[2023] AACR 1

(CK v Secretary of State for Work and Pensions (PIP); JM v Secretary of State for Work and Pensions (PIP) [2022] UKUT 122 (AAC))

Judge Ward **UA-2018-002190-PIP**
5 May 2022 **UA-2020-000227-PIP**

Social Security (Personal Independence Payment) (Amendment) Regulations 2017- Personal independence payments — Human Rights – Article 14 - Discrimination – Ultra Vires- Inadequate consultation

The two claimants in these cases, CK and JM, had type 1 diabetes and challenged the refusal of their personal independence payment (PIP) claims.

CK had an award of the highest rate of the care component of disability living allowance as a child. However, a claim for PIP after she turned 16 was refused by the Department for Work and Pensions (DWP). A subsequent appeal was dismissed by the First-tier Tribunal (F-tT) who awarded 2 points in respect of budgeting and 4 for needing help with therapy for 3.5 - 7 hours per week. Although it appeared that the F-tT had failed to apply the amendments made in 2017 by the Social Security (Personal Independence Payment) (Amendment) Regulations 2017) (2017 Regulations), it still did not score the claimant sufficient points to establish entitlement.

JM had been entitled to the daily living component of PIP at the standard rate on the basis of support needs including supervision and prompting to help manage risks of hypoglycaemia or hyperglycaemia and assistance managing an insulin infusion pump. However, following the amendment made by the 2017 Regulations in relation to Activity 3 (managing therapy or monitoring a health condition), the DWP ended his award. The F-tT upheld the decision, finding that JM's need for help managing medication had not changed but he scored fewer points than previously on account of the 2017 amendments.

Both claimants then appealed to the Upper Tribunal (UT) where their cases were listed to be heard together. The issues before the UT were whether the DWP should have consulted on the amendments made by the 2017 Regulations or, if the policy reflected by the amendments in fact existed in 2013, whether it was obliged to communicate it more effectively, whether the 2017 Regulations were ultra vires, and whether the regulations discriminated against claimants affected by the changes they introduced, in breach of their human rights.

Held, dismissing the appeals, that:

1. the DWP was not obliged to consult in relation to the Social Security (Personal Independence Payment) (Amendment) Regulations 2017 as the changes they made reflected the original policy intention

2. amendments to 'managing medication' criteria in Personal Independence Payment(PIP) activity 3 in 2017 were not ultra vires

3. the need to restate the original policy intention was a legitimate aim and the 2017 Regulations were a proportionate response

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DECISION OF THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

Tom Royston, instructed by Kirklees Law Centre, appeared for the appellant

Jack Anderson and Fiona Paterson, instructed by the Government Legal Department, appeared for the respondent

DECISION

The decision of the Upper Tribunal is to dismiss the appeals.

REASONS FOR DECISION

1. These two appeals raise, by differing routes, whether it is lawful for tribunals to give effect to regulations 2(2) and 2(3) of the Social Security (Personal Independence Payment) (Amendment) Regulations 2017 (SI 2017/194). In this decision I refer to the statutory instrument as "the 2017 Regulations" and regulations 2(2) and 2(3) as "the 2017 amendments". The 2017 amendments amended Schedule 1 of the Social Security (Personal Independence Payment) Regulations 2013 (SI 2013/377) ("the 2013 Regulations") in relation to Activity 3 ("Managing therapy or monitoring a health condition") and related parts of Part 1 of the Schedule, dealing with Interpretation.

2. The 2017 amendments were made in an attempt to reverse the decision of the Upper Tribunal in *Secretary of State for Work and Pensions v LB (PIP)* [2016] UKUT 0530 (AAC) (LB). A summary relied upon by both parties explains the effect of that decision as being that "support to manage medication or monitor a health condition could in certain circumstances also count as support to manage therapy, and could therefore again score 2 or more points depending on the number of hours involved per week, rather than being limited to a score of 1… ". Mr Royston summarises the effect of the 2017 amendments as being to

> "restrict a need for support with a medication and a health monitoring regime to scoring a single point under descriptor 3b, however complex and temporally extensive the required support and however serious the consequences of non-compliance."

While accurate, it should not be inferred from that that all those with such a need were necessarily able to score more than a single point even under the 2013 Regulations.

3. In *LB* at [34], Upper Tribunal Judge Mesher summarised his preferred reading ("alternative interpretation A") of the provisions as they originally stood (which may be discerned by leaving out of account the effect of the marking-up at [10] below):

> "The essence of alternative interpretation A […], is that descriptor 3(b)(ii) does not apply if supervision, prompting or assistance is needed for both managing medication and monitoring a health condition and only applies if it is needed for one only of those alternatives. It also does not apply if the supervision etc is needed for elements of what would ordinarily be regarded as therapy that go beyond either managing medication or monitoring a health condition within the meaning of descriptor 3(b)(ii). In both those circumstances in which descriptor 3(b)(ii) does not apply, the case would potentially fall within the therapy provisions in descriptors 3(c) – (f), depending on how far the supervision etc relates to something that can properly be called undertaking therapy and with the scale of points depending on the time for which the supervision etc is needed. All elements of therapy in its ordinary meaning could then be considered, including any taking of medication or monitoring of a health condition. If the need for supervision etc is limited to one or other of those alternatives in descriptor 3(b)(ii), then in order to allow the descriptor to have any practical application the application of descriptors 3(c) – (f) would be excluded."

The appellants

4. Both appellants have Type 1 diabetes.

5. The following should be understood as description for the purposes of this decision, rather than as findings of fact. JM is a very heavy sleeper. For his Type 1 diabetes, which is relatively uncontrolled, he requires a catheterised insulin infusion pump which automatically dispenses insulin into his blood and also sounds an alarm when he is at risk of hypoglycaemia or hyperglycaemia and human intervention is required. In those circumstances he may not wake and cannot be woken. His mother has to attend to him to administer glucose tablets or other tablets while he sleeps. JM contends that he needs supervision, prompting or assistance with those matters, taking more than 14 hours a week.

6. Prior to the 2017 amendments, JM had been entitled to the daily living component of PIP at the standard rate. Once the amendments were in force, the respondent ended his award. On appeal to the First-tier Tribunal ("F-tT") it found that his needs had not materially changed but, rejecting an argument that it should disapply the 2017 amendments, it went on to award 1 point only.

7. It is JM's case that, if the 2017 amendments fall to be disapplied, the Upper Tribunal should remake the decision in his favour.

8. CK was born in 2001. When a child, she had received the highest rate of the care component of Disability Living Allowance (DLA). On turning 16 she was required to claim PIP, which was refused by a decision dated 9 June 2017. On appeal to the F-tT she was awarded 2 points in respect of budgeting and 4 for needing help with therapy for 3.5 - 7 hours per week. It appears that the F-tT failed to apply the 2017 amendments; no reason is given for that and it may be that the F-tT was unaware of them. CK appealed to the Upper Tribunal arguing, among other things, that the F-tT had erred in law by failing to give reasons for concluding that she did not need more than 7 hours of assistance weekly. The respondent supported her appeal on the errors of law CK had put forward, while maintaining that the F-tT was incorrect not to apply the 2017 amendments.

9. Accordingly, if the Upper Tribunal were to agree that the F-tT's decision was in error of law, CK's case would in all likelihood have to be remitted to a fresh F-tT for further facts to be found.

10. The Upper Tribunal was helpfully presented with marked-up versions of how the 2017 amendments alter Schedule 1 of the 2013 Regulations, which is as follows

> The 2017 amendments alter Schedule 1 of the 2013 Regulations as follows [deletions struck through, and additions italicised]:
>
> Part 2 – Daily Living Activities
>
> | Column 1: Activity | Column 2: Descriptors | Column 3: Points |
> |---|---|---|
> | 3. Managing therapy or monitoring a | (a) Either – (i) does not receive medication or therapy or need to monitor a | 0 |

health condition.	health condition; or (ii) can manage medication or therapy or monitor a health condition unaided.	
	(b) Needs ~~either~~ *any one or more of the following* – (i) to use an aid or appliance to be able to manage medication; (ii) supervision, prompting or assistance to be able to manage medication ~~or~~; *(iii) supervision, prompting or assistance to be able to* monitor a health condition.	1
	(c) Needs supervision, prompting or assistance to be able to manage therapy that takes no more than 3.5 hours a week.	2
	(d) Needs supervision, prompting or assistance to be able to manage therapy that takes more than 3.5 but no more than 7 hours a week.	4
	(e) Needs supervision, prompting or assistance to be able to manage therapy that takes more than 7 but no more than 14 hours a week.	6
	(f) Needs supervision, prompting or assistance to be able to manage therapy that takes more than 14 hours a week.	8

Part 1 - Interpretation
1. In this Schedule...

