



OFFICIAL REPORT
AITHISG OIFIGEIL

Social Security Committee

Thursday 7 November 2019

Session 5



The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 7 November 2019

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SOCIAL SECURITY COMMITTEE

24th Meeting 2019, Session 5

CONVENER

*Bob Doris (Glasgow Maryhill and Springburn) (SNP)

DEPUTY CONVENER

*Pauline McNeill (Glasgow) (Lab)

COMMITTEE MEMBERS

*Dr Alasdair Allan (Na h-Eileanan an Iar) (SNP)

*Jeremy Balfour (Lothian) (Con)

*Michelle Ballantyne (South Scotland) (Con)

*Keith Brown (Clackmannanshire and Dunblane) (SNP)

Mark Griffin (Central Scotland) (Lab)

Alison Johnstone (Lothian) (Green)

*Shona Robison (Dundee City East) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Bell (University of Stirling)

Peter Hastie (Macmillan Cancer Support)

Catherine Henry (Citizens Advice Scotland)

Fiona Moss (Glasgow Health and Social Care Partnership)

Professor Mark Shucksmith (Newcastle University)

Professor Paul Spicker (Robert Gordon University)

CLERK TO THE COMMITTEE

Anne Peat

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Social Security Committee

Thursday 7 November 2019

[The Convener opened the meeting at 09:02]

Decision on Taking Business in Private

The Convener (Bob Doris): Good morning, everyone. I welcome everyone to the 24th meeting in 2019 of the Social Security Committee and remind everyone present to turn off mobile phones and other devices or put them to silent mode so that they do not disrupt the meeting. We have a couple of apologies this morning. Alison Johnstone and Mark Griffin cannot be with us, unfortunately, but some other members are hoping to be with us in the next wee while.

Agenda item 1 is a decision on taking an item in private. The committee is asked to agree to take item 3, which is consideration of evidence, in private. Is that agreed?

Members indicated agreement.

Benefit Take-up

09:03

The Convener: Item 2 is the first evidence session of the committee's inquiry into benefit take-up, to explore how take-up for both reserved and devolved social security benefits can be improved. This week's session comprises two panels. I am delighted to welcome our first panel: Professor Paul Spicker, emeritus professor of public policy, Robert Gordon University; Professor Mark Shucksmith, professor of planning, Newcastle University; and Professor David Bell, professor of economics, University of Stirling. Gentlemen, thank you very much for coming. We appreciate your assistance.

We thought it appropriate to start with an underpinning of how we get accurate estimates of what benefits or entitlements are being claimed in the first place and where the weaknesses may be. It may be worth setting the scene for anyone following the inquiry, as it can vary greatly. Pension credit is estimated to have an uptake of 60 per cent; I understand working tax credits for those without children have an eye-wateringly low take-up level in the mid-30 per cents; and the Scottish child payment is estimated to have an 84 per cent take-up level. Of course, those are estimates and the reality on the ground can be a different thing.

I have a very general question to open with. How confident are the witnesses that the United Kingdom Government, via the Department for Work and Pensions and Her Majesty's Revenue and Customs, has accurate and robust estimates of benefit take-up? What do you think needs to improve? Thanks for combating the noise we had in the background there. Who would like to open it more generally for discussion? Professor Bell.

Professor David Bell (University of Stirling): I am happy to talk a little bit about that—more about the reasons why there are difficulties in getting accurate estimates rather than the reasons why people do not claim. I am sure that we will come on to that.

Essentially, estimates of take-up tend to rely on household surveys—I think that one or two of those are mentioned in the evidence that has appeared thus far. Those surveys are relatively small, so there will always be a degree of inaccuracy associated with them; they typically involve 10,000 people across the UK. Estimates rely largely on self-reporting, but do people know what benefits they are receiving? That is not always clear to people.

Estimating take-up on the basis of how people report their own conditions is also fairly fraught.

Many household surveys ask people questions like, "Can you walk 100m?" or "Can you climb a flight of stairs?", but to go from the set of responses to such questions to an accurate assessment of whether people are eligible for a benefit is a fairly big step, because of course people are not in a position to judge whether an outside assessor would say that whatever disability they may have should merit an award of a benefit. That is difficult. Quite a lot of work has gone on in relation to attendance allowance, for example, to try to assess whether the responses that people give in surveys can usefully predict whether they will be awarded the benefit. In fact, that is what Elaine Douglas and I did for this meeting with our survey. By and large, the kinds of answers that people give to questions about disability are pretty good predictors, but there may be other things that also seem to predict whether people get benefits.

An interesting question might be whether there is a variation across levels of deprivation. You might think that people who are in more affluent areas would be better informed and therefore more likely to successfully claim benefits, but we do not find that that is true. That is an interesting finding in itself, because the benefits that we are talking about largely are not means tested. In fact, we find that people in more deprived areas are more likely to claim, which in a sense means that there is an income-related element to some of these benefits, in that poorer people are more likely to claim. This is a complex area. I have emphasised that it is vital that the Scottish Government gets this right, because the costs of getting it wrong—as I know from my experience with free personal care—are potentially considerable.

Professor Paul Spicker (Robert Gordon University): I would go a little further than Professor Bell, in that I would give a straight no to your question as to whether we can ever have accurate estimates. The difficulties that exist in these figures are things that we have been made aware of in the literature that stretches back over 60 years. At every point there are issues that make it almost impossible to know truly and precisely or accurately what the figures are.

We have to begin with a figure for the whole population that is eligible, and the more conditional that is and the more it relies on meeting the qualifications of benefits, the less certain we are about that basic figure. If we are talking about the whole population, which is how we get estimates for child benefit and for certain classes of pension, we can at least start off with an idea that we are talking about a sample that reflects that population. If we do not even have that, at best we are making educated guesses. That is certainly true in relation to disability.

The Office for National Statistics did an ad hoc survey for the DWP in which it tried to look in more detail at whether people were disabled and whether they were entitled. Fully two thirds of that sample were people who said that they were not disabled and another 12 or 13 per cent said that they were only disabled sometimes. That means that more than three quarters of the population with disabilities do not recognise themselves as being within the eligible population. When that is true, how on earth can we possibly know what the situation ought to be?

There have been a series of censuses of disability based on the same kind of points scheme that is now used for disability living allowance, personal independence payment and certain other benefits. That points scheme was initially designed for the censuses. When the first returns were made, the figures seemed to be reliable and accurate; they were tested and they were validated. Then, when the thing was run again eight years later, another 2 million people with disabilities were added to the census list. Then it was run again and the figures went beyond 10 million people in the UK. It is hugely difficult to rely on the base population figure, and that undermines much of what else you can do.

I invite you to think about the figures in a different way. We should always be aware that official statistics are not precise measures. They never are. They are always estimates, they are always based on some kind of survey or sample and they are always scaled up. What they do provide us with are indicators or pointers. We take pointers together to see whether things are changing in a positive direction or a negative direction. That is about as much as we can look for.

Professor Mark Shucksmith (Newcastle University): I do not have anything to add on this point. The statistical base is not my area of expertise, but what I can talk about—probably you would like me to do that later—is why people in rural areas do not take up benefits.

The Convener: We will absolutely be looking at that.

Can I just probe a little further? We know that there are various household surveys by which you capture the state of the nation in terms of what people's conditions are at a point in time, which then allows you to estimate who may be entitled to various benefits. Professor Bell has mentioned the household surveys and Professor Spicker mentioned censuses—I think that they used plural terms—but there is no catch-all regular household survey that is specifically designed to capture the state of the nation in Scotland or the UK on an annual basis. I know that there is the household survey, but that is not specifically designed to

estimate who may be entitled to benefits. Is there a fragmented approach to collecting the data in the first place?

Professor Bell: There are a number of surveys. The one that was used in relation to free personal care was an add-on survey to a survey that the DWP carried out annually for quite a long time—the family resources survey, which is mentioned in the evidence.

09:15

Much of the work in England has been done with the English longitudinal survey of ageing, which is a survey of the over-50s. It has the great advantage that it is longitudinal. One of the points that I make in my paper is that often disability benefits are long-term commitments. The English longitudinal survey of ageing revisits people every two years to ask them quite a wide variety of questions about their households, including questions on what we call activities of daily living and instrumental activities of daily living, which are about what functions people are able to carry out.

Scotland was one of the relatively few parts of the world that did not have such a survey until recently. The survey that we have used, which is funded by the US National Institute of Ageing and is called HAGIS—healthy ageing in Scotland—is the first attempt at a longitudinal survey that would revisit people from time to time. It is restricted, as most of these surveys are, to those aged 50 plus, but most of the overall population receiving benefits from Social Security Scotland will be people aged over 50.

Professor Spicker: This is a slightly different point. It concerns the question of eligibility and take-up. There was a point made long ago by A B Atkinson in reviewing issues on take-up; he was particularly concerned with pensioners. He invited Governments to think about whether eligibility was the same as the group that was being targeted. There are many cases where we define benefits rules quite deliberately more broadly than the target group, so that we can be reasonably sure of including the people we want to include. A simple example at the moment might be the debate about television licences for the over-75s. It is quite clear that we do not necessarily want to provide free television to everybody but, at the same time, trying to do it in any way that tests the actual target population—people who are isolated and who are in need of free television—could be hugely complex, so the eligibility rules are different from the targeting rules. Maybe what you need to do is to focus more on the question of who you want to reach.

The Convener: Okay. That makes sense to me. However, before we move on to entitlements,

barriers and everything else, our first set of questions are about how robust the current data might be and what changes you would suggest that you wish to put on the record. Professor Bell was helpful in talking about the disability assistance responsibility that is coming to the Scottish Parliament. Obviously, that will be a significant financial exposure for the Parliament and the Government. On that issue specifically, we have already heard from the Scottish Fiscal Commission that there could be quite significant forecasting errors at the outset because there is no baseline. The baseline could be established in the first few years. Professor Bell, how robust are the estimates likely to be on the disability assistance entitlements that are coming to the Scottish Parliament? What additional work might be required in that area?

Professor Bell: The Scottish Fiscal Commission is understandably concerned with aggregates, so the work that it has done has, I think, basically been on claimant trends and the numbers of claimants for the different benefits that are being received.

The data on actual claims is very good—there is no question about that. We know how many people are claiming which benefits in a postcode address area or a small set of postcode address areas.

There are trends for Scotland as a whole, which can be compared with trends in other parts of the UK. That is of great interest if you are interested in what the effect of the transfer of the social security benefits will be on the Scottish budget. The Barnett formula will be used, by and large, and our trends relative to those in the rest of the UK are very important. I have done some work on that, which I have not published, but I would be happy to share it with the committee.

