



Department
for Work &
Pensions

PIP Assessment Guide

A DWP guidance document for providers carrying out assessments for
Personal Independence Payment

Updated on 4 April 2013

Foreword

This document has been produced by the Department for Work and Pensions (DWP) to provide guidance for providers carrying out assessments for Personal Independence Payment (PIP).

It is intended to supplement the contract documents agreed with providers as part of the commercial process, providing guidance for health professionals carrying out assessment activity and for those responsible for putting in place and delivering processes to ensure the quality of assessments.

All Health Professionals (HPs) undertaking assessments on behalf of DWP must be registered practitioners who have also met requirements around training, experience and competence. This document must be read with the understanding that as experienced practitioners and trained disability analysts, HPs will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this guidance.

In addition, the guidance is not a stand-alone document, and should form only a part of the training and written documentation that HPs receive from providers.

Although the guidance may be of interest to lay readers, it must be remembered that some of the information may not be readily understood by those who are not trained and experienced HPs. It also focuses specifically on the role of HPs in the assessment and the quality of their work. It is not intended to cover all the requirements placed on providers as part of the PIP assessment contracts; their full business processes; or work carried out by DWP to monitor and manage provider performance.

Office of the DWP Chief Medical Adviser

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1. Introduction

1.1. About Personal Independence Payment

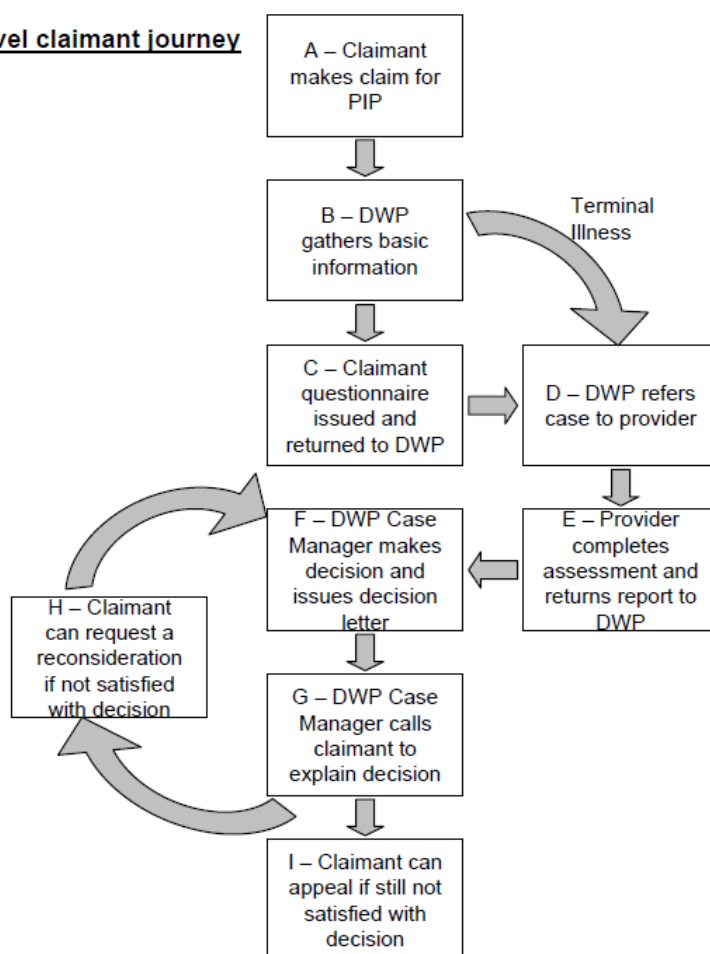
- 1.1.1. Personal Independence Payment (PIP) is a benefit for people with a long-term health condition or impairment, whether physical, sensory, mental, cognitive, intellectual, or any combination of these. It is paid to make a contribution to the extra costs that disabled people may face, to help them lead full, active and independent lives.
- 1.1.2. The benefit is not means tested and is non-taxable and non-contributory. This means that entitlement to the benefit is not dependent on a person's financial status or on whether they have paid National Insurance contributions. PIP is not restricted to people who are out of work. It can be paid to those who are in full or part-time work as well as those who are out of work.
- 1.1.3. PIP will replace Disability Living Allowance (DLA), which has become outdated and unsustainable. The introduction of PIP will ensure the benefit is more fairly targeted at those who face the greatest barriers, by introducing a simpler, fairer, more transparent and more objective assessment, carried out by HPs.
- 1.1.4. PIP will be introduced in April 2013 for claimants aged 16 to 64 years. It applies to new claims from April 2013; and to reassessment of existing DLA awards on a rolling programme. The peak period of reassessment will now start in October 2015. The intention is that by the end of 2017 all eligible DLA claimants aged 16-64 will have been reassessed for PIP. DLA claimants aged under 16 and over 65 will not be affected.

The structure of PIP

- 1.1.5. PIP has two components:
 - **The Daily Living component** – intended to act as a contribution to the extra costs disabled people face in their day-to-day lives that do not relate to mobility.
 - **The Mobility component** – intended to act as a contribution to the extra costs disabled people face in their day-to-day lives related to mobility.
- 1.1.6. Both components are payable at either a standard rate or an enhanced rate, depending on a claimant's circumstances.

The PIP claimant journey

The high-level claimant journey



- 1.1.7. Entitlement to PIP is determined by a DWP Decision Maker – known as a Case Manager in PIP – who acts on behalf of the Secretary of State.
- 1.1.8. Claims to PIP will be made by telephone from roll-out, although paper forms will be used where claimants find it difficult to claim via this route. Claims will also be made through an e-channel expected in 2014, designed to eliminate the use of paper where possible. When an individual makes a claim to PIP, DWP gathers basic information about the claimant and their health condition or impairment. A Case Manager then considers whether the claimant meets the lay conditions – for example, age and residency requirements.
- 1.1.9. If the lay criteria are met, DWP issues a claimant questionnaire (*How your disability affects you*) to gather more information about how the individual's health condition or impairment affects their day-to-day life. This stage is skipped if the individual is claiming under the Special Rules for terminal illness, where the case is instead referred directly to a provider and dealt with as a priority.

- 1.1.10. Claimants will also be encouraged at this stage to provide any supporting evidence that they already have that they feel should be considered alongside their claim information – for example, from a health or other professional involved in their care or treatment.
- 1.1.11. Once the claimant questionnaire has been returned to DWP, the case is referred to a provider along with any additional evidence provided. The provider then conducts the assessment, gathering any additional evidence necessary (see section 2 for more information on the assessment), before providing an assessment report to DWP.
- 1.1.12. If the claimant questionnaire is not returned and the customer has been identified as having a mental or cognitive impairment, the claim will be referred direct to the AP for assessment. See section 2.10 for more information.
- 1.1.13. The Case Manager reviews the assessment report and all other evidence in the case, before making a decision about benefit entitlement. In all cases the Case Manager will consider the claimant's own estimation of their needs in the claimant questionnaire and any additional evidence available.
- 1.1.14. The Case Manager will inform claimants about their entitlement to the benefit in writing. If an individual is not awarded benefit, or if their benefit will be reduced (for example, in DLA reassessment cases), the Case Manager will also telephone the claimant to explain the reasoning for the decision. This is intended to reduce the number of appeals by helping the claimant to understand how the decision was made, as well as giving them the opportunity to present any new evidence.
- 1.1.15. If the claimant is not satisfied with the decision reached, they can request a reconsideration. This will usually be conducted by a different Case Manager. If, following the reconsideration, the claimant is still not satisfied with the decision, they can submit an appeal. A claimant cannot submit an appeal without first requesting a reconsideration.

The PIP assessment

- 1.1.16. The assessment for PIP looks at an individual's ability to carry out a series of key everyday activities. The assessment considers impact, not diagnosis. Benefit will not be paid on the basis of having a particular health condition or impairment but on the impact of the health condition or impairment on the claimant's everyday life.

1.1.17. The activities for the PIP assessment are:

Daily Living (10 activities):

preparing food
taking nutrition
managing therapy or monitoring a health condition
washing and bathing
managing toilet needs or incontinence
dressing and undressing
communicating verbally
reading and understanding signs, symbols and words
engaging with other people face to face
making budgeting decisions

Mobility (2 activities):

planning and following journeys
moving around

1.1.18. Each activity contains a series of descriptors which define increasing levels of difficulty carrying out the activity. A numeric score is allocated to each descriptor. Claimants will be allocated a descriptor (and score) for each activity in the assessment.

1.1.19. The total scores for all of the activities related to each component are added together to determine entitlement for that component. The entitlement threshold for each component is 8 points for the standard rate and 12 points for the enhanced rate. See section 3 for more information on the assessment criteria.

1.2.

The Health Professional role

- 1.2.1. The PIP assessor is a Health Professional (HP) with specialist training in assessing the impact of disability. The role differs from the therapeutic role of HPs in reaching a diagnosis and/or planning treatment.
- 1.2.2. The key elements of the role of the HP in PIP are to:
 - Consider information in the claimant questionnaire and any supporting evidence provided along with it.
 - Determine whether a claim can be assessed on the basis of a paper review and provide appropriate advice.
 - Determine whether any additional evidence needs to be gathered from health or other professionals supporting the claimant.
 - Carry out face-to-face consultations as required.
 - Having considered all the information and evidence of the case, produce a report for DWP containing information on the claimant's circumstances and recommendations on the assessment criteria applying to the claimant.
- 1.2.3. The report to the Department should include:
 - A detailed history of the claimant, including information on any health condition or impairment present, their history, functional effects, current medication and treatment.
 - Advice on the appropriate assessment descriptors for the claimant, based on consideration of the evidence on file and (if appropriate) the evidence that the HP has collected during the face-to-face consultation.
 - Justify the advice explaining the evidence used to inform the advice on descriptor choices.
 - Advice on the likely prognosis of the case (see section 2.9).
 - Advise if the claimant may need additional support to comply with future claims processes.
- 1.2.4. The HP may also be asked to provide advice to the Case Manager on a range of other aspects of a claim (see section 2.11).

1.3. The Case Manager role

1.3.1. Case Managers are lay people, who are familiar with the legislation governing PIP, but do not have a healthcare background or training. The HP enables Case Managers to make fair and accurate decisions by providing impartial, objective and justified advice.

1.3.2. In the PIP process, the key role of Case Managers is to:

- Make initial decisions on whether lay entitlement conditions are met, disallowing cases that are not.
- Consider the claimant questionnaire, the advice report from the HP and any supporting documentary evidence provided by the claimant or gathered during the assessment process.
- Consider whether the advice from the HP on descriptor choices reflects the evidence and identify when key evidence is missing or has been overlooked or any other inconsistency or anomaly in the report.
- Make the decision on assessment descriptor choices and whether the qualifying period and prospective test are met, and therefore on the claimant's benefit entitlement.
- Make the decision on the length of a PIP award and the point at which an intervention will be scheduled to review the claimant's entitlement.
- Provide personalised content to be included in the notification to the claimant to inform them of the entitlement decision, including giving a personalised free-text justification explaining the descriptor choices and decision.
- Verbally communicate the outcome decision to all disallowed claimants or claimants whose benefit is reduced, explaining the decision and next steps.
- Reconsider cases prior to appeal proceedings, including contacting the claimant or their representative to discuss the claim. It may be necessary to provide further explanation of the decision outcome or seek additional information. Where necessary Case Managers may ask the HP to obtain further evidence to support their submission or rework the file.
- Prepare responses to appeals.

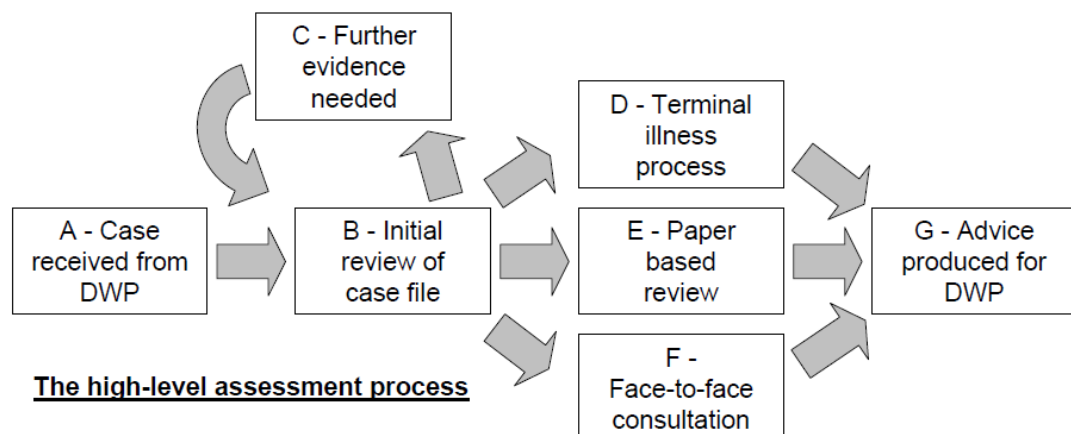
1.3.4 Case Managers are not responsible for liaising directly with providers. This will be done by a DWP Advisor who is knowledgeable in the end-to-end PIP claimant journey and the PIP business process. Part of their responsibility will be to act on behalf of the Case Manager to:

- Liaise with the HP for additional advice either based on current advice or using further evidence.
- Liaise with the HP where there is a discrepancy in descriptor choice or evidence, potentially requesting rework such as reconsidering evidence or requesting missing evidence.

2. Carrying out PIP assessments

- 2.0.1. PIP assessment providers are responsible for carrying out the PIP assessment. HPs advise DWP on the impact of the claimant's health condition or impairment, on their ability to carry out key everyday activities and recommends which of the assessment criteria set out in legislation they believe apply to that individual. The decision for benefit entitlement rests with the Case Manager.
- 2.0.2. This section describes how to carry out the assessment. This includes the different processes for terminal illness cases, paper-based reviews and face-to-face consultations, including guidance on when the different types of assessment should be used. This section also covers other areas on which the HP may be asked to advise.

2.1. The PIP assessment process



Case received from DWP

- 2.1.1. If they pass the lay entitlement conditions (for example, age, residence and presence), claimants will be issued with a *How your disability affects you* form (referred to in this document as the claimant questionnaire). This form asks the claimant to explain the impact of their health condition or impairment on their ability to carry out the daily living and mobility activities. A copy of the claimant questionnaire can be found at www.dwp.gov.uk/pip-toolkit.
- 2.1.2. Claimants will return their completed claimant questionnaire, and any supporting evidence they may have (such as a letter or report from their GP, Community Psychiatric Nurse or social worker), to the

Department. The questionnaire and any evidence will be scanned and saved in the Document Repository System (DRS). The documents will then be available to be viewed via the claimant's record in the PIP Computer System (and subsequently through the PIP Assessment Tool when it becomes available from October 2013).

2.1.3. Once this has been completed, the case will be referred to the appropriate assessment provider via the PIP Computer System.

2.1.4. The following referrals will be sent to providers:

- Claims made under Special Rules for Terminal illness (SRTI).
- New claims.
- Claims that are being reviewed, e.g. reassessment of an existing DLA claim or on a PIP claim where an agreed intervention point is reached or fresh evidence received (the list is not exhaustive).
- Rework requests in relation to assessment reports (see section 4.6 on rework).
- Advice on other issues (see section 2.11)

Initial review of case file

2.1.5. On receipt of referrals from DWP, providers should arrange for an HP to conduct an initial review of the case file to determine whether:

- Further evidence is needed.
- The claim can be assessed on the basis of the paper evidence held at this point (a 'Paper-Based Review').
- A face-to-face consultation will be required.

2.1.6. See section 2.2 for more information on the Initial Review.

Further evidence needed

2.1.7. Providers should seek additional evidence from professionals involved in supporting claimants, where HPs feel that would help inform their advice. See section 2.3 for more information on seeking further evidence.

Terminal Illness process

2.1.8. Cases identified as SRTI will be flagged as such and must be fast-tracked and follow a different process to standard claims. The HP should provide advice on whether the SRTI provisions are satisfied

and advise on the claimant's mobility. See section 2.4 for more information on the SRTI process.

Paper-based review

- 2.1.9. HPs should carry out assessments on the basis of a paper-based review in cases where they believe there is sufficient evidence in the claim file, including supporting evidence, to provide robust advice on how the assessment criteria relate to the claimant. See section 2.5 for more information on paper-based reviews.

Face-to-face consultation

- 2.1.10. In the majority of cases, a face-to-face consultation is likely to be necessary to accurately assess the claimant. This gives the claimant the opportunity to explain to the HP how their impairment or health condition affects them. It should enable the HP to gather sufficient factual information about the claimant and the functional effects of their disabling condition(s) to advise DWP. See section 2.6 for more information on face-to-face consultations.

Advice produced for DWP

- 2.1.11. The assessment process, whether involving a paper-based review of the claim evidence or a face-to-face consultation, will result in a report advising DWP on the claimant's circumstances, the impact of their health condition or impairment on their everyday lives and how the assessment criteria relate to the claimant. Reports should be clear, fully reasoned and justified. See section 5.1.17 for more information on report writing.

2.2.

Initial reviews

- 2.2.1. On receipt of a referral from DWP, an HP should conduct an initial review of the case file to determine the next steps in the assessment process.
- 2.2.2. HPs should consider, as part of their initial review, whether the claim is likely to be a SRTI case. Although claims where individuals have claimed under the TI provisions will be flagged as such, some claimants may be unaware of the SRTI provisions and make a claim under the normal claim process, despite being terminally ill. Should the HP discover a case that appears to fall under the SRTI provisions, it should be processed under the fast-tracked SRTI arrangements (see section 2.4 on SRTI below).
- 2.2.3. The HP should then scrutinise the evidence and complete form PA1 when they decide whether:
 - Additional evidence is required (see section 2.3 on further evidence).
 - Advice can be given on the basis of a paper-based review of the evidence (see section 2.5 on paper-based reviews).
 - A face-to-face consultation will be required (see section 2.6 on face-to-face consultations).
- 2.2.4. The Department expects that face-to-face consultations are likely to be required in the majority of cases to ensure full evidence-based advice to the Department. However, in a proportion of cases there will be sufficient evidence available to advise on the case without the need for a consultation.
- 2.2.5. The HP should ideally wait for the return of any further evidence requested before deciding on whether a face-to-face consultation is needed. However, this is not necessary if it is likely that a face-to-face consultation will still be needed – for example, if the claimant has not returned a claimant questionnaire or where the HP considers that further evidence is only likely to be of limited value.
- 2.2.6. Providers may receive some referrals from the Department from customers who have a mental, intellectual or cognitive impairment (and be flagged as having “additional support needs”) and have not returned their claimant questionnaire. In these cases providers will not have sufficient information on which to advise the Department or to seek additional evidence. Such claimants should usually be asked to attend a face-to-face consultation as standard (see section 2.10 for further information).

- 2.2.7. Providers should document the choice of further action taken by HPs during the initial review and justify this, providing this to DWP as part of the case documentation.
- 2.2.8. HPs should consider the needs of vulnerable customers. Vulnerable customers are defined as someone who has difficulty in dealing with procedural demands at the time when they need to access a service. This may include for example someone noted to have an appointee or where there is evidence of a previous suicide attempt.
- 2.2.9. The HP should complete a PA1 – Review file note explaining the action taken on the case, how the decision was made on the type of assessment and the evidence used.
- 2.2.10. If further evidence is request and returned, a further PA1 should be completed to inform on the next steps after the review of the further evidence.

2.3. Further Evidence

- 2.3.1. The Department will send claimants a questionnaire to gather information on how their health condition or impairment affects their ability to carry out the daily living and mobility activities. This will be returned to the Department and scanned into the Document Repository System before the case is referred to the assessment provider, although the questionnaire may not be provided when the claimant has additional support needs – i.e. where the claimant has a mental, intellectual or cognitive impairment and has not returned the questionnaire.
- 2.3.2. The claimant questionnaire gathers basic information about the claimant's health conditions or impairments, including treatment. It then focuses on each of the daily living and mobility activities in turn. Claimants are asked a series of questions for each activity about their ability to carry out the activity. The questions also include whether the claimant needs to use an aid or appliance and whether they are able to complete the activity safely, to an acceptable standard, repeatedly and in a reasonable time period.
- 2.3.3. Claimants will be encouraged to submit alongside their claimant questionnaire any additional evidence they may have that they think is pertinent to their claim. This is not a requirement and some case files may therefore contain no additional information other than the claimant questionnaire (and in some cases will not even have that).
- 2.3.4. Claimants will receive guidance on documents that may be particularly useful. They will only be encouraged to provide evidence that they already have and not to delay their claim to seek evidence or ask for evidence for which they might be charged – such as a letter from their GP.
- 2.3.5. HPs should consider all claims at initial review and, if they believe that further evidence would help inform their advice to DWP or negate the need for a face-to-face consultation, providers should take steps to obtain this. The consideration of whether further evidence should be sought should take place before any decision to schedule a face-to-face consultation is taken.
- 2.3.6. In the claimant questionnaire, claimants are encouraged to list the professionals who support them and are best placed to advise on their circumstances. HPs should consider which professionals identified can provide useful evidence. They should not simply request evidence from all professionals identified as standard.

- 2.3.7. It will not always be necessary to request further evidence in every case but the HP should always consider whether it is likely to add value to the assessment process and the quality of their advice. This will include both where they feel that further evidence will allow them to offer robust advice without the need for a face-to-face consultation and where they feel that a consultation is needed but that there would still be value in gathering further evidence.
- 2.3.8. The circumstances where obtaining further evidence may be appropriate include (but are not limited to):
- Where they feel that further evidence will allow them to offer robust advice without the need for a face-to-face consultation – for example, because the addition of key evidence will negate the need for a consultation or where they feel that a consultation may be unhelpful because the claimant lacks insight into their condition or a consultation may be stressful to the claimant.
 - Where they consider that a consultation is likely to still be needed but further evidence will improve the quality of the advice they provide the Department – for example, because the existing evidence cannot be balanced or suggests unlikely outcomes or to corroborate findings of other evidence.
 - Where, in reassessment cases, further evidence may confirm that there has been no change in the claimant’s health condition or disability.
- 2.3.9. Providers should strongly consider requesting further evidence before calling for a consultation a vulnerable claimant, defined as someone who has difficulty in dealing with the procedural demands at the time when they need to access a service. This may include someone noted to have an appointee, or suicidal ideation or self harm, a case where there is evidence of a previous suicide attempt).. By gathering further evidence the HP may have sufficient information to complete a paper-based review which may be preferable in these cases to avoid distress to the claimant.
- 2.3.10. On the return of further evidence, the case should, wherever possible, be reviewed again by an HP to see whether this evidence is sufficient to provide advice to the DWP on the impact of the claimant’s health condition without a face-to-face consultation, whether more evidence is required or whether a face-to-face consultation should be arranged. If a face-to-face consultation has already been arranged and, following receipt of further evidence, the HP concludes that they can now advise on the basis of paper evidence, the face-to-face consultation should be cancelled.

- 2.3.11. If a claimant brings further evidence to a face-to-face consultation, the HP should take a copy of it and take it into account when completing their assessment report. A copy of the evidence should also be sent to the Case Manager with the completed report.

Sources of further evidence

- 2.3.12. The HP should consider the most appropriate evidence for the case under consideration. There is a variety of sources of further evidence, including, but not limited to:
- A factual report from a GP.
 - A report from other health professionals involved in the claimant's care such as a CPN.
 - A report from an NHS hospital.
 - A report from a local authority funded clinic.
 - Evidence from any other professional involved in supporting the claimant, such as social workers, key workers, care co-ordinators.
 - Telephone conversations with any such professionals.
 - Information from a disabled young person's school or Special Educational Needs Co-ordinator (SENCO).
 - An occupational therapist's report
 - A report from an ophthalmologist
 - Contacting the claimant by telephone for further information.

Seeking further evidence from professionals

- 2.3.13. The Department is developing three standard proforma for use in seeking evidence in writing from (a) GPs; (b) hospitals and (c) other professionals. These proforma have been provided separately.
- 2.3.14. Where necessary, providers may also seek evidence from professionals by telephone. Such telephone calls should be made by approved HPs not by clerical staff.
- 2.3.15. A written record should be taken of any telephone discussions seeking further information and the content included in the assessment report provided to the Department (or via the PIP Assessment Tool once it is made available). The HP should inform the professional being contacted that this record is being produced and that this may be made available to the claimant and/or their representative.