	"manage medication ~~or therapy~~" means take medication ~~or undertake therapy~~, where a failure to do so is likely to result in a deterioration in C's health;
	"manage therapy" means undertake therapy, where a failure to do so is likely to

result in a deterioration in C's health;

"medication" means medication to be taken at home which is prescribed or recommended by a registered – (a) doctor; (b) nurse; or (c) pharmacist;

"monitor ~~health~~ *a health condition*" means – (a) detect significant changes in C's health condition which are likely to lead to a deterioration in C's health; and (b) take action advised by a – (i) registered doctor; (ii) registered nurse; or (iii) health professional who is regulated by the Health Professions Council, without which C's health is likely to deteriorate;

"therapy" means therapy to be undertaken at home which is prescribed or recommended by a— (a) registered – (i) doctor; (ii) nurse; or (iii) pharmacist; or (b) health professional regulated by the Health Professions Council *but does not include taking or applying, or otherwise receiving or administering, medication (whether orally, topically or by any other means), or any action which, in C's case, falls within the definition of "monitor a health condition"*;
...

11. It is convenient also to set out here material parts of the 2013 Regulations, which explain how the system is to work.

12. Regulation 3(1) provides that:

> "(1) For the purposes of section 78(4) of the Act and these regulations, daily living activities are the activities set out in column 1 of the table in Part 2 of Schedule 1."

13. Regulation 5 explains the points scoring process:

"(1) The score C obtains in relation to daily living activities is determined by adding together the number of points (if any) awarded for each activity listed in column 1 of the table in Part 2 of Schedule 1 ("the daily living activities table").

(2) For the purpose of paragraph (1), the number of points awarded to C for each activity listed in column 1 of the daily living activities table is the number shown in column 3 of the table against whichever of the descriptors set out in column 2 of the table for the activity applies to C under regulation 7.

(3) Where C has undergone an assessment, C has —

(a) limited ability to carry out daily living activities where C obtains a score of at least 8 points in relation to daily living activities; and

(b) severely limited ability to carry out daily living activities where C obtains a score of at least 12 points in relation to daily living activities."

14. Mr Royston attacks the lawfulness of the 2017 amendments on the following grounds:

Ground 1: there was a failure to consult;

Ground 2: the amendments were ultra vires; and

Ground 3: the amendments were discriminatory.

He no longer maintains, as a distinct ground, that they were irrational, while submitting that their rationality (or otherwise) is relevant to the three Grounds above.

15. I consider each Ground in turn but first need to put in place some further legislative building blocks.

<u>The primary legislation</u>

16. The Welfare Reform Act 2012 provides:

"78 Daily living component

(1) A person is entitled to the daily living component at the standard rate if—

(a) the person's ability to carry out daily living activities is limited by the person's physical or mental condition; and

(b) the person meets the required period condition.

(2) A person is entitled to the daily living component at the enhanced rate if—

(a) the person's ability to carry out daily living activities is severely limited by the person's physical or mental condition; and

(b) the person meets the required period condition.

(3) In this section, in relation to the daily living component—

(a) *"the standard rate"* means such weekly rate as may be prescribed;

(b) "*the enhanced rate"* means such weekly rate as may be prescribed.

(4) In this Part *"daily living activities"* means such activities as may be prescribed for the purposes of this section.

(5) See sections 80 and 81 for provision about determining—

(a) whether the requirements of subsection (1)(a) or (2)(a) above are met;

(b) …

(6) …"

17. Section 80 provides

"**80 Ability to carry out daily living activities or mobility activities**

(1) For the purposes of this Part, the following questions are to be determined in accordance with regulations—

(a) whether a person's ability to carry out daily living activities is limited by the person's physical or mental condition;

(b) whether a person's ability to carry out daily living activities is severely limited by the person's physical or mental condition;

(c) and (d) … .

(2) …

(3) Regulations under this section—

(a) must provide for the questions mentioned in subsections (1) and (2) to be determined, except in prescribed circumstances, on the basis of an assessment (or repeated assessments) of the person;

(b) must provide for the way in which an assessment is to be carried out;

(c) may make provision about matters which are, or are not, to be taken into account in assessing a person.

(4)- (6) …"

18. Section 94 addresses the making of regulations. In summary, a statutory instrument containing the first regulations under sections 78(4) or 80 had to be approved by a resolution

of each House of Parliament, while any other statutory instrument was subject to the negative resolution procedure.

19. Section 172 of the Social Security Administration Act 1992 requires the Secretary of State to refer proposals for regulations to the Social Security Advisory Committee (SSAC) unless (by section 173) it either appears to the Secretary of State that by reason of the urgency of the matter it is inexpedient to refer them or if the SSAC itself agrees that they should not be referred. In the former case (again, subject to the ability of SSAC to agree otherwise), the Secretary of State must refer the regulations to the SSAC as soon as practicable after making them.

The process leading to the introduction of PIP and the making of the 2013 Regulations

20. In this section, I aim to give an overview of the structure of the process. Matters of detail are best understood in the context of the submissions made and follow below.

21. The evidence on the consultation and legislative processes was provided by Jane Porter, a Senior Policy Team Leader for PIP in the DWP. She was appointed to her current role in August 2019.

22. The June 2010 Budget announced a decision to reform disability living allowance, with the aim of targeting those with (as it was then put, but inconsistently with the "condition-blind" approach which was subsequently developed) "the highest medical need". This was to involve an objective medical assessment and revised eligibility criteria.

23. The DWP established an Assessment Development Group ("the ADG") to advise on the development of the new criteria. Its membership was drawn from a range of relevant professional disciplines and from organisations representing people with disabilities.

24. Following input from the ADG, on 6 December 2010 the DWP published its consultation paper "Disability Living Allowance Reform". This set out its plans to replace DLA with PIP in relation to people of working age.

25. The Bill which became the 2012 Act was introduced into the House of Commons in February 2011.

26. The "Government's response to the consultation on Disability Living Allowance Reform" was published in April 2011.

27. In May 2011 the DWP published an initial draft of the assessment criteria in the form of draft Regulations. These were accompanied by a technical note.

28. Formal testing was carried out over the Summer of 2011. Also, between May and August 2011, the DWP carried out informal consultation with user-led and representative organisations and also received responses from individuals. Early findings were shared with the ADG, leading to testing of a second draft of the assessment criteria and further scrutiny by the ADG on 8 September 2011.

29. A second iteration of the assessment criteria was published in November 2011, accompanied by an explanatory note. This was followed in January 2012 by a further consultation on the assessment criteria, which resulted in approximately 1,100 responses being received.

30. In March 2012 a further consultation took place, this time on the detailed design of PIP. It did not, as such, purport to address the assessment criteria. In the same month, the Welfare Reform Act 2012 ("the 2012 Act") received Royal Assent.

31. In December 2012 the DWP published the response to the January 2012 consultation on the assessment criteria and draft regulations and also, following testing reliability and validity using a sample of 99 individual claimants, the final draft of what was to become the 2013 Regulations.

32. The 2013 Regulations were made on 25 February 2013, laid in draft before both Houses of Parliament and approved by a resolution of each House pursuant to section 94(6) of the 2012 Act. They came into force for a limited category of claimants on 8 April 2013 and more generally on 10 June 2013.

33. The DWP published the PIP Assessment Guide on 8 April 2013, intended to provide guidance for providers who were carrying out assessment. The Guide is updated from time to time.