I understand the Scottish Fiscal Commission's reason for focusing on trends. That will get at the issue of the Barnett consequential that Scotland will get as a result of any difference in the trends between the two countries. However, the only way to look at why people claim, how they claim, and the sets of benefits that they claim is through the household surveys. The DWP pays for quite a significant proportion of the English longitudinal survey of ageing and the family resources survey, but neither of those is perfect. There are all kinds of rather obscure statistical reasons why we end up with estimates from those surveys that differ from what the DWP knows is the number of claimants in any particular area. A lot of work is going on to try to refine those surveys, and it is very important for Scotland to be part of those discussions so that we understand who is claiming, what barriers there might be to claiming, and issues to do with assessment procedures.

None of the existing household surveys asks questions about those things. It would be quite easy to add a module to see whether people have gone through assessments.

The Convener: That is helpful.

Professor Spicker: I have a cautionary tale about trying to use those figures predictively. When DLA was introduced, it was originally thought that it would be quite a limited benefit. However, over the past 10 to 15 years, it has gradually expanded, mainly because of three factors: psychiatric illness, people with fluctuating conditions, and a growing number of older people receiving extensions of the benefit past the formal eligibility age. All those factors were retained with the personal independence payment, all of them are still there and, as far as I can tell, the figures are still growing.

When the Government announced PIP, it believed and said quite plainly that it was going to save money. It fined the Northern Ireland Assembly for its refusal to implement PIP directly by the amount of saving that it deemed would be made as a result of introducing PIP. We now have the audit figures in on PIP, and it has not saved a penny. We cannot rely on predictive factors for a dynamic and changing situation.

The Convener: I am very tempted to go down a rabbit hole of policy spillover, which we are looking at in another place.

I want to ask about the data that we have. I do not want to put words in your mouth, but I think that I am hearing that the data is as robust as it can be at the present time, but things are constantly changing and, as eligibility criteria are changed, awareness is raised and new benefits are created, the information that has to be captured has to evolve and change. If I were looking at the figures, I would want to know whether the uptake levels for PIP are greater or smaller among black and minority ethnic communities, for women, and in rural areas.

We could pick other entitlements and do a similar exercise. For example, are under-25s less likely to claim some entitlements than others? The aim would be to get beneath the surface of the aggregate predicted cohort in society that could, in theory, claim. We could then ask whether the figure for those who claim is 40, 50 or 70 per cent. Beneath that, are there other inequalities in take-up rates that are based on whether a person is BME, whether they stay in a rural area, whether they are male or female, or whether they are under 25? Is that information captured anywhere?

Professor Bell: Obviously, those are very important issues that we need to understand. One might approach the matter—with all the caveats on surveys—by considering whether there are

factors other than disability that explain why people claim that they are receiving a benefit or not. I have tried to show that, and I would not go to the wall at all on any of my estimates. If I found that somebody in an ethnic minority group was less likely to claim for some reason, that would be a little bit of evidence that suggested that there is an argument for trying to increase take-up among that group. It seems to me that the only way to do that is with a survey.

The Convener: They might, of course, be less likely to complete the survey in the first place.

Professor Bell: There is a load of other issues to do with response rates to surveys. That matter is getting increasingly difficult, but that exercise cannot be abandoned. It is worth trying to understand the claims procedure.

The Convener: I mentioned rurality. Do we have enough data on that, Professor Shucksmith?

Professor Shucksmith: Very few studies disaggregate estimates in respect of rural areas against non-rural areas, or by settlement size or sparsity. It has consistently been found in studies that have been done in rural areas that the take-up of most—if not all—benefits is lower in rural areas. However, the only study that I know of that has followed the methodology that Professor Bell has outlined—that is, using the family resources survey to estimate those who might be entitled and comparing that with administrative data—is one on pension credit that was done by Jonathan Bradshaw and Dominic Richardson back in 2007 at the University of York. It found that 35 per cent of those who were eligible for pension credit in urban areas were not claiming it, whereas 54 per cent of those who were eligible for pension credit in villages and landward areas, as we might describe them in Scotland, were not claiming it. There was a marked disparity in claiming among those who were eligible.

The other research that has been done has been more on the basis of surveys of those who claim and non-claimants as opposed to comparing with the eligibility population. That research looks into the reasons for that, which I think we will come on to.

The Convener: We will come on to those shortly.

That is a very helpful example of where the committee would want to know about the quality of the data. How can we effectively recommend directing uptake and entitlement campaigns if we do not have access to where the disparities are?

Professor Shucksmith: When we are comparing rural and urban areas, it is very unreliable to use claimant counts as a proxy for levels of poverty.

The Convener: That is a fair point.

Pauline McNeill (Glasgow) (Lab): Good morning. Thank you very much for your evidence so far. It is very helpful in understanding the basis of our inquiry, which is benefit uptake, but of course there is a close relationship between that and the scrutiny we are also doing on the transfer of budget. If I am steering outwith your area of expertise, let me know, but it is just too good an opportunity to pass up. We talked about the predictability or unpredictability of some benefits. Professor Spicker gave us a good example about DLA and the way that that was expected to save money.

09:30

I draw attention to Professor Bell's submission. You have mentioned assessments of unmet need in free personal care. My interest is in the relationship between predicting benefits and whether we have the right formula for the budget. It strikes me that without some flexibility, you would worry. This is where I might now steer a wee bit out of the bounds of the inquiry. How will we ensure stability in uptake going forward? Leave to one side anything that we might want to examine in relation to automation of benefits and higher uptake, because we are now clear that that will have implications for the budget.

On page 3, you say that

"The lesson from the Scottish government experience with free personal care is that the accurate assessment of potential take-up and unmet need are of critical importance for the financial viability of any policy which provides cash benefits or benefits in kind to the Scottish population",

and, at the bottom of the page, you say that

"This is further evidence of the need to accurately predict variations in take-up."

The bit that I was coming to is this:

"Significant underestimates will pose a threat to overall Scottish Government budgets, possibly for an extended period of time."

Could you say more about that?

Professor Bell: I was part of the care development group that was set up by the Scottish Government in, I think, 2000. It recommended the adoption of the Royal Commission on Long Term Care for the Elderly's suggestion that personal care be provided free. We commissioned a study that was done at the University of Aberdeen. It used what was called a disability follow-up, which was associated with the family resources survey to estimate unmet need. The numbers that that study came up with were relatively small and the numbers drove the proposed budget for free personal care.

Despite what we have been saying, we are in a much better position now to understand implementation of existing benefits than was the case with free personal care, which was not well understood. Some local authorities were already providing free personal care: the overspend on free personal care is itself an estimate because there was no clear starting point for the costings, given that there were different practices among local authorities.

In another sense, however, we are in a worse position, because we are now talking about more than 9 per cent of the Scottish budget, so the implications will be much bigger for the Scottish budget if we get it wrong. I should caveat what I have said by saying that, in my submission, it is not just whether Scotland increases its take-up per se that matters, but whether it increases take-up relative to trends in the rest of the UK. That is what will determine the Barnett money. I have done some work on that and would be happy to share it with the committee. I did not include it with my submission.

Pauline McNeill: That would be helpful. It has taken the committee a bit of time to understand the relationship between the increase in uptake and the budget.

I am glad that you said we are in a better position, which is a bit more hopeful. Is more flexibility needed, given that there is still unpredictability in the trends in the fiscal framework to accommodate that?

Professor Bell: I will put my Finance and Constitution Committee hat on now. Yes, is the answer. The Scottish budget will face a number of risks each year. We have seen some of them having significant effects, and will do next year because of the shortfall in income tax receipts. The story of why that has turned out as it has is very complicated; nevertheless, there is a negative effect on the Scottish budget. The question, in terms of the fiscal framework, is whether there should be more flexibility in borrowing capacity to deal with unexpected fluctuations in major components of Scotland's budget. There is a strong case for that. The budget would have to be adjusted, in the medium term at least, in order not to constantly borrow to fund additional social security spending. It seems to me that such issues must be on the table in the review of the fiscal framework in 2021-22.

Pauline McNeill: You say in your submission that what matters is the increase in take-up relative to trends. Where there was promotion of a benefit and the Scottish Government spent lots of money, you can see the direct correlation, and that we have affected our trends, whereas other parts of the UK might not have done that. You might expect that we would have to pay for that.

Professor Bell: That might be the case, but the situation is very complicated, and depends on how much effort is being put into uptake south of the border. If equal efforts are being made to increase uptake, that might have a neutral effect on the Scottish budget.

How effective can promotion policies be? I do not have a strong view about that. Obviously the situation reflects unmet need. Unfortunately, we are guessing, but my feeling is that there is certainly less unmet need than we faced at the time of the introduction of free personal care.

Dr Alasdair Allan (Na h-Eileanan an Iar) (SNP): I am interested in what Professor Spicker said about self-identification by disabled people. I appreciate that that makes the task of measuring some of what is to be measured very difficult indeed. What can be done to clarify the question in the minds of people with disabilities? How should policy makers approach the problem that you have described?

Professor Spicker: I am not sure that anything can be done. There is a marked difference between the experiences of people who have successfully claimed a benefit and those who have not, as you would expect. For example, it is fairly obvious that people who successfully claim a benefit are far less likely to see the complexity of the benefit as a barrier to receiving it than the people who have failed in a claim. There have been some very interesting studies on the experience of unsuccessful claimants.

Part of the problem is that people understand the benefits very badly and do not know what they are for. If they are receiving employment support allowance or its equivalent—it is now moving to universal credit—a fair number of people might say, “I might as well have a crack at DLA”, although their application would be completely inappropriate in terms of the criteria for the benefit, so they would be rejected on that basis.

It is difficult to say clearly whether a benefit is for people with disabilities. There is a lot of confusion in the language; I am afraid that people do not really understand what DLA is for, what PIP is for or what attendance allowance is for. It obviously helps to understand that attendance allowance is not about attendance. We have such problems running through the benefit system and, unfortunately, a lot of what people are told does not square with the benefit rules. It is pretty clear that neither DLA nor PIP could be considered to be an extra-costs benefit, so representing it as an extra-costs benefit is misleading for the people who have extra costs.

I am disappointed that the options that have been chosen in relation to disability benefits have been to replicate a system that has been proved to

cause such confusion and so many problems, and that there has not been an attempt to clarify, for the benefit of potential claimants, who the benefits are for. It would be helpful to introduce a severe disablement allowance, which—theoretically, at least—the Scottish Parliament now has the powers to do. It would also be helpful to have a mobility allowance, because people have a pretty rough idea of what it is that is involved with mobility. The care component of DLA and PIP is completely baffling—I am afraid that people do not really understand it.

I am not sure whether clarity would save money or cost money. The experience, however, is that clarity often costs money because that is how you encourage people who have unmet needs to have their needs met.

Dr Allan: You mentioned lack of clarity about benefits. I was interested to hear earlier that there is a lack of clarity in people’s minds as to whether they regard themselves as disabled.

Professor Spicker: That leads, in the claim process, to a lot of churn of people claiming unsuccessfully because they are claiming inappropriately. At the same time as people whom we want to claim are not claiming, other people whom we do not want to claim are doing so.