- 2.3.16. The HP should also clarify whether any information provided by the professional is Harmful or Confidential (See paragraphs 2.8.23 and 2.13.36).
- 2.3.17. Claimants will be asked during the initial claim stage to give consent to contact third parties. See section 2.13 for further information on consent.

Seeking further information from the claimant

- 2.3.18. Where necessary, providers may seek further information from claimants by telephone. Such telephone calls should be made by approved HPs, not by clerical staff.
- 2.3.19. HPs should identify who they are and the purpose of the call. A written record should be taken of any telephone discussions seeking further information, using the claimant's own words as precisely as possible. This information should be included in the assessment report provided to the Department (or via the PIP Assessment Tool once it is made available). The HP should always ask if there is anything else that the claimant wishes to say before concluding the call. The call should conclude by reading back what has been documented and advising the claimant that this information will be added as evidence to the file.

Paying for further evidence

- 2.3.20. The Department currently pays for two specific forms of evidence: factual reports from GPs; and GP and Consultant completed DS1500s.
- 2.3.21. Providers are responsible for making payments for GP Factual Reports (GPFRs) where they have sought them, with DWP reimbursing them the fees paid. DS1500s will be sought and paid for by DWP.
- 2.3.22. More information on the fees payable for further evidence is included in the Appendices at 5.1, including the circumstances when fees may not be paid – for example, due to the inadequacy of the reports.

Late return of Further Evidence

- 2.3.23. Where further evidence is received after the assessment has been completed and returned to DWP, the evidence will be sent to the Case Manager for consideration. If evidence is returned to the provider in error, it should be forwarded to DWP for scanning.

2.3.24. If the evidence is received after the claimant has been scheduled for a face-to-face consultation, the case should be reviewed and the evidence scrutinised to decide whether advice can be given on the basis of a paper-based review or a face-to-face consultation. If advice can be given on the basis of a paper-based review, the consultation should be cancelled.

2.4. Terminal Illness

- 2.4.1. Individuals who identify themselves as terminally ill can seek to claim PIP under the 'Special Rules for Terminal Illness' (SRTI). Such cases will be flagged to the provider at the point of referral. HPs will be required to advise on whether the claimant satisfies the SRTI provisions (see below), and provide advice with appropriate justification to DWP.
- 2.4.2. The criteria for a SRTI claim set out in legislation are that the claimant: *"is suffering from a progressive disease and death in consequence of that disease can reasonably be expected within six months."*
- 2.4.3. If the claimant meets the SRTI provisions, they automatically receive the enhanced rate of the Daily Living component. The claimant does not automatically receive the Mobility component and entitlement for this component will need to be assessed. Information will be available to the provider on the initial claim form.
- 2.4.4. Claimants claiming under the SRTI provisions do not need to satisfy the three-month qualifying period nor the nine-month prospective period to qualify for either the Daily Living or Mobility Component.

Referral procedure

- 2.4.5. If the claimant states that they are terminally ill when applying for PIP, they are advised to obtain form DS1500 from their GP, consultant or specialist nurse. DWP will wait 7 working days for the DS1500 to be returned before making a referral to the Provider.
- 2.4.6. The referral sent to the provider via the PIP Computer System will include the initial claim details together with the DS1500 if it has been submitted by the claimant. Some claimants will have sought a DS1500 before contacting DWP.
- 2.4.7. SRTI referrals will not contain the claimant questionnaire *"How your disability affects you"* due to the need to process claims quickly. However, some relevant information about the claimant's circumstances will be gathered during the initial claim stage and supplied to providers. This will include details of the claimant's key supporting health professional and basic information about their mobility.
- 2.4.8. All SRTI claims will be clearly flagged on the PIP Computer System. TI referrals must be completed and returned to DWP within 48 hours.

2.4.9. Face-to-face consultations are not required where a claim has been referred under the SRTI provisions.

HP advice in SRTI claims

2.4.10. In a SRTI claim, HPs are required to advise on:

- Whether they consider, on balance, the claimant is or is not terminally ill under the prescribed definition.
- If so, which of the descriptors in the mobility activities set out in the assessment criteria are likely to be relevant to the claimant (see sections 2.8 and 3).

2.4.11. The HP must provide a summary justification to support the advice and provide the reasons for the advice. The HP must also include an indication of when the claimant first became terminally ill. Failure to provide this may result in the advice being returned for clarification or rework.

2.4.12. Advice must be evidence-based on the balance of probability. HPs should remember that prognosis can be uncertain and if in their opinion life expectancy is, on balance, likely to be less than six months, they should advise accordingly.

2.4.13. The HP is required to advise DWP on the descriptors in the mobility activities that are most appropriate to the claimant. Although the claimant will have not completed the full claimant questionnaire, there will be information in the initial claim and it should be possible to give this advice in most cases in which the person is terminally ill. The terminal illness itself, or the treatment being given, could impede mobility due to malaise, weakness, fatigue or another factor. The evidence must support the advice that the mobility needs indicated by the descriptors recommended are, on balance, either currently present or are likely to be present in the foreseeable future as a result of treatment or of a deterioration of their health condition.

2.4.14. The HP is required to advise whether the claimant has additional support needs. In all SRTI cases the answer to this question should be 'yes'.

2.4.15. The relevant information required when offering advice on SRTI claims is set out in the clerical form PA2 provided alongside this guide. See section 2.8 regarding completing assessment reports.

DS1500

2.4.16. This form is completed by a health professional involved in the care of a claimant who is suffering from an illness which is likely to result

in their death. The professional might be the claimant's GP, a hospital consultant or a specialist nurse.

- 2.4.17. The DS1500 does not offer a prognosis but gives factual information about the claimant's condition, any treatment received and any further treatment planned.

Further evidence in SRTI claims

- 2.4.18. If there is insufficient information in the claim file to confirm terminal illness and consent is clearly indicated on the file (see section 2.13 on Consent and Confidentiality), the HP should telephone the health professional such as a GP or hospital specialist identified by the claimant detailed in their initial claim. When making telephone contact with a GP or other specialist, the HP should also endeavour to determine whether the claimant is aware of their illness or prognosis and consider whether the information they have obtained may be potentially harmful (see paragraphs 2.8.23 - 2.8.27 on Harmful Information).
- 2.4.19. If no DS1500 has been provided and there is no additional medical evidence, a telephone call to the relevant clinician will always be required. If a DS1500 or additional medical evidence has been provided it may still be necessary to phone the relevant clinician if further information is required in order to give advice.
- 2.4.20. If the HP is unable to contact a clinician then they should try to contact another relevant clinician involved in the patient's care in order to obtain the necessary evidence.
- 2.4.21. Any conversations with clinicians should be captured and form part of the suite of evidence used to provide advice to the Department. This information should be included in the assessment report provided to the Department (or via the PIP Assessment Tool once it is made available).

Referrals of claimants already in receipt of benefits for terminal illness

- 2.4.22. In SRTI referrals DWP will check for an Employment and Support Allowance (ESA) claim under special rules. If the information is available, the Case Manager will transcribe the decision and any justification, word for word, into the medical evidence screen of the PIP Computer System.
- 2.4.23. The HP will be asked to consider the ESA evidence when providing advice to the DWP.

- 2.4.24. Where it is felt that this is still insufficient, the HP would be asked to contact the healthcare professional the claimant has identified on the claim form, to obtain information in order to advise DWP.

Form DS1500 received without a claim form

- 2.4.25. The DS1500 should be sent to DWP not to providers. Any DS1500s received direct by providers cannot be considered. Unsolicited DS1500s should be sent urgently to DWP, with an explanation as to the reason why the provider is sending the form.

Claimant questionnaire or further evidence suggests SRTI applies in standard claims

- 2.4.26. If evidence of a terminal illness meeting the prescribed conditions is uncovered following receipt of the claimant questionnaire or additional evidence in a non-SRTI claim, then advice may be given to DWP that the claimant fulfils the criteria for TI. The case should then be treated as a TI referral. Form PA2 must be completed and returned to DWP within 48 hours from that point. The advice should fully justify why the claim is being treated as a TI case.
- 2.4.27. Should an HP identify that a claimant is likely to meet the TI conditions during a face-to-face consultation and the claimant is aware of their condition; the HP should treat the case a SRTI referral. The HP completes form PA2 where in their opinion the claimant is terminally ill under the prescribed conditions. They should also provide advice for the mobility component based on the evidence received with the referral and/or gathered at the face-to-face consultation.
- 2.4.28. In a small number of cases, the individual may not be aware they are terminally ill. In these cases, providers and the Department must ensure the claimant is not inadvertently advised of their prognosis. Before treating a standard claim as a SRTI claim, the provider should take steps to assure themselves the claimant is aware of their prognosis. For example, if the evidence of terminal illness comes from the claimant's GP, the HP should telephone the GP to check the claimant is aware. In the event that a claimant is not aware of their prognosis, HPs may wish to advise the GP that a third party can make a claim to PIP without their patient's knowledge but until such time as such a claim is expressly made under the SRTI rules we can only treat it as a normal claim. In these rare events the HP should **not** treat the claim as a SRTI case and the claim should be processed as a standard claim.

Author has misunderstood the purpose of the DS1500.

2.4.29. Very occasionally, the HP will encounter a case where the contents of the DS1500 reveal that the author has completely misunderstood its purpose; for example, where there is no implication that the claimant is suffering from a terminal illness. In such cases the HP should contact the author of the DS1500 to clarify that there is no terminal illness. Once this has been confirmed, the HP should return the assessment report to DWP with any supporting evidence, if obtained, stating that the claimant is not terminally ill under the prescribed definition.

2.5. Paper-Based Review

- 2.5.1. It is critical that all advice offered by HPs in PIP assessments is fully evidence-based. It may be possible to give advice on a case on the basis of the documentary evidence alone, without the need for a face-to-face consultation. In such cases a consultation should not be carried out. However, HPs should only choose to advise on an assessment without a face-to-face consultation where there is robust evidence to enable them to advise on all aspects of the case.
- 2.5.2. Examples of where paper-based reviews might be particularly appropriate include, but are not limited to:
- Cases where the evidence indicates that it is unlikely that the claimant's condition has any impact on any of the daily living and mobility activities.
 - Cases where the evidence indicates that the claimant's condition has a significant impact in many of the daily living and mobility activities.
 - Cases where there is a strong evidence on which to advise on the case and where a face-to-face consultation is likely to be stressful to the claimant.
- 2.5.3. In a paper-based review, HPs are required to advise on:
- Which of the descriptors in the activities set out in the assessment criteria are relevant to the claimant (see sections 2.8 and 3).
 - Whether the functional impact of the claimant's health condition(s) or impairments have been present for at least three months and are likely to remain for at least nine months (see section 2.9).
 - The appropriate time to review the case, or indeed whether the case will require a review, and whether the functional restriction identified in the report will be present at the point of any review (see section 2.9).
 - Whether the claimant has a mental, intellectual or cognitive impairment and may need additional support to comply with future claims processes (see section 2.10).
- 2.5.4. The HP must provide a summary justification to support the advice and provide the reasons for the advice. Failure to provide this may result in the advice being returned for clarification or rework.

2.5.5. The relevant information required when offering advice on a paper-based review is set out in the clerical form PA3 provided alongside this guide. See section 2.8 regarding completing assessment reports.

2.6. Face-to-Face Consultation

- 2.6.1. The aim of face-to-face consultations is for the HP to gather sufficient factual information about the claimant and the functional effects of their disabling condition(s) to enable the HP to complete a clear, fully reasoned and justified report to a CM.
- 2.6.2. The consultation process involves interviewing the claimant and, where appropriate, any companion; making informal observations throughout the interview; and carrying out a focused examination where relevant. The information gathered from this process will enable the most appropriate activity descriptors to be chosen and provide the HP with the material required for factual justifications of descriptor choices and other advice.
- 2.6.3. Face-to-face consultations may be carried out at a range of locations, including an assessment centre, local healthcare centre or at the claimant's own home.
- 2.6.4. This section contains guidance for HPs on how to carry out face-to-face consultations, including giving a standard structure to consultations. However, HPs should be prepared to adapt their approach to the needs of the particular claim, not taking a prescriptive approach and ensuring that claimants are able to put across the impact of their health condition or impairment in their own words. It is important that claimants feel they have been listened to and that the consultation feels like a genuinely two-way conversation.
- 2.6.5. The relevant information required when offering advice on a face-to-face consultation is set out in the clerical form PA4 provided alongside this guide. See section 2.8 regarding completing assessment reports.

Before starting the consultation

- 2.6.6. Before starting the consultation, the HP should read the claimant questionnaire and all other evidence on file which may include, but may not be limited to:
- Supporting information supplied by the claimant.
 - Any further medical or other evidence supplied by the claimant.
 - Information from the claimant's GP or other relevant supporting professional gathered by the provider.
 - Information from earlier claims and assessments, if the claimant is being reassessed for an existing entitlement to PIP.

Clinical history

- 2.6.7. The HP should record on the report all conditions that affect the claimant. If the diagnosis is unclear - for example the claimant has low back pain probably of mechanical origin but they are still being investigated to rule out prolapsed intervertebral disc or other specific pathology - the HP should record the condition as a symptom such as "low back pain of uncertain origin", rather than trying to guess at the underlying pathology.
- 2.6.8. The HP should then record a succinct, relevant history of all the disabling conditions, including their duration; what investigations have been carried out or are planned for the future. If the information is available, the HP should record when the condition began, or if the claimant reports a change in their condition, when the change occurred or was first noticed by the claimant. The HP should record treatment given, and how effective it has been, and whether any further intervention, such as physiotherapy or a surgical procedure, has been carried out or is planned.
- 2.6.9. Many conditions fluctuate with time. Symptoms and their disabling effects may vary over minutes, days, weeks, months or years. The HP should record details of fluctuating conditions, indicating how frequent the fluctuations are, how long exacerbations last and, on balance, how many "good" days or weeks and how many "bad" ones the claimant experiences over time.
- 2.6.10. The HP should ask what symptoms the claimant is experiencing, with a particular focus on their functional effects and the functional limitations they cause, for example that "she reports her joints are stiff first thing in the morning, so it takes at least an hour to wash and dress"; "he says he gets out of breath if he walks more than about 20 metres"; "she says on a good day she can walk about 400 metres to the local shops, but this tires her out for the rest of the day".
- 2.6.11. Throughout the history-taking, the claimant's version of events should be recorded - this is their perception of how their condition affects them. Therefore, this part of the report should be written in the third person, making it clear that this is the claimant's view.
- 2.6.12. Although the HP may consider that the claimant's view of the impact of their condition is unrealistic or inconsistent with other evidence, the place to address this is later in the report, when justifying their advice.
- 2.6.13. All current medication should be recorded including frequency and dose. Include "over-the-counter" medication as well as prescribed

drugs. Record each medication and the frequency of dosage in full. Any drug side effects should be recorded here.

- 2.6.14. The HP should record any other prescribed therapies such as physiotherapy, making a note of who prescribed them, how often they are carried out, and how effective they are.

Social and occupational history

- 2.6.15. The HP should record a concise and relevant social and occupational history. What type of dwelling does the claimant live in and do they live alone or with others? Can they access all areas of their home and have they made any modifications? If the claimant is working, the HP should record details of their occupation and the nature of the job, including any adjustments made by their employer. If the claimant has given up or changed work was it due to their health condition or impairment? Social and leisure activities undertaken by the claimant and any they have given up or modified due to their health condition or impairment should be mentioned here.

Functional history and the “typical day”

- 2.6.16. HPs should then record how the claimant’s health condition or impairment affects their day-to-day life and in particular any functional limitations as a result of this. An effective way of exploring this is by talking to claimants about their “typical day”.
- 2.6.17. The HP should invite the claimant to talk through all the activities they carry out on a normal day, from when they get up to when they go to bed. The typical day history is the claimant's own perspective on how they cope with everyday activities. What functional limitations do they have as a result of their health condition or impairment? It is not the HP’s opinion of what the claimant should be able to do. It should be recorded in the third person, and should make it clear that this is the claimant's story. For example, "He gets up at ... and says he can wash and dress without any difficulty"; "She states that she finds it difficult to lift heavy saucepans". Wherever possible, the record should contain specific examples to illustrate difficulty with activities. For example, "He finds buttons difficult and tends to wear clothes that can be pulled over his head"; "She can manage to feed herself but needs to have meat cut up for her".
- 2.6.18. In the typical day, the HP should explore all the PIP activity areas for daily living and mobility, focusing on the activities most likely to be affected by the claimant's condition. The HP should do this by using open-ended questions to begin with (such as "Tell me about ..."), and

not just by asking a series of closed questions (such as "Can you wash yourself without help?"). The HP should encourage the claimant to expand their answer to explore how easy or difficult they find a task. Do they need help to carry it out or are they completely unable to do it and need someone else to do it for them. The HP should explore how long it takes the claimant to carry out a task and whether they experience any symptoms or side-effects such as pain, fatigue or anxiety, either during or after the activity. If help is given from another person, the HP should record the type of help, who gives it, how often and for how long.

- 2.6.19. The HP may also want to explore reasonable activities that the claimant would like to be able to do in a typical day but is unable to undertake as a result of their health condition or impairment.
- 2.6.20. The HP should explore any variability or fluctuation in the claimant's condition and functional ability by asking the claimant what they can do on "good" days and "bad" days. How many "good" and "bad" days do they have over a period of time? For some conditions different time periods will need to be considered, such as the potential impact of different times of the day. If a claimant is unable to complete an activity or needs support to do so at a point in the day when you would reasonably expect them to complete it, the need should be treated as existing for the whole of the day, even if it does not exist at other points in the day. In general HPs should record function over an average year for conditions that fluctuate over months, per week for conditions that fluctuate by the day, and by the day for conditions that vary over a day. Information about variability is important in assessing the functional effects of the claimant's condition that apply on the majority of days (bearing in mind that their advice will need to consider the impact of conditions over a year-long period). A "snapshot" view of their condition on a particular day at a particular time is not an adequate assessment.
- 2.6.21. As well as covering all the PIP activity areas, the typical day should cover other activities such as housework, shopping and caring responsibilities for adults, children and pets. Although these are not specifically considered in determining entitlement to benefit, they give additional supporting information about functional ability. For example, doing housework provides information about mobility, manual dexterity and fatigability. Shopping habits provide information about mobility and cognitive functioning.
- 2.6.22. Similarly, asking about hobbies and pastimes provides useful additional information. For example, doing crossword puzzles requires visual acuity, manual dexterity, concentration and cognitive

ability. Asking about hobbies and pastimes allows the HP to check the consistency of what the claimant is saying. For example, a claimant's statement that they take the dog out for a walk every day would not be compatible with a statement that their mobility is limited to house and garden.

Informal observations

- 2.6.23. Throughout the consultation, the HP should be making informal observations and evaluating any functional limitations described by the claimant. Informal observations start from "meeting and greeting" (where HPs may be able to observe claimant's appearance, manner, hearing ability, walking ability) and continue throughout history taking. The claimant's mood, powers of concentration and ability to stand, sit, move around freely and use their hands should be observed. They may also be observed performing activities such as bending down to retrieve objects such as a handbag on the floor beside them, or reaching out for an object such as their medication.
- 2.6.24. HPs may note how claimants stand and mobilise to any examination couch and observe the ease with which they get on and off the couch. How does the claimant remove their clothes or shoes? Informal observations should be recorded in the report, for example: "I observed the claimant... and they appeared to have no difficulty with..."; "I saw the claimant lean heavily on a walking stick to cover the distance to the consulting room".
- 2.6.25. The HP should note any aids or appliances in evidence, such as a walking aid, and the extent to which they are used during the consultation. Aids are devices that help a performance of a function, for example walking sticks or spectacles. Appliances are devices that provide or replace a missing function, for example artificial limbs, wheelchairs, or collecting devices for stomas.
- 2.6.26. The HP's informal observations will also help check the consistency of evidence on the claimant's functional ability. For example, there is an inconsistency of evidence if a claimant bends down to retrieve a handbag from the floor but then later during formal assessment of the spine, declines to bend at all on the grounds of pain or states that they have no mobility problems but they appear to struggle to walk to the consulting room. In deciding their advice, the HP will need to weigh this inconsistency, and decide, with full reasoning, which observation should apply.

Clinical Examination

2.6.27. HPs may wish to examine areas of function relevant to the claimant's health conditions or disability. Such examinations should be tailored to the individual claimant and will vary depending on the nature of the disabling conditions present. HPs do not need to conduct a clinical examination where sufficient evidence already exists e.g. if the claimant has a certificate of visual impairment, there will be no need to carry out an eye examination. They may cover one or more of:

- Mental function assessment.
- Sensory impairment.
- Cardiorespiratory system.
- Musculoskeletal system.
- Nervous system.
- Other body systems (e.g. abdomen, skin).

2.6.28. Before starting an examination, the HP should explain the procedure to the claimant, and obtain explicit verbal consent to continue. The HP should explain to the claimant that he/she is going to carry out a clinical examination but that it will be different from the examination they might get at their GP's surgery. This is because the HP is not trying to make a diagnosis of their condition but is interested in how their ability to carry out everyday tasks is affected by it. The HP should note in the report that they have explained the procedure to the claimant and obtained their consent to proceed. Obtaining consent may need to be repeated as the examination progresses.

2.6.29. Any examination should be carried out in a professional and sensitive manner, aiming to avoid causing the claimant any distress. Active rather than passive movements should be assessed. The HP should always stress to the claimant that they should not carry out a movement or activity to the point where it causes them discomfort.

2.6.30. The HP should never disturb underwear; never ask the claimant to remove their underwear; and never carry out intimate examinations (breast, rectal or genital examinations).

2.6.31. Some examinations – for example, of the lower limbs – are best carried out with the claimant reclining on an examination couch. If this is not feasible – for example, if the consultation is carried out in the claimant's own home – the HP should make a note of the circumstances and carry out such assessment as he/she can while the claimant is sitting or standing.

- 2.6.32. The mental function assessment should be tailored to individual claimants and may include appearance and behaviour, speech, mood, depersonalisation/derealisation, thought, perception, cognitive function, insight and additions.
- 2.6.33. If an area of function is examined but no abnormal findings discovered, this should be indicated in the assessment report.
- 2.6.34. If any element of function is not examined at the consultation, the HP should record that this area was not examined, not simply leave the section of the report form blank. It would be reasonable, for example, not to examine a claimant's musculoskeletal function where they are claiming purely because of a mental health condition. Providing justification material can be helpful – such as "Claimant states she has no problems with speech, hearing, or vision".
- 2.6.35. If the claimant is unaccompanied at a consultation, the HP should consider whether a chaperone would be appropriate during any examination. The presence and name of the chaperone should be recorded in the report.

Concluding the face-to-face consultation

- 2.6.36. Prior to concluding face-to-face consultations, HPs should give claimants an overview of the findings they have taken from the consultation. Claimants should be invited to clarify any points, ask any questions they have about the assessment procedure and if there is anything else they would like to say before they leave. The HP should answer any issues or concerns they express.
- 2.6.37. No opinion on entitlement to benefit should be given by the HP. Claimants who ask should be reminded that it is for the Case Manager to decide entitlement. The report and all other evidence available will be used by the Case Manager who will contact the claimant in due course.
- 2.6.38. Claimants who request a copy of their report should be advised that HPs are not authorised to give them a copy at the time of the consultation. The claimant can request a copy of their report from the Case Manager.
- 2.6.39. HPs should be ready to terminate consultations at any point should it become too stressful for the claimant.

Interview skills

- 2.6.40. Throughout consultations, the HP should use clear language that the claimant will readily understand. For sighted claimants body

language should be positive – for example, sitting to face the claimant, maintaining good eye contact, nodding to indicate understanding of what is being said and leaning forward toward the claimant from time to time. Where the HP decides to record information on any computer systems, the HP should ensure that they look up frequently from the screen and continued to maintain eye contact, thereby demonstrating that they are focusing on the claimant and what they are saying. For blind and partially sighted claimants, the HP should explain what they are doing at each stage of the assessment.