LB and the process leading to the making of the 2017 Regulations

34. On 28 November 2016, the Upper Tribunal issued its decision in *LB*, the effect of which is described at [2] and [3] above

35. As described in Ms Porter's evidence:

> "93. …[T]he Secretary of State … considered that the public interest (in particular legal certainty) required that he take immediate legislative action to reverse the effects of the decision concerned with "managing medication and monitoring a health condition" and to restore the original policy intention. …
>
> 94.… The 2017 Regulations overturn the effect of the Upper Tribunal's decision by stipulating that an individual can only score points for descriptors 3(c), 3(d), 3(e) and 3(f) "for reasons other than medication and monitoring health". This returns to the Government's original policy intention, namely that where an individual has needs arising from help to manage medication or monitor health they would be able to score under descriptor 3 (bii). Where an individual needs help with therapy (that does not include medication or monitoring health) then, subject to the time each week that this support is required then they may score points under activity 3 (c) (d) (e) and (f).
>
> 95. The Secretary of State considered whether to conduct a further public consultation before making the 2017 Regulations. However, as the Secretary of State was of the view that the 2017 Regulations were restoring the original policy intention, he did not consider that there was any need to consult before making the regulations. Furthermore, the Secretary of State considered the need to limit the period of uncertainty with decision making and minimise delays resulting from an increased stockpiling of cases due to the large number of PIP claims processed each week.

96. The Secretary of State also considered whether to refer the 2017 Regulations to the Social Security Advisory Committee under Part XIII of the Social Security Administration Act 1992 […]. The Secretary of State decided not to refer the regulations before they were made as it appeared to him that by reason of the urgency of the matter it was inexpedient to refer them.

97. In reaching his decision to lay amending regulations, the Secretary of State considered a number of factors, including policy, operational and fiscal implications and impacts on claimants and users of the legislation. These were recorded in the explanatory memorandum accompanying the 2017 Regulations, which states that:

> "the Secretary of State considers that the Upper Tribunal judgment departs from the intended meaning of the PIP Regulations, and that it is necessary to reverse the effect of the decision in order to restore the original policy intention, provide clarity for all users of the legislation (claimants and advisers, assessors and decision makers), and avoid inappropriate increases in public expenditure.""

36. A Ministerial Briefing dated 10 February 2017 explained that:

> The estimated costs of *MH* are very significant. For *LB* our estimates are lower, however, *LB* involves much greater complexities and so there is a significant risk that these costs could be much higher than estimated, posing a substantial fiscal risk.
> …

Round (£5m)	16/17	17/18	18/19	19/20	20/21	21/22
MH	**-110**	**-580**	**-725**	**-875**	**-985**	**-1,100**
LB	**-**	**-**	**-5**	**-10**	**-10**	**-10**
Total	**-110**	**-580**	**-730**	**-885**	**-995**	**-1,110**

(*MH* was the decision which led to the amendments considered in *RF*, discussed at [53] below).

37. The 2017 Regulations, accompanied by an Equality Impact Assessment were laid before Parliament on 23 February 2017 and came into force on 16 March 2017.

38. On 27 March 2017 the House of Lords considered two motions relating to the draft regulations. A motion to annul the regulations was defeated, but a "motion to regret", not fatal to the regulations but indicating the concern of the House, was carried.

39. On 29 March 2017 there was an emergency debate on the draft regulations in the House of Commons. No motion was passed to annul the regulations; indeed, no vote took place.

40. Attempts had been made to appeal against the decision in *LB*, but were eventually abandoned as unnecessary, given the making of the 2017 Regulations.

Ground 1 – failure to consult – the submissions

41. Mr Royston submits that the basis for failing to consult in relation to the 2017 amendments affecting activity 3, as described in paragraph 95 of Ms Porter's statement, is based on an erroneous assumption as to what the policy was in 2013. It was not the case that the policy had all along been as the Secretary of State considered it to be in 2017. In the alternative, it was procedurally unfair to proceed without consultation, given that if there had been the claimed policy in 2013, it had not been shared as part of the consultation leading to the 2013 Regulations. He submits that the respondent has not sought to argue that the amendments were lawful if the Secretary of State did not have the policy claimed in 2013.

42. While Mr Royston acknowledges that by November 2016 when *LB* was heard the policy was as the respondent now states, that does not mean it was the policy in 2013. He seeks to make good the submission that in 2013 there was no policy of excluding help with medication from constituting therapy by reference to the matters discussed in [43] to [52].

43. The initial draft assessment criteria (May 2011) had proposed two distinct activities: "Managing medication and monitoring health conditions" (then Activity 4) and "Managing prescribed therapies other than medication" (then Activity 5). They were presented in a context indicating that, within the scheme of the activities and descriptors as a whole, both were proposed to be "low scoring", thus neither was seen as more significant than the other. Further, because medication had to be expressly excluded from the second activity, without that exclusion "therapies" could include "medication". The structure of both of the activities included 5 descriptors, reflecting a wide range of need.

44. While Ms Porter's evidence was that it was clear at an early stage that therapy did not include medication, that was only because there was an exclusion of medication from "therapy", as noted above, and otherwise "therapy" would bear its natural meaning and be apt to include help with medication. Further, in referring to "prescribed" therapies, the draft was using language more aptly referring to medication than to therapy.

45. In the second iteration of the draft criteria in November 2011 activities were merged, not on the basis that therapy was in some way more important than medication, but rather following feedback that they covered similar activities; yet it is the former is which is the approach of the 2017 amendments.

46. In its explanatory note to accompany the second draft regulations (November 2011) (feeding back on the earlier informal consultation) the DWP recorded the feedback from a large number of respondents that activity 4 (Managing medication and monitoring health conditions) should be weighted as medium or high scoring, rather than low, in recognition of the potential for a severe adverse effect if vital medication is not taken and that a smaller number had suggested that activity 5 (Managing prescribed therapies other than medication) should be medium scoring, rather than low. If the DWP's policy all along had been that activity 4 should be restricted to 1 point (i.e. the opposite of what the consultees were saying), that would have been worthy of comment in the explanatory note, but there was none.

47. The December 2012 document responding to the consultation responses received records how the DWP intended to take into account a "wide spectrum of therapies", but there is no mention of excluding all medication from "therapy".

48. In the same document, the DWP explain that the activity is not designed to replicate the exact amount of time a carer might spend supporting an individual but to identify the amount of time their circumstances require. However, if the policy was as claimed, the response would have needed to say that the amount of time was irrelevant where managing medication was concerned.

49. The title of what by that point following the merger of activities had become activity 3 was "Managing therapy or monitoring a health condition". Although the title failed to mention medication, a number of the descriptors included references to medication, thus it is implicit that assistance with managing medication was considered to be a mode of carrying out the activity described by the title.

50. There had been feedback about whether complementary therapies should be included. The Government took the view that by including therapy which is prescribed or recommended by a registered doctor, nurse or pharmacist, it was covering a wide spectrum of therapies. What a pharmacist prescribes or recommends, submits Mr Royston, is highly likely to be medication, which thus fell within therapy at that point.

51. The draft guidance for health assessors appended to the Government's December 2012 Consultation response gives as a mode of therapy a nebuliser, which Mr Royston seeks to characterise as a device for administering medicine, submitting that this provides a strong sign that there was no policy precluding providing help with medication from constituting "therapy" at that time. Ms Porter relies on a passage from the PIP Assessment Guide, purportedly in its updated version published on 27 May 2014, as indicating that :

> "A nebuliser could be considered to be delivering either medication or therapy depending on the clinical indication and use. In some cases, it will be used to deliver medications such as salbutamol in asthma. However, it can also be used in a therapeutic role to deliver nebulised saline water in chronic chest conditions to help loosen mucous secretions and aid chest physiotherapy".

Mr Royston does not accept that administering saline solution is not medication. In any event, the passage relied upon by Ms Porter comes not from the version as at 27 May 2014, which contained no elaboration on the role of nebulisers apart from in delivering medication but from an amendment made at a later date, unknown, but no later than the version of the Assessment Guide dated 17 May 2021 which is in evidence. Mr Royston accepts that if one were to accept the proposition that saline is not medication, the passage quoted by Ms Porter would be consistent with a distinction between medication and non-medication use, but submits that as there is no evidence of when the amending passage was introduced, it is more suggestive of a change of policy to reflect the 2017 amendments.

52. When in evidence Ms Porter states that the

> "policy…is that someone who is receiving support in order to manage medication, monitor a health condition or both combined, is likely to have a lower level of need and fewer barriers to live independently than someone who needs support with therapy"

there is no doubt that such is the policy following the 2017 Regulations but her assertion is not linked to any document and does not provide an adequate evidential basis to demonstrate the existence of a policy in 2013 to exclude medication-related therapies.

