WELFARE FACTS • TAX-BENEFIT MICROSIMULATION & EMPIRICAL BRIEF

The Timms Review (CP 1721): PIP Rebalancing & Single Gateway Impact Assessment

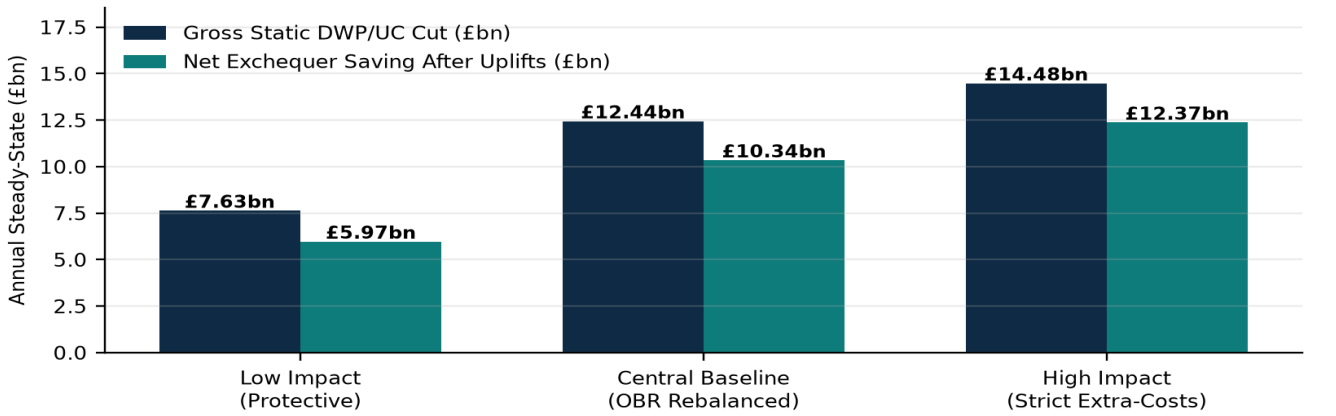
FRS 2023/24 Microsimulation (2029/30) • DWP Stat-Xplore Disability Forecast • UKDS SDC Compliant • NHS & Mortality Risk

NET EXCHEQUER DELTA	AFFECTED LOSING HHs	NHS & GP MH SPILLOVER	NEW AHC POOR HHs
£10.34bn / yr	1,883,400	£427.7m / yr	+297,700
Range: £5.97bn–£12.37bn (Driven by WCA abolition)	97,000 lose Motability (Central OBR rebalancing)	508,600 incident MH cases (Barr et al. / PSSRU 2025)	Range: +195,300 to +337,600 (60% HBAI median AHC)

1 • Executive Summary, Policy Scope & Subgroup Incidence

Using DWP Family Resources Survey microdata (FRS 2023/24, UKDS SN 9367, uprated to 2029/30) paired with DWP Stat-Xplore disability caseload and review distributions, this brief models the Timms Review (*Making PIP fit for purpose: A new vision*, CP 1721, November 2026) alongside the abolition of the Work Capability Assessment (WCA). While CP 1721 keeps aggregate PIP spending inside the OBR forecast (£34.6bn by FYE 2032), rebalancing awards via a dual daily-life and extra-costs Impact Assessment—combined with making Daily Living PIP the single gateway to the UC Health Element—creates severe cliff-edge losses concentrated among psychiatric and musculoskeletal claimants.