- 2.6.41. The approach should be relaxed and unhurried, allowing the claimant time and encouraging them to talk about themselves and put across the impact of their health condition or disability in their own words. The claimant and any companion should feel fully involved in the process and feel that the consultation is a genuine two-way process. Summarising back to the claimant what has been said is useful to show active listening and to ensure that key pieces of information have been correctly heard.
- 2.6.42. Different types of questions should be used where appropriate:
- **Open** questions which need more than a "yes" or "no" answer (for example, "Tell me about..."; "What do you do when..."; "How do you...") encourage the claimant to describe how their health condition or impairment affects them.
 - **Closed** questions which need a specific answer (for example, "Can you..."; "How often...") are needed when establishing a fact, such as how often medication is being taken.
 - **Clarifying** questions invite the claimant to explain further some aspect of what they have said – (for example, "Let me make sure I've understood this correctly...").
 - **Extending** questions allows the HP to develop the story the claimant is giving (for example, "So what happens after...").
- 2.6.43. Throughout the consultation, HPs should be evaluating what they are being told and mentally checking whether the evidence is consistent. Inconsistencies could result in claimants either over exaggerating or under emphasising, the impact of their conditions and efforts should be made to avoid both. For example, is the level of functional disability claimed in one activity compatible with that claimed in another? If a claimant can handle kitchen cutlery, it is unlikely they cannot handle a toothbrush. If a claimant cannot bend to put on their shoes, it is unlikely that they are able to wash below the waist. The HP should check the consistency of what is being said by using

different approaches, asking questions in different ways, coming back to a previous point. When considering inconsistencies, HPs should bear in mind that claimants can often underplay the impact of conditions.

2.7. Other issues related to face-to-face consultations

Companions at consultations

- 2.7.1. Claimants should be encouraged to bring another person with them to consultations where they would find this helpful – for example, to reassure them or to help them during the consultation. The person chosen is at the discretion of the claimant and might be, but is not limited to, a parent, family member, friend, carer or advocate.
- 2.7.2. Consultations should predominantly be between the HP and the claimant. However, the companions may play an active role in helping claimants answer questions where the claimant or HP wishes them to do so. This may be particularly important where the claimant has a mental, cognitive or intellectual impairment. In such cases the claimant may not be able to give an accurate account of their health condition or impairment, through a lack of insight or unrealistic expectations of their own ability. In such cases it will be essential to get an accurate account from the companion. However, the involvement of companions should be at the discretion of the HP. It is essential that the HP's advice is based on the claimant's actual circumstances and not the companion's views on these. If the presence of a companion becomes disruptive to the consultation, the HP may ask them to leave. However, this should be avoided wherever possible.
- 2.7.3. HPs should use their judgement about the presence of a third party during any clinical examination. Both the claimant and the HP should agree to companions being in the room for an examination. Companions should take no part in examinations unless the HP asks them, for example, to help the claimant with their garments.
- 2.7.4. The presence of any companion at a consultation should be recorded in the assessment report.

Audio recording of PIP consultations

- 2.7.5. The recording of consultations by providers is not currently part of the specification for PIP assessments.
- 2.7.6. Claimants may use their own equipment to record their face-to-face consultation, should they wish to, subject to any reasonable conditions the Department chooses to impose on such recordings. These reasonable conditions are:

- **The claimant must inform the provider in advance** that they wish to record their consultation. This is to allow the provider to ensure the HP scheduled to carry out the consultation is willing to be recorded. If the HP is unwilling to be recorded, an alternative appointment should be made with the HP who is willing.
- **The claimant must be able to provide a complete and accurate copy of the recording to the HP at the end of the consultation.** Acceptable formats for such recordings are restricted to CD and audio cassette only. Mobile phones and laptops are not suitable mediums for recording consultations.
- **The claimant must sign a form** in which they agree that they will provide a copy of the recording and not use the recording for unlawful purposes.

2.7.7. Providers must publicise these conditions and ideally include them in communications sent to claimants before they attend a face-to-face consultation.

Suitable mediums for recording consultations

2.7.8. To record their consultations, claimants must use appropriate equipment that can provide two copies of the recording in such a way that the provider can be assured that the recording has not been tampered with and is a reliable and accurate record of the assessment. A copy must be given to the provider at the end of the assessment. For this reason certain devices that have the capability of editing, real-time streaming or video recording the session are not approved; such as computing devices (not limited to PCs, tablets, smart phones, MP3 players) or devices that are not capable of providing a verifiable media copy that can be easily verified during the assessment. Media types that are acceptable are standard CD and audio tapes only.

2.7.9. Video recording of assessments is not permitted in order to ensure the safety and privacy of staff and other customers.

Restrictions placed on claimants about the use of recordings

2.7.10. If it is only the claimant's personal data that is recording then there are no restrictions on the use the claimant can make the recording. However the DWP reserves the right to take appropriate action where the recording is used for unlawful purposes, for example, if it is altered and published for malicious reasons.

Covert recording of assessments

2.7.11. If the HP notices a claimant is covertly recording their assessment, the restrictions relating to the recording of consultations should be explained to the claimant. If the HP is content to be recorded, the claimant is content to sign the agreement form and the claimant's equipment meets the specified requirements, the consultation can continue. If this is not the case the claimant should be asked to stop recording. If the claimant refuses the consultation should be terminated and the case should be returned to DWP using the return assessment function with reason failure to participate. The Case Manager will consider whether the claimant has good reason for failing to participate in the consultation. If the only reason for failure to participate is the claimant refused to stop recording their consultation, it is likely the Case Manager will make a negative determination.

Young People

2.7.12. HPs may need to adapt their approach when assessing young people. Care should be taken, as always, to avoid creating stress or anxiety to the claimant. HPs should be mindful that young people are encouraged to be positive about their health condition or impairment and to focus on what they can do, rather than what they cannot. In addition, young people may have limited experience undertaking many activities unsupervised in an independent environment. HPs should ensure that this does not create an unfair perception of the young person's abilities and the impact of their health condition or impairment.

2.7.13. Young people may attend a face-to-face consultation with a parent. In these cases, it may be particularly important to distinguish between what a young person can or could do for themselves and what the parent does for them as part of their caring role. There may be some activities that have been done for them all of their lives that a young person without a health condition or impairment of the same age may do themselves. There may also be activities that could be carried out by the young person but the parent continues to assume responsibility. It should be emphasised whether the help given is suitable to the role of parent or a carer.

DS1500 presented

2.7.14. If the claimant provides further evidence at a consultation in the form of a DS1500, the HP should consider the evidence presented and provide advice as to whether the claimant is terminally ill. Where the HP considers the claimant terminally ill, they should action these

cases as per paragraphs 2.4.26 to 2.4.28. If the claimant is not considered terminally ill, the HP should continue with the consultation and complete a full assessment report (PA4), advising on all aspects of the case.

Unexpected findings

- 2.7.15. Very rarely during the assessment, the HP may identify that the claimant appears to have a significant undiagnosed medical condition. Examples include a significantly raised blood pressure or an apparently unrecognised depressive illness. If the HP identifies such a condition, the HP has a responsibility as a health professional to take appropriate action, by notifying a suitable person involved in the claimant's care. This will usually be their General Practitioner.
- 2.7.16. The HP also has a duty to protect the confidentiality of the information obtained during the consultation. Therefore consent to inform the GP of the unexpected finding should be obtained from the claimant. The HP should explain what information will be shared and why: "Your blood pressure is a bit higher than normal - I think your GP should be told. Is it okay if I write to him? Can you make an appointment to see your GP about your blood pressure in a few days time?" If the claimant agrees, the HP should complete the relevant referral form to the claimant's GP, and give the claimant a copy.
- 2.7.17. The HP should ensure the referral form is sent to the claimant's GP within 24 hours. If the unexpected finding is of a life-threatening nature, he/she should seek the claimant's consent to telephone the GP and advise the claimant to see their GP as soon as they can. Such a telephone call should be followed up with a written notification to the GP.
- 2.7.18. If the claimant declines to give consent for the HP to contact their GP, the HP should make a judgement as to whether the situation is sufficiently serious that it warrants breaking confidentiality by telling the GP even without the claimant's consent. Both the General Medical Council and the Nursing and Midwifery Council provide guidance on medical ethics and when it is acceptable to break medical confidentiality. If the HP acts within the guidelines, and is able to justify his/her actions, they should have no need to fear being sanctioned. Procedures to follow and sources of support and guidance should be covered in HP training.

Home Consultations

- 2.7.19. Consultations may potentially be carried out at a variety of locations but some will need to be carried out at the claimant's home.

Providers may also decide to carry out a home consultation for business reasons or simply to give claimants choice. As a minimum they should consider whether a home consultation is necessary where a claimant indicates that they are unfit to travel to a consultation in a location other than their home or where travel would require high levels of support.

- 2.7.20. When considering a request for a home consultation, providers should consider:
- Does the claimant have a medical condition that precludes them from travelling?
 - Has there been medical verification of the severity of the condition that precludes them from attending a consultation?
 - Are there health and safety implications for a home consultation? For example, the claimant or a person associated with them has had unacceptable claimant behaviour identified.
 - Any accessibility issues related to the planned location of consultations.
- 2.7.21. The request for a home consultation may come from a GP or other healthcare professional involved in the claimant's care. When assessing such requests, providers should consider issues such as:
- Whether the request is based on medical fact rather than opinion e.g. "My patient has severe agoraphobia and cannot leave the house" rather than "I feel my patient would benefit from an assessment at home" or "My patient tells me they are unable to travel to an assessment centre"
 - Does the request relate to the claimant's medical condition rather than social circumstances at home?
- 2.7.22. In each case the evidence should be reviewed. At times it may be necessary to seek further clarification from the author of the report to clarify the medical facts.
- 2.7.23. Information that may help support a home consultation request may be:
- Diagnosis suggesting significant disability that may make travel extremely difficult – e.g. incomplete quadriplegia.
 - Evidence that the claimant receives home visits or telephone consultations with their GP.

- Evidence that the claimant has home visits from the psychiatrist/CMHT.
- Claimants who are likely to find travel extremely stressful as a result of their physical or mental health condition

2.7.24. Providers may also consider whether other options may be acceptable - for example if travelling on public transport is the issue, could a taxi be considered?

Home consultations and further evidence

2.7.25. If, during a home consultation, the claimant provides further evidence that they want to be considered, HPs should inform the claimant that this will need to be taken away and used to inform advice to the Department but will be returned back to them once used.

2.7.26. If claimants refuse to allow the evidence to be removed from their presence, the HP should take sufficient details of the evidence that will allow them to use it when providing advice to the Department. This should be recorded in the assessment report (or via the PIP Assessment Tool once it is available).

Uncooperative claimants

2.7.27. If the claimant is uncooperative during a face-to-face consultation, the HP may terminate the consultation where they have gathered sufficient evidence to complete the assessment report and provide advice for the Case Manager. If the claimant is persistently uncooperative – for example, if they are under the influence of alcohol or drugs – the consultation should be terminated and the case returned to the Department, along with an explanation of why the interview had to be terminated.

2.7.28. The provider should not send incomplete reports to the Department.

2.8. Completing assessment reports

- 2.8.1. Once HPs have completed assessment activity, they will need to complete a report containing advice for the Department.
- 2.8.2. DWP is currently in the process of developing an IT tool (the PIP Assessment Tool) that will allow the provision of HP advice to the DWP in an electronic format. The tool is planned to be available from October 2013. In advance of this the following clerical forms should be used:
- PA1 – Review file note.
 - PA2 – Review report form (terminal illness).
 - PA3 – Review report form (paper-based review).
 - PA4 – Consultation report form.
 - PA5 – Supplementary advice note.
 - PA6 – Supplementary advice note (change of advice).
 - PA7 – Harmful information note.
- 2.8.3. Copies of all the forms are provided alongside this guidance. Example assessment reports will also be shared with providers.
- 2.8.4. These forms will be superseded by the PIP Assessment Tool once it is available.
- 2.8.5. The nature of the information required in reports varies depending on the nature of the activity. Reports produced further to face-to-face consultations require the most content, as HPs will need to record the discussion, observed findings and conclusions from the consultations.
- 2.8.6. Section 5.1.17 provides more information on the principles of giving advice and effective report writing.

Choosing descriptors

- 2.8.7. The most important areas of advice in relation to benefit entitlement are the assessment criteria themselves. For each activity area, the HP should use evidence to choose the descriptor that is the one which best reflects the claimant's ability to carry out an activity, taking into account whether they need to use aids or appliances and whether they need help from another person or an assistance dog.

- 2.8.8. Before selecting a descriptor, the HP must consider whether the claimant can reliably complete the activity in the manner described in the descriptor, taking into account where they can do so:
- Safely.
 - To an acceptable standard.
 - Repeatedly.
 - In a reasonable time period.
- 2.8.9. The HP must also take into account that most health conditions or impairments can fluctuate over time. The HP should consider ability over a 12 month period as this helps to iron out fluctuations and presents a more coherent picture. For some conditions different time periods will need to be considered, such as the potential impact of different times of the day. If a claimant is unable to complete an activity or needs support to do so at a point in the day when you would reasonably expect them to complete it, the need should be treated as existing for the whole of the day, even if it does not exist at other points in the day.
- 2.8.10. For a scoring descriptor to apply, the claimant's health condition or impairment must affect their ability to complete the activity on more than 50 per cent of days in the 12 month period. Where one single descriptor in an activity is likely to not be satisfied on more than 50 per cent of days, but a number of different scoring descriptors in that activity together are likely to be satisfied on more than 50 per cent of days, the descriptor likely to be satisfied for the highest proportion of the time should be selected.
- 2.8.11. See section 3 for more comprehensive guidance on the assessment criteria, including notes on interpretation of the descriptors, the interpretation of issues of reliability and the assessment of fluctuating conditions.

Evaluation and analysis of evidence

- 2.8.12. It is essential that the Case Manager is made aware of the evidence the HP has used to complete the assessment report, by listing and referring to it in their advice to the Case Manager.
- 2.8.13. All evidence must be interpreted and clearly evaluated using medical reasoning and considering the circumstances of the case and the expected impact on the claimant's daily living and/or mobility. When weighting up the evidence, it is important to highlight any contradictions and any evidence that does not sufficiently reflect the

claimant's health condition or impairment or the affect on their daily life.

2.8.14. The HP's advice and justification must provide a clear explanation as to why more reliance has been placed on some evidence and not others. The age of the evidence should also be considered in deciding whether it is relevant to the claim. However, the HP should bear in mind that for claimants with stable long-term conditions, the evidence available may be older. Evidence can include, but is not limited to:

- The PIP claimant questionnaire – where the claimant sets out their circumstances and the impact of their health condition or impairment.
- Further evidence – e.g. factual report from the GP, hospital report, other health and social care professionals involved in the claimants care.
- Face-to-face consultation – the history, informal observations and clinical findings.
- Statements from family and friends.

Summary Justification

2.8.15. Report forms should contain a "summary justification" providing a succinct overall summary for the Case Manager of the evidence obtained and used in their consideration and the reasons for descriptor choice.

2.8.16. The advice must be able to stand up to challenge and the HP should draw out key evidence in support of their choice of descriptors in the report, drawing fact-based findings and/or well supported opinion from all of the evidence.

2.8.17. If the HP's opinion on descriptor choice differs from information provided by the claimant, the HP should refer to evidence to fully justify their advice. HPs should justify all descriptor choices by reference to objective evidence in the file.

2.8.18. When the HP evaluates the opinion of a third party that provides evidence – for example, a carer or health professional, the HP should evaluate the strength of the opinion being expressed. The HP's evaluation should include the level of expertise of the individual offering the opinion; their direct knowledge of the claimant's health condition or impairment; and whether it is medically reasonable. The HP should also consider whether the third party is acting impartially, or as the claimant's advocate. Consideration should also be given to

whether, as a result of the claimant's health condition or impairment, the claimant's companion or advocate may be better placed to describe their needs. For example, some claimants with mental, intellectual, cognitive or developmental impairments may lack insight into their condition.

- 2.8.19. If there are discrepancies in the evidence about the claimant's ability to carry out an activity, the HP should draw attention to the discrepancies when justifying his/her choice of descriptors, for example "He claims his right hand is too weak for him to be able to grip anything. However, on examination I found no evidence of muscle wasting or reduced strength in the right upper limb; and I observed him gripping his walking stick when walking across the room".

Variability

- 2.8.20. Advice about variability should be clarified by looking at the effects of the health condition or impairment on daily living and/or mobility on good, bad and average days and not on how the claimant was on the day of assessment. The HP must quantify the proportion of "good" days to "bad", for example if the claimant has epilepsy it is a question of the strength, frequency and after effects of the seizures. It is essential to describe the claimant's function as described both on "bad" days and on "good" days for the Case Manager to understand the claimant's circumstances and the consequences of their health condition or disability. The advice should allow the Case Manager to understand whether the described variability is in keeping with the nature of the health condition or disability.

Requirements of a justified report

- 2.8.21. A properly justified report should contain the following:
- A brief summary of the individual's health conditions or impairment and their severity.
 - A clear explanation of the reasons for the advice contained in the report including areas such as, but not limited to:
 - Referencing evidence used to support descriptor choice.
 - Explanations where the HP's opinion differs from those of the claimant, carers or other healthcare professionals.
 - Clarification of any contradictions, including those arising from the claimant's view of their needs
 - Explanation of the HP's choice of evidence.

- The evidence that underpins the advice and balances:
 - History.
 - Formal examination.
 - Informal observations.
 - The HP’s knowledge of the disabling effects of the medical conditions.
 - Treatment that the claimant receives.
 - Any other evidence available.

Who will see the report?

2.8.22. The consultation report is primarily for Case Managers but the claimant has a right to see it and can request a copy from the DWP. In the case of an appeal, the claimant, his/her representative and members of the tribunal will see a copy of the report.

Harmful Information

2.8.23. In **all** cases when giving advice, the HP should check their advice and the evidence upon which it is based for any information which could be seriously harmful to their health if it were disclosed – for example, a poor prognosis that is unknown to the claimant or a diagnosis of a psychotic illness in a claimant who lacks insight into their condition. This is known as “Harmful Information”. In law, this is the only information that can be withheld from a claimant.

2.8.24. No harmful information should be included in advice reports to the Department and HPs will be expected to verify that this is the case.

2.8.25. Should Harmful Information be present – either contained in supporting evidence or identified at a face-to-face consultation - this should be recorded separately to the advice report, clearly marked as “harmful”. A clerical proforma has been produced to facilitate this. The HP should indicate where any Harmful Information is contained in supporting evidence – for example: *“Part X of the GP Factual Report dated XXXX contains harmful information.”*

2.8.26. Any information received subsequent to the initial claim should be reviewed to identify any information which could be harmful.

2.8.27. In relation to TI claims:

- When the claim pack has been completed and signed by the claimant, and submitted by them and they have submitted the

DS1500, information about terminal illness should not be considered harmful.

- Where the claim has been made on behalf of the claimant by a third party, the claimant may not be aware of any of the information, and therefore the HP should consider all of the evidence carefully to determine whether any information may potentially be harmful.
- The GP or Hospital Consultant may flag up on the DS1500 that the claimant is unaware of their diagnosis or prognosis. Such information is likely to be considered harmful.

2.9. Prognosis

2.9.1. During PIP assessments, HPs are asked to give advice to Case Managers on the probable timescales over which a health condition or impairment is likely to affect a claimant's function and if/when it would be medically sensible to review the claimant's circumstances. To formulate this opinion the HP should use their knowledge and experience, and the consensus of medical opinion, taking into account the specific details relating to the case under consideration.

Advice on prognosis issues

2.9.2. Entitlement to PIP is dependent on the functional effects of a health condition or impairment having been determined as likely to have been present at the required level for at least three months and being expected to last for at least a further nine months. These periods are known respectively as the Qualifying Period and Prospective Test. Case Managers will decide whether these conditions are met but need advice from the HP on prognosis to help inform this.

2.9.3. The Case Manager also needs advice to help inform decisions on when claims should be reviewed, taking into account issues such as the likely progression of the condition and whether it's likely to improve, stay the same or worsen. For example, if the claimant has corrective surgery planned for the near future which would be expected to significantly impact their level of ability, a review at a point following the surgery might be appropriate. Other conditions are likely to deteriorate over time, so a review may be appropriate to see whether the claimant is now entitled to a higher rate of PIP. Other conditions might be unlikely to see significant changes in impact, which might suggest a longer period between reviews.

2.9.4. HPs will specifically be asked to advise on:

- Whether the functional restriction(s) affecting the daily living and mobility activities are likely to have been present for three months (the Qualifying Period).
- Whether the functional restriction(s) affecting the daily living and mobility activities are still likely to be present for at least a further nine months (the Prospective Test).
- When it would be appropriate to review the case, based on the claimant's prognosis.

- Whether the functional restriction(s) affecting the daily living and mobility activities are likely to be present at the recommended point of review.

Advising on prognosis

- 2.9.5. Advising on prognosis is not an exact science. However, the HP is expected to offer advice in keeping with the balance of probability, using their knowledge of health conditions or impairments; their effects and likely course; the results of treatment and adaptation; and the evidence provided in the case.
- 2.9.6. Advice must be current, logical, take into account recent advances in medical care and in keeping with the consensus of medical opinion.
- 2.9.7. The advice should consider if improvement in the condition or its functional effects can be expected as a result of factors such as, but not limited to:
- Further treatment.
 - Time.
 - Natural progress of the underlying condition.
 - Adjustments or adaptation.
- 2.9.8. The advice should consider if deterioration in the condition or its functional effects can be expected as a result of factors such as, but not limited to:
- Time.
 - The natural progress of the underlying medical condition.
- 2.9.9. The advice should take into consideration that even though in some conditions there may be no expectation of improvement of the underlying condition, it may be possible for the person to adapt given sufficient time or with appropriate treatment and/or support, thereby reducing the effects on function. HPs should consider whether there is evidence that such an adaptation or adjustment has taken place.
- 2.9.10. If there is more than one relevant functional condition, the prognosis should take account of the effects of all conditions and the added disability resulting from their interactions that may occur, and thus based on the overall functional prognosis.
- 2.9.11. Each case should be considered on its own merits. The same health condition may have different prognoses.

- 2.9.12. Age is not a medical cause of incapacity but it can be an indicator of disease progression. The functional effects of a health condition or impairment may be worse in an older person. For example, it might be reasonably expected that a 25-year-old man who is otherwise healthy but has lost his lower leg in an accident might adapt well to the loss. However, a sixty year old with multiple other pathologies who loses the lower leg because of complications due to diabetes is more likely to struggle.
- 2.9.13. Prognosis advice must be fully explained and comprehensively justified. Where the HP's opinion differs from other opinions on file – for example in further medical evidence or a previous HP's advice – then a full explanation of the reasons for the difference of opinion should be given.

Completing the prognosis advice on the assessment report

- 2.9.14. It is important that the HP bear in mind how the Case Manager may use advice on prognosis to help inform on decision for entitlement.
- 2.9.15. After the Case Manager has decided on their chosen descriptors and determined entitlement, they must select the most appropriate award type and duration. The advice given by the HP on prognosis will help the Case Manager decide on the type of award.

Qualifying Period and Prospective Test

- 2.9.16. HPs will be asked to advise on whether the functional restrictions affecting both the daily living and mobility activities are likely to have been present for 3 months and to continue to be present for 9 months. This advice will be used by the Case Manager to inform decisions on whether the Qualifying Period and Prospective Test have been met.
- 2.9.17. If the Case Manager determines that either the Qualifying Period or Prospective Test has not been met, the claim may be disallowed.
- 2.9.18. If the HP considers the claimant has no health condition or impairment affecting function, and therefore that they cannot advise on prognosis, they should select the 'Not applicable' box.

Review dates

- 2.9.19. The HP will be asked to provide advice on when it would be medically appropriate to review the claim. The Case Manager will use this advice to inform decisions on the duration of benefit awards and on when in a claim it would be sensible to review the claimant's circumstances.