53. The second part of Mr Royston's Ground 1 is that if, contrary to his primary position, there had in 2013 been the policy on which the respondent seeks to rely, it was not communicated and so the failure to consult in 2017 was unfair. In doing so, he draw an analogy with the decision of Mostyn J in *R(RF) v SSWP* [2017] EWHC 3375; [2018] PTSR 1147, which concerned the application of the 2017 Regulations to a different set of descriptors, used for assessing entitlement to the mobility component. In the words of the headnote:

> "The table in Part 3 of Schedule 1 to the 2013 Regulations, setting out descriptors relevant to the assessment of an individual's ability to carry out various mobility activities, included descriptors c, d and f relating to the ability to plan and carry out journeys. In a decision in unconnected proceedings, the Upper Tribunal ruled against the defendant that a person coming within those descriptors was not excluded from entitlement to personal independence payments (PIP) if his or her inability was caused by psychological distress. In response, without further consultation and pursuant to the negative resolution procedure, the defendant made the Social Security (Personal Independence Payment) (Amendment) Regulations 2017, regulation 2(4) of which amended descriptors c, d and f so as to exclude from entitlement to personal independence payments those whose inability to plan and carry out journeys was caused by psychological distress. The claimant brought judicial review proceedings seeking to quash regulation 2(4) on the ground that it was discriminatory contrary to article 14 read with article 8 of, or article 1 of the First Protocol to, the Convention for the Protection of Human Rights and Fundamental Freedoms, and unlawful."

54. Mostyn J found that the amendment was prima facie discriminatory against people with mental health impairments and that the Secretary of State could not show that the discrimination was justified, with the consequence that the part of the 2017 Regulations in issue in that case was indeed in breach of Article 14 of the European Convention on Human Rights, read with Article 8 and Article 1 Protocol 1. He also found the amendment concerned to be unlawful because of a failure to consult. His conclusion on that aspect was brief:

> "63. Similarly, I am of the view that a measure which introduces a change (and I emphasise introduces) of this magnitude should have been consulted on, and that the failure to do so was unlawful. If it was apt to consult first time round, then it was even more apt to do so this time round when the change was so momentous."

55. That conclusion was reached against the background of the learned judge's finding in paragraph 30:

> "It is not (now) disputed that it was the intention of the department when formulating the 2013 Regulations to make a policy distinction between those afflicted by psychological distress and those who were not and to treat the former group less favourably. … But as I have made clear, that intention was never communicated to the outside world, and cannot be deduced from either a literal or purposive construction of the Regulations."

56. Mr Royston's submission is that if, contrary to his primary position, the policy intention existed in 2013 to exclude medication from constituting "therapy", it, similarly, was not communicated to the outside world. He relies on the Supreme Court's decision in *R(Mosely) v LB Haringey* [2014] UKSC 56, in particular for its endorsement at [25] of the criteria in *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, which

as Mr Royston puts it, indicate the importance of communicating what the public body is doing and why, and for two general points made at [26] –

> "Two further general points emerge from the authorities. First, the degree of specificity with which, in fairness, the public authority should conduct its consultation exercise may be influenced by the identity of those whom it is consulting. Thus, for example, local authorities who were consulted about the Government's proposed designation of Stevenage as a "new town" (*Fletcher v Minister of Town and Country Planning* [1947] 2 All ER 496, 501) would be likely to be able to respond satisfactorily to a presentation of less specificity than would members of the public, particularly perhaps the economically disadvantaged. Second, in the words of Simon Brown LJ in *Ex p Baker* [1995] 1 All ER 73, 91, "the demands of fairness are likely to be somewhat higher when an authority contemplates depriving someone of an existing benefit or advantage than when the claimant is a bare applicant for a future benefit."

Mr Royston submits that the former point indicates a particular need for specificity when a measure affects the economically disadvantaged and that the second point applies to JM, who was formerly in receipt of PIP until the 2017 Regulations resulted in him losing entitlement. To the extent that the respondent relies on consultation with the ADG, it was not informed of the claimed policy either.

57. The respondent seeks to distinguish *RF* (and/or to submit that it was wrongly decided) but, says Mr Royston, the distinction based on the comparative costs expressed in the Ministerial Briefing dated 10 February 2017 (see [36]) is very tentatively expressed. The respondent's position is inconsistent in saying on the one hand that *RF* can be distinguished because the subject matter of the present case was much less important in financial terms and on the other that there was no consultation in respect of the 2017 Regulations because of the urgency of the matter. An option paper dated 20 December 2016 presented to the Minister acknowledges that, even on the premise that what was involved was restoring an exiting policy, "Legislating would present a difficult balance between the need for urgency and the need for consultation and equality analysis". In a context where, if there was such a policy, nobody outside the Department had been told about it, Mr Royston submits that, as in *RF*, the demands of fairness are obvious.

58. Ms Paterson presented the respondent's case on the consultation issue. She referred to the definition of "manage medication" in the 2011 initial draft of the regulations: "manage medication" meant take medication at the time advised by a healthcare professional, suggesting that this showed it referred to an event occurring at a specific time as compared with something extending for several hours over the course of a day. The DWP was then looking at a relatively narrow concept of therapy from the outset, limiting it to therapies carried out at home rather than those such as chemotherapy requiring a clinical setting and which required a significant amount of time – far more than swallowing tablets. The divergence between medication and therapy was evident by comparing the original Activity 4 with the original Activity 5, especially the higher-scoring descriptors of the latter. That such a distinction existed is unaffected by Mr Royston's point that both (original) Activities 4 and 5 were identified as "low-scoring". The assessment criteria in respect of medication are aimed at something which can be administered swiftly; "therapy" was aimed at such matters as administering oxygen or chest compressions, undertaking greater responsibility than helping someone take medications.

59. When the second draft of the regulations appeared, it contained the merged activity. Descriptors c to f were all limited by reference to amounts of hours, consistent with the DWP's concept of therapy. Thus, despite the merging of the two activities, it was quite clear that the concepts of "medication" and "therapy" remained separate.

60. This position was demonstrated in case studies which appeared in the "Assessment Thresholds and Consultation" document of January 2012. In case study 10, relatives call in on an insulin-dependent diabetic to give her the necessary injections: she would score 1 point. In case study 12 a woman with learning difficulties needed to be reminded by her mother to take her blood pressure tablets: she, too, would score 1 point.

61. The consultation was launched as a formal consultation on weightings, which were set out (with the higher scores attaching to time required to provide therapy).

62. The December 2012 document in which the Government addressed responses received to the 2012 consultation preserved the form of what had become activity 3, while the accompanying explanatory text demonstrated the intent that administering medication could not fall within "therapy". Activity 3 then found its way unchanged into the 2013 Regulations and was reflected in the Assessment Guidance.

63. As to the updating of the Assessment Guidance, the version of 27 May 2014 made changes to certain matters (eg indicating that therapy could be recommended by a wider range of health professionals) but was not directly relevant to the issues before the Upper Tribunal. The later amendment addressing nebulisers sought to clarify that a nebuliser is a means of delivery and consistent with either medication or therapy.

64. The proposed 2017 Regulations were the subject of an Equality Impact Assessment.

65. Ms Penny Mordaunt MP, the Minister for Disabled People, Health and Work, wrote to the Chair of the SSAC explaining that because of the urgency of the matter the 2017 Regulations had not been referred to the SSAC and that she was presenting them as soon as practicable after they had been made. The SSAC decided that it did not require them to be formally referred to it.

66. The debates in the House of Lords and the House of Commons are referred to above; in the course of the latter, the Minister, Mr Damian Green MP, provided an assurance to the House that it was not a policy change nor was intended to make new savings, but rather was about restoring the original intention of the benefit, which had been expanded by the legal judgments (including *LB*).

67. The respondent says that the appellants have cherry-picked. The consultation process, regulations and guidance demonstrate that there was a policy and it was communicated. Consultation was extensive and included non-governmental organisations and charities, including (relevantly in the present case) Diabetes UK. Clinical and social work expertise had been available.