Dr Allan: One of the other things I was keen to pick up was the earlier comment about some of the trends that there may be in different parts of the country or different communities. You may not see this as your role, but I would like to delve into the reasons behind those trends. For instance, Professor Shucksmith, you know my part of the world quite well, given your previous work on crofting. Anecdotally, my impression is that, in many parts of rural Scotland, there is an older generation of people who have pretty deep-set cultural worries about claiming benefits, including loss of face, lack of belief that anything in their community is anonymous and all sorts of cultural concerns about being perceived as receiving, rather than giving to the community. I do not know whether you feel that any of that is within your scope, but have you looked at trends? Has anyone tried to delve into what the reasons might be for low take-up in rural areas?

09:45

Professor Shucksmith: Yes, there is quite a lot of information on the reasons for take-up being low, although there is less information on trends. You mentioned that I have worked in your constituency. Twenty-five years ago, I did a study on these matters, with Harris as one of the study areas. Harris is also one of the study areas in our new project on rural lives, so we have been there

again and we are trying to see what the differences might be.

It would be helpful if I talked through some of the explanations for lower take-up, including the one that you highlighted, which is that the older generation is resistant and very concerned about visibility, privacy and stigma in small communities. We and other researchers have found that that is the case not just in rural areas on the islands, but across rural Scotland—and in Northumberland, where I have recently done some work—and I know that it is a feature from studies that have been done in rural America. It is a feature of small rural communities in developed countries around the world.

In addition, we found in our work that members of the older generation often do not see themselves as poor. The issues are similar to those raised by Professor Spicker, but couched in a different way. People say, “When I grew up, we did not have running water, electricity or television and now we have all those things. How can we be poor?” The reference point is often their own past rather than the everyday lifestyles of the majority today. That is a barrier. The question of how you overcome that is a quite difficult, ethical one. Do you want to persuade somebody that they are poor? You do, in the sense that you want them to have the benefits, but you do not want them to change their view of themselves in a harmful way.

Another reason that we have come across in the literature and in our current work is that sources of advice and information are distant, as they are often located in urban centres. That has become more of an issue as the benefit system has become more and more complex, so it is probably more necessary to have advice and support, not just when someone makes an initial claim, but when they have to fill in journals and attend assessments regularly, have appeals and all the rest of it.

So much is now online, which was not the case 25 years ago when we were working in Harris and other areas of rural Scotland. That is a really important issue for rural claimants and rural take-up, not only because of the poor digital infrastructure—whether there is broadband or a mobile signal, for example—but because of the cost of a digital connection. Can the claimant afford broadband? If they are just relying on a mobile phone, is it pay as you go, which runs out 20 minutes into the hour and a half long session that they need to have? How do they get support when they are trying to work online? Where do they go to go online? Do they go to a public library—if there is still a public library near them? Do they have to spread out their personal papers and keep running over to the counter to ask

somebody to help them, with everything spread out for the world to see?

Another reason is housing tenure. There is quite a lot of research that shows that people who live in social housing are more likely to be informed and helped with support in relation to the availability of benefits, both from their social landlords, but also from their peers. That is an issue given that people who live in private housing in rural areas are more likely to be living in poverty.

Those things are well established in the literature. One or two other things are beginning to emerge from our rural lives project, although this is very preliminary, as we have only really just started doing fieldwork in two areas in rural Scotland. One is the worry that people have about moving on to universal credit because of the disability assessment regime, which they perceive to be very threatening. They perceive that if they move on to universal credit they are more likely to be subjected to sanctions that stop all their benefits and leave them in a much worse position. Even when they are told that they could be getting quite a lot more money by making that move on to universal credit, they see the risks as not worth taking.

Related to that, and not only for disability benefits, are the unpredictability and volatility of incomes in many rural areas, whether that is do with seasonality or casual work, with people having a number of jobs. It seems that there is quite a lot of evidence of unpredictability and volatility of incomes, which lead to worries about overpayment—people are not aware of overpayment happening, and then they have to repay that debt. In a sense, they see that as going into debt and they are worried about sanctions and all sorts of things as a result of that volatility of income.

If it helps the committee, I can talk about a separate piece of work that we have been doing that is along the lines that Professor Bell talked about and which is looking at longitudinal data. We have been analysing the British household panel survey, in which households are interviewed every year, and comparing rural households to urban households not just in Scotland but across Britain over the period since 1990. It appears that the proportion of people who have been in poverty at some point over that period is almost the same in rural and urban areas—50 per cent of the people in rural households were poor at some point from 1991 to 2008, compared to 55 per cent of the people in urban households. It also appears that the periods spent in poverty tend to be quite short. That reinforces and underlines the point about volatility of income and people moving in and out of poverty. It is about that churn.

You asked about trends. The other major trend that we see is the increased use of food banks. There are all sorts of issues around that. You will have seen on the news a couple of days ago that we have had a very important report from the Trussell Trust about who is using food banks and the reasons for that. I will not repeat what it says, but you will be aware of that.

Dr Allan: That was very interesting, thank you.

The Convener: The deputy convener wants to look at improving benefit take-up.

Pauline McNeill: I mentioned the question of having a better way of people getting their benefits, which is something that I am interested in looking at. The committee has looked at the question of automation at a number of levels. If you could find a way to automate a system, I suppose that your starting point would be the assumption that levels of expenditure would be much higher. A number of councils have been able to automate some of their benefits. In Glasgow, which I am familiar with, the school clothing grant was matched up quite easily for people who were eligible for housing benefit. However, the introduction of data protection has made that a wee bit more complicated. In my opinion, most organisations have gone over the top with data protection—I hope that that will calm down.

How would you go about automation? What would the implications be? Given what has been said already, is it even worth exploring, because even if we were to achieve it, how would we pay for it all? Undoubtedly, it would put expenditure up quite dramatically.

Professor Spicker: We have recently seen Government placing rather too much emphasis on information technology and the belief that IT will make the problems disappear as if by magic. People can answer only the questions that make sense to them and that they know the answers to. If you ask somebody whether they can walk or whether they are disabled, they often cannot often make sense of those questions. A standard experience of just about everybody who has ever done welfare rights work is to have somebody looking at them in bafflement, saying, “I do not know what to write. Please tell me what I should put down.” That is not going to be solved by an IT process, and we cannot expect IT to resolve human problems that we do not know the answers to ourselves.

There is a separate issue, which is about automaticity and the question whether it is possible to put things into the benefits that mean that people get paid, whether they expect it or not. We put an awful lot of emphasis on the initiative coming from the claimant. In technical terms, we

treat benefits as what is called a subjective right: people have to take the initiative in starting off a claim. That does not necessarily have to be the case. If you know about hospital procedures, for example, you will know that, for many years, a standard part of the invalidity benefit was the hospitals issuing a yellow slip and saying, “Just put that into the benefits office.” You can remove barriers from the process through which the benefit is delivered. That is quite different from the sort of thing that we have been looking to do with what we call automation.

Pauline McNeill: That is really helpful. You put it very succinctly: the initiative is given to the applicant, and getting paid whether you make the application or not is a quite different concept.

Is there anything else to be said about what other barriers can be removed? In some cases, benefits may be necessarily complex, because you have to test. That is maybe not a good example. There might be other areas where forms could be a lot simpler. I am familiar with one such area. I did a bit of work with One Parent Families Scotland, which told me that a high proportion of single parents do not claim benefits largely because their lives are taken up looking after their children. They are single parents, so they just do not get around to filling in forms if they are complicated. There is probably anecdotal evidence of there being less opportunity for people to phone up the advice centre to get the form filled in for them because of the cuts that advice centres have had. Is there anything else you can say about removing barriers?

Professor Spicker: We have been creating barriers in recent years. The whole idea of putting every person through an individual assessment in a points scheme means that a lot of people are being put through unnecessary hoops. We know that there are certain channels of information that could be drawn on. You will never be able to produce the position where nobody gets that sort assessment, but there could be far fewer assessments; indeed, there could be assessments with far fewer questions. Let me give you a simple example. The points scheme was devised initially by the Office of Population Censuses and Surveys. It did a validation that basically said that, after you know about the three most serious disabilities, any further information makes no difference to the assessment.

What are we actually doing when we ask people questions? We ask everyone, “Can you go to the toilet?” That is completely irrelevant and unnecessary. It is an embarrassing, awkward question. It does not need to be there for the vast majority, for whom that is not an issue. Even for some people for whom it is an issue, if you had followed the advice of the people who initially

developed the points scheme, you would not be asking the question anyway.

Professor Shucksmith: Related to that are two points that we are being told about by the advice and support workers we speak to in rural Scotland in our current study. One is about the way in which general practitioners' evidence is ignored in the assessments. One way of completely cutting out the assessment as it is done at the moment is for a GP to say that somebody is not fit to work. The second is that we are being asked why it is necessary for people with chronic conditions to be assessed at such frequent intervals. Those are a couple of things that people on the ground are telling us are unnecessary. The system could be simplified in that way.

The Convener: On that point, which was covered in a few supplementaries, we will look at the regulations for disability assistance when they come forward. The Government has made great play of the fact that this will be done differently. Following a debate in Parliament in which I spoke about disability assistance, I put something out on social media. It got quite a lot of traction on Facebook, where people who had been unsuccessful with PIP and DLA were saying, "Oh, what if this newer system comes in? I might qualify." There is a cohort of people out there who may have been unsuccessful under the current system who are waiting for the new system to kick in because they think they might qualify under it.

Does the Government know which people have been unsuccessful in the past one to three years? If we know where they are, in theory we could reach out to them and say, "You might not get a penny, but guess what, you are entitled to apply." Would that be a very expensive thing to do if they were successful? Is that the kind of clever use of data that we should be looking at? I am not talking about automation or passporting but just joining the dots more effectively within the policy sphere of social security.

10:00

Professor Bell: I have some experience that is relevant to that. We have conducted our own HAGIS survey of older people. We linked it, with individuals' consent, to their health records so we have a lot of objective information about their health history and so on. We are seeking to link that to their DWP records, but we have not yet succeeded in doing so. Linking to DWP records is a really difficult process. I do not know whether any research group in the UK has managed to do that, but, on accessing the administrative data, it is clear that there are pieces of information that could be absolutely vital to an application or assessment procedure for the new Scottish social security agency.

Difficulty with linking data is not all to do with the general data protection regulation; much of it is to do with the fact that the agencies are bound by the legislation that set them up in terms of how far they can share data. A few years ago, we were led to believe that we were moving into an era in which it would be much easier to do that kind of exercise, but so far it has not proved easy.

The Convener: I used that example because the committee is looking for concrete examples of how we could move towards making entitlement and benefit take-up more effective. There are several supplementaries on this. I call Jeremy Balfour, to be followed by Keith Brown. I also have Michelle Ballantyne's name down.

Jeremy Balfour (Lothian) (Con): Good morning. What do you call a bunch of professors?

Dr Allan: A university?