- 2.9.20. Where an HP considers that there is no health condition or impairment present or that these result in no or a very low functional limitation, they should still advise on a medically appropriate review point (even if the claimant may not subsequently be awarded benefit). These are likely to be after a relatively short period, such as six months.
- 2.9.21. Where an HP considers that a claimant has a stable health condition or impairment and that it is highly unlikely to improve or deteriorate, they can advise that they consider there to be no medical justification for a review. In such cases the Case Manager may seek to give an ongoing award of benefit (although this may still have some infrequent reviews built into it).
- 2.9.22. Where an individual's needs are likely to continue but may increase, the HP should provide advice on a medically appropriate review point, rather than that no review is needed, to ensure the case is reviewed and increased support provided where appropriate.

Functional restriction affecting daily living and mobility

- 2.9.23. The HP is asked to confirm whether the functional restriction is likely to be present at the recommended point of review.
- 2.9.24. Selecting the 'Yes' box will indicate that the claimant's functional restriction is likely to still be present at the recommended point of review, regardless of whether it is likely to improve, remain the same or deteriorate. It indicates to the Case Manager that the case will need to be reviewed to determine the correct level of any ongoing entitlement. In these cases, the Case Manager is likely to arrange for a review before the end of the claim.
- 2.9.25. It is expected that the 'Yes' box will be ticked in most cases.
- 2.9.26. The HP should select the 'No' box if they consider it likely that the claimant's health condition is likely to improve – or that they will adapt – to the point that there will be no or a very low level of functional restriction – for example, in the case of a broken limb where a full recovery is likely in a relatively short period of time. In these cases, the Case Manager is likely to make a short-term fixed award of benefit. At the end of the award, the claim will end and the claimant must re-claim if their needs continue.
- 2.9.27. The 'Not applicable' box should be selected where the HP considers that there is no health condition or impairment affecting function present at the point of the assessment (and therefore they are not able to advise on prognosis).

2.9.28. Below are some examples of prognosis advice.

Example 1 - Qualifying period not met

2.9.29. 60 year old man who had a severe left sided stroke 2 months ago – Has made some improvement with physiotherapy but still has significant difficulties with daily living and mobility activities.

| | |
|---|--------------------|
| The functional restriction affecting the daily living activities identified in this report is likely to have been present for : | Less than 3 months |
| The functional restriction affecting the daily living activities identified in this report is likely to remain for : | At least 9 months |
| The functional restriction affecting the mobility activities identified in this report is likely to have been present for : | Less than 3 months |
| The functional restriction affecting the mobility activities identified in this report is likely to remain for : | At least 9 months |
| Based on the claimant’s likely future circumstances, it would be appropriate to review the claim in: | 18 months |
| It is likely that the functional restriction identified in this report will be present at the recommended point of review | Yes |

Explanation: Most of a person’s recovery will occur within the first 6 months following a stroke, with the majority of this occurring in the first 12 weeks. Improvement may continue for up to one year especially in younger people. After one year from the stroke further recovery is likely to be limited.

Example 2 - Prospective test not met/no significant functional restriction

2.9.30. 40 year old man who fractured his left tibia 4 months ago – treated with internal fixation; walks well with crutches and has no significant problems with daily living activities.

| | |
|---|----------------|
| The functional restriction affecting the daily living activities identified in this report is likely to have been present for : | Not applicable |
| The functional restriction affecting the daily living activities identified in this report is likely to remain for : | Not applicable |
| The functional restriction affecting the mobility activities identified in this report is likely to have been present for : | Not applicable |
| The functional restriction affecting the mobility activities identified in this report is likely to remain for : | Not applicable |
| Based on the claimant’s likely future circumstances, it would be appropriate to review the claim in: | 3 months |
| It is likely that the functional restriction identified in this report will be present at the recommended point of review | Not applicable |

Explanation: Although the claimant has no identified functional restrictions related to the PIP criteria, the HP must still offer an appropriate review date. As the vast majority of people with this condition should be weight bearing after 6 months from the date of the injury, the HP recommends a 3 month review date.

Example 3 - Prospective test not met/significant functional restriction

2.9.31. 50-year-old man with severe osteoarthritis of left hip for 2 years – due for hip surgery next month; has no significant problems with daily living activities but currently with significant mobility difficulties.

| | |
|---|--------------------|
| The functional restriction affecting the daily living activities identified in this report is likely to have been present for : | Not applicable |
| The functional restriction affecting the daily living activities identified in this report is likely to remain for : | Not applicable |
| The functional restriction affecting the mobility activities identified in this report is likely to have been present for : | At least 3 months |
| The functional restriction affecting the mobility activities identified in this report is likely to remain for : | Less than 9 months |
| Based on the claimant’s likely future circumstances, it would be appropriate to review the claim in: | 6 months |
| It is likely that the functional restriction identified in this report will be present at the recommended point of review | No |

Explanation: Even though the prospective test is likely to not be satisfied, the HP must still offer an appropriate review date. In this case, following surgery, in the absence of complications, a full recovery can be expected by 6 months.

Example 4 – Chronic long-term disabling condition

2.9.32. 35-year-old woman with a severe learning disability – faces significant barriers to completing daily living and mobility activities.

| | |
|---|-------------------|
| The functional restriction affecting the daily living activities identified in this report is likely to have been present for : | At least 3 months |
| The functional restriction affecting the daily living activities identified in this report is likely to remain for : | At least 9 months |
| The functional restriction affecting the mobility activities identified in this report is likely to have been present for : | At least 3 months |
| The functional restriction affecting the mobility activities identified in this report is likely to remain for : | At least 9 months |
| I consider there to be no requirement for future reviews of this claim as significant change is unlikely | Yes |

| | |
|---|-----|
| It is likely that the functional restriction identified in this report will be present at the recommended point of review | Yes |
|---|-----|

Explanation: There is unlikely to be any change in the functional ability in this case in the long term and therefore the advice is that there is no medical requirement for future reviews.

2.10. Identifying claimants with additional support needs

- 2.10.1. It is recognised in PIP that claimants who have a mental, intellectual or cognitive impairment may not comply fully with the claims process due to a lack of mental capacity or insight – for example, not understanding or caring about the consequences of not returning a claim form. In PIP, these claimants are stated as having “Additional support needs”. Elements of the PIP claims process have been adapted to provide further support for this group.
- 2.10.2. In relation to the assessment, claimants identified as having additional support needs and who do not return the claimant questionnaire (*“How your disability affects you”*) will not automatically be disallowed the benefit but will be referred to providers and should usually be assessed on the basis of a face-to-face consultation.
- 2.10.3. Many claimants with mental, intellectual or cognitive impairments will have no problems returning the questionnaire. Others will have support from a family member, carer, Community Psychiatric Nurse or other person who will usually ensure that the questionnaire is returned. However, this will not always be the case and this process ensures that such claimants are not unfairly penalised because of the impact of their impairment.
- 2.10.4. During the gathering of initial claim information, questions will be asked by DWP in order to identify claimants who potentially have additional support needs. This will be flagged on their case file on the PIP Computer System. Claimants with additional support needs flagged should be invited by providers to attend a face-to-face consultation even if they have not provided a claimant questionnaire.
- 2.10.5. During all face-to-face consultations HPs should consider whether claimants have a mental, intellectual or cognitive impairment that would create additional support needs in relation to future activity. They should do so even where the claimants have not been previously flagged as having additional support needs. This is because the HP should be able to make a more sensitive and specific assessment of the presence or absence of additional support needs as a result of a mental, intellectual or cognitive impairment, considering the claimant’s mental capacity and insight. The HP should use their knowledge, training and experience, along with any evidence received or findings reached during a consultation – such as whether they needed support from another person at the consultation – to inform their advice.

2.10.6. We would expect the HP to identify if a claimant has additional support needs even if the claimant themselves have not identified such a need.

2.10.7. Examples of health conditions that may affect mental capacity and potentially lead to additional support needs include (but are not limited to):

| Health conditions (note: these conditions may occur in addition to or be exacerbated by physical health conditions) | Examples |
|--|--|
| Mental health condition | Depression Anxiety Post Traumatic Stress Disorder (PTSD) Obsessive Compulsive Disorder (OCD) Psychosis Schizophrenia Personality disorders |
| Behavioural condition | Attention Deficit Hyperactivity Disorder (ADHD) Conduct disorder |
| Learning difficulty | Down syndrome Fragile X syndrome |
| Developmental disorder | Autistic Spectrum disorder Developmental delay Speech or language disorders |
| Dementia or cognitive disorder | Alzheimer's Dementia with Lewy bodies Vascular dementia Dementia associated with other conditions such as Parkinson's disease Brain injury after an accident |

2.10.8. The HP's opinion on additional support needs should be indicated in the advice given to DWP.

2.11.

Requests for Supplementary Advice

- 2.11.1. Case Managers may make requests for supplementary advice at any stage in the decision-making process.
- 2.11.2. HPs might be asked for advice on matters related to areas of the assessment process covered elsewhere in this section – in particular to clarify or explain their advice further or any inconsistencies between this advice and evidence from the claimant or another professional.
- 2.11.3. They also might be asked for ad-hoc advice, covering issues such as, but not limited to:
 - Interpreting and explaining medical terminology the claimant has provided in claim packs or that health professionals have included in medical reports. This could include advising on the nature of diagnoses, the use and significance of medication, the interpretation of clinical examination findings, the significance of special investigations and the nature of surgical or other treatments.
 - Give non-prescriptive advice of a general nature on the likely functional restrictions arising from a specific health condition or impairment.
 - Advice on whether a claim is being made for “substantially the same condition” as a previous claim (see 2.12).
 - To inform a fraud investigation (such requests are likely to be rare).
- 2.11.4. HPs should answer questions posed by the Case Manager but must avoid giving any prescriptive advice that refers to possible benefit entitlement, as final decisions rest with the Case Manager. Advice should be clear, succinct, justified and in accordance with the consensus of medical opinion.
- 2.11.5. Where consideration of Supplementary Advice requests results in the HP changing their previous advice to the DWP, this should be clearly flagged.
- 2.11.6. Requests for Supplementary Advice may be made to providers by telephone or through the PIP Computer System, depending upon the nature of the request. Telephone requests can be resolved by a discussion. Requests made through the PIP Computer System should be responded through the return assessment function and

using the clerical forms PA5 or PA6, provided alongside this guide (or via the PIP Assessment Tool when it is available).

- 2.11.7. HPs should use form PA5 to provide supplementary advice that does not affect the descriptor choices or advices on prognosis in the original report. For example, it maybe used to respond to a request for clarification about medication or treatment that affects the claimant's health condition or impairment. The PA5 should also be used where the additional information does not change the original advice.
- 2.11.8. If there are changes to the descriptor choice, the HP should complete form PA6 to highlight the evidence used to support the any changes and provide full justification for their choice. The PA6 may also be used for changes to advice that does not relate to descriptor choice, e.g. prognosis.

2.12. Advice on substantially the same condition

- 2.12.1. One area that HPs may be asked to advise on is whether a claim for PIP is being made for “substantially the same condition” as an earlier claim.
- 2.12.2. Where the functional effects of a claimant’s health condition or impairment reduce – for example, as a result of remission – their entitlement to PIP may stop. Re-claims to PIP by individuals who have developed a new condition or conditions which are unconnected with the condition or conditions that gave rise to the previous entitlement will be treated as an entirely new claim and have to fulfil the Qualifying Period of three months.
- 2.12.3. Some conditions, however, can subsequently deteriorate leading to a further entitlement to PIP – for example, certain types of multiple sclerosis have periods of remission and deterioration, while a person with cancer may respond well to treatment and then relapse.
- 2.12.4. As such, the legislation allows for a linked claim where the claimant is claiming for either:
 - Substantially the same condition or conditions for which the previous award was made.
 - A new condition (i.e. a sequela) which developed as a result of a condition for which the previous award was made.

In such cases, if the claimant re-claims PIP as a result of a deterioration in their condition, they do not need to satisfy the three-month qualifying period for any component or components to which they previously had been entitled – provided they re-claim within two years if of working age (16 to 64 years) or one year if they are aged 65 or over. All claimants need to satisfy the prospective test regardless of previous entitlement.

- 2.12.5. In most cases it should be possible for Case Managers to identify those cases where a claim has been made for substantially the same physical or mental condition or range of conditions. However, in cases of doubt HPs may be asked for advice, based on their knowledge of the disabling effects of physical and mental conditions and considering the evidence of the case.
- 2.12.6. Considerations that the HP should make include, but are not limited to:
 - Whether the claimant has a condition which is likely to have fluctuations in the functional effects over time.

- Whether the claimant has a condition which is likely to have sequelae which cause deterioration or fluctuation of function.
- Whether the condition is the same condition but with a different diagnostic label - e.g. mitral valve disease / mitral stenosis.
- Whether the original diagnosis has been amended but the underlying impairment and functional effects remains the same – e.g. bronchial asthma in the past but now suffering from COPD which is substantially the same condition.
- Whether the same condition is present and responsible for the functional effects but worsening has occurred due to a second condition. For example, asthma control is poor because of failure to take preventative medication regularly due to the development of depression, which resulted in mobility problems.

2.12.7. Case studies of such considerations are as follows:

- Mr X has diabetes and depression with agoraphobia. His diabetes was not well controlled and he had become depressed. He was awarded the Daily Living component and Mobility component at the standard rates. Once good diabetic control was maintained his mental health condition improved so he was not entitled to either component. 9 months later both lower limbs were amputated following gangrene secondary to peripheral neuropathy and he applied for PIP again. As it is probable that the peripheral neuropathy was due to diabetes he did not have to fulfil the 3 month qualifying period for either component as it would be considered he was suffering from substantially the same condition.
- Mr Y has diabetes and depression. His diabetes was not well controlled and he had become depressed. He was awarded the Daily Living component at the standard rate. Once good diabetic control was maintained his mental health condition improved so he was not entitled to either component. 9 months later both lower limbs were amputated following gangrene secondary to peripheral neuropathy and he applied for PIP again. As it is probable that the peripheral neuropathy was due to diabetes he did not have to fulfil the 3 month qualifying period for the Daily Living component as it would be considered he was suffering from substantially the same condition. As he had not been entitled to the Mobility component in the past he had to fulfil the 3 month qualifying period before becoming entitled to the Mobility component.
- Mr Z has diabetes and depression with agoraphobia. His diabetes was not well controlled and he had become depressed.

He was awarded the Daily Living component at the standard rate and the Mobility component at the standard rate. Once diabetic control was maintained his mental health condition improved so he was not entitled to either component. 9 months later both lower limbs were amputated following a road traffic accident and he applied for PIP again. As the disabling condition was not substantially the same he had to fulfil the 3 month qualifying period for both components.

- Miss B was diagnosed with Schizophrenia and fulfilled the PIP criteria for standard rate Mobility component. Her condition improved with treatment but 6 months later she re-claimed benefit because of depression and paranoia. Low mood and paranoid feelings were a significant feature of her schizophrenic episode. As the disabling condition was substantially the same she did not have to fulfil the 3 month qualifying period.

2.12.8. In Miss B's case the link can be made as it is merely a different way of expressing her mental health condition. However, care should be taken to ensure that the advice given is appropriate for the individual case as opposed to general advice. For example:

- Miss T was diagnosed with Schizophrenia and fulfilled the PIP criteria for standard rate Mobility component. Low mood and paranoid feelings were a significant feature of her schizophrenic episode. Her condition improved with treatment but 6 months later she re-claimed benefit because her mobility was restricted due to mitral valve disease. As the disabling condition was not substantially the same she did have to fulfil the 3 month qualifying period.

2.12.9. Miss T's mental health condition is the same as Miss B's, but the root cause of her mobility problem was not the same.

2.13. Consent and Confidentiality

Consent

- 2.13.1. Consent is an integral part of claims for benefit but it cannot be assumed that in an individual case consent has been given or that consent previously given remains valid. Thus in every case, before each instance that information is obtained or released, checks should be made to ensure valid consent is held.
- 2.13.2. Consent may be written, verbal and in certain circumstances given by a third party.
- 2.13.3. For consent to be lawful under the Data Protection Act 1998 (DPA) it must be 'fully informed and freely given'.
- 2.13.4. For consent to be **fully informed and freely given** the claimant must know exactly why the information is needed, what is going to be done with it, and with whom it might be shared. The claimant must not be coerced into giving consent when he/she is unwilling to give it – e.g. it is inappropriate to say things such as “unless you agree to a report from your GP being obtained we cannot advise on your claim”. HPs may, however, flag that a DWP Case Manager will make a decision on benefit entitlement based on the evidence available in the case and it is important that they have access to the best evidence.
- 2.13.5. In the case of information defined as 'sensitive' in Schedule 3 of the DPA, consent must be explicit. The categories of sensitive information under DPA are:
- Health or physical condition.
 - Race/ethnic origin.
 - Sexual orientation.
 - Religious beliefs.
 - Trade union membership.
 - Any offence committed by them or any court proceedings against them.
- 2.13.6. For consent to be **explicit**, in the case of sensitive information, the claimant must be fully aware of the nature and content of the information being processed.
- 2.13.7. Consent to contact third parties will be sought by DWP during the initial claim information gather – regardless of whether the claimant

claimed over the telephone or on a written claim form. The fact that consent has been given (or not) will be made clear in the referral from DWP. Providers should check that this has been provided.

- 2.13.8. Should there be no claimant consent provided at the initial claim stage, it can be sought verbally by providers over the telephone.

Timescales for consent applying

- 2.13.9. All staff (HPs and administrative staff) should be made aware that it is important to be confident that the consent is still valid. Depending on how it is worded, consent - and in particular implicit consent - may only cover a particular stage in the processing of a claim, and thus fresh consent may need to be sought. If there is any doubt as to whether the consent is still valid, fresh consent should be sought.
- 2.13.10. Consent can be withdrawn by claimants at any time in the claim.
- 2.13.11. In order to ensure that consent remains valid, the Department advises that in any case where consent is over 2 years old, action should be taken to confirm that it still reflects the claimant's wishes. The Department is exploring opportunities to gather refreshed consent when PIP claims are subsequently reviewed.
- 2.13.12. It is good practice to check that there is valid consent every time further evidence is sought.

Consent to a physical examination

- 2.13.13. Although it could be taken that by attending a face-to-face consultation, the claimant has given consent to a physical examination; it should not be assumed that this is the case. At every stage of the proceedings the claimant should be advised as to what is going to happen and agree to it happening.

Appointees

- 2.13.14. Claimants who are unable to manage their own financial affairs can have a person appointed to do this for them. Appointee action is only taken where the claimant is incapable of managing their affairs. This is usually because the claimant is mentally incapable but, exceptionally, may also be appropriate when the claimant is physically disabled – e.g. if they have suffered a severe stroke. An officer acting on behalf of the Secretary of State authorises an appointee to act for the claimant in specified circumstances.

- 2.13.15. An appointee becomes fully responsible for acting on the claimant's behalf in all the claimant's dealings with the DWP. This includes:
- Claiming benefits, including completing and signing any claim, and the consent to get further evidence.
 - Collecting/ receiving benefit payments.
 - Reporting changes in the claimant's circumstances.
 - Reporting any changes in their own circumstances that the DWP may require – e.g. a change of name or address.
- 2.13.16. The fact that claimants have an appointee will be flagged by DWP in the initial referral to providers.
- 2.13.17. Any paperwork supplied by a corporate appointee using a signature stamp rather than a manuscript signature is not acceptable. The paperwork would need to be returned for a manuscript signature. If a person is acting for the corporate appointee then they should ideally sign "Joe Bloggs acting as the agent/representative of the corporate appointee" or similar. Where there are doubts, providers can check matters relating to appointees with DWP.

Power of Attorney/Deputy

- 2.13.18. A Power of Attorney/deputy is a formal instrument by which one person (a donor/the Court of Protection) empowers another (a donee, who is the attorney/deputy) to act on his behalf either generally or in specific circumstances.
- 2.13.19. The responsibilities of an attorney/deputy may include, but are not limited to:
- Making a claim to benefit, including completing and signing any claim forms, and providing the consent to seek further medical evidence.
 - Collecting/receiving benefit payments.
 - Reporting changes in the circumstances of the person they represent. (**Note:** Power of Attorney (but not a deputyship) can occur when the claimant retains full capacity and so is able to manage their affairs. In these cases there is no duty on their attorney to disclose a change in the claimant's circumstances. This is the case even where the attorney is receiving the benefit. The onus to disclose remains with the claimant. This only changes where the claimant loses mental capacity and cannot be expected to report any changes and responsibility will fall to the attorney).

Proof of consent

- 2.13.20. Proof of consent given by claimants need not be routinely sent by providers when requesting further evidence. The NHS accepts that consent is an integral part of claims for benefit, and proof of consent is not necessary before information is released by hospitals, trusts and clinics funded by the NHS or local authorities. From time-to-time hospitals are reminded of their obligations to provide information in connection with claims for benefit and that proof of consent is not necessary.
- 2.13.21. The position that proof of consent are not required is supported by the General Medical Council, which advises that: '*...you may accept an assurance from an officer of a government department or agency or a registered health professional acting on their behalf that the patient or a person properly authorised to act on their behalf has consented*'.
- 2.13.22. If GPs, consultants and doctors request proof of consent they should be reminded of the General Medical Council's advice.
- 2.13.23. Occasionally an HP may be asked to provide evidence that consent is held before the information is forthcoming. Only in exceptional circumstances where the GP or hospital has given a valid reason as to why they do not follow the GMC and/or the NHS guidance should proof of consent be sent when requesting further evidence.
- 2.13.24. In such cases the provider should contact the Department to obtain a copy of the relevant transcript from the initial claim stage.
- 2.13.25. In non-Terminal Illness (TI) cases it may be appropriate to obtain further evidence from an alternative source should proof of consent be an issue.
- 2.13.26. In TI cases, a telephone call to a different health professional should be considered. If there is no suitable alternative the HP should provide proof of consent. Once this has been provided, the HP should call the healthcare professional involved in the claimant's care again. If the healthcare professional involved in the claimant's care remains unwilling to provide the information in TI cases, an appropriate alternative person - e.g. their consultant - should be telephoned.

Consent in third party claims

- 2.13.27. The PIP Terminal Illness legislation creates special provision for a third party to make a claim on behalf of a disabled person without their knowledge.

- 2.13.28. Further information relating to the TI claim may be required and, due to the tight timescales involved in TI claims, contact with the claimant's own health professionals may be required. When making contact with that professional by telephone the HP must make it clear if they do not hold consent from the disabled person to permit disclosure of information about their condition and explain the provision for third party claims under the Terminal Illness rules.
- 2.13.29. The HP should also ensure that the claimant's health professional understands that a written record will be made of any information given during the telephone conversation and that this will be available to the patient at a later date unless there is "Harmful Information".
- 2.13.30. It will be for the individual professional to determine whether they wish to release information about the claimant to the HP. The HP should not apply pressure to the professional to supply this information.

Confidentiality

- 2.13.31. Personal information held by DWP is regarded as confidential. Confidentiality is breached when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. The duty of confidentiality continues after the death of an individual to whom that duty is owed.
- 2.13.32. DWP takes confidentiality very seriously and all confidential information should be held securely and in accordance with legislation. With regard to requests for personal information, providers should:
- Only ask for what they need, and should not collect too much or irrelevant information.
 - Protect it, storing both clerical and electronic information securely.
 - Ensure that only staff who need to have access to the personal data in order to undertake their work should have access.
 - Do not keep it longer than necessary.
 - Do not make personal information available for commercial use without the claimant's permission.

Telephone conversations

- 2.13.33. It is important that in all telephone contact with claimants or their representatives, the correct person is being spoken to. For all incoming calls the caller's identity must be verified. If there is any doubt, the telephone call should be terminated and, if necessary, the claimant or their representative be contacted using the telephone contact number on file.
- 2.13.34. Personal information should never be left on answering machines or voice-mail facilities.

Confidential information

- 2.13.35. Any written information that is marked by a claimant or a third party as "confidential" or "in confidence" cannot be used in a claim for PIP as it cannot be further disclosed to a Case Manager.
- 2.13.36. If the claimant states that they want to tell the HP something "in confidence" and that they do not want recorded in the HP's advice, the HP should explain to them that they are unable to take such information into account, as the Case Manager would have no access to it.

Releasing information to the claimant

- 2.13.37. Other than information about their appointments with the HP, it is not the role of the provider to release information to the claimant; and/or their representative, Appointee or person who has Power of Attorney/Deputy. Anyone making a request must be advised that requests for information should be made to the DWP.