68. Turning to the law, Ms Paterson refers to *R (BAPIO Action Limited) v SSHD* [2007] EWCA Civ 1139. At [43] to [45] Sedley LJ considered the implications if the common law were to recognise a general duty of consultation in relation to proposed measures which were

going to adversely affect an identifiable interest group or sector of society, concluding that if such a duty were to be introduced, it should be done by Parliament rather than the courts. At [58], Maurice Kay LJ, with whom Romer LJ agreed, observed:

> "Whilst I do agree with Sedley LJ that the Rules are susceptible to judicial review on grounds such as ultra vires or irrationality, I doubt that, as a matter of principle, a duty to consult can generally be superimposed on a statutory rule-making procedure which requires the intended rules to be laid before Parliament and subjected to the negative resolution procedure. I tend to the view that, in these circumstances, primary legislation has prescribed a well-worn, albeit often criticised, procedure and I attach some significance to the fact that it has not provided an express duty of prior consultation, as it has on many other occasions. The negative resolution procedure enables interested parties to press their case through Parliament, although I acknowledge that their prospects of success are historically and realistically low. They also retain the possibility of challenge by way of judicial review on the sorts of substantive ground to which I have referred. For these additional reasons, I would be minded to reject the appeal to procedural fairness as the basis of a legal duty of consultation. I do not feel driven to this conclusion by authority. Indeed, I share Sedley LJ's view that the *Nottinghamshire* case… and *Bates v Lord Hailsham* … are not or are no longer directly in point. However, as a matter of principle, I consider that where Parliament has conferred a rule-making power on a Minister of the Crown, without including an express duty to consult, but subject to a Parliamentary control mechanism such as the negative resolution procedure, it is not generally for the courts to superimpose additional procedural safeguards. In one sense, this view gains support from the reasoning by reference to which Sedley LJ would dismiss the appeal. The lack of specificity and the absence of a clear principle of limitation which exist in the present case would, in my view, be present in most cases in which an unexpressed duty to consult might be postulated."

69. Ms Paterson submits this is not a case where legitimate expectation required consultation. As Laws LJ put it in *R (Bhatt Murphy) v SSHD* [2008] EWCA Civ 755:

> "29. There is a paradigm case of procedural legitimate expectation, and this at least is in my opinion clear enough, whatever the problems lurking not far away. The paradigm case arises where a public authority has provided an unequivocal assurance, whether by means of an express promise or an established practice, that it will give notice or embark upon consultation before it changes an existing substantive policy…
>
> 30. In the paradigm case the court will not allow the decision-maker to effect the proposed change without notice or consultation, unless the want of notice or consultation is justified by the force of an overriding legal duty owed by the decision-maker, or other countervailing public interest such as the imperative of national security (as in CCSU)…"

She submits that as the 2017 Regulations were not abandoning a policy on the point, but merely making a point of clarification, there was no duty to consult.

70. As to *RF*, she submits that (a) the amendments in issue in that case were different in the magnitude of their effect and (b) it was clear in the present case when the 2013 Regulations were made that "medication" and "therapy" were different and thus the case

could be distinguished. She further submits that the apparent focus of Mostyn J's consideration was on the discrimination issues, while consultation appeared somewhat secondary, and that his conclusion on consultation was arrived at without addressing the authorities cited above.

Consideration of Ground 1

71. The DWP's position leads to an odd result, particularly in the context of a benefit which is intended to focus on the effects of a condition rather than on the condition itself – as noted in *LB*, time spent administering medication and/or monitoring a health condition, no matter how extensive, on such a view can never score more than 1 point. There may well be people requiring medication frequently, the administration of which may prove thoroughly time-consuming, even more so if they are resistant, perhaps through learning disability or mental ill-health. There may be others whose condition is such that monitoring it takes up significant amounts of time. But the scheme of PIP is to provide a series of proxies for differing levels of need. On the respondent's case, it accepted all along that "therapy" (as it understood it) is a proxy for higher levels of need than a requirement to administer medication or to monitor a health condition. One may disagree, though there is no evidence before me of such disagreement being expressed through the consultation process after the descriptors with their proposed points were published in November 2011. Some responses to the earlier, informal consultation had expressed the view that managing medication ought to score more highly than administering therapies because of the severity of the potential consequences, but this view did not commend itself to the DWP whose focus in policy terms appears to have been on the amount of input time required.

72. Mr Royston says that the key question is whether the respondent can show that the concept of "therapy" necessarily excludes the administration of medication even when that necessitates long periods of input from another person. He invites the Upper Tribunal to answer that in the negative, suggesting that while the materials show that there will always be some difference between medication and therapy, the notion, which he says is a different one, that therapy should exclude medication does not have any basis in the material.

73. Mr Royston points out that at the time of the first informal consultation, the original Activity 5 had addressed "Managing prescribed therapies other than medication" i.e. that medication had to be the subject of an express carve-out from "prescribed therapies". While a definition indicated what a prescribed therapy is, there was no definition of therapy as such. He is correct, but I do not consider that materially advances his argument. For better or worse, the DWP had begun on the basis that there was to be a distinction between its original Activity 4 and Activity 5 and that administering medication was to come within the former. The words of exclusion to which Mr Royston refers may be seen as an acknowledgment that there are some medication-based treatments which, as a matter of common usage, might be seen as falling within either box (as I previously observed in *PC v SSWP (PIP)* [2015] UKUT 622 (AAC)). However, nor do I consider that the evidence demonstrates Ms Paterson's submission to the effect that at that stage there was a distinction between the two categories that reflected a view that the administration of therapy required substantially more time or was less of an isolated action than taking medication or monitoring a health condition: at that time Activity 4 envisaged, for instance that its most onerous descriptor would be fulfilled by a person who "At least three times a day, requires continual assistance or prompting to manage medication or monitor a health condition" (emphasis added). I agree with her that because both activities were seen as "low-scoring" does not detract from the fact that there was a

difference between the descriptors within Activities 4 and 5 – if anything, I would see that as going to a substantive dispute about the relative weightings, which is not the matter before me – but it does provide further support for the notion that significance had not at that point been attributed to the DWP's view of a requirement for "therapy" as a proxy for relatively higher level of need.

74. By the time of the second iteration of the assessment criteria (November 2011), the former Activities 4 and 5 had been amalgamated. Although Mr Royston says that the amalgamation was on the grounds that they overlapped, rather than out of any desire on the part of the DWP to make one subordinate to the other, that does not mean that the DWP at that point did not want to make one subordinate to the other. That is the point at which "therapy" was added as a defined term, while descriptors c to f of the merged Activity continued to be linked to the hours of input required in connection with therapy. This trend was furthered by the addition of points, for the purposes of a formal consultation on the weightings, where descriptor b was allocated its now familiar 1 point, while a range of higher points was allocated to weightings c to f. While I accept that the title of the merged activity at that point does not refer to "medication" and thus an argument can be maintained that, as taking medication does not fall within "monitoring a health condition" it must be within "therapy", the title is in effect an umbrella term for the range of descriptors, which are what score the points, and I do not consider that as much can be inferred from it as to the DWP's intention as Mr Royston wishes: for further discussion, see under Ground 2 below.

75. Whether or not the DWP succeeded in its aim of ring-fencing a concept of therapy which alone would attract higher awards of points has been the subject of other decisions in the Upper Tribunal, such as *LB* and *PC*. The Department's success or otherwise in achieving it is, however, not the issue in the present case, which is concerned with whether it had a policy intention. For the reasons in the preceding paragraph, I accept that by around the end of 2011, it had. If the subsequent consultation process did not lead to pressure to change it, resulting in the present unsatisfactory situation for those whose needs are connected with administering medication and/or with the monitoring of a health condition, that does not mean that the policy did not exist.

76. It is noteworthy that both of the relevant examples in the January 2012 case studies are at the lower end of the spectrum in terms of the extent of help needed to monitor a health condition. Should one infer from that, as Mr Royston invites me to, that that was because there was no policy at that time to exclude those with more time-consuming needs for help associated with their medication from claiming under "therapy"? I acknowledge that it is perhaps surprising, that the DWP, with considerable resources of expertise and experience available to it, did not see fit to include an example of someone with more temporally-extensive needs, along with a stipulation that s/he would score 1 point, just as it is surprising that the point was (so far as in evidence) not raised in consultation responses. However, this needs to be seen together with the introduction in November 2011 of a definition of therapy (albeit one which does not itself exclude time-intensive medication needs) and the juxtaposition, within the merged activity, of descriptors concerned with (inter alia) managing medication and others concerned with therapy. If all administration of medication could constitute therapy, it is not clear why the DWP would have felt the need to retain descriptor (b) in that regard.

77. As the question is what the policy was by 2013 and I have reached a conclusion in favour of the respondent on the issue without taking into account the "nebuliser" issue referred to at [51], which relates to a subsequent period, I need not dwell on it.