Jeremy Balfour: I will pursue a couple of lines of questioning with regard to barriers. The Glasgow Disability Alliance raised the issue of the names of the new benefits, and particularly the disability assistance for working age people, which will replace the PIP here in Scotland. Its concern is that if we use "working age" as the terminology, that will put off people with disabilities who are not working and there will maybe be an underlying presumption that you have to be in work to get the benefit. On that issue, and more broadly, how important are titles and names as barriers for people taking up benefits? Should we be looking at trying to get the name right?

Professor Spicker: A long time ago, I tried to work out whether that issue had any effect. I did a survey about attitudes to, and knowledge of, benefits. I am sorry to say that it was an early study and I cannot put my hand on my heart and say that it was worth the effort that I put in at the time, but what I found was that people who had a positive view of benefits would say that they knew about benefits and that they had heard of benefits—including the ones that I had just invented and did not exist—whereas people who disapproved of benefits said that they did not know about any of them and just went down the column of benefits saying, "No, no, no, no, no."

One of the flaws of the threshold model that I referred to in the submission is the belief that we can separate people's knowledge of benefits from their attitude to benefits. It is quite clear that, regardless of what the headings say, people who say, "I am not that sort of person. I do not want to go near this", will not try it, whereas somebody who already receives a benefit—I mentioned ESA as an example—might well say, "I have this benefit. I will see whether I can get that one as well." It is not necessarily down to rules.

There are other problems. I largely agree with the point that you made. I think that there is a problem in the current administration of benefits, which is that people are being asked about work for benefits for which work is irrelevant. The whole point about the non-means-tested benefits is of course that they are available to people regardless of whether they work—work is not part of the test. I agree that it is misleading.

I am concerned, too, that we are creating barriers at the point of change. Currently, as the situation stands with DLA and PIP, if you claim before retirement age, you are entitled to mobility allowance and you get an extension after retirement age. That leads to perverse and inequitable consequences. I cannot see why the Scottish Government wants to maintain that distinction.

Jeremy Balfour: Thank you for that simple answer, but we will not go over that today. I will push you and your colleagues a bit more on whether names matter. Does the name of a benefit affect how people might take it up? I refer back to the Glasgow Disability Alliance example. Does using the word “work” in a title put off people who are not working and who are disabled, or do people not think that deeply?

Professor Bell: I am trying to think of an alternative.

Jeremy Balfour: Do.

Professor Bell: It is not that easy. I do not know.

Jeremy Balfour: The second point to follow up is the comment that Professor Spicker made in his submission that if nothing changes there is nothing to promote for the new benefits—that is a basic summary of what he said. Will that be an issue with regard to take-up? Going back to what the convener said, if people think that it is exactly the same as we have at the moment, there is unlikely to be a massive uptake because people will think, “I did not get it under PIP. I will not get it under the new system.” Does the system need to be radically different to get a higher take-up?

Professor Spicker: I certainly do not see any evidence that changing the name of DLA to PIP has made a radical difference in terms of the pattern of take-up and claims. You should also beware of the assumption that all we have to do is advertise and say to people, “Hey, there is money here” and people will flock to receive it. There is absolutely nothing to back that up. The most successful take-up campaigns in the past have been those where people have an entitlement and where you can build on that entitlement through some sort of outreach and support. It is very noticeable, for example, in the take-up of housing benefit that having a social landlord guiding

someone through the process makes an enormous difference to what happens.

In the past, Scotland has not been blessed with large numbers of disability organisations. I see a very substantial transformation in the country in the past 10 to 15 years in that regard, which I think will make a difference over time. The support mechanisms have improved immeasurably from when I arrived here 30 years ago. I think that there will be certain trends in that direction anyway. Certainly I think it would help if the benefits that people were claiming made some sort of sense to them and if they knew what the benefit was for. I think that that would help to streamline in some ways a process that is far too difficult to access.

The other thing that would make a difference would be to have smaller standalone benefits. One of the problems that we have consistently had in the benefits system in this country has been the assumption that all you have to do is have one large benefit covering everything and people will somehow get it. I am afraid that the effect of having a large benefit is often that people do not get all the component parts of it that they should get. If there are any problems in the administration of that benefit, everything stops and the effect for claimants is catastrophic. You can build up something that is more personalised, which is more responsive to people by putting together small, simpler benefits in a predictable way.

Jeremy Balfour: I say for the record that I am in receipt of PIP.

Keith Brown (Clackmannanshire and Dunblane) (SNP): I think that the correct term in this company is a pile of professors, but that gives a bit of my background away, I suppose.

From what has been discussed, it seems that it is an appalling system that does not work. We have spoken about the limitations of the data, such as it being based on surveys with self-selecting participants. Of course, that can apply to the jobseeker figures, which are accepted as being on tablets of stone and not open to question. If the information and data are not there, that is a fundamental limitation on improving the system. It has been said, quite rightly, that even claimant counts do not provide data that is of sufficient integrity to enable predictions to be made. Given all that and the limitations that committee members have talked about to do with rurality, ethnicity and gender, which can lead to a lesser take-up, it strikes me that we should be looking to make sure that we improve the system.

The deputy convener asked whether new IT or automation could improve things. She said that that would be more expensive, but given examples such as child tax credit, for which the UK Government made a £4 billion overpayment, and

the fraud that we are told is in the system, surely savings could be made if it was more accurate. As Professor Spicker said—his evidence has been really compelling this morning—we should think differently.

I invite you to think differently about the potential of an IT solution based, for example, on one's national insurance number or data that can be obtained from the health service, such that everyone has a personalised data set. I know that there are issues around data, but that could start the process off and be the means by which all the entitlements are put into the system. If we do not want the recipient to be the initiator, the state can be the initiator. It can suggest that someone might also be eligible for a free TV licence or concessionary travel, but the decision whether to take that up would always be taken by the recipient. Surely we can do better than the system that we have now. It would not necessarily be more expensive.

Professor Bell: There are a number of things there. In your first remarks, you said that our understanding of the current system is not good, which means that there is not good predictability of the system and it will not help us to understand which groups are being particularly disadvantaged by the system. That is one set of problems.

There is another set of problems to do with improvement in the system, which might mean changing names, and then more fundamentally changing the structure of benefits. I certainly think that the Scottish Government should look into that and look at how benefits interact with the social care system, given the types of benefits that Scotland has.

On the data side, we could do better. I do not see that there are any innovations planned that would help us in that regard. I guess that this will reinforce your views, but our data is split, in a sense. For example, our negotiations on access to health data take place here in Scotland, but our negotiations for access to DWP data are in London, and the same would apply with HMRC data. We then become a small part of a bigger whole. There might be solutions but, first, they are hard to come by, and secondly, you have to be a little bit cautious about having an all-singing, all-dancing IT solution to your problems.

10:15

Professor Shucksmith: There is a lot to be said for prepopulating forms with existing information, but it is really important that that should be transparent to the individual and that they are able to check that the information is correct. Beyond that, I am told that it is very difficult to understand exactly what are the

calculations behind the benefits and, in particular, behind changes to the payments that are received. The transparency of the system to the recipient is really important. The more that it is automated, the more important that becomes.

Professor Spicker: We need to avoid the assumption that we are going to find a magic solution for everybody. We have to understand that one size does not fit everybody and that the ways in which the benefits system, particularly in relation to disability, has to work are going to be much more varied—not necessarily individuated, because that creates huge problems in fluctuating conditions and for people who are uncertain about their own situation, but rather varied in the sense of saying that we can take out categories. We will not be able to simplify the situation with a system that is quite complicated. We need one that is potentially responsive to the needs of people.

One thing that has been found about professional assessment is that the more trained the professional is, the more needs that person is able to identify. Doing things well will cost more, because we do things at the moment so badly and miss so many of the people in need. It is unavoidable that it will cost money; I do not think that there is any way around that. In many ways, that will be one of the tests of how well the Scottish system is performing, but I do not think that that should be a reason not to do it.

Keith Brown: An IT solution will not necessarily be simpler; it could be very complex.

On transparency, we have heard evidence that most people have a real problem understanding the basis of their entitlements, and even some of the names, such as attendance allowance, are misleading. With transparency there has to be accountability. I am not sure that everyone has to know how every system works. It is perfectly possible to have that transparency in an IT system. I just wonder—and I mean no disrespect by this—whether we might have had a different response from somebody in the IT field who could perhaps come up with something. We are talking about personal information and I appreciate Professor Spicker's point that the system has to be adaptable and dynamic over time, because people's conditions change. I understand that, but there must be some scope to use that kind of IT system to help with some of the shortcomings.

Professor Spicker: Yes, you can be absolutely confident that you would get a different answer from somebody in the IT field. That is usually because they do not know about benefits.

The Convener: I am not sure whether we should leave that hanging and move on to the next line of questioning.

Michelle Ballantyne (South Scotland) (Con): I want to pick up on a couple of things about the assessment process that Professor Shucksmith talked about. You talked about relying on GPs to make the decision on whether somebody is fit to work and you said that that was the word on the ground. Where is that word on the ground coming from? When I have talked to GPs, quite a few of them have expressed concern about the possibility of the decision coming down to them, and they are worried about the disruption of the relationship with their patients. That is my first query.

Secondly, I was particularly interested when Professor Spicker said that only the first three questions need to be asked in an assessment, then it is a case of job done. I wondered why all the other questions were developed if the conclusion could be arrived at with only the first three.

Professor Shucksmith: What I said about GPs did not come from GPs; it came from people themselves and from the advice of support workers who work with them. The point is that people cannot understand why, when a GP says that they are unfit to work, that evidence is not taken into account in the assessment that is made, or in the appeal, until it gets to quite a high level after they have waited for several months and been denied that benefit. That is what I am referring to. Of course the issue is more complicated and I can quite understand that GPs might be resistant to what you talked about.

Michelle Ballantyne: Taking the GP's opinion into account is quite different from the GP making the decision. I see that.

Professor Shucksmith: Yes.

Professor Spicker: I should explain myself more clearly. It is not that the three questions are enough, but that by the time that you have considered the three most serious disabling conditions somebody has, and you get on to what they rank as number 4, 5, 6 or 7, you are not adding anything to your information. The first question is, "What are the disabilities that you have?"

Michelle Ballantyne: I am trying to get my head around why, when the organisation was designing the points system, it did not design it like a flow chart, so that it said, "If the answer to this is yes, go the end. You have finished." Why did it allow it to continue down?

Professor Spicker: When the organisation developed the points system, it first identified a series of domains with different points in them. Then it put that to professional experts to validate the responses. It is the professional experts who said, "There is a certain point beyond which we do not need to add in more than three domains

because we have the top information from those, and all the factors after that either do not make a difference or are balancing." There are a number of conditions that are enough in themselves, such as terminal illness. Quite apart from that, let us say that we have somebody who has an amputation and respiratory problems. That might be all you need to know. You do not need to go through every one of the domains and ask, "Is there anything here?" The problem with the current system is that we are asking everybody questions that are completely irrelevant to their circumstances and condition.

Michelle Ballantyne: Did the original design get changed along the way? Was that the issue?