Chart 1: Timms Review Scenario Modelling — Gross Losses vs. Net Exchequer Delta



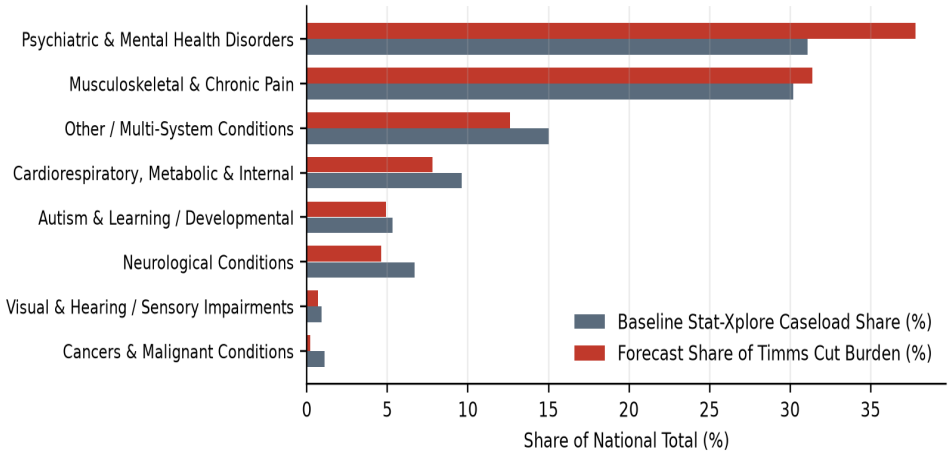
Losing Subgroup (Central OBR Rebalancing, UKDS SDC)	Unwtd N	Losing HHs	Mean Loss	Total (£bn)	New AHC Poor
G1: Standard Daily Living Only (Pathway B)	260	368,500	£5,720	£2.108	+49,700
G2: Dual PIP + UC Health (WCA Abolition Cliff)	380	533,300	£7,130	£3.804	+93,900
G3: Enhanced DL (Bottom Care Tier Rebalanced)	160	218,700	£4,070	£0.889	+17,600
G4: Mobility-Only / Lost Motability Access	70	97,000	£9,090	£0.882	+16,900
G5: Newly Re-Exposed to Benefit Cap	50	65,600	£9,180	£0.602	+10,500

Note: Subgroups G1–G5 overlap where households experience multiple simultaneous transitions (e.g. Standard DL loss triggering UC Health and Benefit Cap loss) and are not additive.

2 • PIP Caseload Risk Forecast by Primary Disability Group

Integrating DWP Stat-Xplore disability caseload and award-review distributions by primary medical condition with the CP 1721 dual-gate criteria (Para 138–140 & 441) identifies which disability cohorts carry the highest risk of loss. Claimants with **psychiatric/mental health disorders** (anxiety, depression, PTSD, ADHD) and **musculoskeletal/chronic pain conditions** face disproportionate exposure because fluctuating daily-living impairments are harder to evidence through ongoing extra-cost receipts, and high UC Health (LCWRA) co-claiming amplifies Single Gateway cliff-edges. Conversely, **cancers** and progressive **neurological conditions** are largely shielded by SREL and lifelong fast-track exemptions.

Chart 6: Primary Disability Groups Most Exposed to Timms Review Cuts (Stat-Xplore Calibrated)



Primary Disability / Condition Group (DWP Stat-Xplore)	Caseload Share	Loss Share	Forecast Losing HHs	Forecast Cut (£bn)	New AHC Poor
Psychiatric & Mental Health Disorders	31.1%	**37.8%**	711,900	£3.909	+112,500
Musculoskeletal & Chronic Pain	30.2%	**31.4%**	591,400	£3.247	+93,500
Other / Multi-System Conditions	15.0%	**12.6%**	237,300	£1.303	+37,500
Cardiorespiratory, Metabolic & Internal	9.6%	**7.8%**	146,900	£0.807	+23,200
Autism & Learning / Developmental	5.3%	**4.9%**	92,300	£0.507	+14,600
Neurological Conditions	6.7%	**4.6%**	86,600	£0.476	+13,700
Visual & Hearing / Sensory Impairments	0.9%	**0.7%**	13,200	£0.072	+2,100
Cancers & Malignant Conditions	1.1%	**0.2%**	3,800	£0.021	+600

