

Despite improvements having been made to waiting times and other aspects of benefit delivery, fundamental problems remain with respect to the design of the benefit, specifically around assessments, medical evidence, length of awards, accuracy of decision making and mandatory reconsideration. These are all issues that CAS raised in our response to the first independent review, and it is now crucial that solutions to these issues are found before more people undergo the transition from DLA to PIP.

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Appendix: Recommendations from CAS response to the 2014 Independent Review of Personal Independence Payment

There are a number of clear recommendations which emerge from the evidence presented from Scottish bureaux. These include:

- Identify and take urgent measures to address the significant delays in the claim process;
- Re-examine the initial phone call process, particularly for clients who have difficulties with phone calls because of their health condition or disability, or because of language barriers;
- Bureaux should be able to request forms without the client being present;
- The timescale for returning the PIP2 form should be re-examined, particularly where clients need support to complete the form. DWP should establish a maximum timescale for issuing these forms following the claimant's initial call;
- Letters issued by DWP and Atos must be clear about which benefit they are referring to;
- Claimants should be provided with more information about the claim process, including an overview of the process, and information about what information they will need to provide at each stage of the process;
- There should be more information available to claimants about the progress of their claim. DWP should acknowledge receipt of forms so that claimants and bureaux know that they have not been lost;
- Medical evidence should be collected at an early stage and used to inform the assessment process;
- A more appropriate balance should be found between use of medical evidence and the findings of the medical assessment;

- Further roll out of PIP reassessment should be delayed until current problems in the system are rectified and in particular the backlog of assessments is dealt with;
- DWP should commission an urgent independent review of the impact of benefits delays on sick and disabled claimants and take appropriate action on the conclusion of the review.