Professor Spicker: It did, yes. The original design was intended to conduct a census of people with disabilities in the United Kingdom and the purpose of that was to see what level of services would be required. At the time, the Government was looking at the move to incapacity benefit and it said, "There is a points scheme there, we can use that." Therefore, a points scheme that was developed for one purpose got lifted and dropped into another system. The Government was convinced that that would reduce the number of people entitled to incapacity benefit. There was public advice from the Department of Social Security to that effect. It had the opposite effect.

Michelle Ballantyne: That makes more sense. I will have to go and research that.

Professor Spicker: On assessment, one size does not fit all. It is not that you want a medical note for everybody, but rather that people with long-term conditions will typically have somebody with whom they have a continuing relationship who can give you far more valid information than you would get from their afternoon assessment in an office in a strange location. Often, that will be a hospital consultant or somebody in a day hospital or something of the sort, but there will be somebody who knows. The more that the process can be whittled down, the less work is needed in order to do the assessments.

Michelle Ballantyne: This is about not taking a particular diagnosis and saying, "There you are, that is it." For example, I have somebody who works for me who has multiple sclerosis. She holds down her job perfectly well and does not want her disability to define her.

The Convener: This issue is fascinating and we will look at it in December when the disability assessment regulations for younger people come before the committee, but I am conscious that it is not within the scope of the inquiry that we are doing. We are happy for the witnesses to respond

to the question, but it is not within the scope of our inquiry.

Michelle Ballantyne: Fair enough.

Professor Spicker: The question that you need to ask is whether you want a benefit that is responding to the level of need that somebody has at the point of application—MS is known for its fluctuations—or whether you want it for another reason. The real reason why attendance allowance was initially introduced was not to make sure that people got someone to attend on them and it was not do with extra costs. It was introduced because of compelling evidence that long-term disability had a disadvantageous effect on income throughout a person's life, regardless of their status or their level of income. They would always effectively be at a disadvantage. The idea was to create a disability benefit to supplement the person's income.

Michelle Ballantyne: And level the playing field.

Professor Spicker: Yes, it would help to level the playing field. I am afraid that current benefits have lost sight of that objective, but that is why attendance allowance was introduced.

The Convener: In the limited time that we have left, I would like to ask a few questions on behalf of the entire committee so that we can get something on the record in relation to the Scottish Government's recently launched take-up strategy for benefits in Scotland. Looking at my briefing, I can see that the only estimate that we have for take-up rate so far is in relation to best start grant pregnancy and baby payments. The aggregate figure for uptake is 67 per cent, with 53 per cent for first births and 77 per cent for subsequent births. I remember that Social Security Scotland said that the number of initial applications for that exceeded its estimate.

The system is still bedding in and a new benefit take-up strategy has been published, which is the result of a statutory duty on Social Security Scotland and the Scottish Government. Do you have any initial views on the Scottish Government's take-up strategy, particularly in relation to any estimations that it might have on benefit uptake?

Professor Shucksmith: No.

Professor Spicker: No.

The Convener: You do not have to have any views, but if you do, we would be keen to hear them.

Professor Bell: The Government needs to do more detailed analysis and possibly look at new sources of data. We have spent some time

discussing the estimation of take-up and nothing has particularly improved in relation to that.

The Convener: It is helpful to put that on the record.

Citizens Advice Scotland suggested that in any benefits take-up strategy, targets might be important. We understand all the caveats about that: you need a baseline, you need an initial estimate of what take-up is, and you hope that you have robust data. If the figure is sitting at 60 per cent when you launch your strategy, should your target be to get to 70 per cent or 65 per cent in three years' time? Should there be targets attached to any benefits take-up strategy?

Professor Spicker: The answer to that is yes, but the targets should not necessarily be in relation to take-up. The point that I was making earlier was on the difference between eligibility rules, which will define how many people potentially could receive a benefit, and the target population whom you wish to reach. It would be helpful to get a sense of whom the Scottish Government wishes to reach with each of the benefits.

The Convener: That would be depend on whether it is a universal entitlement or a targeted benefit, because with a targeted benefit you want 100 per cent take-up. That would have to be caveated, I suppose.

Are there any other thoughts on whether there should be targets attached to strategies so that we can measure outcomes?

Professor Bell: I would be a little worried about who is being targeted. Would you end up with a system that helps even more a particular group who you may already be helping? You have to understand how the system works before you embark on any kind of targeting.

Professor Shucksmith: What I have to say is not directly about targeting in the sense that you mean it, but I have two important points about developing the strategy. One is that it should be piloted in rural areas. There is a need to rural proof any change to the welfare system, preferably working with those who do not take up benefits, to see how it would affect those people.

Secondly, you will hear from the second panel about something that we are also finding, which is the need for better access to information, advice and continuing support and the way in which innovative partnership practices are being used in rural Scotland, such as fuel poverty schemes through which people are offered benefit checks and that sort of thing. Taking that kind of approach can lead to benefit advice being given through partnerships.

10:30

The Convener: I appreciate that my final question could open up a long line of evidence, so I ask for a brief reply. If you are able to supplement it after the meeting, that would be very helpful. On the benefits take-up strategy, Citizens Advice Scotland recommended:

"This should include estimates for universal credit, as it acts as a passport to a number of current and future devolved benefits."

There are already issues in relation to take-up of universal credit, which is still being rolled out across the UK.

Our committee has looked, with the Scottish Fiscal Commission, which I mentioned earlier, at policy spillover. If you have a take-up campaign for what is, in essence, a reserved benefit, which causes an identifiable change in behaviour, the UK Government would not be liable for the cost of that. Under the fiscal framework, the Scottish Government would have to pick up that tab.

More generally, my view is that it is crazy to have a take-up strategy for Scottish devolved benefits and a separate take-up strategy for UK benefits. The people whom we will meet in the next evidence session just want to help those who are in need to access the benefits that they are entitled to and to improve their lives.

There is a lot in that. I am asking more generally whether there is a need for a more strategic approach—a one-Scotland approach—to a benefits take-up strategy. Do you have any concerns? The committee has expressed concerns that a one-Scotland approach to a benefits take-up strategy, irrespective of whether benefits were devolved or reserved, could cost the Scottish Government more money vis-à-vis a UK Government tab that it may have to pick up.

There is a lot in that, but I would not be doing my job properly if I did not at least put that to you on the record this morning. Do you have any initial thoughts? Perhaps you could contact the committee after this morning's session.

Professor Bell: This is clearly a potentially important issue. It is difficult to put any scale on the no-detriment implications of actions that the Scottish Government takes that end up costing the UK Government additional resource. However, a more strategic approach should, it seems, be a target of the fiscal framework review, because ultimately people should not be disadvantaged by the machinations of the interrelationship, or lack of a good interrelationship, between the Scottish and UK Governments.

Professor Shucksmith: I agree with that. A person-centred approach is what is important. Working out how that affects the financial

budgetary lines between the UK and Scotland is a secondary matter. It is the person-centred approach to people who are very vulnerable in society that is the important thing.

Professor Spicker: I do not think that you need to worry about financial consequences of differential benefit take-up in Scotland. Such difference already exists and it is a standard part of the UK system. For example, the ESA and the related elements on incapacity within universal credit are more claimed in Scotland than they are in the UK. I do not think there has been any indication that there was a plan to change the rules to break away what is in Scotland, so I am not sure that that applies as a problem.

In the past, when welfare rights campaigns have been successful in Scotland and it has cost the UK money, we have heard Governments complain about that. In the 1980s, for example, it was the Government's view that if people wished not to claim, that that was their right and indeed ought to be encouraged, as that showed a proper sense of pride and dignity. However, the fact is that we did have take-up campaigns that were moderately successful, and it is in the nature of the UK system that that can take place.

I will mention something that is coming down the tracks. It has already been put off several times and I am not sure that it will happen immediately. Housing benefit for pensioners will be transferred into pension credit. That could have quite serious implications for pension credit and housing benefit. It was announced in about 2012, but it has been put off and put off. Nominally it is down to take place in 2021 or 2022, and the Treasury announcement has been reannounced. Whether it will actually happen, I cannot tell you, but be aware that that is a large issue about UK benefits that will have an immediate implication in Scotland.

Pauline McNeill: I missed the beginning of what you said there. Which pensioners will be affected?

Professor Spicker: Pension credit will be combined, in effect, with housing benefit for pensioners. The announcement has been made more than once, but it has not happened yet, in the same way that most transfers to universal credit have not happened yet.

The Convener: The committee may look at that at some point down the line. I am conscious that pension credit reform for mixed-age couples was floated many, many years ago and everyone thought that that might never happen, then all of a sudden it did and there were households in detriment, so I thank you for flagging that up.

Witness should feel free to stay in contact with the committee with any issues that you have, particularly with regard to a one-Scotland

approach to a benefit strategy for the entire nation and the no-detriment principle. That might be a sensible way forward. We will see what witnesses think.

I thank all three of our witnesses for their evidence. We will suspend briefly before we move to the next agenda item.

10:36

Meeting suspended.

10:41

On resuming—

The Convener: Welcome back everyone. In our second panel, we will hear from organisations that have undertaken successful projects to increase benefit uptake. I welcome Catherine Henry, financial health check service project manager, Citizens Advice Scotland; Fiona Moss, head of health improvement and equalities, Glasgow health and social care partnership; and Peter Hastie, project manager, Macmillan Cancer Support. Thank you for coming this morning. We will move straight to questions.

Shona Robison (Dundee City East) (SNP): Good morning. After hearing from the first panel, what we are now trying to get into is what works in helping people to take up their benefit entitlements. What has come across through your submissions is partnership working. There is no wrong door where people turn up or where there is interaction with people. How do you seize that opportunity with a generic expertise but then harness specialist expertise when appropriate? How do we develop and maintain those partnerships to improve benefit take-up and address the pressures on that? How can we do more of that and ensure that we are taking a holistic approach in which we are able to look at the wide range of needs but access specialist support when required?

Fiona Moss (Glasgow Health and Social Care Partnership): As you have said, partnership working is fundamental. I work in Glasgow city and across NHS Greater Glasgow and Clyde. My experience in both is that the partnership work is easier to create and maintain where multiple partners agree on the issue. It is important. In Glasgow city we have high levels of poverty and the national health service is absolutely involved in that. In some of our other partnerships, the relationships are quite different, because staff will not come across the issues quite as often.

Therefore, part of the answer is about finding common ground to work on. It is also about having some time to build the partnerships, because that takes time. As the partners are stretched in other

areas, they struggle to keep and maintain that time. I chair 28 partnerships in Glasgow city alone, so it is a daily task to bring together people with a wide range of interests. From my experience, I know that finding that common ground takes time and effort.

Catherine Henry (Citizens Advice Scotland): I will add to what Fiona Moss said about it taking time and requiring longer-term funding. One of the problems that we have with partnership working is that initiatives pop up and disappear just as they are starting to achieve things and just as people are starting to get that common ground and understand how they work. We have also seen that a lot of our partnerships work best when they are local and locally focused—when they grow from the ground up with national support to allow that to happen but without the national level dictating that you will form a partnership with that person.