Solicitors & representatives and Third Party Requests

- 2.13.38. Solicitors and/or claimant representatives such as support agencies may approach a provider with requests for copies of all information held – e.g. in personal injury compensation cases. Providers have no role to play in releasing information to a third party, and the person making the requests must be advised to contact the DWP.

Release of information to the claimant's MP

- 2.13.39. It is usually accepted that if a claimant has authorised their MP to write on their behalf they have consented to the MP seeing information relating to their claim. This authorisation does not extend to the claimant's spouse or relatives so in these circumstances consent from the claimant to communicate with the MP should be sought by the MP themselves.

3. The Assessment Criteria

3.0.1. This section outlines the assessment criteria for Personal Independence Payment. It explains how the assessment is structured, including how the activities and descriptors fit together to determine entitlement to each of the two components. It also includes the assessment criteria themselves and guidance for HPs on how to apply them.

3.1. The assessment approach

3.1.1. Personal Independence Payment will provide a cash contribution towards the additional costs faced by disabled people as a result of needs arising from a health condition or impairment. The Department considered whether it would be possible for the Personal Independence Payment assessment to assess the actual extra costs incurred by an individual. However, it was felt that doing so would create a very complicated and lengthy assessment, which would be both subjective and inconsistent, going against the aims of the new benefit. The Department instead decided that the most effective means of determining entitlement would be to consider a proxy for the impact and additional costs arising from disability.

3.1.2. The PIP assessment will therefore focus on assessing an individual's ability to participate, defining 'participation' as 'involvement in life situations'. The criteria are focused on outcomes and the impact of a health condition or impairment on an individual's ability to carry out a range of activities which are fundamental to everyday life. It would not be practical for the assessment to take account of the impact of a health condition or impairment on all everyday activities, nor to seek to include all possible areas where extra costs may be generated. This would lead to over-complexity and be challenging for consistency, administration and the time needed for assessments. Instead the assessment considers a series of key activities that cumulatively act as a proxy and so seeks to identify those individuals who are likely to have the highest level of need. There are ten daily living activities and two mobility activities.

3.1.3. Underpinning each activity are a number of descriptors, each describing a varying level of ability to carry out the activity – for example, ranging from being able to carry out an activity unaided to not being able to carry it out at all. Some activities have more descriptors than others.

- 3.1.4. When assessing an individual, the descriptor most appropriate to the individual within each activity will be chosen.
- 3.1.5. Each descriptor in the assessment criteria has a numeric point score attached to it, reflecting both the level of ability it represents and the overall importance of the activity. The total scores for all of the activities related to each component are added together to determine entitlement for that component. The entitlement threshold for each component is 8 points for the standard rate and 12 points for the enhanced rate.

3.2. Applying the criteria

- 3.2.1. The assessment will consider a claimant's ability to undertake the activities detailed below. Inability to undertake activities must be due to the effects of a health condition or impairment and not simply a matter of preference by the claimant.
- 3.2.2. A health condition or impairment may be physical, sensory, mental, intellectual or cognitive, or any combination of these. The impact of all impairment types can be taken into account across the activities, where they affect a claimant's ability to complete the activity and achieve the stated outcome. For example, a claimant with a severe depressive illness may physically be able to prepare food and feed himself, but may lack the motivation to do so, to the extent of needing prompting from another person to carry out the task. However, some activities focus on specific elements of function. For example, *Moving around* relates to the physical aspects of walking, whilst *Engaging with other people face to face* relates to the mental, cognitive or intellectual aspects of interacting with other people.

Descriptor choice

- 3.2.3. When assessing a claimant, the HP should consider all the evidence of the case and the likely ability of the claimant over a year-long period (see 3.2.9) before selecting the most appropriate descriptor to the claimant relating to each of the assessment activities, taking into account their level of ability, whether they need to use aids or appliances and whether they need help from another person or an assistance dog.
- 3.2.4. In choosing descriptors, the HP should use their knowledge of the health condition or impairment as a measure of the level of disability that would be expected from the claimant's condition. For example, it is unlikely that mechanical low back pain is unremitting day after day, because the natural history is of pain that varies from day to day; it would be appropriate to make this observation in the report. However, it is insufficient for the HP to argue just from the general principle when justifying descriptor choices; the evidence has to relate to the specific claimant.
- 3.2.5. The fact that an individual can complete an activity is not sufficient evidence of ability. HPs may find it helpful to consider:
- Approach – what the individual needs to do; how they carry out the task; what assistance or aids are required; how long it takes; and whether it is safe.

- Outcome – whether the activity can be successfully completed and the standard that is achieved.
 - Impact – what the effects of reaching the outcome has on the individual and, where relevant, others; and whether the individual can repeat the activity within a reasonable period of time and to the same standard (this clearly includes consideration of symptoms such as pain, discomfort, breathlessness, fatigue and anxiety).
 - Variability – how an individual’s approach and outcomes change over time and the impact this has on them.
- 3.2.6. People are influenced by their perceptions and beliefs about their condition; and this can affect the level of disability they experience. Some individuals are able to cope to a large extent and may perceive a much lower level of disability, while others may be far more disabled than might be expected from their condition. The key to choosing descriptors is to evaluate whether the history and the claimant's behaviour are consistent, not just with the nature of the disabling condition, but with the claimant's lifestyle.
- 3.2.7. HPs should not consider the point scores associated with descriptors or whether these will confer entitlement to the benefit if chosen by Case Managers. HPs should only consider whether the descriptor is appropriate to the claimant’s circumstances.

Reliability

- 3.2.8. For a descriptor to be able to apply to a claimant, the claimant must be able to reliably complete the activity as described in the descriptor. More information on this can be found in section 3.3.

Time periods, fluctuations and descriptor choices

- 3.2.9. The impact of most health conditions and impairments can fluctuate over time. Taking a view of ability over a longer period of time helps to iron out fluctuations and presents a more coherent picture of disabling effects. Therefore the descriptor choice should be based on consideration of a **12 month** period. This should correlate with the Qualifying Period and Prospective Test for the benefit – so the HP should broadly consider the claimant’s likely ability in the **three months before** the assessment and in the **nine months after**.
- 3.2.10. A scoring descriptor can apply to claimants in an activity where their impairment(s) affects their ability to complete an activity, at some stage of the day, on more than 50 per cent of days in the 12 month period. The following rules apply:

- If one descriptor in an activity is likely to apply on more than 50 per cent of the days in the 12 month period – i.e. the activity can be completed in the way described on more than 50 per cent of days – then that descriptor should be chosen.
- If two or more descriptors in an activity is likely to apply on more than 50 per cent of the days in the period, then the descriptor chosen should be the one which is the highest scoring.
- Where one single descriptor in an activity is likely to not be satisfied on more than 50 per cent of days, but a number of different scoring descriptors in that activity cumulatively are likely to be satisfied on more than 50 per cent of days, the descriptor likely to be satisfied for the highest proportion of the time should be selected. For example, if descriptor 'B' is likely to be satisfied on 40 per cent of days and descriptor 'C' on 30 per cent of days, descriptor 'B' should be chosen. Where two or more descriptors are satisfied for the same proportion of days, the descriptor which is the highest scoring should be chosen.

3.2.11. If someone is awaiting treatment or further intervention it can be difficult to accurately predict its level of success or whether it will even occur. Descriptor choices should therefore be based on the likely continuing impact of the health condition or impairment as if any treatment or further intervention has not occurred.

3.2.12. The timing of the activity should be considered, and whether the claimant can carry out the activity when they need to do it. For example if taking medication in the morning (such as painkillers) allows the individual to carry out activities reliably when they need to throughout the day, although they would be unable to carry out the activity for part of the day (i.e. before they take the painkillers), the individual can still complete the activity reliably when required and therefore should receive the appropriate descriptor.

Risk and Safety

3.2.13. When considering whether an activity can be undertaken safely it is important to consider the risk of a serious adverse event occurring. However, the risk that a serious adverse event *may* occur due to impairments is insufficient – the adverse event has to be likely to occur.

Support from other people

3.2.14. The assessment takes into account where claimants need the support of another person or persons to carry out an activity –

including where that person has to carry out the activity for them in its entirety. The criteria refer to various types of support:

- **Supervision** is a need for the continuous presence of another person for the purpose of ensuring the claimant's safety to avoid a serious adverse event from occurring. The risk must be likely to occur in the absence of such supervision. To apply, supervision must be required for the full duration of the activity.
- **Prompting** is support provided by another person by reminding or encouraging a claimant to undertake or complete a task or explaining it to them but not physically helping them. To apply, this only needs to be required for part of the activity.
- **Assistance** is support that requires the presence and physical intervention of another person to help the claimant complete the activity - including doing some but not all of the activity in question. To apply, this only needs to be required for part of the activity.

3.2.15. A number of descriptors also refer to another person being required to complete the activity in its entirety. These descriptors would apply where the claimant is unable to undertake any of the activity for themselves, even with help.

3.2.16. Activities 7 and 9 refer to **Communication support** and **Social support**, which are defined in the notes to the activities.

3.2.17. The assessment does not look at the availability of help from another person but rather at the underlying need. As such claimants may be awarded descriptors for needing help even if it is not currently available to them – for example, if they currently manage in a way that is unreliable but could complete it reliably with some help.

Aids and appliances

3.2.18. The assessment takes into account where individuals need aids and appliances to complete activities. In this context:

- **Aids** are devices that help a performance of a function, for example, walking sticks or spectacles.
- **Appliances** are devices that provide or replace a missing function, for example artificial limbs, collecting devices (stomas) and wheelchairs.

3.2.19. The assessment will take into account aids and appliances that individuals normally use and low cost, commonly available ones

which someone with their impairment might reasonably be expected to use, even if they are not normally used.

- 3.2.20. This may include mainstream items used by people without an impairment, where because of their impairment the claimant is completely reliant on them to complete the activity. For example, this would include an electric can-opener where the claimant could not open a can without one, not simply where they prefer to use one.
- 3.2.21. Activity 11 refers specifically to “orientation aids”, which are defined as **specialist** aids designed to assist disabled people in following a route, for example long canes.
- 3.2.22. Claimants who use or could reasonably be expected to use aids to carry out an activity will generally receive a higher scoring descriptor than those who can carry out the activity unaided.
- 3.2.23. When considering whether it is reasonable to expect a claimant to use an aid or appliance that they do not usually use, the HP should consider whether:
- The claimant possesses the aid or appliance.
 - The aid or appliance is widely available.
 - The aid or appliance is available at no or low cost.
 - It is medically reasonable for them to use an aid or appliance.
 - The claimant was given specific medical advice about managing their condition, and it is reasonable for them to continue following that advice.
 - The claimant would be advised to use an aid or appliance if they sought advice from a professional such as a GP or occupational therapist.
 - The claimant is able to use and store the aid or appliance.
 - The claimant is unable to use an aid or appliance due to their physical or mental health condition – for example, they are unable to use a walking stick or manual wheelchair due to a cardiac, respiratory, upper body or mental health condition.

Assistance dogs

- 3.2.24. We recognise that guide, hearing and dual sensory dogs are not ‘aids’ but have attempted to ensure that the descriptors capture the additional barriers and costs of needing such a dog where they are required to enable claimants to follow a route safely. Activity 11 therefore explicitly refers to the use of an ‘assistance dog’.

Assistance dogs are defined as dogs trained to help people with sensory impairments.

'Unaided'

3.2.25. Within the assessment criteria, the ability to perform an activity 'unaided' means without either the use of aids or appliances or help from another person.

3.3. Reliability

- 3.3.1. Central to the application of all the activities within the PIP assessment is a consideration of the manner in which they are undertaken. If an individual cannot reliably complete an activity in the way described in a descriptor then they should be considered unable to complete it at that level and a higher descriptor selected. For example a claimant may be able to complete an activity unaided, but in a manner that is unsafe; they require supervision in order to do so safely and therefore should be awarded the higher descriptor which refers to supervision.
- 3.3.2. Considering reliability involves looking at whether the claimant can complete the activity as described:
- Safely – in a manner unlikely to cause harm to themselves or to another person, either during or after completion of the activity.
 - To an acceptable standard.
 - Repeatedly – able to repeat the activity as often as is reasonably required.
 - In a reasonable time period – no more than twice as long as the maximum period that a non-disabled person would normally take to complete that activity.
- 3.3.3. Judgement and experience will be required to determine whether something is “reasonable” or “acceptable”. More information on these issues is set out below.
- 3.3.4. This applies to every activity within the assessment.

Safely

- 3.3.5. Safely means in a manner unlikely to cause harm to themselves or to another person, either during or after completion of the activity.
- 3.3.6. When considering whether an activity can be undertaken safely it is important to consider the risk of harm occurring. However, the risk that harm *may* occur due to impairments is insufficient – the harm has to be likely to occur.
- 3.3.7. The risk of harm occurring also has to be higher than that for a non-disabled person completing the same activity. For example, most individuals will occasionally burn or scald themselves slightly while cooking; you must consider whether the claimant is at a notably greater risk of burning or scalding themselves as a result of their health condition or impairment.

- 3.3.8. Harm includes damage to an individual's health. For example if carrying out an activity could cause a substantial and sustained worsening of a claimant's condition, meaning it is not safe for them to do it at all, the individual should not be considered able to complete the activity safely at the level described in the descriptor. Given the nature of the activities within the assessment this is likely to be rare.
- 3.3.9. As made clear in legislation, harm is in relation to an individual or another person it therefore does not include damage to property. Damage to property may, however, be relevant to whether an activity can be completed to an acceptable standard or repeatedly.
- 3.3.10. The regularity with which any risk occurs is also important, for example if an individual has forgotten to take their medication at times in the past but ordinarily manages to remember unaided there is unlikely to be a risk to their safety.
- 3.3.11. Even if the impact of the risk is significant, it must still be likely to occur. For example everyone is at risk of drowning whilst bathing if they were to lose consciousness for any reason, but for some individuals that risk will be higher, for instance if they are likely to have a fit. You must consider whether the risk of the adverse event is great enough to require continuous supervision for the duration of the task..
- 3.3.12. The following situations highlight examples for each activity where there may be a potential risk to the safety of the claimant or others. The list is not exhaustive and further consideration would be required as to the level of risk and whether mitigation, such as suitable aids and appliances, would be possible. Any risks presented by the claimant should be considered.

Preparing food

- Fire as a result of not understanding how to use an electrical appliance or gas hob correctly.
- Increased risk of cutting oneself or another person as a result of a health condition or impairment.
- Burning or scalding oneself if, for example, an individual is likely to drop a saucepan or spill the contents.

Taking nutrition

- Choking.

Managing therapy or monitoring a health condition

- Overdosing.
- Taking too little medication, forgetting to take medication or not taking the correct medication at the right time due to a health condition or impairment.
- Failure to carry out therapy which is likely to lead to a significant deterioration of an individual's health condition as a result.

Washing and bathing

- Falling or slipping which causes injury to the claimant.
- Drowning as a result of having a fit whilst bathing.

Managing toilet needs or incontinence

- Slipping or falling when getting on or off the toilet.
- Sickness or infection due to an inability to maintain a hygienic environment.

Dressing and undressing

- There are no obvious risks to safety for this activity.

Communicating verbally

- There are no obvious risks to safety for this activity. It should be noted that the risk of being unable to understand emergency instructions is addressed by the activity itself.

Reading and understanding signs, symbols and words

- There are no obvious risks to safety for this activity. It should be noted that the risk of being unable to read emergency signs is addressed by the activity itself.

Engaging with other people face to face

- Becoming aggressive which presents a serious risk of harm to the claimant and/or another person.

Making budgeting decisions

- There are no obvious risks to safety for this activity.

Planning and following journeys

- Injury as a result of being unaware of obstacles, for example due to visual impairment.
- Lacking a perception of danger which may present a risk of injury to themselves or others, for example as a result of running into the road.
- Getting into an unsafe situation as a result of getting lost due to a health condition or impairment and being unable to resolve being lost.

Moving around

- Falling.

To an acceptable standard

3.3.13. This term is not defined in legislation, which means it should have its ordinary meaning, i.e. that activities should be carried out to a standard that is acceptable.

3.3.14. When considering acceptability there is clearly a range, from what is not perfect but is sufficient (“good enough”) at one end, through what most people would normally expect to achieve, to an extremely high standard at the top end. In order for it to be acceptable, the standard which a claimant achieves must fall within this range. An ‘acceptable standard’ is one which is “good enough”.

3.3.15. The following examples indicate what an acceptable standard is in relation to the activities. This list is not exhaustive.

Preparing food

- The outcome of this activity is a simple cooked meal for one prepared from fresh ingredients which is edible and properly cooked. Note – for this activity “cook” means heat at or above waist height.
- This activity does not consider an individual’s cooking ability, therefore elements such as presentation of the food should not be taken into account.
- Factors such as nutrition and variety should not be considered as this activity is looking at the ability to prepare and cook, as opposed to plan a meal.

Taking nutrition

- The outcome in this case is being nourished, either by cutting food into pieces, conveying it to the mouth, chewing and swallowing; or through the use of therapeutic sources.
- The manner in which this activity is carried out should be considered. For example a claimant may be able to feed themselves sufficient food, but in the process spills food and drink on themselves, the table or others. Clearly most individuals will usually make a few crumbs or occasionally spill food/drinks but regularly spilling food to the extent that an individual has to change their clothes after eating is not acceptable.

Managing therapy or monitoring a health condition

- The outcome in this case is taking the medication or completing the recommended therapy as prescribed/recommended, without which the claimant's health is likely to deteriorate.
- Consideration should be given to whether the individual has taken the medication or completed the recommended therapy to the required standard. For example an individual may be able to follow the prescription and use an inhaler at the correct times, but does not use it correctly so the medication is not as effective as it should be, while this may not present a risk to their safety, they are not able to carry it out to the required standard and may require assistance, supervision or an aid in order to do so.

Washing and bathing

- The outcome in this activity is that the claimant is able to wash and bathe. Wash means clean oneself, including removing dirt and sweat, and bathe includes getting into or out of an unadapted bath or shower.
- Consideration needs to be given not only to whether the claimant can carry out the activity (i.e. get in and out of the shower and wash themselves), but also whether they achieve an acceptable standard (i.e. they clean at the end). Clearly there is a range of acceptability when it comes to washing and bathing, see 1.1.14.

Managing toilet needs or incontinence

- In this activity the outcome is being able to evacuate the bladder and bowel (including using collecting devices) and clean oneself afterwards.
- Where aids are used to manage incontinence, they must be appropriately and properly changed

- This activity clearly has a high standard when it comes to acceptability.

Dressing and undressing

- The outcome in this activity is that the claimant is able to put on and take off un-adapted clothing [that is suitable for the situation and culturally appropriate].
- Consideration should also be given to whether the clothing is clean and appropriate for the weather conditions. As with all activities, the failure to carry out this activity to an acceptable standard must be due to a health condition or impairment, as opposed to personal choice.

Communicating verbally

- The outcome of this activity is that an individual can understand spoken information and be understood themselves.
- Clarity of the claimant's speech should be considered. In some cases the other participant in the conversation may have to concentrate slightly harder than normal, for example if the claimant has a stammer. That is not unacceptable. It would, however, be unacceptable if the claimant had to resort to gestures, writing information down or needing assistance from a third party to make themselves readily understood.

Reading and understanding signs, symbols and words

- The outcome in this activity is that the individual can both read and understand the written information. Reading does not include Braille.
- While literacy will clearly play a role in determining the individual's ability to understand the information, the activity only considers the individual's ability to read and understand basic and complex information as defined in legislation. Basic written information is signs, symbols and dates. Complex written information is more than one sentence. For example a claimant who can understand their bank statement or utility bill is able to complete the activity to an acceptable standard because they can understand more than one sentence, even if they cannot understand newspapers and magazines.

- In order to be taken into account illiteracy must be as a direct result of a health condition or impairment and not due to a lack of suitable education.

Engaging with other people face to face

- The outcome in this activity is that they can engage with other people face to face in a contextually and socially appropriate manner, understand body language and establish relationships.
- Clearly there is a range of acceptability when it comes to engaging with other people and some individuals will be more outgoing than others. Simple shyness and reticence are not unusual and would not automatically mean a claimant cannot complete the activity to acceptable standard. However an individual who always suffers severe anxiety or panic attacks when engaging with other people, even with support, and is therefore unable to do so clearly cannot complete the activity at that level to an acceptable standard and an alternative descriptor must be selected.
- Other factors that should be considered are whether the claimant is likely to be verbally or physically abusive as a result of their health condition or impairment.

Making budgeting decisions

- The outcome in this activity is that the individual is able to make budgeting decisions. Simple budgeting decisions are decisions involving calculating the cost of goods and calculating change required after a purchase. Complex budgeting decisions are decisions involving calculating household and personal budgets, managing and paying bills and planning future purchases.
- In order to complete this activity, claimants do not need in-depth financial knowledge. Complex budgeting decisions are those that are involved in calculating household and personal budgets, managing and paying bills and planning future purchases. The activity does not include the sort of decisions which require financial knowledge, such as calculating interest rates or comparing mortgages.
- This activity does not specify whether the decisions are necessarily good decisions, however the individual must understand the decision they have made. For example, an individual may understand the importance of budgeting and know they have bills to pay at the end of the month, yet decides they will

splash out on an expensive purchase at the start of the month, despite knowing that means they will not be able to pay their bills. Although that is not a good decision, the individual understands how to budget. However where bad budgeting decisions are made, consideration must be given to whether it is as a result of a health condition or impairment.

- As with all activities, the inability to carry out the activity must be due to the claimant's health condition or impairment. Many individuals may make bad decisions or be slightly indecisive, if this is not as a result of a health condition or impairment it should be discounted.

Planning and following journeys

- The outcome of this activity is that the individual is able to work out how to get somewhere and then follow that route for either a familiar or unfamiliar journey.
- When planning the journey the claimant must be able to work out a sensible route, however, in order to be acceptable it may not need to be the most direct route, for example many individuals will plan a train journey that is slightly longer but involves fewer changes, or a car journey that is not the most direct but avoids difficult or busy roads and junctions.
- When following the journey, consideration needs to be given to whether the claimant is likely to get lost. Clearly many people will get a little lost in unfamiliar locations and that is expected, but most are able to recover and eventually reach their target location. An individual who would get excessively lost, or be unable to recover from getting lost would be unable to complete the activity to an acceptable standard.

Moving around

- The outcome of this activity is being able to stand and then move various distances.
- In order to complete this activity to an acceptable standard the claimant should be able to move the distance in an upright position.

Repeatedly

3.3.16. Repeatedly means as often as the activity being assessed is reasonably required to be completed.

- 3.3.17. How often the claimant needs to complete each activity is not specified. The HP should consider how often they would normally expect each activity to be completed, for example you would normally expect an individual to prepare food three times a day, but to heat food only once a day. In most cases the HP should use this norm as a benchmark when considering whether the claimant can complete the activity repeatedly.
- 3.3.18. However, some individuals may need to complete an activity more frequently as a result of their health condition or impairment. For example an individual with colitis may need to go to the toilet more frequently. In these cases the HP should consider whether it is reasonable for the individual to complete the activity more frequently as a result of their health condition or impairment, and if so what the reasonable number of times is in their individual case. You should then consider whether the claimant is able to complete the activity that number of times.
- 3.3.19. Where the act of completing the activity means the individual is unable to repeat the activity again, within a period when they could reasonably be expected to do so, they are likely to be considered as not completing the activity repeatedly. For example, an individual can prepare their breakfast, but the exertion of doing so leaves them exhausted and they are unable to prepare their lunch as a result, but by the evening they have recovered enough to prepare an evening meal. Because, after preparing breakfast, you would reasonably expect someone to be able to prepare a meal again by lunchtime, in this example the individual cannot be considered able to complete the activity repeatedly.
- 3.3.20. Consideration should also be given to whether an individual is able to repeat a task on subsequent days. For example an individual may be able to fulfil the 'Moving around' criteria one day, but the exertion of doing so means they are unable to do so the following day. When considering repeatability over longer periods of days and weeks, the HP should apply the rules governing fluctuating conditions (set out in regulation 7 of the Social Security (Personal Independence Payment) Regulations 2013) and consider whether which descriptor applies on the majority of days in that period.
- 3.3.21. Symptoms such as pain, fatigue and breathlessness should be considered when determining whether an activity can be carried out repeatedly. While these symptoms may not necessarily stop the claimant carrying out the activity in the first instance, they may be an indication that it cannot be done as often as is required.