Summary of Disability Group Exposure & Lowest Forecast Additional Costs/Needs: Under the Timms Review dual-gate assumptions, the burden of forecast reductions falls most heavily on **Psychiatric & Mental Health Disorders** (37.8% of forecast losses vs. 31.1% of baseline caseload; 711,900 losing households) and **Musculoskeletal & Chronic Pain** (31.4% of losses; 591,400 losing households). Together, these two groups account for **69.2% of all forecast losing households**, primarily because fluctuating or non-receipted daily-living needs are most vulnerable to failing the extra-costs verification gate and losing passported UC Health (LCWRA) entitlement. By contrast, the groups forecast to exhibit the lowest relative exposure and least unverified additional-cost vulnerability under the CP 1721 assumptions are **Cancers & Malignant Conditions** (0.2% of forecast losses; 3,800 households, heavily shielded by SREL and serious-illness fast-tracks), **Visual & Hearing / Sensory Impairments** (0.7%; 13,200 households), and progressive **Neurological Conditions** (4.6% of losses vs. 6.7% caseload share; 86,600 households), where lifelong fast-track protections and clearly evidenced specialist equipment/care needs insulate claimants from the extra-costs stepdown.

Source: DWP Stat-Xplore PIP Caseload & Award Review Clearances by Disability (2016–2026) weighted by CP 1721 extra-cost/fast-track parameters and FRS 2023/24 Central Scenario totals (rounded to nearest 100 per UKDS SDC).

3 • Regional Incidence & Cross-Departmental Fiscal Ledger

UK Data Service (UKDS) Statistical Disclosure Control (SDC): Every regional and subgroup cell satisfies the minimum unweighted sample threshold (n ≥ 10; all 12 UK regions achieve n ≥ 20). Unweighted counts are rounded to base 10 and weighted household/caseload figures to the nearest 100.

Chart 2: Regional Fiscal Incidence — Direct Benefit Loss vs. NHS Mental Health Cost

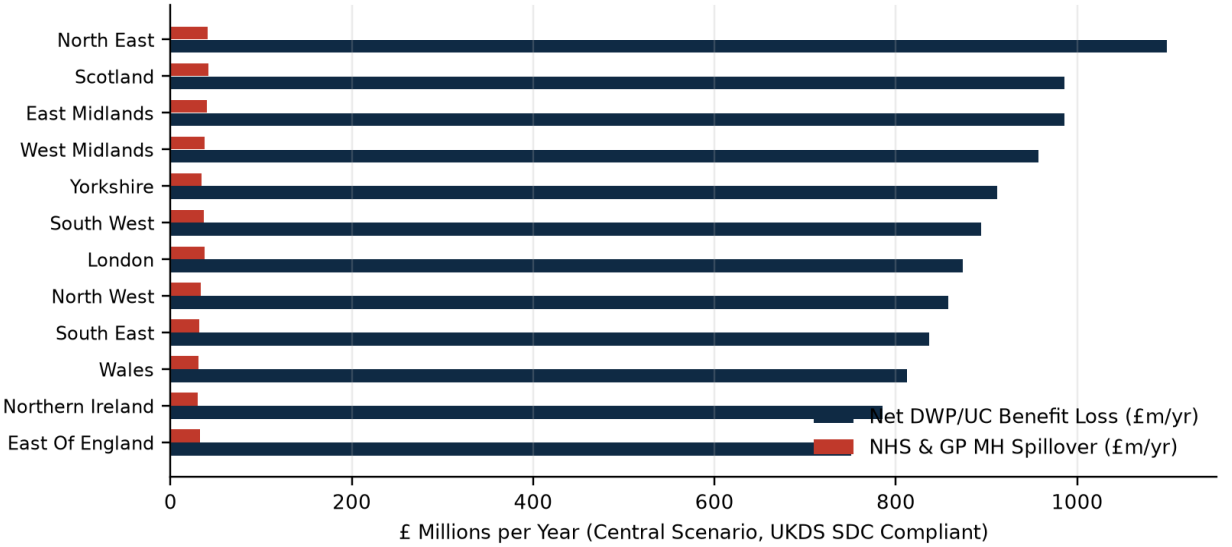
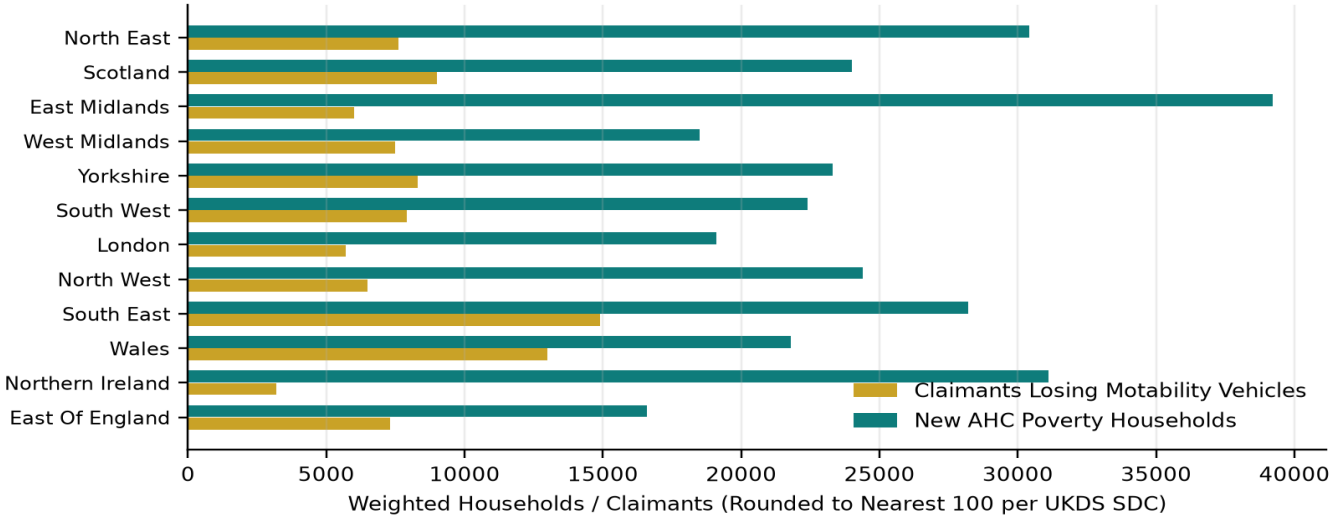