10:45

Peter Hastie (Macmillan Cancer Support): Everything that Macmillan Cancer Support does is about partnerships. Our written evidence pointed to the improving the cancer journey—ICJ—partnership in Glasgow, which signposts to over 100 different organisations; it is not all about what Macmillan is doing. You start off with NHS Greater Glasgow and Clyde sending out a letter to somebody who has cancer. Then Glasgow City Council staff and Macmillan link workers get involved. We are then signposting to a range of different advice and support providers. Without all those organisations taking part, it would break down. The key for Macmillan is getting the person signposted. That is the start of the journey.

That is not easy. Some health professionals find it difficult to raise the issue of somebody's finances. The person has just been given a long-term illness diagnosis, but the biggest hit that we find with cancer patients is the cost of cancer after their diagnosis, which is huge. It is hard to raise those issues with people. What we want is the holistic needs assessment and the personalisation of care, so that it just feels like a natural part of the journey for somebody to be signposted to welfare support as well as the range of other types of support that they will need. It is still a difficult issue for a lot of people.

Your earlier evidence showed that people do not like benefits and do not like talking about them a lot. We are trying to make that conversation an everyday reality for somebody with a long-term condition such as cancer.

Shona Robison: I hear what you are saying about that being a difficult conversation, but is it sometimes easier for people if the other person is

not from the DWP but is someone with whom they have built up a relationship for whatever reason? In Macmillan's case, it is someone with a diagnosis of cancer, but it may be, in other cases, a caregiver. Is that conversation easier because of that? Secondly, is it more likely to lead to a positive outcome of a claim if there is that encouragement rather than discouragement?

Peter Hastie: The best example that I have ever seen is when the Scottish Government started with Macmillan about 10 years ago funding benefit advisers in the five cancer centres. The work of the benefit advisers involves them literally going into the chemotherapy ward as people are linked up getting their chemotherapy, handing them a form and then taking the form to the clinical nurse specialist to be signed. That is it done there and then.

There is trust that someone's Macmillan nurse is signposting them to benefits and to the link workers and is signing their benefits form. The evidence that we submitted pointed to the importance of supporting patients in the hospital setting, before they fall off the cliff edge when they leave the hospital setting and the support of all the clinicians, consultants, nurses and allied health professionals. If we can capture people there, the element of trust is more likely to be there, as you suggest.

Catherine Henry: We have seen similar in some of the work that we have done with health visiting and midwifery. There is trust between the new parent and their midwife and their health visitor. Removing the barrier to a health professional making a referral to welfare rights, whether that is co-location or whether it is having electronic referral mechanisms, has certainly proved to be successful.

We have a project in Fife as part of the money talk team in which the adviser has a dedicated space in the midwifery ward and the health visitors and midwives, through the system that they use already, ask, "Are you having any money worries?" It is a simple question and it does not need to go into the matter in depth. If the new parent answers yes, it can trigger a referral to the adviser automatically.

Fiona Moss: I would like to pick up on that with our experience of the healthier, wealthier children programme. There is trust personally, because you know the individual, but also trust in roles. Sometimes you do not know the individual. You may have had a different midwife each time or you may see a different health visitor. It is not always just personal trust that is important; it is trust in roles.

The other thing that arises from my experience of the healthier, wealthier children programme is

that it is about how people perceive their entitlement to benefit. Having a baby has a massive impact on your finances. The question might be, "Are you there any issues that you would like to talk to somebody about?" You do not have to label yourself as having money worries or being in debt or being poor to be able to have a legitimate conversation. From that we have found that the vast majority of women using our healthier, wealthier children programme are on the lowest possible incomes. Therefore, we are reaching the right women but we are doing so by having different kinds of conversations.

The Convener: Can I follow up briefly on the idea of partnership working. Fiona Moss, did you say that there are 28 partnerships?

Fiona Moss: There are 28 that I chair, yes.

The Convener: My goodness. I want to mention one partnership that is falling apart, and I am going to apportion blame for that, although it needs to be fixed, to make a wider point.

For the past three years at the Queen Elizabeth university hospital spinal injuries unit in Glasgow, consultant neurosurgeons were able to send a letter to the DWP to intimate the nature of the injuries of the people who were unfortunately having to be supported in that unit. That fast-tracked a PIP application from 30 weeks down to eight weeks. It saved the NHS £86,000 per patient on delayed discharge as well but, more important, it was better for the patient. It was clever working and it was well supported by the DWP and the NHS at the Queen Elizabeth. The centralisation of PIP administration to Birmingham, I think—I cannot quite remember—meant that that locally organised partnership fell apart. I know that the UK Secretary of State for Work and Pensions is looking at that again and I hope that we will get a positive outcome.

The wider point to make is that, if regional or national agencies change the rules of engagement and are not aware of local partnerships, there can sometimes be some detrimental and unintended consequences. If it is not an issue, please do not raise it, but 28 partnerships is a lot of plates to keep spinning, and it may be difficult to ensure that the relevant agencies are aware of what is going on locally.

Fiona Moss: Absolutely. Not all those partnerships have financial aspects; they are a part of my other roles. Not all partners are the same. Working with more remote partners is challenging, because the system and processes that are put in place often do not co-ordinate neatly with local systems unless they are given flexibility.

In relation to the DWP, there are a number of aspects on which, although we have staff around

the table, they do not have the power or the ability to make the changes that would make our partnerships work more smoothly. That is not to call out the DWP in particular, but the further away the decision making is from the local partnership, the more problematic it usually is to be able to have conversations that lead to local changes, because a change in one part is not necessarily needed in another part, and that is what makes it difficult.

The Convener: Are there any other comments on unintended consequences that have arisen because Social Security Scotland, the DWP or whoever has been unaware of local partnerships? If there is not, that is fine, but I wanted to see if there was anything else.

Fiona Moss: I will raise the issue of support for universal credit. In Glasgow, we had a wide range of organisations involved in that but, obviously, a decision that was made elsewhere made that not work quite so well.

Jeremy Balfour: We have asked this question quite a lot in different discussions, but I am interested in getting your view from a local ground level. It is the question of the GDPR and whether you can share information. I agree with the deputy convener that the GDPR has been overinterpreted by some organisations and by some groups. At ground level, is it causing you problems that you get information and then cannot pass it on to somebody else, or are you able to get round that?

Peter Hastie: One of the things that we have strived for the most in Macmillan over the past 10 or 15 years since we started providing financial advice is trusted organisation status. We have worked so hard on learning and development with the DWP that it recognises Macmillan's benefit advisers through the long-time engagement that the convener mentioned.

One of the key achievements of ICJ link workers has been to cut down the need for people to make lots of separate applications. If someone is going through this process and the ICJ Glasgow link worker says that they are also eligible for a clothing grant, for example, that is allowed to go through. ICG has been given that trusted status. We need to build trust in professionals such as the clinical nurse specialists and a range of people in this field, so that we can avoid the constant need to make applications in different ways. We could save a lot of money and a lot of people's time if we were more able to do that.

Fiona Moss: We have a number of experiences where we ask for patient consent and, if they consent, we are able to share that information.

Catherine Henry: I agree. One of the examples that we found is where we embed advice in a GP practice. With the patient's consent, an adviser

can get access to their medical records. A welfare rights adviser who can see medical records filling out a benefit form has a hugely higher rate of success, which means that the number who have to go to appeal and mandatory reconsideration, where that happens, is many times lower. It is all based on consent.

I agree that the GDPR rules can be interpreted quite strictly, but it is more important by far for us to have a reputation of trust and confidentiality in our interactions with clients than it is for us to say, "Oh, you need to make sure that the GDPR rules are strictly followed." If we are operating by our own values of confidentiality, that happens anyway.

Jeremy Balfour: I am interested in the point that you made about getting the medical records. Is there resistance to that from GPs? It seems very sensible, if you are doing an application for people, to be able to know exactly what a GP is diagnosing at that level. Does that happen a lot? I have not heard of it before.

Fiona Moss: We have welfare rights and financial advisers going into 22 general practices in Glasgow city at the moment. It is helpful, although quite often the adviser will need to go and speak to someone in the practice and say, "What does this mean?", because some of the medical terminology is not easy to follow in the notes, which are often written for an audience of medics. Therefore, there still has to be some interaction to understand that, but it helps immensely.

Catherine Henry: There is evidence. The Improvement Service has published a report on that as well. I can share that.

Jeremy Balfour: If you could, I would be obliged. Thank you.

The Convener: I will take Keith Brown next. If members have any particular themes that they want to cover, please bid to ask questions on them because, otherwise, you will have to listen to my voice for the whole morning, which is not desirable for anyone.

Jeremy Balfour: Hear, hear.

Keith Brown: I want to ask about three different things that have been mentioned. One is the need for a holistic needs assessment, another is personalisation and the third is the difficulty of sharing information appropriately, which we have just discussed. I want you to take a bit of an imagination leap for a second and imagine that a person has on the system somewhere all the different factors about their background, such as medical, social and work factors, and that is all known about. If an event then happens, such as the person being diagnosed with cancer or having

a baby, is it not possible to get round those three problems—making sure that there is a holistic needs assessment, making it personalised and making sure that the information is held appropriately—by enabling that person to simply go into an app or whatever and say that their circumstances have changed and they are now pregnant or have been diagnosed with cancer?

The app could immediately show an estimate of what the financial implications for benefits and other matters would be and it could suggest local groups to get in touch with. For example, if someone was diagnosed with cancer, it could suggest Macmillan. Would not that approach leave people with autonomy? I know that there are issues with data being held, but would that be a good way to personalise the approach and provide a holistic needs assessment?

11:00

Peter Hastie: Macmillan has been trialling in a lot of areas electronic holistic needs assessments in which, in a sense, the person does the assessment. The link worker will do it with them, but the person is given an iPad with a list of opportunities. If the person does not want to go down a certain road, they do not have to—we are giving people the choice. I am not sure how soon we could get to the next stage that you suggest, but certainly the use of electronic holistic needs assessment has come a long way in quickly opening up all the possibilities. That is what the dream personalisation focus for us would be.

As Ms Robison mentioned, in 2016, the Scottish Government cancer plan announced the transforming cancer care partnership of £18 million to spread that best practice across Scotland. The First Minister announced it in August this year, and we have already started in Dundee and Fife. West Dunbartonshire and Renfrewshire are next. We will spread it across Scotland so that the holistic needs assessment is put in place.

As the years go past, we will learn from what we have done in Glasgow and from what is now happening in Dundee and we will move faster towards what Keith Brown is getting at. That journey will take time, but certainly an electronic holistic needs assessment is going down very well where it works well. Not all health professionals enjoy using it but, where it works well, we know that the patient appreciates it.