3.3.22. The following situations highlight examples where an individual may be considered unable to repeatedly complete a descriptor in the way described due to the impact this would have:

- A person who is able to stand and move 20 metres unaided, but is unable to repeat it again that day cannot do it repeatedly as you would reasonably expect people to move 20 metres more than once a day.
- A person who is able to prepare a meal, but the exhaustion from doing so means they can only do it once a day cannot do it repeatedly as you would reasonable expect people to prepare a meal more than once a day.

3.3.23. This list is not exhaustive.

In a reasonable time period

3.3.24. Reasonable time period means no more than twice as long as the maximum period that a non-disabled person would normally take to complete that activity.

3.3.25. When looking at whether the individual can complete the activity in a reasonable time period, consideration should be given to the maximum period it is normally likely to take an individual without a health condition or impairment to complete the activity. In order to complete the activity within a reasonable time period, a claimant must take no more than twice this amount of time.

3.3.26. When considering whether an individual completes the activity in a reasonable time period you should consider whether, due to their health condition or impairment, it is twice the maximum time a non-disabled person would *normally* take to complete the activity. For each activity there will clearly be a range of times from those individuals who are very quick through to those who are much slower. There will also be non-disabled individuals who take an extremely long time to complete an activity; these should be discounted as they would not be covered by the reference to “normally”.

3.3.27. The following situations highlight examples where an individual may be considered unable to complete a descriptor in a reasonable time period due to their approach or the impact their health condition or impairment has on them:

- An individual who becomes breathless and exhausted whilst washing and dressing, and needs two hours to complete these tasks.

- An individual who is physically capable of preparing a meal, but whose need for formalised ritual means they take all morning to prepare breakfast.
- Someone who, as a result of their health condition, has obsessive ideas around cleanliness and takes considerably prolonged periods of time to complete activities due to repetitive and extended hand washing.

3.3.28. This list is not exhaustive.

Worked example 1

3.3.29. Mr X is able to stand and move unaided. He can comfortably walk up to 150 metres at a normal pace. After 150 metres he starts to become breathless and to experience some mild pain. He can continue to walk but his pace slows. The pain and breathlessness gradually increases and after 250 metres he needs to stop and rest for about 5 minutes before starting to walk again. Mr X can repeatedly walk 250 metres, with short 5-minute rests in between for around an hour. After an hour of this, he needs a longer rest of about an hour before walking again. It takes Mr X around three minutes to walk 200 metres.

3.3.30. In the Moving Around activity, the HP should work their way through the descriptors considering each aspect of reliability, to find the one that best describes Mr X's ability to complete the activity reliably.

| | |
|---|---|
| A | Can stand and then move more than 200 metres, either aided or unaided. |
| B | Can stand and then move more than 50 metres but no more than 200 metres, either aided or unaided. |
| C | Can stand and then move unaided more than 20 metres but no more than 50 metres. |
| D | Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres. |
| E | Can stand and then move more than 1 metre but no more than 20 metres, either aided or unaided. |
| F | Cannot, either aided or unaided. – (i) stand; or (ii) move more than 1 metre. |

3.3.31. Based on the initial information the HP should consider awarding descriptor A but needs to consider whether Mr X can complete it reliably.

- **Safely** – there is no evidence that this activity poses any risk to Mr X’s safety. He has said he experiences some pain and breathlessness and, while this may be uncomfortable, he knows when to stop and rest and there is no indication that this causes him any harm.
- **To an acceptable standard** – this is not an issue in this instance.
- **Repeatedly** – Mr X has to stop and rest for about 5 minutes after walking 250 metres, before he can start walking again, but he can repeat the activity for up to an hour multiple times in one day. This is more frequently than would reasonably be expected so Mr X can be said to complete the activity repeatedly.
- **In a reasonable time period** – Mr X can walk the first 150 metres at a normal pace before he begins to slow, but it only takes him three minutes to walk 200 metres. Although a little slower than normal, this is a reasonable time period for someone to walk 200 metres and therefore Mr X can complete the activity in a reasonable time period.

3.3.32. The HP therefore concludes that Mr X can stand and then move more than 200 metres and selects descriptor A.

Worked example 2

3.3.33. Mr Y is able to stand and move with a walking stick. He can walk up to 50 metres at a slightly slowed pace with some discomfort. After this distance he starts to experience increasing hip pain. He can continue to walk, but his pace slows even further and after 100 metres he needs to stop and rest. This takes a lot out of him and for a few hours after he is unable to go more than a few steps without experiencing further severe hip pain.

3.3.34. It takes Mr Y between one and two minutes to walk 50 metres the first time.

3.3.35. In the Moving Around activity, the HP should work their way through the descriptors considering each aspect of reliability, to find the one that best describes Mr Y’s ability to complete the activity reliably.

| | |
|---|---|
| A | Can stand and then move more than 200 metres, either aided or unaided. |
| B | Can stand and then move more than 50 metres but no more than 200 metres, either aided or unaided. |
| C | Can stand and then move unaided more than 20 metres but no more than 50 metres. |

| | |
|---|---|
| D | Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres. |
| E | Can stand and then move more than 1 metre but no more than 20 metres, either aided or unaided. |
| F | Cannot, either aided or unaided. – (i) stand; or (ii) move more than 1 metre. |

- **Safely** – there is no evidence that this activity poses any risk to Mr Y’s safety. He has said he experiences pain but he knows when to stop and rest. There is no indication that this causes him any harm.
- **To an acceptable standard** – this is not an issue in this instance.
- **Repeatedly** – Mr Y has to stop and rest after walking 100 metres and experiences increasing discomfort after the first 50 metres. It is then several hours before he can walk this distance again. As this is not as often as would reasonably be expected, Mr Y cannot be said to complete the activity repeatedly. He can repeatedly manage a few steps using his stick, which is less than 20 but more than 1 metre, therefore descriptor E best describes how he is able to repeatedly move around.
- **In a reasonable time period** – Mr Y can walk the first 50 metres in a minute or two. Although slower than normal, this is a reasonable time period for someone to walk this distance and therefore he can complete the activity in a reasonable time period.

3.3.36. The HP therefore concludes that Mr Y can stand and then move more than 1 metre but no more than 20 metres, and selects descriptor E.

Worked example 3

3.3.37. Ms Z can prepare and cook a simple meal. However she lacks a perception of danger and occasionally cuts herself from mishandling knives or burns herself on hot pans. She is also impatient and does not cook food for as long as it should be cooked, as a result she prepares food that is lukewarm and meat that is not cooked properly – for example, chicken that is pink in the middle. Her sister usually has to be in the kitchen when she is cooking meals to make sure she does so safely and to remind her to leave food to cook fully.

3.3.38. In the Preparing Food activity, the HP should work their way through the descriptors considering each aspect of reliability, to find the one that best describes Ms Z's ability to complete the activity reliably.

| | |
|---|--|
| A | Can prepare and cook a simple meal unaided. |
| B | Needs to use an aid or appliance to either prepare or cook a simple meal. |
| C | Cannot cook a simple meal using a conventional cooker but can do so using a microwave. |
| D | Needs prompting to either prepare or cook a simple meal. |
| E | Needs supervision to either prepare or cook a simple meal. |
| F | Needs assistance to either prepare or cook a simple meal. |
| G | Cannot prepare and cook food and drink at all. |

- **Safely** – Ms Z lacks a perception of danger and has previously cut and burnt herself. The HP should therefore conclude that descriptor A is not suitable for Ms Y as she cannot do so safely. Descriptor B, descriptor C and descriptor D are also not suitable as they do not remove the potential danger from using knives and hot pans. Descriptor E reflects the support that Ms Z needs to ensure her safety while cooking and is therefore the most suitable descriptor regarding safety.
- **To an acceptable standard** – Ms Z is impatient and does not cook food for as long as it should be cooked. As a result the food is lukewarm and meat is not cooked through. The HP must consider whether that is an acceptable standard and in this case would conclude it is not. The HP should therefore conclude that descriptor A is not suitable because Ms Z is unable to do so to an acceptable standard. Descriptor B and descriptor C are also not suitable as they do not help Ms Z to complete the task to an acceptable standard. Descriptor D best describes how Ms Z is able to cook a meal to an acceptable standard and is therefore the most suitable descriptor regarding the standard.
- **Repeatedly** – this is satisfied as Ms Z is able to cook all of her meals.
- **In a reasonable time period** – this is satisfied as Ms Z has not indicated it takes her an overly long time to cook her meals.

3.3.39. In this case there are two possible descriptors – D and E. For a descriptor to apply, all aspects of reliability must be satisfied. As descriptor D does not describe a manner in which Ms Z is able to carry out the activity safely, the HP should select descriptor E.

3.3.40.

3.4. Daily Living Activities

| Activity 1 – Preparing food | | |
|--|---|---|
| <p>This activity considers a claimant’s ability to prepare a simple meal. This is not a reflection of a claimant’s cooking skills but instead a consideration of the impact of impairment on ability to perform the tasks required. It assesses ability to open packaging, serve food, peel and chop food and use a microwave oven or cooker hob to cook or heat food.</p> <p><i>Notes:</i></p> <p><i>Preparing food means the activities required to make food ready for cooking and eating, such as peeling and chopping.</i></p> <p><i>Cooking food means heating food at above waist height – for example, using a microwave oven or on a cooker hob. It does not consider the ability to bend down – for example, to access an oven.</i></p> <p><i>A simple meal is a cooked one-course meal for one from fresh ingredients. Packaging includes tins, which may require the use of a tin opener.</i></p> <p><i>In this activity aids and appliances could include, for example, prostheses, perching stool, lightweight pots and pans, easy grip handles on utensils and single lever arm taps.</i></p> <p><i>Pre-chopped vegetables are not considered an aid or appliance. However, a claimant who is reliant on them because they would be unable to peel or chop fresh vegetables may be considered as requiring an aid or appliance or support from another person to complete the activity.</i></p> | | |
| A | Can prepare and cook a simple meal unaided. | 0 |
| B | Needs to use an aid or appliance to be able to either prepare or cook a simple meal. | 2 |
| C | Cannot cook a simple meal using a conventional cooker but is able to do so using a microwave. | 2 |
| <p><i>For example: may apply to claimants who cannot safely use a cooker hob and hot pans.</i></p> | | |

| | | |
|--|--|---|
| D | Needs prompting to be able to either prepare or cook a simple meal. | |
| <p style="text-align: center;"><i>For example: may apply to claimants who lack motivation, who need to be reminded how to prepare and cook food or who are unable to ascertain if food is within date.</i></p> | | 2 |
| E | Needs supervision or assistance to either prepare or cook a simple meal. | |
| <p style="text-align: center;"><i>For example: may apply to claimants who need supervision to prepare and cannot safely use a microwave oven; or to claimants who cannot prepare or safely heat food</i></p> | | 4 |
| F | Cannot prepare and cook food. | |
| | | 8 |

| Activity 2 – Taking nutrition | | |
|---|---|---|
| <p>This activity considers a claimant’s ability to be nourished, either by cutting food into pieces, conveying to the mouth, chewing and swallowing; or through the use of therapeutic sources.</p> <p><i>Notes:</i></p> <p><i>A therapeutic source means parenteral or enteral tube feeding using a rate limiting device such as a delivery system or feed pump.</i></p> <p><i>A key consideration when considering whether supervision is required should be whether the claimant has a real risk of choking when taking nutrition.</i></p> | | |
| A | Can take nutrition unaided. | 0 |
| B | Needs – i. to use an aid or appliance to be able to take nutrition; or ii. supervision to be able to take nutrition; or iii. assistance to be able to cut up food. | 2 |
| C | Needs a therapeutic source to be able to take nutrition. | 2 |
| <i>For example: may apply to claimants who require enteral or parenteral feeding but can carry it out unaided.</i> | | |
| D | Needs prompting to be able to take nutrition. | 4 |
| <i>For example: may apply to claimants who need to be reminded to eat or who need prompting about portion size.</i> | | |
| E | Needs assistance to be able to manage a therapeutic source to take nutrition. | 6 |
| <i>For example: may apply to claimants who require enteral or parenteral feeding and require support to manage the equipment.</i> | | |

| | | |
|---|--|----|
| F | Cannot convey food and drink to their mouth and needs another person to do so. | 10 |
| | | |

Activity 3 – Managing therapy or monitoring a health condition

This activity considers a claimant's ability to:

- (i) appropriately take medications in a domestic setting and which are prescribed or recommended by a registered doctor, nurse or pharmacist;
- (ii) monitor and detect changes in a health condition; and
- (iii) manage therapeutic activities that are carried out in a domestic setting and prescribed or recommended by a registered doctor, nurse, pharmacist or healthcare professional regulated by the Health Professions Council;

and without any of which their health is likely to deteriorate.

Notes:

Managing medication means the ability to take prescribed medication in the correct way and at the right time.

Monitoring a health condition or recognise significant changes means the ability to detect changes in the condition and take corrective action as advised by a healthcare professional.

This activity does not take into account medication and monitoring requiring administration by a healthcare professional.

Examples of prescribed or recommended medication include tablets, inhalers and creams and therapies could include home oxygen, domiciliary dialysis, nebulisers and exercise regimes to prevent complications such as contractures. Whilst medications and therapies do not necessarily have to be prescribed, there must be a consensus of medical opinion that supports their use in treatment of the condition.

Supervision due to the risk of accidental or deliberate overdose or deliberate self harm is captured in these descriptors as the person would require continuous support from another person in order to prevent this.

For the purpose of this activity, the majority of days test does not require the individual to actually be receiving therapy on the majority of days in a year. However, the descriptor would still need to accurately describe the claimant's circumstances on a majority of days – i.e. on a majority of days the statement about how much support an individual needs a week must be true. For example, if a claimant needs assistance to undergo home dialysis for three hours on Monday and Friday, they would not actually be receiving therapy on a majority of days in a year. However, on a majority of days in the year, the statement that they need 'assistance to be able to manage therapy that takes more than 3.5 but no more than 7 hours a week' would still apply as it accurately describes the level of support needed in a week.

| | | |
|---|---|---|
| A | <p>Either –</p> <ul style="list-style-type: none"> i. Does not receive medication or therapy or need to monitor a health condition; or ii. Can manage medication or therapy or monitor a health condition unaided. | 0 |
| | | |
| B | <p>Needs either –</p> <ul style="list-style-type: none"> i. to use an aid or appliance to be able to manage medication; or ii. supervision, prompting or assistance to be able to manage medication or 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 |
| | | |

| Activity 4 – Washing and bathing | | |
|--|--|---|
| This activity considers a claimant's ability to wash and bathe, including washing their whole body and getting in and out of an un-adapted bath or shower. | | |
| A | Can wash and bathe unaided. | 0 |
| B | Needs to use an aid or appliance to be able to wash or bathe. | 2 |
| <i>For example: suitable aids could include a long-handled sponge, shower seat or bath rail.</i> | | |
| C | Needs supervision or prompting to be able to wash or bathe. | 2 |
| <i>For example: may apply to claimants who lack motivation or need to be reminded to wash or require supervision for safety.</i> | | |
| D | Needs assistance to be able to wash either their hair or body below the waist. | 2 |
| <i>For example: may apply to claimants who are unable to make use of aids and who cannot reach their lower limbs or hair.</i> | | |
| E | Needs assistance to be able to get in or out of a bath or shower. | 3 |
| F | Needs assistance to be able to wash their body between the shoulders and waist. | 4 |
| G | Cannot wash and bathe at all and needs another person to wash their entire body. | 8 |

Activity 5 – Managing toilet needs or incontinence

This activity considers a claimant’s ability to get on and off the toilet, to clean afterwards and to manage evacuation of the bladder and/or bowel, including the use of collecting devices.

This activity does **not** include the ability to manage clothing, for example fastening and unfastening zips or buttons, as this is covered in activity 6.

Notes:

Toilet needs means the ability to get on and off the toilet, evacuation of the bladder and bowel and clean oneself afterwards.

Managing incontinence means the ability to manage evacuation of the bladder and/or bowel including using collecting devices and clean oneself afterwards.

Claimants with catheters and collecting devices are considered incontinent for the purposes of this activity.

| | | |
|---|---|---|
| A | Can manage toilet needs or incontinence unaided. | 0 |
| B | Needs to use an aid or appliance to be able to manage toilet needs or incontinence. | 2 |
| <i>For example: suitable aids could include commodes, raised toilet seats, bottom wipers, bidets, incontinence pads or a stoma bag.</i> | | |
| C | Needs supervision or prompting to be able to manage toilet needs. | 2 |
| <i>For example: may apply to claimants who need to be reminded to go to the toilet or need supervision to get on and off the toilet safely.</i> | | |
| D | Needs assistance to be able to manage toilet needs. | 4 |
| E | Needs assistance to be able to manage incontinence of either bladder or bowel. | 6 |

| | | |
|---|---|---|
| F | Needs assistance to be able to manage incontinence of both bladder and bowel. | 8 |
| | | |

| Activity 6 – Dressing and undressing | | |
|--|---|---|
| <p>This activity assesses a claimant’s ability to put on and take off culturally appropriate, un-adapted clothing that is suitable for the situation. This may include the need for fastenings such as zips or buttons and considers the ability to put on/take off socks and shoes.</p> | | |
| A | Can dress and undress unaided. | 0 |
| B | Needs to use an aid or appliance to be able to dress or undress. | 2 |
| <p><i>For example: suitable aids could include modified buttons, zips, front fastening bras, trousers, velcro fastenings and shoe aids.</i></p> | | |
| C | Needs either – i. prompting to be able to dress, undress or determine appropriate circumstances for remaining clothed; or ii. prompting or assistance to be able to select appropriate clothing. | 2 |
| <p><i>For example: may apply to claimants who need to be encouraged to dress. Includes a consideration of whether the claimant can determine what is appropriate for the environment, such as time of day and the weather.</i></p> | | |
| D | Needs assistance to be able to dress or undress their lower body. | 2 |
| E | Needs assistance to be able to dress or undress their upper body. | 4 |
| F | Cannot dress or undress at all. | 8 |

Activity 7 – Communicating verbally

This activity considers a claimant’s ability to communicate verbally with regard to expressive (conveying) communication and receptive (receiving and understanding) communication.

Notes:

This activity considers the ability to convey and understand verbal information with other people in one’s native language.

Basic verbal information is information conveyed in a simple sentence.

Complex verbal information is information conveyed in either more than one sentence or one complicated sentence.

Verbal information can include information that is interpreted from verbal into non-verbal form or vice-versa – for example, speech interpreted through sign language or into written text.

Communication support means support from another person trained or experienced in communicating with people with specific communication needs (for example, a sign language interpreter) or someone directly experienced in communicating with the claimant themselves (for example, a family member).

Individuals who cannot express or understand verbal information and would need communication support to do so should receive the appropriate descriptor even if they do not have access to this support. For example, a deaf person who cannot communicate verbally and does not use sign language might need another person to support them in another way – such as by writing verbal information down – even if they do not routinely have such help.

| | | |
|---|---|---|
| A | Can express and understand verbal information unaided. | 0 |
| | | |
| B | Needs to use an aid or appliance to be able to speak or hear. | 2 |
| <i>For example: may apply to claimants who require a hearing aid or an electrolarynx.</i> | | |
| C | Needs communication support to be able to express or understand complex verbal information. | 4 |

| | | |
|---|---|----|
| <i>For example: may apply to claimants who require a sign language interpreter.</i> | | |
| D | Needs communication support to be able to express or understand basic verbal information. | 8 |
| <i>For example: may apply to claimants who require a sign language interpreter.</i> | | |
| E | Cannot express or understand verbal information at all even with communication support. | 12 |
| | | |

Activity 8 – Reading and understanding signs, symbols and words

This activity considers a claimant’s ability to read and understand signs, symbols and words.

Notes:

This activity considers the capability to read and understand written or printed information in the person’s native language.

Basic information is signs, symbols or dates. Complex information is more than one sentence of written or printed standard size text – for example, text found in utility bills and bank statements.

Consideration needs to be given to whether the claimant can read and understand information both indoors and outdoors. In doing so consideration should also be given to whether the claimant uses or could reasonably be expected to use aids or appliances, such as a large magnifier to read text when indoors and a portable magnifying glass to do so when outdoors. If the claimant is unable to complete the activity as described either indoors or outdoors, the descriptor may apply.

To be considered able to read, claimants must be able to see the information.

For the purpose of this activity, accessing information via Braille is not considered as reading.

| | | |
|---|--|---|
| A | Can read and understand basic and complex written information either unaided or using spectacles or contact lenses. | 0 |
| | | |
| B | Needs to use an aid or appliance, other than spectacles or contact lenses, to be able to read or understand either basic or complex written information. | 2 |
| <i>For example: may apply to claimants who require low vision aids.</i> | | |
| C | Needs prompting to be able to read or understand complex written information. | 2 |
| <i>For example: may apply to claimants who require another person to explain information to them.</i> | | |

| | | |
|---|---|---|
| D | Needs prompting to be able to read or understand basic written information. | 4 |
| <i>For example: may apply to claimants who require another person to explain information to them.</i> | | |
| E | Cannot read or understand signs, symbols or words at all. | 8 |
| <i>For example: may apply to claimants who require another person to read everything for them.</i> | | |

Activity 9 – Engaging with other people face to face

This activity considers a claimant’s ability to engage with other people which means to interact face to face in a contextually and socially appropriate manner, understand body language and establish relationships.

Notes:

An inability to engage socially must be due to the impact of impairment and not simply a matter of preference by the claimant.

Social support means support from a person trained or experienced in assisting people to engage in social situations, or someone directly experienced in supporting the claimant themselves (for example a family member), who can compensate for limited ability to understand and respond to body language, other social cues and assist social integration.

‘Psychological distress’ means distress related to an enduring mental health condition or an intellectual or cognitive impairment. However, this condition may have a physical root cause.

When considering whether claimants can engage with others, consideration should be given to whether they can engage with people generally, not just those people they know well.

| | | |
|--|---|---|
| A | Can engage with other people unaided. | 0 |
| B | Needs prompting to be able to engage with other people. | 2 |
| <i>For example: may apply to people who need encouragement to interact with others by the presence of a third party.</i> | | |
| C | Needs social support to be able to engage with other people. | 4 |
| <i>For example: may apply to people who are only able to interact with others by the presence of a third party.</i> | | |
| D | Cannot engage with other people due to such engagement causing either – i. overwhelming psychological distress to the claimant; or ii. the claimant to exhibit behaviour which would result in a substantial risk of harm to the claimant or another person. | 8 |

Activity 10 – Making budgeting decisions

This activity considers the ability of a claimant to make everyday budgeting decisions.

Notes:

Complex budgeting decisions are those that are involved in calculating household and personal budgets, managing and paying bills and planning future purchases.

Simple budgeting decisions are those that are involved in activities such as calculating the cost of goods and change required following purchases.