78. The respondent's characterisation of the appellants' approach as "cherry-picking" is, perhaps, somewhat unfair. It is a question of drawing inferences as to the existence or otherwise of a policy at a given time. Mr Royston has undoubtedly been assiduous, as the earlier part of this decision shows, in identifying passages which, to a greater or lesser degree, might advance the appellants' case. I have taken them all into account and in this section have discussed the main ones and for the reasons above conclude that on balance the respondent has satisfied me that the policy now reflected in the 2017 Regulations was in existence by late 2011 or early 2012.

79. The appellants' case that there was an obligation to consult in relation to the 2017 Regulations is predicated on the notion that the 2017 amendments were effecting a change of policy or that, if there was such a policy, it had not been communicated. I have held that there was no change of policy and so turn to the alternative basis on which the consultation duty is advanced.

80. In *RF* Mostyn J found there was a duty to consult before making the 2017 Regulations on the point with which that case was concerned (a) because they introduced a change of policy and (b) because of the magnitude of that change. As he put it:

> "If it was apt to consult first time round, then it was even more apt to do so this time round when the change was so momentous."

81. For the reasons above, I do not consider there was a change in policy. Further, the estimated effects, albeit subject to a caveat, of not amending the position as it had been declared by *LB* to be, were of a far lesser magnitude: see [36]. I derive little assistance from Mr Royston's reliance on the cases cited in paragraph 26 of *Moseley*. The "general point" made by Lord Wilson was that the degree of specificity may be influenced by the identity of consultees. The consultations in the present case had a broad audience and plainly numerous individuals (and organisations representing people with disabilities) were able to respond to the consultations which led to the 2013 Regulations. While the application of the proposals to those requiring substantial time-input in relation to administering medication and/or monitoring a health condition could have been more overtly put in the 2012 consultation, such situations had been identified in the original Activity 4 and it was open to consultees to respond to question the apparent drastic reduction in provision for such circumstances proposed in late 2011 and early 2012. While the proposed 2017 amendments were depriving JM of a benefit, albeit on my findings an unintended one, the relatively modest possible increase in the demands of fairness alluded to in *Ex p. Baker* are not such in my view as to outweigh the notes of caution expressed in *BAPIO Action Limited* in relation to when the courts should intervene to require consultation at common law when there are other mechanisms provided for by statute, as there are in the present case in the form of the negative resolution procedure and in the mechanisms for the involvement of the SSAC.

82. Accordingly, Ground 1 fails.

Ground 2 – ultra vires – submissions

83. To recap, section 78 (1) and (2) stipulate that there is entitlement to the daily living component if the person's ability to carry out daily living activities is limited (or severely limited) by the person's physical or mental condition. Subsection (4) defines "daily living activities" as those prescribed for the purpose of the section. The prescribing is done by reg 3 of the 2013 Regulations. Section 80(1), submits Mr Royston, does not make a descriptor-based choice essential, while by contrast subsection (3) provides that there must be an assessment.

84. Mr Royston submits that, following the 2017 Regulations, the descriptor relating to "managing medication" cannot fall with the activity of "managing therapy or monitoring a health condition" as they are now defined (i.e. in view of, in particular, the express carve-out of administering medication from the definition of "therapy"). By creating the concept of "daily living activities", Parliament has restricted the power to prescribe descriptors to those which fall within the daily living activity. If this were not so, "dally living activities" would have no purpose.

85. He submits that the respondent's position is inconsistent with *Hickey v The Secretary of State for Work and Pensions [2018] EWCA Civ 851* at [44] and with *PC*.

86. As there is no way of reading a descriptor relating to "managing medication" as within the meaning of the daily living activity following the 2017 amendments, those amendments are in Mr Royston's submission to that extent ultra vires.

87. Mr Anderson for the respondent submits that sections 80 and section 94 (the section addressing the making of regulations) confer a broad discretion on the Secretary of State. In particular, s.80(3) does so. He submits that the Secretary of State is only constrained by rationality as to what goes into the descriptor. It is clear that a person who meets the descriptor will get the relevant points. There is a clear connection between what is set out in the second column and what is in the first column. The Secretary of State has done what section 80(3) requires. Mr Anderson addressed me in some detail about the rational basis for the 2017 amendment but I do not dwell on that as my conclusions below do not depend on the rationality (or otherwise) of the descriptors.

Ground 2 - Consideration of submissions

88. The purpose of the "daily living activities" is that set out in section 78(4) ie to identify the activities by which the extent of the limitation on a person's ability is to be assessed. As the 2012 Act created only a broad structure and an enabling framework, the only chance Parliament had to approve the activities selected was when considering undersection 94 whether to approve the 2013 Regulations. There may be others which would provide valid insight into the degree of limitation, but those stipulated by regulation 3 are those Parliament saw fit to endorse. Daily living activities could not, of themselves, have served as a basis for awarding benefit without any way of calibrating the severity of impairment under each, nor of weighing impairments in relation to one activity against those in relation to another and would thus not have contributed to the desired more objective basis of assessment. They are necessarily expressed in headline terms and were plainly intended to require supplementing, hence section 80 (and in particular, section 80(3)(c) which provides that regulations under the section "may make provision about matters which are, or are not, to be taken into account in

assessing a person" (which appears to be the enabling power for descriptors to be prescribed, albeit that terminology is not used.) Such a process is consistent with the legislative aim of replacing, for people of working age, the broad and relatively flexible criteria of DLA with a more "objective" system, in PIP and is reflected in the operation of the points-based system, explained in regulation 5(2) (see [13]). Parliament could simply have provided in the 2012 Act for eligibility to be determined by reference to a series of point-scoring descriptors carrying different numbers of points but these would inevitably have grouped themselves by subject matter, reflecting different levels of impairment in relation to the same activity.

89. Due weight should be given to the particular activities approved and, because of the way in which PIP is structured (in particular by virtue of sections 78 and 80 and regulation 3), to the very concept of a "daily living activity". However, the nub of entitlement to benefit is to be found in the descriptors, not the activities, so it is likely that the latter were intended to be seen as umbrella descriptions, under which the operationally important descriptors would fall.

90. Under the 2013 Regulations, the activity was "Managing therapy or monitoring a health condition". The definitions as they stood of "therapy" and "monitor health" could, at least in some circumstances, be read as encompassing managing medication. *LB* ruled accordingly and there is no indication that a problem was perceived in the inclusion at that time of the descriptors concerned with managing medication, nor has either party sought to argue before me that the inclusion of those descriptors at that time was ultra vires.

91. What changed in 2017 was the express exclusion of "managing medication" and "monitoring a health condition" from constituting "therapy". The present difficulty arises because the legislative vehicle recording Parliament's approval of what I have characterised as the umbrella descriptions contains defined terms. The defined terms are stated to apply "to this Schedule" (opening words to part 1, paragraph 1 of the Schedule" and are not qualified by wording such as "unless the context otherwise requires". For that reason, and on general principles of statutory interpretation, it would be wrong to apply the definition to the descriptors but not also to the activity within the same paragraph of the Schedule.

92. Mr Anderson's suggestion that the test is <u>solely</u> one of rationality in my view pays insufficient regard to the structure and purpose of "daily living activities", as the rational link must be to the daily living activity <u>as defined</u>.

93. I do not derive any assistance from *Hickey*, which in my view is discussing the interplay between a particular - different - set of descriptors and definitions associated with it and does not advance matters, nor in the present specific context from *PC*. I do however agree with Mr Royston that as activity 3 now stands, its language, once the definitions added in 2017 are taken into account, is not apt to encompass the descriptors concerned with "managing medication", but then what follows? The effect of the 2017 amendments was (*inter alia*) to narrow the scope of activity 3 as a matter of legislative drafting, albeit on the respondent's case (and as I have found) so as to accord with the original policy intention. There is no reason why the respondent should not have done that: by providing that daily living activities were to be prescribed by regulation, even though the original daily living activities had to be positively approved by Parliament, Parliament countenanced the possibility of subsequent changes to daily living activities by delegated legislation and subject to the lesser degree of control offered by the annulment procedure (which the 2017 Regulations got through).