Fiona Moss: There are opportunities to do what Mr Brown suggests, but there are complexities in that. Even with something as straightforward as pregnancy, not every pregnancy goes to full term so we need to consider what would happen under those and other circumstances. A lot of nuances

would need to be worked through for something as straightforward as a pregnancy. However, it is an idea to be explored.

There is a lot of discussion about the IT systems that are used for benefits, but we also have to be mindful of the IT systems that are used by the receiving organisations such as the NHS. We have multiple systems, and some of them are better than others at talking to other systems. There are complexities in the benefits systems and in the receiving systems that would need to be worked through.

The Convener: One reason why we were keen to have your three organisations here was because you have demonstrated significant success in helping those in need of support. We have the figures in our briefing paper, but could each of you talk about the number of clients and referrals that you have had and the amount of money that you have been able to get for individuals and families, as well as the amount of debt that has been written off? It would be helpful if you put that on the record before we have a follow-up question.

Who wants to go first?

Peter Hastie: It will be whoever is first to look quickly through their briefing.

To give an example, we recently started the ICJ programme in Dundee, following on from the work in Glasgow. In March, we put out a press release saying that £350,000-worth of benefits had already been realised through the link workers. That is the sort of scale involved.

Excuse me while I quickly look through my briefing, but we are talking about—

The Convener: I apologise. I was not attempting to catch you out on the data. I thought that, rather than me talk about your success, it would be better if you put it on the record. However, the Scottish Parliament information centre has helpfully prepared some of that data. So far, improving the cancer journey has generated £1.6 million in financial gain, with £107,000 of debt written off, which is a substantial benefit for people who are in significant need at a crisis point in their lives.

Peter Hastie: The ICJ programme in Glasgow has found the scale of need to be dramatic. Housing and benefits have been the main issues. There is a range of needs but, sadly, cancer diagnosis, particularly late diagnosis, often comes in tandem with many other difficulties in a person's life. ICJ in Glasgow is uncovering far more need than perhaps was initially envisaged. As the SPICe briefing shows, the numbers are absolutely huge. Clearly, the programme needs to be spread across Scotland.

The Convener: You can almost guess what my follow-up question will be. I ask Fiona Moss to say a little about the benefit to the clients that she has been serving.

Fiona Moss: The NHS has been developing work in a number of areas. The reason why I am here is because of the healthier, wealthier children programme, but that is only one of the areas. I gave you last year's figures but, in the first quarter of this year, we had 1,322 referrals, with a gain of just shy of £2 million. We now have a really substantial service. We get more referrals from health visitors than from midwives, which is an issue that we are constantly trying to address. At the moment, only 29 per cent of our referrals come from midwives.

There is a small army of people across the NHS who are constantly going out to train health visitors and midwives and to keep the issue on the agenda. We have set targets for some of the local teams so that people are undertaking the work to make it happen. It does not just happen by itself.

The Convener: Catherine Henry, do you want to add something in relation to Citizens Advice?

Catherine Henry: Yes. I have figures for the money talk team, which was formerly known as the financial health check project. I am in the process of pulling together the 12-month report for the period since the team's inception in November 2018, so I do not have the figures for that period, but I have the figure for nine months. Between our face-to-face service in every citizens advice bureau and our national telephone line, we dealt with 7,777 clients. Of them, we have outcomes recorded for 3,198—I expect that number to go up, because we follow up with clients after two months—and there has been more than £6 million of financial gain for those clients.

The Convener: Clearly, each of you has demonstrated substantial success for people. The reason why I wanted to get all that on the record is because we want the inquiry to make recommendations to improve things further. Is the future of the initiatives that you are running secure for the long term, given the success that you have demonstrated? More important, are there gaps across Scotland where more such work could happen in a more systematic way. How do we drive that kind of change, not just in the area that you work in but in other areas of welfare advice where you think that partner organisations are maybe missing a trick and could do something similar.

We can talk theoretically about all this as much as we like but, at the end of the day, it is about the actuality of what happens on the ground. All three of you have demonstrated how you help people in need and the figures in pounds and pence. What

is the future of your initiatives and how could the work be widened to help a greater cohort of people?

Peter Hastie: As I said, we were absolutely over the moon when, in August, we launched with the Scottish Government the £18 million transforming cancer care partnership. That will spread across Scotland. We know from the experience in Glasgow, Dundee and Fife that not everybody takes up the offer, because not everybody needs it. We do not suggest that every single cancer patient or person with a long-term condition will necessarily want to go through the process. However, we aim to have that offer for every cancer patient the length and breadth of Scotland by the time that we have rolled out. As I said, we are going to West Dunbartonshire and Renfrewshire in the next few months. Obviously, it takes time, because we have to build up trust among health professionals. They are very busy people and they would be upset if they were signposting to a system that did not work, was not there or was out of date.

It takes a long time. In NHS Greater Glasgow and Clyde, when we first signed up to it, the board sent a letter to every cancer patient but, actually, more people now get the holistic needs assessment from a referral. That is the key. It is a workforce issue. As you suggest, it is about whether we can sustain the workforce. We believe that we can do so through the partnership, but obviously there are always challenges in partnerships with local authorities. The workforce is the key, and we see spreading ICJ across Scotland through the transforming cancer care programme as the way to give everybody the opportunity to have a holistic needs assessment, which then starts their journey of personalisation of support.

Fiona Moss: For NHS Greater Glasgow and Clyde, the majority of our financial advice support across the NHS, whether in hospitals or in primary care, is funded from non-recurring sources or from external partners who have acquired resources for a period of time. Every year, I go through a few months of trying to sort that out so that the programme exists for the next year. We are committed, so we are trying where we can, but it is an expensive undertaking.

For example, we have 22 GP practices where one session a week of financial advice is in place. We calculated what it would cost for Glasgow city to make that available for one session a week in all our deep end practices—our most deprived practices—and one session a fortnight in all other practices. That would cost £800,000 a year just for Glasgow city. Therefore, it is a challenge. We would like to do an awful lot more, but it is a significant commitment for the NHS.

The Convener: It is important that you put that on the record, so thank you.

Catherine Henry: The funding for the money talk team goes until the end of October 2020. There is a two-year commitment in legislation to the project, so as yet we do not know what it will look like beyond that.

I echo the earlier points about longer-term funding leading to much better outcomes and much better ability to measure outcomes. Some of the things that we fund through the money talk team project and our welfare reform mitigation project, which is another Scottish Government funded project, involve outreach work, and that comes with an extra cost. There is the cost of physically getting someone to a different location and there is the time cost if it involves home visiting, for example. However, that service is valued by the people who it reaches. It is not just a straight numbers exercise in which you can think that, if you have seen 10 people, that is good. You might have seen only one person in that outreach work, but the difference that you have been able to make to that one person might be of great value.

Pauline McNeill: That is helpful. We have to register in the course of the inquiry that there is a cost to promoting uptake. If funds for it fall, that will definitely be problematic. The key thing about your organisations is that there are pathways. Macmillan Cancer Support has contact with cancer patients, so that pathway can be used for promotion. In respect of health improvement, there is a pathway through GP practices, albeit that promotion is expensive.

My question is for Catherine Henry. I would like to hear a wee bit more about the people with unmet need. I know that the evidence mentions older people, and we heard evidence from the previous panel that uptake might be lower in more affluent communities, for reasons that I do not quite understand. It strikes me that for foster parents, single parents and parents with chronically ill children remoteness from services must be a major factor. There are no obvious pathways for those groups unless they come into contact with general practices and health services.

How variable is the service that CAS provides? A parent with a chronically ill child who needs support and is wanting to know what benefits they are entitled to might know of CAS and ring up. What would be the pathway? Is provision sporadic across the country? I am acutely aware that there have been cuts to advice centres, so I ask the question in that context.

Catherine Henry: Face-to-face advice varies by local authority and according to rurality, as we heard earlier, and distance. We are trying to move towards multichannel advice. I know that there is

not a one-size-fits-all solution, but our telephone advisers can give the same level of advice to anyone. Obviously, when it comes to filling in forms, there is an issue, but we are using telephony for talking people through solutions, and we are piloting webchats and other projects in order to overcome barriers.

On data protection, all our bureaux are independent individual charities, so we have put in place agreements between bureaux in order to allow clients to move. A telephone adviser who is based at one bureau can access data from a client of another bureau. That was important to us for the project so that clients do not feel that they are phoning a helpline that belongs to one bureau but must go to see an adviser in another bureau, and instead just see the citizens advice service. It is important that we bring such barriers down.

11:15

Pauline McNeill: That is helpful to know. Does that mean that no one in Scotland who phones for advice will be told that they are not calling the correct service and must go somewhere else?

Catherine Henry: The situation is a bit complicated for the money talk team, because we are funded for a specific target group, obviously, but are not in the business of turning away people who are in need. Our advisers help people regardless of whether they fit in a neat box. People phone the money talk team helpline for benefits support and for income maximisation advice. For wider advice issues—consumer issues and so on—there are other helplines.

Dr Allan: We talked with the previous panel about whether there are disincentives in, and differences between, different parts of the country when it comes to claiming benefits. Are there barriers, in your view, to applying for benefits? Are particular groups or communities disadvantaged?

Fiona Moss: I will pick up on one group. We have experience in Glasgow of our special needs in pregnancy service, which a local money advice organisation acquired resources to provide and which has worked very well. However, feedback from that organisation to us has been that the women with whom it works have levels of vulnerability by which it has been really shocked, although it has been working in financial advice for many years. The women are completely outwith the welfare system: they are not part of it at all.

We have been having some local discussions about groups that we need to advocate for and support more proactively, because it seems that we are coming across more people locally who are outwith every system. Are other groups more vulnerable? We discovered that group only

because there was an opportunity to look. There will be many others.

Peter Hastie: One of the main issues with remoteness is that a person might live in a remote part of a housing estate in a distant part of a city and be two or three buses away from the hospital. We have tried, as I said earlier, to capture people in the hospital setting, because when they get back to their remote or rural community access is less easy. No matter how big the workforce is, and despite the fantastic partnerships with the Scottish Government, health boards and so on, it is still very hard to capture some people.

For example, a person who has had a cancer diagnosis and is going through their treatment wants to get home: they want to get out of the hospital, so there is a very narrow window for us to capture them, particularly those from remote and rural communities. We really want to get to people in the cancer centre. Services exist, of course, from Macmillan and lots of other fantastic organisations, but we strive really hard. We have a brilliant Glasgow-based Macmillan phone line, but it does not capture rural people as much as we would like. We do not totally understand why. We desperately try to get hold of people in the five cancer centres because everybody with cancer goes through a cancer centre at some point in their journey.

Dr Allan: Thank you. You anticipated one of my questions. I sympathise with what you are saying, because I represent a constituency where people who have cancer diagnoses are often told to try to get home by plane. It can be a difficult situation for many people.

I am just keen to know whether, to put you on the spot, panel members have stories of means that you have used to target groups that are less likely to claim, and whether barriers can be overcome.