Assistance in this activity refers to another person carrying out elements, although not all, of the decision making process for the claimant..

| | | |
|---|---|---|
| A | Can manage complex budgeting decisions unaided. | 0 |
| | | |
| B | Needs prompting or assistance to be able to make complex budgeting decisions. | 2 |
| | <i>For example: may apply to claimants who need to be encouraged or reminded to make complex budgeting decisions.</i> | |
| C | Needs prompting or assistance to be able to make simple budgeting decisions. | 4 |
| | <i>For example: may apply to claimants who need to be encouraged or reminded to make simple financial decisions.</i> | |
| D | Cannot make any budgeting decisions at all. | 6 |
| | | |

3.5. Mobility activities

| Activity 11 – Planning and following journeys | | |
|---|---|----|
| <p>This activity considers a claimant’s ability to work out and follow the route of a journey.</p> <p><i>Notes:</i></p> <p><i>A person should only be considered able to follow an unfamiliar journey if they are capable of using public transport (bus or train).</i></p> <p><i>Journey means a local journey, whether familiar or unfamiliar.</i></p> <p><i>Consideration should be given to safety and whether there would be a substantial risk to the claimant or others if they went out alone.</i></p> <p><i>Orientation aids are specialist aids designed to assist disabled people in following a route.</i></p> <p><i>‘Psychological distress’ means distress related to an enduring mental health condition or an intellectual or cognitive impairment. However, this condition may have a physical root cause – such as unmanageable incontinence which leads to anxiety about making journeys.</i></p> <p><i>Small disruptions and unexpected changes, such as roadworks and changed bus-stops, are commonplace when following journeys and consideration should be given to whether the claimant would be able to carry out the activity as described if such commonplace disruptions occur.</i></p> | | |
| A | Can plan and follow the route of a journey unaided. | 0 |
| B | Needs prompting to be able to undertake any journey to avoid overwhelming psychological distress to the claimant. | 4 |
| <p><i>For example: may apply to claimants who are only able to leave the home when accompanied by another person.</i></p> | | |
| C | Cannot plan the route of a journey. | 8 |
| D | Cannot follow the route of an unfamiliar journey without another person, assistance dog or orientation aid. | 10 |

| | | |
|---|--|----|
| | | |
| E | Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant. | 10 |
| <i>For example: may apply to claimants who are unable to leave the home at all.</i> | | |
| F | Cannot follow the route of a familiar journey without another person, an assistance dog or an orientation aid. | 12 |
| | | |

Activity 12 – Moving around

This activity considers a claimant’s physical ability to move around without severe discomfort such as breathlessness, pain or fatigue. This includes the ability to stand and then move up to 20 metres, up to 50 metres, up to 200 metres and over 200 metres.

Notes:

This activity should be judged in relation to a type of surface normally expected out of doors such as pavements on the flat and includes the consideration of kerbs.

Standing means to stand upright with at least one biological foot on the ground with or without suitable aids and appliances (note – a prosthesis is considered an appliance so a claimant with a unilateral prosthetic leg may be able to stand whereas a bilateral lower limb amputee would be unable to stand under this definition).

“Stand and then move” requires an individual to stand and then move independently while remaining standing. It does not include a claimant who stands and then transfers into a wheelchair or similar device. Individuals who require a wheelchair or similar device to move a distance should not be considered able to stand and move that distance.

Aids or appliances that a person uses to support their physical mobility may include walking sticks, crutches and prostheses.

When assessing whether the activity can be carried out reliably, consideration should be given to the manner in which they do so. This includes but is not limited to, their gait, their speed, the risk of falls and symptoms or side effects that could affect their ability to complete the activity, such as pain, breathlessness and fatigue. However, for this activity this only refers to the physical act of moving. For example, danger awareness is considered as part of activity 11.

| | | |
|---|---|---|
| A | Can stand and then move more than 200 metres, either aided or unaided. | 0 |
| B | Can stand and then move more than 50 metres but no more than 200 metres, either aided or unaided. | 4 |
| C | Can stand and then move unaided more than 20 metres but no more than 50 metres. | 8 |

| | | |
|---|---|----|
| D | Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres. | |
| <i>For example, this would include people who can stand and move more than 20 metres but no further than 50 metres, but need to use an aid or appliance such as a stick or crutch to do so.</i> | | 10 |
| E | Can stand and then move more than 1 metre but no more than 20 metres, either aided or unaided. | 12 |
| | | |
| F | Cannot, either aided or unaided – i. stand; or ii. move more than 1 metre. | 12 |
| | | |

4. Health Professional Performance

4.0.1. This chapter sets out the processes to be followed by providers to ensure HPs carrying out PIP assessments meet the required performance standards, including the requirements around competencies, training, approval audit and complaint handling.

4.1. Health Professional Competencies

4.1.1. All HPs recruited for the delivery of PIP assessments (or any parts of these) must meet the following requirements:

- Be an occupational therapist, nurse (level 1), physiotherapist, paramedic or doctor.
- Be fully registered with the relevant licensing body (doctors must have a licence to practise).
- Have no sanctions attached to registration.
- Have at least 2 years post full registration experience, except where individually agreed by exception with the Department.
- Have passed a Criminal Records Bureau check.

4.1.2. Before they are approved to carry out assessments (see section 4.3), providers must be able to demonstrate that HPs:

- Have appropriate knowledge of the clinical aspects and likely functional effects of a wide range of health conditions and disabilities.
- Have appropriate skills in assessing people with physical health conditions, including history taking, observation and ability to perform a relevant examination.
- Have appropriate skills in assessing people with conditions affecting mental, intellectual and cognitive function, including history taking, observation and ability to perform a relevant examination.
- Are able to critically evaluate evidence and use logical reasoning to provide accurate evidence-based advice.
- Have excellent interpersonal and written communication skills that include the ability to:

- Interact sensitively and appropriately, with particular regard for an individual's cultural background and issues specific to disabled people.
- Take a comprehensive, appropriately focused and clear history.
- Accurately record observations and formal clinical findings.
- Produce succinct, accurate reports in plain English, fully justifying conclusions from evidence gathered, and dealing appropriately with apparent conflicts of evidence and fluctuating condition.

4.2. Training of Health Professionals

Initial training

- 4.2.1. Assessment providers are required to put in place suitable training programmes to ensure that HPs carrying out assessments meet the competency requirements set out in 4.1. They should involve the Department in the quality assurance process for the development and ongoing refinement of these programmes and the quality standards associated with them. Where relevant, training programmes should be based on this guidance.
- 4.2.2. The training programmes should include, but not be limited to, ensuring HPs have:
- An understanding of the legislative framework in which they are working and the legislative requirements for PIP.
 - An understanding of, and an ability to perform, the role of a disability analyst in order to assess claimants with health conditions or disabilities, affecting either physical or mental function.
 - An up-to-date knowledge of relevant clinical subjects.
 - An understanding of the importance of customer service and equal opportunities and any relevant policies and procedures.
 - An awareness of different cultures and their potential impact on the assessment process.
 - An understanding of the needs of and challenges faced by disabled people.
 - An ability to deal with potentially violent situations.
 - An ability to competently use relevant IT systems.
- 4.2.3. Training programmes should involve both theoretical and simulated practical elements, with relevant examinations. Following training, HPs should undergo a written and practical assessment to ensure that the required level of competence has been achieved and that they can demonstrate this to the Department (see section 4.3 below).

Refresher Training and ongoing Continuing Professional Development

- 4.2.4. Providers are required to develop, deliver and evaluate a programme of refresher training and Continuing Professional Development (CPD) on an annual basis for all HPs involved in delivering PIP assessments.

- 4.2.5. Each HP should be given a personal training plan on an annual basis, containing details of the modules to be delivered to the individual and the timescales in which they will be delivered.
- 4.2.6. The Department may require that topics be included in the CPD programme.

Training Plans

- 4.2.7. Providers are required to undertake a Training Needs Analysis at organisational level to identify areas of training needs together with priorities for implementation. The scope, objectives and methodology of the analysis will be subject to prior approval by the Department.
- 4.2.8. Providers are also required to supply the Department with a Training Plan setting out in detail the manner in which their training programme, both initial training and refresher training / CPD, will be delivered. This plan should be developed in co-operation with the Department and will be subject to Departmental approval.
- 4.2.9. Any subsequent changes to the Training Plan must be submitted to the Department for approval.
- 4.2.10. Providers must evaluate the effectiveness of their training and CPD programmes. The format and timescales of the evaluation should be agreed with the Department.

4.3. Approval / Revocation of Health Professionals

- 4.3.1. Before an HP can carry out PIP assessments they must go through a formal Approval Process to ensure they meet the Department's requirements in relation to experience, skills and competence. Failure to demonstrate that HPs have reached or maintained the necessary standards or co-operate with feedback and/or retraining will result in Approval being refused/revoked.
- 4.3.2. Approval for an HP must be conferred by the DWP Chief Medical Adviser (CMA) on behalf of the Secretary of State for Work and Pensions. This will, in turn, be based on the recommendation of providers who must provide evidence that the HP has demonstrated that they meet the required standards.
- 4.3.3. The section describes processes to be followed during the live-running of PIP assessment contracts. The Department accepts that some variation in approach may be needed during the implementation period in advance of PIP contracts commencing and will work with providers to agree an alternative approach that ensures the necessary quality standards are achieved.

Initial Approval

- 4.3.4. The Initial Approval process must be undertaken:
- For all new recruits.
 - For all HPs who have not completed PIP assessments for 12 months or more.
 - For all existing employees who have not worked on PIP before.
- 4.3.5. There are four stages in the Initial Approval process:
- **Stage 1 – Training.** This should involve all trainee HPs undergoing a DWP-approved training programme, which should include both theoretical and practical simulated assessments (including face-to-face consultations, paper-based reviews and terminal illness advice) to ensure that they can meet the competence and knowledge requirements (as outlined in 4.1 and 4.2).
 - **Stage 2 – Assessment of Competence.** Once Stage 1 is complete, the provider should carry out an assessment of whether the trainee HP meets the required competence and knowledge standards. This should include written and practical elements (including on completion of face-to-face consultations, paper-based reviews, terminal illness advice and advice on when

further evidence or face-to-face consultations are appropriate steps).

- **Stage 3 – Supervision.** Once stage 2 has been successfully completed by the trainee HP, they will have Provisional Approval by DWP to carry out assessments on claimants – both paper-based reviews and face-to-face consultations. Assessments should initially be supervised until the provider is satisfied that the HP is continuing to meet the required standards in an operational setting. The number of assessments that must be supervised is at the discretion of the provider.
- **Stage 4 - Approval-related Audit.** Once Stage 3 has been successfully completed by the trainee HP, they will be able to carry out assessments without supervision but subject to 100% audit until Full Approval is given by the Department.

Provisional Approval

- 4.3.6. Once HPs have successfully completed Stage 2 (Assessment of Competence) they will have Provisional Approval by DWP to carry out assessments.
- 4.3.7. At this point the provider must supply DWP with details of the HP and evidence to demonstrate that the HP meets the required competence standards.
- 4.3.8. HPs with Provisional Approval should initially be supervised but once the provider is satisfied that they meet the required standards, they will be able to carry out assessments without supervision but subject to 100% audit until Full Approval is given by the Department.

Full Approval

- 4.3.9. Providers will be able to seek Full Approval from DWP for an HP once that HP has shown an ability to consistently apply the competence standards by achieving the following number of consecutive Grade A audit results at Stage 4:
 - 5 reports produced following a face-to-face consultation; and
 - 5 reports produced following a paper-based review including Terminal Illness (where descriptor advice is provided).
- 4.3.10. Providers with HPs who specialise in one area of assessment only will also be able to seek approval from DWP to carry out either face-to-face consultations or paper-based reviews (including TI). In these cases, HPs must show an ability to consistently apply the

competence standards in their area by achieving the following number of consecutive Grade A audit results at Stage 4:

- 5 reports following a face-to-face consultation; or
- 5 reports following a paper-based review including Terminal Illness (where descriptor advice is provided).

4.3.11. Providers must supply DWP with evidence demonstrating that the HP has achieved the required standard. The CMA reserves the right to not approve an HP if he has any concern that an individual does not satisfy one or more of the required criteria, regardless of the actions or views of the provider.

4.3.12. Until Full Approval is given by DWP, HPs with Provisional Approval will remain subject to 100% quality audit.

Submitting HPs for approval

4.3.13. When the AP is satisfied that the HP has successfully completed all four stages of the approval process the following information should be sent to DWP:

- The HP's name and address
- The AP's assurance that the relevant register has been checked for that HP's profession, they can confirm that they are registered and have two year's post-registration experience
- A list of the training the HP has completed and the dates that it was completed
- A list of all the examinations/assessments the HP has completed, including dates and whether they have failed or passed. Where the HP had more than one attempt to pass a module, the AP should list the dates and the results in each instance
- The dates of all the assessment reports the HP has completed and the audit grade (A, B or C)
- Assurance from the clinical lead that he/she is satisfied the HP has reached the standard necessary to carry out PIP assessments

4.3.14. The DWP Chief Medical Adviser will review the HP's papers and approve them, if all is in order. DWP will maintain a database of approved HPs. If the status of the HP changes, the AP should advise DWP as soon as possible.

Maintenance of Approval

4.3.15. The HP's ongoing Approval is dependent upon the HP undertaking PIP assessment work for the provider and fulfilling the following criteria:-

- The HP continues to satisfy the required quality standards.
- The HP completes any mandatory training required.

4.3.16. Providers should keep records for each HP containing all information relating to quality – for example, on training, CPD, quality monitoring, rework and complaints.

Revocation of Approval

4.3.17. The CMA reserves the right to suspend or revoke Approval – both Provision and Full Approval – at any time where there is concern that an individual may no longer satisfy one or more of the required criteria. This is at the discretion of the CMA and is irrespective of any action that providers are undertaking.

4.3.18. Providers must consider whether the circumstances surrounding any revocation of Approval warrant them informing the HP's professional body.

4.3.19. Revocation of an HP's Approval should routinely be sought for a number of reasons:

- Poor Performance.
- Temporary Unavailability.
- Mandatory Training Missed.
- Permanent Unavailability – both voluntary and involuntary.

4.3.20. More information on these areas is covered below.

4.3.21. Providers should inform the DWP CMA where any of the above apply, together with any relevant documentation.

Poor Performance

4.3.22. Where there is evidence that the required standards are not being consistently met, this should be drawn to the HP's attention without delay. Appropriate feedback should be given.

- 4.3.23. Providers should have guidance and processes in place to address issues with an HP's performance, including issues of productivity, reliability, quality of outputs and complaints. This may include formal retraining or periods of supervised practice where necessary. Work should be kept under review until evidence of consistent improvement is obtained. If this does not occur, then formal Revocation must be sought.

Temporary Unavailability

- 4.3.24. The Temporary Unavailability of an HP to carry out PIP assessments will require action by providers in relation to that HP's Approval.
- 4.3.25. If the Temporary Unavailability is for a period of **less than 3 calendar months**, the HP may resume their normal duties afterwards.
- 4.3.26. If the Temporary Unavailability is for a period of **more than 3 but less than 6 months**, the HP should be subject to targeted quality audit on their return to ensure the required standards are being met. The number of assessments audited will be at the discretion of the provider.
- 4.3.27. If the Temporary Unavailability is for a period of **more than 6 but less than 12 months**, the provider should suspend the HP from carrying out assessments, seek revocation of approval from DWP and return the HP to Stage 4 of the approval process, requiring them to undergo audit. As per Stage 4, the HP will be required to achieve 5 consecutive grade A reports produced following both face-to-face consultations and paper-based reviews.
- 4.3.28. If the Temporary Unavailability is for a period of **more than 12 calendar months**, providers should immediately suspend the HP from carrying out PIP assessments and seek Revocation of Approval from DWP. To carry out PIP assessments in the future, the HP must go through the full Initial Approval process again.

Mandatory Training Missed

- 4.3.29. If an HP fails to undergo a module of mandatory training, providers should normally suspend the HP from carrying out PIP assessments as soon as the time limit for taking the training expires.
- 4.3.30. Should the HP not take steps to complete the required training in an appropriate timeframe, providers should approach the Department to have the HP's Approval revoked.

Permanent Unavailability

- 4.3.31. Revocation of Approval on the grounds of **Voluntary Permanent Unavailability** may take place where HPs no longer wish to carry out PIP Assessments – for example, due to retirement, ill-health or resignation. The HP concerned should inform the provider of their intent who should then seek the revocation of Approval from DWP.
- 4.3.32. Revocation of Approval on the grounds of **Involuntary Permanent Unavailability** may take place where HPs are no longer able to carry out PIP Assessments – for example, due to an upheld serious complaint, a conviction for a serious crime or due to the imposition of sanctions by a professional body.
- 4.3.33. In these circumstances providers should immediately suspend the HP from carrying out PIP assessments and seek Revocation of Approval from DWP.

Administrative processes

- 4.3.34. The detailed administrative processes to support the Approval and Revocation requirements will be developed shortly, in liaison with providers.
- 4.3.35. Providers must maintain a database detailing approvals / revocations of approval. The database content must be agreed with the Department and shared with it on request.

4.4. Quality Audit

- 4.4.1. Providers are required to put in place the following processes for auditing the quality of assessments:
- Lot-wide audit.
 - Approval-related audit.
- 4.4.2. Audits should focus on ensuring that reports produced by HPs are high-quality, both in terms of presentation and content, that all procedures have been followed and any advice or opinion evidence-based and justified.
- 4.4.3. Assessments reports subject to audit will be examined and graded A, B and C based on the following guidelines:
- In A grade reports, the quality requirements will be satisfied to the extent that the report fully conforms to the required standards.
 - In B grade reports, the quality requirements will be adequately satisfied but there will be elements which would quantifiably enhance the quality of the report.
 - In C grade reports, the quality requirements will not be satisfied to the extent that the report fails to meet the required standards.
- 4.4.4. More detailed guidance on how reports should be audited and the criteria to be used are set out in section 4.5.
- 4.4.5. The Department also recommends that providers undertake additional audit activity to ensure quality standards are being met, including:
- New entrant audit.
 - Rolling audit.
 - Targeted audit.

Lot-wide audit

- 4.4.6. Lot-wide audit is an audit of a controlled random sample from across each contract Lot, feeding in to routine performance reporting to DWP.
- 4.4.7. Providers must develop a system for random sampling which must be agreed with DWP. The sample should include terminal illness, paper-based review and consultation outputs.

4.4.8. The lot-wide audit sample size must be selected using the Lancaster model which has been designed in conjunction with DWP analysts. The model produces an appropriate sample size to specified margins of error. The model and guidance on its use have been supplied to providers separately.

4.4.9. Providers' targets are:

- In year 1, for 4% or less grade C reports and 20% or less grade B reports.
- In year two and subsequent years, for 3% or less grade C reports and 15% or less grade B reports.

Approval-related audit

4.4.10. During Stage 4 of the HP approval process HPs should be subject to 100% audit to ensure that they are consistently able to apply the competence standards (see 4.3.9).

New entrant audit

4.4.11. Once an HP has been approved, the Department recommends that they continue to be subject to regular audit until the provider is satisfied that consolidation of skills has been achieved. The frequency and volume of monitoring should be determined by providers.

Rolling audit

4.4.12. Rolling audit is an audit of the work of each HP on a three-month rolling basis to assess the quality of their work on a continuing basis, ensure maintenance of standards and for revalidation purposes.

4.4.13. The Department recommends that providers ensure that an appropriate proportion of an HP's assessments are subject to audit in every three month period. The number of cases that will need to be subject to rolling audit may be affected by the number of examples of that HP's work which have formed part of other audit activity – for example, cases selected as part of the lot-wide audit. Some HPs will not need rolling audit at all because they are regularly audited in random or targeted audit activity.

Targeted audit

4.4.14. Targeted audit is audit activity triggered where a quality, rework or complaint issue has been identified to establish whether there is evidence of an ongoing problem or where it is felt that auditing should be carried out to ensure the required standards are met.

- 4.4.15. Targeted audit is carried out at the discretion of providers or at the request of DWP – for example, where rework volumes are significantly high indicating problems with quality, or where successful appeals indicate that the evidence was insufficient.

Experience of auditors

- 4.4.16. Providers should put in place processes to ensure that individuals carrying out audit activity are Approved HPs and have the requisite skills, knowledge and experience to carry out their roles. Where possible, they should have been carrying out PIP Assessments for a minimum of 12 months.

Live cases

- 4.4.17. Audit activity should be carried out while cases are “live” and before they are submitted to DWP. As such all audit activity should be carried out swiftly to avoid delay to the case.

Feedback

- 4.4.18. Providers should put in place processes to ensure that appropriate feedback is given to HPs as a result of auditing.

Alteration of C grade reports

- 4.4.19. Where assessments have been graded as C grade, remedial activity should be taken before the case is submitted to DWP. Where possible, this activity should be taken by the HP who carried out the original assessment.
- 4.4.20. Any changes made to clerical forms should be justified, signed and dated. It should be made clear that any changes are made as a result of audit activity.
- 4.4.21. Where necessary a new report form should be completed.

Maintaining records

- 4.4.22. Providers should keep records of all audit activity described in this section. These records should be retained for a minimum period of two years.

4.5. Quality Audit Criteria

- 4.5.1. These audit quality requirements apply to cases audited under lot-wide audit and approval-related audit. However, providers may wish to use the same criteria for other audit activity, such as rolling and targeted audit.

Areas to be audited

- 4.5.2. When auditing cases, providers should look at the entire case at the point at which it is finalised and due to be returned to the Department, considering both the final output and the processes followed.
- 4.5.3. Reports should be audited in four areas:
- Presentation and process¹.
 - Consultation.
 - Reasoning.
 - Professional issues.

Attributes

- 4.5.4. Attributes break the areas down into subcategories that must be considered. They can be incomplete at a major or minor level:
- Minor – errors or omissions are present but not sufficient to mislead the decision maker into making an incorrect decision.
 - Major – errors or omissions are present and may mislead the decision maker into making an incorrect decision or inability to make a decision at all.

Grading

- 4.5.5. Reports are graded as A, B or C as follows:
- A – Missing up to 1 attribute at a minor level.
 - B – Missing 2 or 3 attributes at a minor level.
 - C – Missing 1 or more attributes at a major level; and/or Missing 4 or more attributes at a minor level.

Audit criteria

- 4.5.6. The full audit criteria are set out below. Further explanation of each attribute is included at appendix 5.4.

¹ Process in this context refers to the process followed being in accordance with defined procedures which are common across assessment providers, as covered in Chapter 2.

| Area | Attribute |
|--------------------------|--|
| Presentation and process | <p>Legible, grammatically reasonable and few spelling or typographical errors</p> <p>No jargon or unexplained abbreviations</p> <p>Clear</p> <p>Consistent</p> <p>Clarification of contradictions or conflicts</p> <p>In accordance with defined procedures</p> <p>In accordance with legislation and policy intent</p> <p>Complete</p> <p>Fully justified</p> <p>Does not contain directive advice that could compromise decision making</p> |
| * Consultation | <p>All conditions that have a functional impact listed</p> <p>History of conditions appropriately recorded</p> <p>Current medication and treatment appropriately recorded</p> <p>Aids or appliances regularly used, appropriately recorded</p> <p>Social and occupational history appropriately recorded</p> <p>Functional history appropriately detailed and recorded</p> <p>Variability appropriately recorded</p> <p>General appearance appropriately recorded</p> <p>Mental state appropriately recorded</p> <p>Appropriately detailed examination of relevant areas recorded</p> <p>Informal observations appropriately recorded</p> |
| Reasoning | <p>Further evidence requested appropriately and suitably sourced</p> <p>All evidence is considered fully and this is documented</p> <p>* Terminal illness advice medically reasonable, logical and based on adequate evidence</p> <p>* Daily living descriptor choices are medically reasonable, logical and based on adequate evidence</p> <p>* Prognosis advice for daily living is medically reasonable, logical and based on adequate evidence</p> <p>Mobility descriptor choices are medically reasonable, logical and based on adequate evidence</p> <p>Prognosis advice for mobility activities is medically reasonable, logical and based on adequate evidence</p> <p>Justification is reasonable, logical and comprehensive</p> <p>Advice on additional support is reasonable, logical and based on adequate evidence</p> |
| Professional standards | <p>Standards independent, impartial, ethical, honest and fair</p> <p>Appropriate action taken on harmful information</p> <p>* Appropriate action taken on unexpected clinical findings</p> |

* not applicable in all cases

4.6. Rework

- 4.6.1. Where the Department considers that assessment reports are not fit for purpose it may return them to providers for rework, which will be carried out at their expense.
- 4.6.2. The criteria are that reports will be:
1. Fair and impartial.
 2. Legible and concise.
 3. In accordance with relevant legislation.
 4. Comprehensive, clearly explaining the medical issues raised, fully clarifying any contradictions in evidence.
 5. In plain English and free of medical jargon and unexplained medical abbreviations.
 6. Presented clearly.
 7. Complete, with answers to all questions relating to disability matters raised by the Department.
 8. Capable of comprehensively providing information to the Department.
- 4.6.3. Providers should develop procedures for accepting, recording and dealing with rework quickly and effectively.