94. It is true, as Mr Royston's skeleton argument notes, that the preamble to the 2017 Regulations does not recite that they were made pursuant to powers conferred by section 78, but pursuant to sections 80(1) and 3(b) and (c) and 94 (1)(2) and (3) (a) of the 2012 Act. Section 94(3)(a) does confer a wide power to make incidental and supplementary provision but there may, perhaps (I have not been addressed on it) be an argument that narrowing the scope of Activity 3 by drafting changes fell (additionally or alternatively) to be done under section 78. In any event, it matters not if the enabling powers are mistakenly cited: see ***R v Murray, Goodman and Kumar*** [2006] NICA 33, cited in *Bennion, Statutory Interpretation*, 7th edition, at page 77). The power under section 78 to prescribe daily living activities undoubtedly exists.

95. What Mr Royston needs in order to return JM to the position under the post-*LB*, pre 2017 amendment law and to offer CK the hope that, if her case came to be remitted, she could score more points applying such law is a finding that in consequence the 2017 Regulations, to the extent that they effected the 2017 amendments, were thereby ultra vires.

96. It seems to me that such an argument runs counter to the scheme under the 2012 Act. The daily living activities are umbrella terms and are important. Their scope could be varied by subsequent delegated legislation and that of activity 3 has been. For the reasons in [92] and [93] I disagree with his submission that the amendments are not rescued by the existence of power under section 78. His argument requires me to conclude that, because there are descriptors inconsistent with the daily living activity as amended, the amendment could not lawfully be made. Given the place of the daily living activities within the structure, that in my view is to elevate the descriptors to a greater significance relative to the daily living activities than the descriptors merit - in the everyday metaphor, "the tail is wagging the dog". At its highest, his submissions could lead to the conclusion that the descriptors concerned with "managing medication" are no longer authorised and should be disapplied, but neither party invites me so to conclude and I do not do so.

97. Consequently, Ground 2 also fails.

<u>Ground 3 – discrimination</u>

98. The challenge in the present proceedings is not to the whole scheme of activity 3 as set out in the 2013 Regulations (as amended); it is, as Mr Royston's skeleton puts it, "about whether it is lawful for tribunals to give effect to regulations 2(2) and 2(3) of the Social Security (Personal Independence Payment) (Amendment) Regulations 2017." The disadvantaged group are those who could otherwise have argued that their need for help with medication and/or monitoring a health condition, on the previous state of the law as declared by *LB*, constituted "managing therapy".

99. The issues to be considered are as follows:

a. do the circumstances fall within the ambit of another Convention right?

b. is there a difference in treatment between the appellants and another person whose situation, in relevant respects, is analogous to the appellants'?

c. is that difference in treatment on the grounds of a "status" recognised under Article 14?

d. is there an objective and reasonable justification for the difference in treatment?

100. In the present case it is common ground that Article1 of Protocol 1 ("A1P1") is engaged. The respondent is prepared to proceed on the basis that Article 8 is also engaged, while formally reserving her position, but it makes no difference to the outcome.

101. The difference in treatment is that those who require help for substantial periods of time to manage medication or monitor their health condition and who would have qualified on the previous state of the law (including, so far as relevant, as declared in *LB*) are restricted to one point, whereas those needing an equivalent amount of support for "therapy" (as now defined) may receive up to 8 points. Both are claimants for benefit and in terms of the extent of care they require are in an analogous situation.

102. Mr Anderson seeks to argue that the difference in scoring only makes a practical difference when it affects whether a person is eligible for PIP or not. Whether there is a difference in treatment depends on the totality of a person's needs, by reference to the various activities, and the evidence does not demonstrate that persons with diabetes are, overall, less likely to be found eligible for PIP. However, in my view the difference of treatment in this case is the restriction to 1 point of the group in question and, in the context of a benefit eligibility for which is determined by adding up points, the restriction in the number of points obtainable under activity 3 will inevitably be a difference in treatment, albeit the practical consequences may vary.

103. Turning to "status", Mr Royston puts forward two alternatives. First, that the appellants have the status of "people with diabetes". Secondly, that they have the status of "people requiring support in order to manage medication or monitor health". Mr Royston, while not abandoning it, does not press the second of these. For my part, I agree with Mr Anderson that the latter is open to objection both because people may move in and out of it (a similar concern to that in relation to capacity which carried some weight with the Court of Appeal in *MOC by MG v SSWP* [2022] EWCA Civ 1 at [65]) and because it appears to be an example of status being defined by the differential treatment complained of, which I consider is precluded following *Mayor and Burgesses of the London Borough of Haringey v Simawi* [2019] EWCA Civ 1770 at [41], considering *R v Docherty* [2016] UKSC 62. Mr Anderson does however accept that being a person with diabetes is a status.

104. In the Equality Impact Assessment prepared for the purposes of the 2017 Regulations, the DWP give a list of conditions most likely to be affected by reversing the ruling in *LB*, in which diabetes mellitus (types 1 and 2 and unknown type) all figure prominently.

105. Mr Anderson accepts that if I accept the appellants' submissions on indirect disparity in relation to persons with diabetes (as I do, given the preceding paragraph) then such treatment is on grounds of the status of being a person with diabetes.

106. Thus one arrives at justification. Mr Anderson submits that the Upper Tribunal should be slow to intervene. His starting point is Lord Reed's judgment in *R(SC) v SSWP* [2021] UKSC 26. While I have re-read all the passages to which I was referred, perhaps the passage that can most helpfully be set out here is the following.

> "157. In the light of the foregoing discussion, I am not persuaded by the argument, based on *JD* [2020] HLR 5, that the "manifestly without reasonable foundation" formulation can never have any part to play, even in relation to differences of treatment on "suspect" grounds, outside the context of transitional measures. …
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> 158. Nevertheless, it is appropriate that the approach which this court has adopted since *Humphreys* should be modified in order to reflect the nuanced nature of the judgment which is required, following the jurisprudence of the European court. In the light of that jurisprudence as it currently stands, it remains the position that a low intensity of review is generally appropriate, other things being equal, in cases concerned with judgments of social and economic policy in the field of welfare benefits and pensions, so that the judgment of the executive or legislature will generally be respected unless it is manifestly without reasonable foundation. Nevertheless, the intensity of the court's scrutiny can be influenced by a wide range of factors, depending on the circumstances of the particular case, as indeed it would be if the court were applying the domestic test of reasonableness rather than the Convention test of proportionality. In particular, very weighty reasons will usually have to be shown, and the intensity of review will usually be correspondingly high, if a difference in treatment on a "suspect" ground is to be justified. Those grounds, as currently recognised, are discussed in paras 101-113 above; but, as I have explained, they may develop over time as the approach of the European court evolves. But other factors can sometimes lower the intensity of review even where a suspect ground is in issue, as cases such as *Schalk*, *Eweida* and *Tomás* illustrate, besides the cases concerned with "transitional measures", such as *Stec*, *Runkee* and *British Gurkha*. Equally, even where there is no "suspect" ground, there may be factors which call for a stricter standard of review than might otherwise be necessary, such as the impact of a measure on the best interests of children.
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> 159. It is therefore important to avoid a mechanical approach to these matters, based simply on the categorisation of the ground of the difference in treatment. A more flexible approach will give appropriate respect to the assessment of democratically accountable institutions but will also take appropriate account of such other factors as may be relevant. As was recognised in *Ghaidan v Godin-Mendoza* and *R (RJM) v Secretary of State for Work and Pensions* [2004] UKHL 30 the courts should generally be very slow to intervene in areas of social and economic policy such as housing and social security; but, as a general rule, differential treatment on grounds such as sex or race nevertheless requires cogent justification.
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> 160. It may also be helpful to observe that the phrase "manifestly without reasonable foundation", as used by the European court, is merely a way of describing a wide margin of appreciation. A wide margin has also been recognised by the European court in numerous other areas where that phrase has not been used, such as national security, penal policy and matters raising sensitive moral or ethical issues.