The Convener: Fiona Moss is always first to catch my eye.

Fiona Moss: I always have something to say, as members will appreciate. We have trialled, in a number of areas, linking financial advice to services. We have a human immunodeficiency viruses service, there is cancer work going on, and we have other work going on in acute and primary care. Those are the bits of the jigsaw that the NHS can support, and there are ways to connect with patient groups through them.

We are also trying to explore where there is potential unmet need. The committee talked about data, earlier. We did a very big health and wellbeing survey in Glasgow, in which we surveyed 4,500 people every three years. We also had a survey done of our five largest ethnic communities. We found that the black African

community was showing levels of poverty that were equivalent to the levels in the poorest places in Glasgow. We are now doing a wee bit of work on engaging with people on where such levels might be, what is going on there and whether we need to offer support. We need to be inquisitive and to ask where the need is that we are not seeing.

Peter Hastie: Macmillan has many partnerships with libraries. The big one was with Easterhouse library, through Glasgow City Council. That gave people a safe space with soft couches and softer branding than a DWP office or other difficult place, such as the hospital, where people might not want to be. The library setting is also a much softer and less formal place for volunteers. From there, we go into the system and try to signpost people to the right support line or link worker. The library is a place in the community that feels different from an office or an acute care setting, which people find difficult.

Catherine Henry: We have found that just being where people are rather than expecting people to come to us helps. For the money talk team, we thought quite a lot about targeting young parents. Where are young parents and where do they go? One of our bigger successes was in Renfrewshire, with the registrar there. What is the one place where a person absolutely must go when they have had a child? They must register the birth. We have also done work with early years settings and nurseries that has been quite successful.

Keith Brown: Your comments about Macmillan have been interesting. I represent Clackmannanshire and Dunblane, where Alva academy has, for the past four or five years, topped the UK league for money raised for Macmillan. There are slightly different challenges from those in Glasgow, because my constituency is a semi-rural area.

It seems to me, from your comments about pregnant women and the black African community in Glasgow, and workers being appalled at their levels of poverty, that what you are trying to do is all about trying to cope with the effects of the system. That is a massive indictment of the system. I have the feeling that designing some of the flaws out of the system might be productive. Are there examples that you could give of initiatives on uptake that have had beneficial impacts that have been verified by scrutiny? Do any strike you as being worth replicating?

Fiona Moss: We know the take-up of benefits through things like our healthier, wealthier children programme. When we did the full evaluation, 20 per cent of those who had used the service had been able to access DLA for their child. At the moment we are trialling work on people picking up

on pensioner credits through our flu vaccination clinics. We look at what we do as we do it, and I think that there is quite a lot of evidence that benefit uptake has improved from our various initiatives.

Peter Hastie: I will give two examples. We found that link workers often had people bringing with them carers, or partners, who also need benefits advice. It is quite difficult to broach such matters because the person is there as a carer, but it often comes out in conversations that they need support and signposting just as much as the person who has the long-term condition.

We also have a support line that is based in Glasgow. We have centres in York and London, but people in Scotland mostly get through to the Glasgow one to speak to a nurse. People who call include people who have previously been in hospital, and something has gone wrong at the weekend or on a Tuesday morning and they cannot go back into the hospital setting, so they phone the Macmillan support line. Our support nurses might gently try to sign them over to our financial advisers, who are on the same floor, but that is not easy because the person has first asked whether they are experiencing an effect, headaches for example, of cancer or something else. We want to talk through that with the person and support them, but they have had what we call a warm introduction, because they have trusted the nurse and are talking back and forward with the nurse on the support line.

We try to gently get people over to the benefits advisers, but that is not easy because for many people who get cancer that will be the first time that they have had to deal with the benefits system. We forget sometimes that many people just have no idea how to deal with benefits, so it comes as a surprise to them when we approach the matter.

It is quite hard to approach the matter, but we try to do it in those two ways.

Catherine Henry: In our marketing for the money talk team, which is our “For your benefit” campaign, we found something that provided ease of access to advice and support services. As part of our radio advertising, we set up a text service to which people could text the word “Check”, which triggered an email to our team of advisers, who then called the person. That takes the onus off people of having to phone to see what they are entitled to. The person sends a simple and quick text message, then we phone them and arrange an appointment. You can have the best advertising in the world, but that must be followed by easy access to support. That is the main point that we want to make.

The Convener: Okay. This may be our final line of questioning, depending on whether Jeremy Balfour asks about theme 5, which is on the new Scottish Government benefits uptake strategy, on which I would like to get some thoughts on the record at some point.

Jeremy Balfour: I wanted to go with a different theme, but I will happily cover that very quickly.

The convener has laid it out for our witnesses. Are there any comments on the Government’s strategy? The witnesses do not have to answer; if they do not, I will go back to my other question.

The Convener: Just hang on; that may not be the way that we want to do this. We have to get some comments on the record, Mr Balfour, before we close the evidence session.

A new range of devolved benefits is coming to Scotland: some will be former UK benefits, and some will be new benefits that we create. The Scottish Government and Social Security Scotland have a statutory duty to have a benefits uptake strategy in relation to those new benefits. The initial strategy has just been launched—it is just emerging. In general, is the advice sector taking account of the changing landscape of the benefit system in terms of what is devolved and what is reserved? The strategy is only a few weeks old. Have our witnesses even had a chance to look at it?

Peter Hastie: We have been meeting the new Scottish social security agency to discuss what we have always done in the past with learning and development. One of the key things that we would like—we are working very closely with the new agency on this—is for it almost to refer to us in relation to reserved benefits. That would enable us to treat the cancer patient, whatever benefits—devolved or reserved—they get. Macmillan is always referring people to other organisations, but we would appreciate people being referred to us by the new agency, so that we can support them. Everybody should link up, as far as that can be done.

We have talked about relationships, and this is about having that status of being a trusted organisation. If we can build that relationship with the new social security agency and achieve that trusted organisation status, we will be able to get past a lot of time-consuming paperwork and appeals. We would really like that to be a circular relationship between the DWP, the SSA and Macmillan, with the DWP and the SSA signposting people to us to support in terms of devolved or reserved benefits.

The Convener: That is helpful.

Fiona Moss mentioned using a flu vaccine clinic to highlight pension credit entitlement. People

have entitlements to reserved benefits and to a whole range of devolved benefits. It seems as if the HSCP is just getting on with things, irrespective of whether a benefit is devolved or reserved. How will the new strategy work with what you are doing, Fiona?

Fiona Moss: We are working well with Social Security Scotland. Our challenges relate to the complexity of what is devolved and what is not devolved, and that affects some things that we would love to be able to take forward. Beyond that, I am not an expert in the different benefits.

The Convener: What about the funding? The funding tends to follow the benefit, so if there is a strategy for a UK benefit, the DWP will make the funding decisions. For example, with the help to claim programme, the UK Government will decide how much money to assign to that and then it will identify the partner organisation that will roll it out. Citizens Advice Scotland offers a wide range of advice services, but the funding can be quite strand driven and fragmented. We are trying to work out whether there is a better way to co-ordinate these things. Does Catherine Henry have any comments on that?

11:30

Catherine Henry: I agree that it would be better if things were far more co-ordinated. One of the challenges that our bureaux face is when they are pushed down a certain path by a funding stream. People do not fit into those paths easily. A person might come in through the help to claim programme, but then it turns out that they have entitlement to Scottish benefits and have income maximisation issues and problems with their gas and electricity.

Like Peter Hastie, what is important to us—certainly, this is what comes back from our bureaux—when we work with Social Security Scotland is referring and that circular pathway of making sure that people get holistic support from wherever they access advice. The main concern of our bureaux is to avoid the duplication of services. Someone might access support through Social Security Scotland, avoiding our adviser, but then we might do a benefit check with them and go through the same things that they have already been through with Social Security Scotland.

The Convener: That is helpful. I will not ask another question—I want Mr Balfour to have time to ask his question. However, please get back to us with any information you might have about the new strategy. I see that there is to be a series of benefits take-up weeks. Have a think about what those should involve—you are at the coalface, so you know what those should look like.

On how such things are funded, when I discussed help to claim at a meeting with Citizens Advice Scotland the other day, I asked about what happens after a claimant gets their first payment and whether the funding finishes at that point. I was told that, by that point, the adviser has built up the relationship, so the claimant comes back the next week—and the next, and the next. CAS is funded for part of that relationship with the claimant and then that funding ends, but the claimant still has that relationship with their adviser, so there are on-costs. I am sorry that there is no time for you to reply to that just now, but your thoughts on funding would be really quite helpful.

I apologise to Jeremy Balfour, but I had to get some of that on the record. Jeremy will ask the final question.

Jeremy Balfour: This is for Peter Hastie. We are looking at uptake, and one of the issues that we have looked at is the change around terminal illness. At this stage, we have not seen exactly what the new guidance will say or how the system will work, but are you reasonably content with the direction of travel?

Peter Hastie: Macmillan, Marie Curie and lots of other charities sat on the Scottish Government's terminal illness stakeholder reference group. That work ended a couple of months ago, after about nine months. It was a difficult group because what is coming is a big change and we want to get it right. The Scottish Government has set up a new implementation group with a different group of stakeholders, and we are looking forward to seeing what emerges from that, which will involve the chief medical officer's guidance for GPs. In truth, I think that we need to get started. Once that happens, we will know how GPs and health professionals are starting to take the new wider criteria on board. We are certainly very positive about the change; we are now awaiting the final guidance and getting started.

Jeremy Balfour: Are you confident that, training will be provided for GPs and nurses in particular? Could Macmillan, for example, offer—

Peter Hastie: Macmillan will be absolutely at the heart of that. Once that guidance is published and once the new criteria are set, GPs want to get going. GPs have been asking us a lot about when it will start. You cannot rush these things—it is a big change—but there is a real opportunity for that learning to be taken forward so that we make sure that we support the person at the end of life. Support can be built in once a person has that terminal diagnosis, and their GP will not have to worry about specifying an exact moment in time. We will just have to wait until it launches and we get that guidance going.

The Convener: That was a really helpful line of questioning—perhaps not for this inquiry but for future work that we are going to do from December onwards, when the draft guidance on disability assistance for younger people will come to Parliament. The Scottish Commission on Social Security will look at that and give thought to how that will all work. Your thoughts, Mr Hastie, are very welcome.

I apologise to the witnesses that we have been so rushed this morning. Please stay in contact with us. In particular, we deal with the abstract—politicians always do—but it would be helpful if you could give us concrete examples of how we can passport benefits better, or automate them better, how we can take stigma away from the process and how we can make funding more secure. When we get to the point of making recommendations, we want to focus on improving rather than just producing another report that talks about the kinds of things that we would like to do. I know that you have not had much time to talk about that today, so please keep the relationship going after this evidence session and get back in touch with us. Thank you for your evidence.

We now move very briefly to agenda item 3, which we have agreed to take in private.

11:35

Meeting continued in private until 11:40.

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