Rework Action

- 4.6.4. The action to be taken in relation to rework will vary on a case-by-case basis. Wherever possible, cases should be discussed with the original HP or referred back to them for further action to be taken.
- 4.6.5. In some cases it may be necessary for an additional face-to-face consultation to be carried out, either with the original HP or a different HP. The impact of any such consultations on claimants should be considered when making the decision to carry out a repeat consultation. Where possible further consultations should be avoided, so as not to place extra burdens on claimants. However, this should not compromise the quality of the advice to DWP.
- 4.6.6. If clerical report forms are being used, Rework activity should result in the production of an entirely new report form (PA2, PA3 or PA4). All changes should be clear and fully justified. It should be made clear that this advice comes as a result of rework activity and the nature of the error or omission and action taken made clear to the Case Manager.

Feedback and Record keeping

- 4.6.7. Providers should establish procedures to ensure that feedback is provided to HPs whose reports require rework.
- 4.6.8. Providers should record the feedback given and remedial action taken as a result of rework. Providers should consider targeted audit of HPs where rework is required.

4.7. Assessment quality feedback from Her Majesty's Courts and Tribunal Service

- 4.7.1. The PIP assessment specification made clear that PIP Assessment Providers may receive feedback from Her Majesty's Courts and Tribunal Service (HMCTS) about the quality of the assessment reports. Providers should consider this feedback and take the appropriate action.
- 4.7.2. Where a medical member of an appeal tribunal identifies that an assessment report is below the standard expected of providers, they may consider giving feedback on the report to the provider in question. The criteria are that reports will be:
- Fair and impartial;
 - Legible and concise;
 - In accordance with relevant legislation;
 - Comprehensive, clearly explaining the medical issues raised, fully clarifying any contradicts in evidence;
 - In plain English and free of medical jargon and unexplained medical abbreviations;
 - Presented clearly;
 - Complete, with answers to all questions relating to the disability matters raised by DWP;
 - Capable of comprehensively providing information to DWP.
- 4.7.3. Providers will need to work with the DWP and HMCTS to develop the processes for receiving this feedback.
- 4.7.4. Providers will also need to develop internal processes for recording referrals from HMCTS, action taken and responding to HMCTS. This should include processes for considering feedback from HMCTS, and where they agree that quality is substandard, steps to ensure that the feedback is passed to the relevant HP where appropriate and any necessary improvement activity taken.
- 4.7.5. Providers will also need to develop processes for liaising with HMCTS where they do not agree with the feedback received and for escalating any unresolved disagreements to the DWP Chief Medical Advisor, who is the final arbiter on assessment quality standards.

4.8. Complaints

- 4.8.1. A complaint is an expression of dissatisfaction about the services delivered by providers which originates from a claimant. They may be made verbally or in writing by the claimant or their representatives.
- 4.8.2. Providers should put in place processes to effectively manage complaints in accordance to meet the contractual targets times that:
- Complaints are acknowledged within 2 working days.
 - 90% of responses are to be made within 20 Working Days.
 - The Actual Average Outstanding Time (AAOT) in relation to claimant responses should be 30 working days.
- 4.8.3. Final responses to complaints should specifically address the issues raised within the complaint and include:
- A factual account of the evidence.
 - A balanced assessment of the evidence obtained and considered.
 - Relevant information about an outcome following the complaint.
- 4.8.4. A further contractual requirement is that 95% of all responses must be fit for purpose.
- 4.8.5. Complaints may – but do not necessarily – relate to the competence of HPs carrying out assessments. Providers should establish procedures to ensure that feedback is provided to HPs following a complaint and that the appropriate action is taken to ensure ongoing quality. Where complaints identify a clear breach in the required competence standards, providers should consider suspending the HP from assessment activity or requesting from the Department that Approval be revoked, pending capability or disciplinary procedures.
- 4.8.6. Where complaints identify evidence of significant errors or omissions that could potentially affect the decision making process or be contrary to professional standards, the Department should be informed.

Serious Complaints

- 4.8.7. A complaint in which there is an allegation of professional malpractice against an HP is classed as a Serious Complaint. This includes, but is not limited to, allegations of:

- Assault / injury during the course of an assessment.
 - Inappropriately intimate examinations.
 - Racial / sexual abuse.
 - Theft or fraud.
 - Criminal activity.
- 4.8.8. Providers should develop processes to manage Serious Complaints separate to the overall complaints processes, with escalation routes to appropriately senior staff.
- 4.8.9. Where a Serious Complaint is made against an HP, the DWP CMA should be informed immediately. Providers should also consider suspending the HP from carrying out PIP assessments until any investigations into the complaint have been completed.
- 4.8.10. Providers should liaise with the DWP CMA on the outcome of any investigation into a Serious Complaint. If a Serious Complaint is upheld, providers should consider:
- Liaising with the relevant professional body (General Medical Council, Nursing and Midwifery Council, Health Professions Council etc).
 - Requesting Revocation of Approval from DWP.

5. Appendices

5.1. Fees for further evidence

- 5.1.1. DWP pays fees for General Practitioner Factual Reports (GPFRs); GP and Consultant completed DS1500s.
- 5.1.2. Fees are not paid by DWP for other sources of evidence, such as Hospital Factual Reports from NHS hospitals and clinics; Local Authority funded clinics; or factual reports / GPFRs completed by professionals other than GPs or Consultants.
- 5.1.3. For many years the Department has not accepted “Treasury fees”, which doctors often quote.
- 5.1.4. The DWP sets its own fees for factual reports and information where a fee is payable and providers should not negotiate individual fees with doctors (GPs or hospital staff).

General Practitioner Factual Reports

- 5.1.5. As independent contractors, GPs are permitted to receive a fee for completing GPFRs and providing factual information unless the information required is included in their contractual agreement.
- 5.1.6. Where it is permissible to pay a fee, this should be the standard fee that the Department pays – currently £33.50 for a GPFR and £17.00 for a DS1500 completed by a GP (although providers will usually not need to seek DS1500s from GPs). If the GP’s surgery is VAT registered, VAT should also be paid in addition to the appropriate fees.

Hospital Factual Reports

- 5.1.7. Under a longstanding agreement (which dates back to the start of the NHS and is sometimes referred to as the “concordat”) hospitals and Trusts are obliged to provide hospital case notes (or copies), X-rays and Factual Reports, on request, within laid down time scales, and free of charge to the DWP and providers working on their behalf.
- 5.1.8. Hospital Factual Reports from NHS hospitals, hospitals who have Trust status, and clinics financed from the NHS or Local Authority are therefore provided free of charge and should not be paid for.

- 5.1.9. Care should be taken to ensure the hospital etc. is funded by the NHS. Private hospitals are not covered by the agreement with the NHS.
- 5.1.10. The responsibility to provide factual reports lies with the hospital, and requests should be addressed to the hospital as opposed to a particular member of staff - though the requests may specify the type of information that would help (e.g. from a physiotherapist).
- 5.1.11. No fee is payable to the person completing the report.
- 5.1.12. Sometimes hospital staff state that they are not contracted to carry out this work on behalf of the hospital. If so they should ask the hospital to arrange for someone else to complete it on behalf of the hospital.

Consultant Reports

- 5.1.13. Consultant reports (CRs), also referred to as Consultant opinions. These are usually prepared following an examination, but can be prepared from the case notes. These are considered as private work and do attract a fee.
- 5.1.14. However, CRs are rarely required for DWP purposes and requests can take a considerable time to be returned. As such CRs should only be obtained in exceptional circumstances.

Rejecting requests for payment

- 5.1.15. Providers are responsible for making payments for the above evidence types where they have sought them, with DWP reimbursing them the fees paid.
- 5.1.16. Where requests are made for payment that do not meet the above criteria, providers should issue a notice rejecting the request.
- 5.1.17. Requests may also be rejected where a professional has responded to a request that would normally be payable but the response was not of an acceptable standard and provided no help in the case – for example, where the professional has made no effort to provide useful information – or the professional has returned their report significantly later than the date requested. However, judgement should be applied when making such decisions, as incomplete returns may be as a result of professionals having insufficient information about the claimant, rather than an unwillingness to help. Such rejections are likely to be rare.

5.2. The principles of good report writing

Clarity

5.2.1. Good quality reports should:

- Be legible.
- Be written in clear English.
- Use appropriate language.
- Explain technical terms.
- Avoid medical jargon.
- Avoid internal contradiction.
- Be correct.
- Be complete.

Clear English

5.2.2. When HPs explain medical reasoning or expressing opinion, it is essential that there should be no misunderstanding. As in all forms of medical (and other) writing the guiding principles should be that HPs:

- Use familiar words.
- Use short words in short sentences.
- Make every word count.

5.2.3. Use of vague or ill defined words such as “may”, “possibly”, “occasionally”, “sometimes” do nothing to refine an account of a case; they merely generate uncertainty. The HP should assist the Case Manager by providing quantifiable data wherever possible.

Appropriate language

5.2.4. PIP assessments are a serious matter that have a direct bearing on benefit entitlement. As such flippancy in reports is not appropriate. Light-hearted remarks about the claimant, the domestic environment, the forms, the benefit and the system in general should not be made as these can cause offence and difficulty.

5.2.5. Reports should not include terms which could cause offence. Appropriate language should be used when describing the claimant, for example "overweight" or "obese" as opposed to "fat". Unless it is essential to the determination of the claim, any information that may be construed as a value judgement should be avoided in advice. For example, comments about the claimant appearing dishevelled are

inappropriate, unless they are part of the evidence supporting a level of self-neglect due to mental health problems.

Explanation of technical terms

- 5.2.6. Attempts to express medical terms in non-technical language can often be difficult and confusing. It is usually preferable to use medical language to describe medical issues and then to explain what they mean.
- 5.2.7. The functional implications of any findings must be explained in the summary justification. For example, “the claimant has reduced shoulder movement – this means that he needs to use an aid to dress and undress and wash and bathe.”

The avoidance of medical jargon

- 5.2.8. Medical jargon should be distinguished from technical medical language. Jargon is medical slang, or shorthand such as:

“SOB++ JVP↑ Ankle oed. R=L AF Δ ?CCF”

- 5.2.9. Such jargon may not be understood by the DM or the next HP to read it and should be avoided.
- 5.2.10. However, in more complex cases involving, for example, the measurement of the range of movement of a number of joints, the use of exact medical terminology would greatly aid precision and so assist the next HP to assess progress.

Avoidance of internal contradiction

- 5.2.11. Medical reports must be internally consistent.
- 5.2.12. If the HP makes the observation in one part of the report that a claimant has only minor restriction of lower limb function due to osteoarthritis, and in another section gives an opinion that he is unable to negotiate stairs due to painful arthritic knees, the reader will question the point.
- 5.2.13. If the HP’s opinion does conflict with information provided by the claimant, the HP should fully explain why there is an inconsistency and the evidence on which their advice is based.

Correctness

5.2.14. Correctness embraces a number of principles:

- The advice must be medically “correct” - that is it must be in keeping with the consensus of medical opinion.
- The account must be factually accurate. One of the commonest criticisms of HPs by claimants in relation to assessments for existing benefits is that some of the information written in the report is wrong.
- The terminology must be correct. If the HP uses phrases such as ‘disability’, he/she must be sure that he/she knows the exact meaning, as they have specific connotations in disability analysis.

5.2.15. Prescriptive language which quotes or reflects phrases (e.g. ‘reconsideration’) used to define conditions for entitlement should be avoided.

Completeness

5.2.16. It is very easy to miss out a key factor in a consultation. For example, the HP realised too late that a claimant who departed five minutes previously had claimed a hearing problem and they had neglected to carry out a formal hearing test, despite conversing with the claimant during the consultation. Good preparation is important and it can be helpful to write down a checklist of all the salient aspects of the case before embarking on the consultation.

Facts versus opinion

5.2.17. A fact is a verifiable statement about the claimant – for example, "He takes paracetamol as required for pain in his left knee"; "She has fine crackles in her lungs, which support a diagnosis of heart failure".

5.2.18. An opinion is the perception or view of an individual – for example, "In my opinion, he only has mild pain"; "In my opinion, she requires supervision in the kitchen". Unsupported opinion should not be included in reports.

5.2.19. Facts provide strong evidence for opinions because they are verifiable. Facts should be used to support descriptor choice. Opinions are most robust if they are based on fact – for example, "In my opinion, his level of pain from osteoarthritis is mild, as he only needs to take paracetamol twice a day"; "She is not safe unless she is supervised while cooking, as she has several times burned saucepans by forgetting them on the hob".

5.2.20. When the HP evaluates the opinion of a third party that provides evidence – for example, a carer or health professional - the HP should evaluate the strength of the opinion being expressed. The HP's evaluation should include the level of expertise of the individual offering the opinion; their direct knowledge of the claimant; and whether it is medically reasonable. An unsupported opinion will carry no weight, whereas an authoritative, well-justified opinion from an expert source will carry far more weight, especially if it is supported by factual evidence. The HP should also consider whether the third party is acting impartially or as the claimant's advocate.

5.3. Sample Quality Audit Proforma

| | | | |
|-------------------------------|--|------------------------|--|
| PIP Quality Audit Form | | Grade of report | |
| Date of audit | | | |
| Auditor name | | | |
| HP name | | | |
| Claimant name | | | |
| NINO | | | |

| Area | Attribute | Met | Minor | Major | N/A | Comments |
|--|--|-----|-------|-------|-----|----------|
| Presentation and process | Legible, grammatically reasonable and few spelling or typographical errors | | | | | |
| | No jargon or unexplained abbreviations | | | | | |
| | Clear | | | | | |
| | Consistent | | | | | |
| | Clarification of contradictions or conflicts | | | | | |
| | In accordance with defined procedures | | | | | |
| | In accordance with legislation | | | | | |
| | Complete | | | | | |
| | Fully justified | | | | | |
| | Does not contain directive advice that could compromise decision making | | | | | |
| Consultation | All conditions that have a functional impact listed | | | | | |
| | History of conditions appropriately recorded | | | | | |
| | Current medication and treatment appropriately recorded | | | | | |
| | Social and occupational history appropriately recorded | | | | | |
| | Functional history appropriately detailed and recorded | | | | | |
| | Variability appropriately recorded | | | | | |
| | General appearance appropriately recorded | | | | | |
| | Mental state appropriately recorded | | | | | |
| | Appropriately detailed examination of relevant areas recorded | | | | | |
| Informal observations appropriately recorded | | | | | | |
| Reasoning | Further evidence requested appropriately and suitably sourced | | | | | |
| | All evidence is considered fully and this is documented | | | | | |
| | Terminal illness advice medically reasonable, logical and based on adequate evidence | | | | | |
| | Daily living descriptor choices are medically reasonable, logical and based on adequate evidence | | | | | |
| | Prognosis advice for daily living is medically reasonable, logical and based on adequate evidence | | | | | |
| | Mobility descriptor choices are medically reasonable, logical and based on adequate evidence | | | | | |
| | Prognosis advice for mobility activities is medically reasonable, logical and based on adequate evidence | | | | | |
| | Justification is reasonable, logical and comprehensive | | | | | |
| | Advice on additional support is reasonable, logical and based on adequate evidence | | | | | |
| | Further evidence requested appropriately and suitably sourced | | | | | |
| Professional standards | Standards independent, impartial, ethical, honest and fair | | | | | |
| | Appropriate action taken on harmful information | | | | | |
| | Appropriate action taken on unexpected clinical findings | | | | | |

| |
|-------------------------|
| Overall Comments |
|-------------------------|

| | |
|----------------------------|--|
| Action required Y/N | |
| If yes what? | |
| Auditor signature | |
| Date | |

| | |
|-------------------------|--|
| Action completed | |
| Comments | |
| Name | |

5.4. Audit Quality criteria definitions

| Presentation and process | | | | |
|---------------------------------|---|--|--|--|
| Code | Attribute | Met | Minor error | Major error |
| PP1 | Legible, grammatically reasonable, and few spelling/typographical errors | Fully comprehensible, all words easily legible, less than 3 spelling/typographical errors | Some words illegible; or some incorrect grammar; or more than 3 spelling/typographical errors; but overall report comprehensible | Legible only with difficulty; or many spelling/typographical errors; or poor grammar throughout |
| PP2 | No jargon or unexplained abbreviations | Any abbreviations used (other than ones in common use, e.g. "BP" for blood pressure) are explained | Contains jargon or abbreviations but report is comprehensible to decision maker | Jargon and/or abbreviations used that make the report difficult to understand or could mislead decision maker |
| PP3 | Clear | Easily understood by decision maker | Some lack of clarity but not sufficient to mislead decision maker or require them to need clarification | Lack of clarity makes report unusable, or could mislead decision maker |
| PP4 | Consistent – no part of the report advice contradicts conclusions in any other part; | Fully consistent throughout | Some inconsistency but not sufficient to mislead decision maker or require them to need clarification | Report internally inconsistent and decision maker may be misled or unable to accurately make a decision without clarification |
| PP5 | Clarification of contradictions or conflicts in evidence gathered, including that from claimant and/or external sources such as factual reports | Any conflict between evidence obtained by HP and evidence provided in external documentation fully explained and justified | Minor conflicts of evidence not addressed in report but insufficient to mislead decision maker or require clarification | Major conflicts of evidence, not addressed in report such that decision maker cannot reliably use report to support entitlement decision |
| PP6 | In accordance with defined procedures | Fully compliant with documented procedures common to both providers and DWP guidance | Minor breach of documented procedures common to both providers and DWP guidance | Documented procedures common to both providers or DWP guidance not followed |

| | | | | |
|----------------------|---|--|--|---|
| PP7 | In accordance with legislation and policy intent | Fully compliant with legislation and policy intent | Not applicable | In breach of legislation and/or policy intent |
| PP8 | Complete | All parts fully completed | Minor omission that does not impact on decision maker's ability to use report | One or more section of report not completed; Major omission such that the Decision Maker may be unable to make a decision without clarification |
| PP9 | Fully justified: justification fully supported by evidence gathered | Fully compliant | Justification could be better supported from the evidence gathered but is sufficient for decision maker without clarification | Justification not supported by evidence gathered and decision maker may be misled or unable to accurately make a decision without clarification |
| PP10 | Does not contain directive advice that could compromise decision making | No directive advice in report | Not applicable | Contains directive advice |
| *Consultation | | | | |
| Code | Attribute | Met | Minor error | Major error |
| C1 | All conditions that have a functional impact listed | All relevant conditions listed | Omission of condition with minor functional impact; or inclusion of conditions that have no functional impact | Omission of one or more conditions with significant functional impact |
| C2 | History of conditions appropriately recorded: all information relevant to functional effects and prognosis concisely recorded | History concise, comprehensive, no irrelevant information included | Contains some irrelevant information, or minor omissions of relevant information | Omission of significant elements of history, or large amounts of irrelevant information included |
| C3 | Current medication and treatment appropriately recorded: all relevant medication/treatment included, with explanation for decision maker of purpose of each | Fully and comprehensively recorded and explained | All medication/treatment recorded, with record of effectiveness/side effects; but explanation for decision maker is not sufficient | Omission of relevant medication/treatment, or of significant side effects; or no explanation of purpose of medication/treatment |

| | | | | |
|----|--|--|---|--|
| | medication/treatment, dosage/frequency; effectiveness; any significant side-effects recorded | | | |
| C4 | Aids or appliances regularly used, appropriately recorded | Fully recorded | Some omissions but with no impact on decision making | Omissions of relevant information that impact on decision making |
| C5 | Social and occupational history appropriately recorded: relevant to functional ability; where occupational history is relevant, impact of disabling condition(s) on ability to work | Full record of relevant information | Some omissions, but with no impact on decision making | Omissions of relevant information that impact on decision making |
| C6 | Functional history appropriately detailed and recorded: using the “typical day” approach, all functional areas covered; information comprehensive and includes level of difficulty in carrying out activity, and any assistance required to carry it out including full consideration of standard attained, repeatability, safety and timeliness | Fully and comprehensively recorded | Some omissions of detail, but with no impact on decision making | Omission of one or more functional areas; or many omissions of detail such that report cannot be reliably used by decision maker to support entitlement decision |
| C7 | Variability appropriately recorded: including frequency of relapses/remissions; and level of functional ability during both relapse and remission | Fully and comprehensively addressed | Not applicable | Variation of one or more conditions not addressed; or functional ability not related to relapses/remissions |
| C8 | General appearance appropriately recorded: only | Appropriate information sensitively recorded | Record broadly appropriate and sensitive, but contains minor | Relevant information not recorded; or record contains |

| | | | | |
|------------------|--|--|---|--|
| | information relevant to decision making is recorded, in a sensitive manner that will not cause offence | | level of inappropriate detail | significant inappropriate detail; or is recorded in a potentially offensive manner |
| C9 | Mental state appropriately recorded: all relevant conditions assessed, with details of their severity and functional effects; claimant's level of insight into their condition is recorded | Full relevant assessment, all relevant details recorded | Omission of minor details, but with no impact on decision making | Omission or inadequate assessment of one or more mental state conditions such that report cannot reliably be used by decision maker to support entitlement decision |
| C10 | Appropriately detailed examination of relevant areas recorded: all relevant areas included; examination and recorded findings are relevant to functional ability | Full relevant examination, all relevant findings fully recorded. | Minor omissions or irrelevant findings that have no impact on decision making | Omission or inadequate examination of one or more relevant areas. |
| C11 | Informal observations appropriately recorded: all observations relevant to functional ability recorded; no irrelevant observations recorded | Full record of relevant information | Some minor omissions, or with minor level of inappropriate detail | Relevant observations not recorded; or record contains significant inappropriate observations |
| Reasoning | | | | |
| Code | Attribute | Met | Minor error | Major error |
| R1 | Further evidence requested appropriately and suitably sourced: evidence requested will assist handling of the case; evidence sought from the most appropriate person/source | Further evidence is necessary to progress the case, and is sought from the most appropriate source | Further evidence is necessary to progress the case, but selected source is not the most appropriate one | Further evidence requested but case can easily be processed without any further evidence; or further evidence is necessary but has not been requested; or further evidence is sourced from a completely inappropriate source |

| | | | | |
|----|--|--------------------------------------|--|---|
| R2 | All evidence is considered fully and this is documented | Fully documented | Documentation lacks detail, but clear from the report that further evidence has been taken into consideration in completing report | No record to show what, if any, evidence has been considered in completing report |
| R3 | *Terminal illness advice medically reasonable and logical | Fully compliant | Not applicable | Advice not medically reasonable or logical |
| R4 | * Daily Living descriptor choices are medically reasonable and logical including full consideration of standard attained, repeatability, safety and timeliness | Fully compliant | Not applicable | Advice not medically reasonable, logical or fully considered |
| R5 | *Prognosis advice for daily living is medically reasonable and logical | Fully compliant and justified advice | Advice not medically reasonable or logical | Advice completely out with consensus of medical opinion |
| R6 | Mobility descriptor choices are medically reasonable and logical including full consideration of standard attained, repeatability, safety and timeliness | Fully compliant and justified advice | Not applicable | Advice not medically reasonable, logical or fully considered |
| R7 | Prognosis advice for mobility activities is medically reasonable and logical | Fully compliant and justified advice | Advice not medically reasonable or logical | Advice completely out with consensus of medical opinion |

| | | | | |
|-------------------------------|--|--------------------------------------|--|--|
| R8 | Justification is reasonable, logical and comprehensive | Fully compliant | Justification is reasonable and logical but in no more than one or two areas, such as an individual descriptor, it lacks detail and/or could be better supported by reference to relevant evidence | Justification is not reasonable or logical; or is not supported by evidence; or it lacks detail in more than two areas; or it has been omitted for any one area (such as an individual descriptor) |
| R9 | Advice on additional support is reasonable, logical and based on adequate evidence | Fully compliant and justified advice | Advice consistent with expert opinion and logical, but not fully explained | Advice not consistent with expert opinion, not logical or based on inappropriate or inadequate evidence |
| Professional standards | | | | |
| Code | Attribute | Met | Minor error | Major error |
| PS1 | Standards independent, impartial, ethical, honest and fair | Fully compliant | Not applicable | Not compliant in any one parameter |
| PS2 | Appropriate action taken on harmful information | Fully compliant | Not applicable | Harmful information not recognised |
| PS3 | *Appropriate action taken on unexpected clinical findings | Fully compliant | Not applicable | Unexpected clinical findings not recognised; or protocol for dealing with them not followed |