Chart 3: Regional Social & Mobility Shock (Central Scenario)



4 • UKDS SDC Regional Table & Empirical Literature Grounding

Region	Losing HHs	Static Cut (£bn)	Realised Cut (£bn)	New AHC Poor	Add. MH Cases	NHS Cost (£m)
East Midlands	176,800	£1.141	£0.986	+39,200	47,700	£40.14m
East Of England	144,700	£0.869	£0.751	+16,600	39,100	£32.86m
London	165,800	£1.011	£0.874	+19,100	44,800	£37.65m
Northern Ireland	132,100	£0.909	£0.785	+31,100	35,700	£29.99m
North East	179,800	£1.272	£1.099	+30,400	48,500	£40.82m
North West	147,200	£0.993	£0.858	+24,400	39,800	£33.44m
Scotland	182,200	£1.142	£0.986	+24,000	49,200	£41.38m
South East	137,800	£0.969	£0.837	+28,200	37,200	£31.29m
South West	163,500	£1.035	£0.894	+22,400	44,100	£37.13m
Wales	137,300	£0.939	£0.812	+21,800	37,100	£31.19m
West Midlands	167,100	£1.107	£0.957	+18,500	45,100	£37.94m
Yorkshire	149,100	£1.055	£0.912	+23,300	40,300	£33.87m
UK Total	**1,883,400**	**£12.44**	**£10.75**	**+299,000**	**508,600**	**£427.70m**