> 161. It follows that in domestic cases, rather than trying to arrive at a precise definition of the ambit of the "manifestly without reasonable foundation" formulation, it is more fruitful to focus on the question whether a wide margin of judgment is appropriate in the light of the circumstances of the case. The ordinary approach to proportionality gives appropriate weight to the judgment of the primary decision-maker: a degree of weight which will normally be substantial in fields such as economic and social policy, national security, penal policy, and matters raising sensitive moral or ethical issues. It follows, as the Court of Appeal noted in *R (Joint Council for the Welfare of Immigrants) v Secretary of State for the Home Department (National Residential Landlords Association intervening)* [2020] EWCA Civ 542; [2021] 1 WLR 1151 *and R (Delve) v Secretary of State for Work and Pensions* [2020] EWCA Civ 1199; [2021] ICR 236, that the ordinary approach to proportionality will accord the same margin to the decision-maker as the "manifestly without reasonable foundation" formulation in circumstances where a particularly wide margin is appropriate.
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> 162. It is also important to bear in mind that almost any legislation is capable of challenge under article 14. Judges Pejchal and Wojtyczek observed in their partly dissenting opinion in *JD*, para 11:
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> "Any legislation will differentiate. It differentiates by identifying certain classes of persons, while failing to differentiate within these or other classes of persons. The art of legislation is the art of wise differentiation. Therefore any legislation may be contested from the viewpoint of the principles of equality and non-discrimination and such cases have become more and more frequent in the courts."
>
> In practice, challenges to legislation on the ground of discrimination have become increasingly common in the United Kingdom. They are usually brought by campaigning organisations which lobbied unsuccessfully against the measure when it was being considered in Parliament, and then act as solicitors for persons affected by the legislation, or otherwise support legal challenges brought in their names, as a means of continuing their campaign. The favoured ground of challenge is usually article 14, because it is so easy to stablish differential treatment of some category of persons, especially if the concept of indirect discrimination is given a wide scope. Since the principle of proportionality confers on the courts a very broad discretionary power, such cases present a risk of undue interference by the courts in the sphere of political choices. That risk can only be avoided if the courts apply the principle in a manner which respects the boundaries between legality and the political process. As Judges Pejchal and Wojtyczek commented (ibid):
>
> "Judicial independence is accepted only if the judiciary refrains from interfering with political processes. If the judicial power is to be independent, the judicial and political spheres have to remain separated."

107. Mr Royston, whilst accepting that in many cases a wide margin of appreciation is to be given, points to a number of factors making a greater degree of scrutiny appropriate in the present case.

108. The first is because the case involves persons with disabilities. As Lord Reed put it at [112]:

> "112. A relatively strict approach has also been adopted in cases concerned with persons with disabilities, in order to "foster their full participation and integration in society": *Glor v Switzerland* (Application No 13444/04) (unreported) given 30 April 2009, para 84 … . In the more recent case of *Guberina* (2016) 66 EHRR 11, which concerned a refusal to grant a tax exemption for persons with special accommodation needs to the father of a disabled child, the court noted that, on the one hand, a wide margin is usually allowed to the state under the Convention when it comes to general measures of economic or social strategy, including measures in the area of taxation (para 73). On the other hand, it continued:
>
> > "… if a restriction on fundamental rights applies to a particularly vulnerable group in society that has suffered considerable discrimination in the past, then the state's margin of appreciation is substantially narrower and it must have very weighty reasons for the restrictions in question. The reason for this approach, which questions certain classifications per se, is that such groups were historically subject to prejudice with lasting consequences, resulting in their social exclusion. Such prejudice could entail legislative stereotyping which prohibits the individualised evaluation of their capacities and needs.""

109. In Mr Royston's submission, the respondent appears to consider that the group requiring help with medication/monitoring a health condition are less likely to be in need than those with non-medication therapies.

110. The second is that there is said to be a tension, calling for greater scrutiny, between the policy reflected in the 2017 Regulations and the "condition-blind" aim of PIP a described by Mostyn J, having reviewed the consultation documents, at [6] of *RF*:

> "Thus, the dominant set of ideals or beliefs underpinning the reform, indeed its very core objective, was that the focus would be on the impact of the impairment. Now, the analysis would be on effect not cause. The relevant question for the decision-maker would be ""what?" not "why?"

111. The third is the potential severity of the consequences for at least some claimants within the group affected. A person whose health condition is not monitored may in an extreme case, die. Indeed, in JM's case it is said to be "life-critical" that as he cannot wake up when the monitor goes off, his mother responds. While PIP does not pay directly for needs to be met, the clear intention is that the funds it provides may be used by recipients to help with care and mobility needs.

112. The fourth is that the need for the courts to show deference towards the legislator recognises the institutional competence of Parliament and the Executive by way of access to research, the ability to canvass public views and so on but, in the absence of a consultation process on the 2017 Regulations, Parliament and the Executive did not avail themselves of those facilities.

113. The fifth is that the negative resolution procedure, which had involved a vote in the House of Lords and a debate but no vote in the House of Commons) represented an amount of democratic scrutiny which was "the minimum possible level of scrutiny which regulations can enjoy" and far different from that being considered in *SC*, which had involved primary

legislation, a manifesto commitment, submissions from civil society and debates in Parliament.

114. Mr Royston submits that the rationale based on the needs of the disadvantaged group being less is not evidenced and nor are considerations of practicability. Rather, budgeting difficulties had emerged because of a misunderstanding of the effects of the law as it previously stood. In my judgement, the room for consideration of human rights issues here is relatively narrow. I have found that the policy involving a split between managing medication and monitoring a health condition (on the one hand) and therapy (on the other) did exist at the time of the 2013 Regulations (albeit imperfectly articulated in those Regulations) and budgeting will doubtless have bene carried out on the basis of the policy understanding. Accordingly, what has to be justified is the action in restoring the Regulations to a form which would achieve that policy objective; as I have said, the challenge is not to activity 3 as a whole, or as it originally stood. Judge Mesher himself acknowledged (at [33]) that he was acutely aware that other cases would throw up circumstances and difficulties that he had not thought of and which might not be catered for in a ruling made in the context of the circumstances of the case before him. While *LB* was the judge's response to the case before him, the issue for the legislative drafter was rather different – how to restore the policy intention, something which involved not only reversing *LB* but finding a formula which would cater for applying that policy to cases other than those involving the circumstances of *LB.*

115. The 2013 Regulations had been the subject of considerable consultation, summarised above, and, under section 94(6) of the 2012 Act had been approved by Parliament by affirmative resolution. It was a legitimate aim to seek to restore the position to what had previously been intended.

116. In relation to Mr Royston's points on the extent of the margin, the 2017 Regulations did not bear adversely on disabled claimants generally, nor even on all people with diabetes or other relevant conditions, but, rather, on a particular subset – those caught by the effect of the 2017 amendments, whether by the reversal of *LB* or otherwise. The present situation is very different from *Guberina*, for instance, where the relevant tax concession offering help to property buyers considered the suitability of property without any regard to the needs of people with disabilities at all. PIP as a whole is concerned with fostering participation and integration (though no doubt there will be those who would like it to go further in that regard). The 2017 amendments in this respect do not of themselves concern issues of fostering participation and integration but technical issues, involving the redrawing of bright lines which contribute to defining eligibility for the benefit.

117. There is indeed something of a tension between a condition-blind approach and the failure of the legislative scheme to make more than minimal provision for those with time-consuming needs for help with managing medication or monitoring a health condition. However, that tension is to be found in the 2013 Regulations as well (even as understood in the light of *LB*) and I do not see it as carrying significant weight in relation to the 2017 amendments, whose function is one of restoring the status quo.

118. Mr Royston's third point concerns the potential severity of consequences. That is a point which could properly have been made as part of the consultations leading to the 2013 Regulations.

119. Whilst I accept that in general terms the negative resolution procedure is at the lower end of the available tools of democratic scrutiny, in this case the 2017 Regulations did receive the Parliamentary scrutiny, as set out at [38] and [39] above and it is not for the courts and tribunals to determine the cogency of Parliament's evaluation of the issue (*SC* at [183]).

120. In my view, the legislator is entitled to a wide margin of appreciation in making (this part of) the 2017 Regulations. The case appears to fall within the type of case envisaged by Lord Reed at [161] and [162] of *SC*. The need to restore the original policy intent, to reduce going forward the unintended expenditure caused by the 2013 Regulations as originally drafted having failed to achieve the original intent was a legitimate aim and the original consultations, the degree of democratic scrutiny which (in different ways) the 2013 Regulations and the 2017 Regulations received and the degree of latitude to be afforded to the draftsman in responding to the situation created by *LB* mean that in my judgment the 2017 Regulations were a proportionate response.

121. It remains to express regret to the parties for the considerable delay affecting this decision. Along with the impact of Covid-19, there have been other staffing and operational issues affecting the Chamber over the last year and I am sorry that the parties have had to be so patient.

122. I thank all counsel for their submissions on this appeal.