Empirical Literature, Data Sources & Study Anchors

Analytical Domain	Primary Study / Official Source	Empirical Parameter / Calibration Anchor
Policy Design & Fiscal Envelope	Timms Review Final Report (CP 1721, Nov 2026), Paras 20, 441–444, 451–456; DWP Stat-Xplore	Replaces functional PIP assessment with SREL/lifelong fast-tracks (~32% ongoing caseload, Para 195) + dual-gate Impact Assessment (daily life + extra costs) within the OBR forecast (£34.6bn by FYE 2032), coupled with WCA abolition.
Extra-Costs Rebalancing	DWP Areas of Extra Cost (2026f); Resolution Foundation (Judge & Murphy, 2026)	16% of PIP recipients report no awareness of extra costs; 24% of Enhanced DL recipients sit in the bottom third of care needs (4% none), while 16% of nil-DL claimants sit in the top third.
Tax-Benefit Microsimulation	DWP Family Resources Survey (FRS 2023/24, UKDS SN 9367) Microsimulation Engine	Static and behavioural household net income, Single Gateway (WCA abolition) cliff-edges, Benefit Cap re-exposure, and HBAI 60% median AHC poverty under UKDS SDC rules (n >= 10).
Condition-Level Review & Appeal Risk	DWP Stat-Xplore PIP Caseload & Award Review Clearances (2016–2026); DWP PIP Stats (2026h); Inclusion London (2025)	Condition-level caseload shares combined with 54% initial award rate rising to 59% post-MR/Tribunal, anchoring 9%–12% appeal recovery and differential condition exposure.
Mental Health & NHS Spillover	Barr et al. (2016) J Epidemiol Community Health; PSSRU Unit Costs (2025); Timms Survey (NatCen, 2026)	+2,700 incident mental health cases and +7,020 antidepressant items per 10,000 claimants reassessed; priced at £302.11 per specialist MH contact, £48.00 per GP consultation, and £11.40 per Rx item.
Ex Ante Mortality Calibration	ONS Age-Specific Mortality (Working-Age Disabled 16–66); Loopstra et al. (2018); JRF Destitution Studies	Calibrates baseline mortality m0 (0.0048–0.0092) to working-age disability cohorts (16–66) across dual-loss, Motability, and AHC poverty pathways, paired with published log-normal relative risks.

5 • Ex Ante Mortality Risk Simulation (Calibrated to Working-Age 16–66)

Calibrating baseline mortality rates specifically to ONS age-specific rates for working-age adults (16–66) with long-term health conditions (m_0 = 0.0048–0.0092), 10,000 Monte Carlo trials yield a steady-state mean of **6,666 excess deaths/year** (P10–P90: 4,812–8,612), **25,561 cumulative over 5 years**, and **58,892 cumulative over 10 years** (P10–P90: 42,043–77,213).

Chart 4: Ex Ante Mortality Risk Trajectory (Working-Age 16-66 Calibrated, 10,000 Trials)

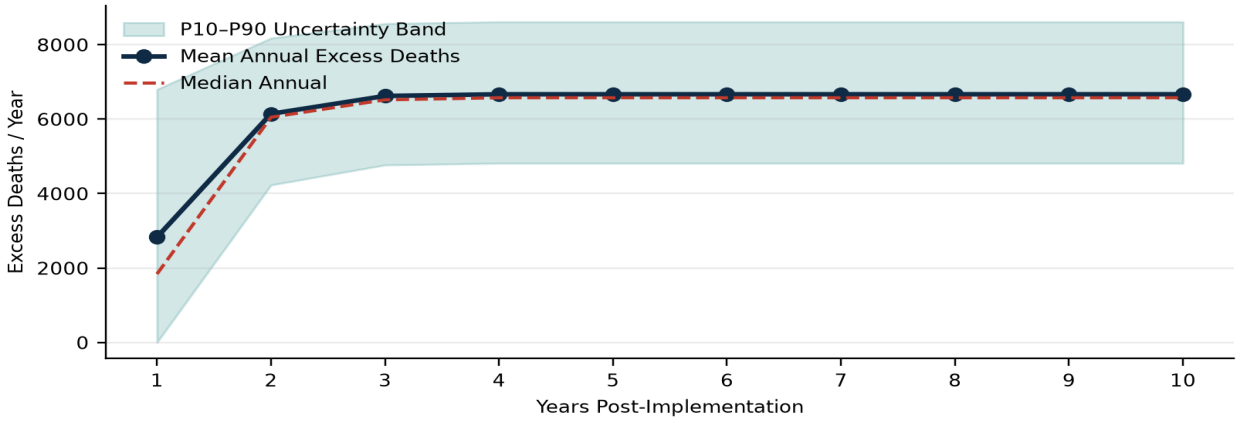
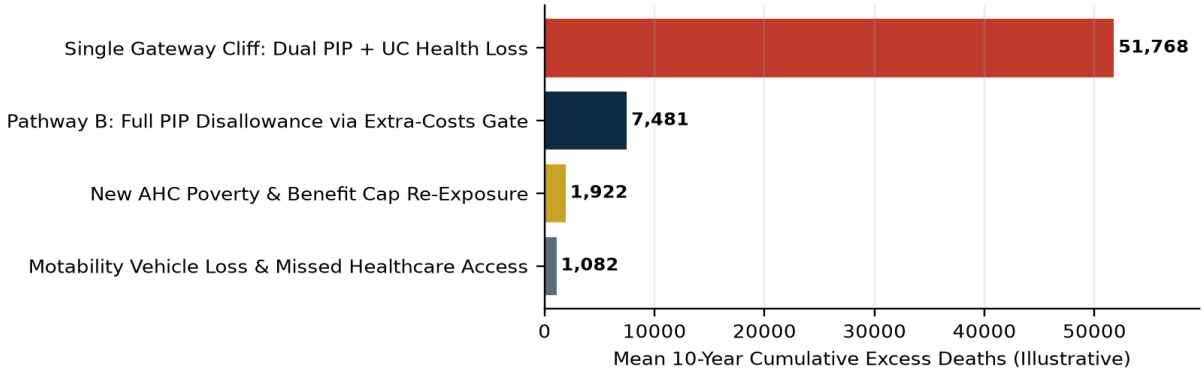


Chart 5: 10-Year Ex Ante Mortality Risk by Causal Pathway



6 • Report Conclusions & Policy Implications

1. **Fiscal Rebalancing Creates Hidden Cliff-Edges:** While the Timms Review (CP 1721) maintains aggregate PIP expenditure within the £34.6bn OBR envelope, pairing a dual daily-life and extra-costs gate with WCA abolition generates £10.34bn/year in net realised household losses in the central scenario—driven overwhelmingly by the loss of passported UC Health (LCWRA) entitlement among 533,300 dual-claimant households.
2. **Concentrated Clinical & Regional Burden:** Nearly seven in ten forecast losing households (69.2%) have psychiatric/mental health or musculoskeletal conditions, while losses fall disproportionately on higher-caseload regions such as the North East, Scotland, and the East Midlands, pushing an estimated 297,700 additional households into after-housing-costs (AHC) poverty.
3. **Cross-Departmental Spillovers Offset Exchequer Savings:** Reassessing and removing support from 1.88 million households is projected to generate 508,600 additional mental health cases and £427.7m/year in direct NHS and GP mental health spillover costs, alongside elevated downstream mortality and deprivation risks unless strong transitional protections and automatic UC Health safeguards are enacted.

Methodological Guardrails & Ex Ante Disclaimer

DISCLAIMER: This report does not prove that specific groups or disabilities will lose support; it is purely a forecast and early-warning microsimulation model based on the assumptions and parameters set out within the Timms Review final report (CP 1721). No specific policies, eligibility thresholds, or final recommendations have been accepted or enacted by the UK Government on how the proposals will be taken forward. Furthermore, the ex ante mortality figures represent an illustrative risk simulation—not a causal estimate, not a DWP/HMT forecast, and not a prediction that a stated number of people will die—illustrating the order of magnitude of risk if published relative risks (Barr et al. 2016; Loopstra et al. 2018) apply to exposed populations. Exposed populations across T1 and T2 overlap within dual-claimant benefit units and are not strictly additive.