



Department  
for Work &  
Pensions

# PIP Assessment Guide

## Part One - The Assessment Process

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

Updated on 03 April 2023

# Foreword

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

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

All 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 consultation and examination 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 APs.

It must be remembered that some of the information may not be readily understood by those who are not trained and experienced HPs. The guide 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 APs as part of the PIP assessment contracts, their full business processes, or work carried out by DWP to monitor and manage AP performance.

There are three parts to the guide for assessment providers (APs) carrying out assessments for Personal Independence Payment (PIP). Each guide focuses on a different part of the process as detailed below:

Part One – The Assessment Process

Part Two – The Assessment Criteria

Part Three – Health Professional Performance

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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 can be paid to those who are in full or part-time work as well as those out of work.
- 1.1.3 PIP was introduced in April 2013 for people aged 16 to 64 years and is replacing Disability Living Allowance (DLA) for adults. The roll-out of PIP to existing DLA claimants commenced from October 2013. DLA claimants aged under 16 and those who were aged 65 or over on 8 April 2013 will not be affected.

### The structure of PIP

1.1.4 PIP has two components:

- Daily Living – 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; and
- Mobility – intended to act as a contribution to the extra costs disabled people face in their day to day lives that relate to mobility.

### The PIP claimant journey

1.1.5 Claimants currently make an application for PIP by phone and once basic entitlement conditions are established, the claimant is asked to complete the *How your disability affects you* questionnaire, referred to in this guide as the 'claimant questionnaire'. At this stage claimants are encouraged to

provide any supporting evidence they already have that they feel should be considered alongside their claim information - for example evidence from a health or other professional involved in their care or treatment.

- 1.1.6 Once the claimant questionnaire has been returned to DWP, in cases where an assessment is required by a Health Professional (HP), the case is referred to an assessment provider (AP) along with any supporting evidence provided. The AP then conducts the assessment, gathering any further evidence necessary before providing an assessment report to DWP.
- 1.1.7 If the claimant questionnaire is not returned and the claimant has been identified as having a mental or cognitive impairment, the claim will be referred directly to the AP for assessment.
- 1.1.8 If the individual is claiming under the Special Rules for End of Life (SREL) criteria, the case will be processed by the DWP if possible. However, if the case requires medical advice it will be referred directly to the AP and dealt with as a priority.
- 1.1.9 Once all evidence gathering has taken place, including an assessment with a HP where appropriate, the DWP Case Manager (CM) will review the claim and all evidence provided and make a decision regarding the award of benefit.
- 1.1.10 If the claimant is unhappy with the decision on their award, they have the right of reconsideration and, if a claimant disagrees with the reconsideration, they have the right to appeal to Her Majesty's Courts and Tribunal Service (HMCTS).

### **The PIP assessment**

- 1.1.11 The assessment for PIP looks at an individual's ability to carry out a series of everyday activities. The assessment considers the overall impact of a claimant's health condition or impairment on their functional ability, rather than focusing on a particular diagnosis. PIP is not a compensation payment for ill health / disability; it is to help people with the increased costs of daily living in cases of long term ill health or disability. PIP sits alongside support provided by the NHS and local authorities and is not meant to duplicate that support.
- 1.1.12 The activities explored during the PIP assessment are:

**Daily Living** (10 activities):

- preparing and cooking a simple meal
- 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

1.1.13 Each activity contains a series of descriptors which describe increasing levels of difficulty with carrying out the activity. The HP will choose a descriptor for each activity and a DWP CM will review the suggested descriptors and decide if the evidence supports those choices. Each descriptor has a score. The total scores for all of the activities related to each component 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.



## 1.2 The Health Professional role

1.2.1 The HP's role is to assess the overall functional effects of the claimant's health condition or impairment on their everyday life over a 12 month period, using the assessment criteria.

1.2.2 The key elements of the HP's role 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 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.

1.2.3 The report to the Department should include:

- Relevant history of the claimant, including information on the disabling health conditions or impairments, their functional effects and information on their 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 consultation. The HP should also take into account the variability of a claimant's condition and their ability to carry out assessment activities in a reliable manner
- Justification of the advice, explaining the evidence used to inform the advice on descriptor choices
- Advice on the likely prognosis for the claimant's condition
- Advice regarding whether the claimant may need additional support from the DWP to comply with future PIP claims processes

1.2.4 The HP may also be asked to provide advice to the CM on a range of other aspects of a claim. HPs enable CMs to make fair and accurate decisions by providing impartial, objective and evidence-based advice. HPs will not liaise directly with CMs, but will liaise with DWP Service Assurance Managers (SAMs) where the CMs have queries, for example:

- seeking additional advice either based on current advice or because further evidence has been submitted
- where there is uncertainty about descriptor choice because of contradicting or unclear evidence has been received. This may result in, a request to consider the evidence or acquire further evidence.

1.2.5 If the Provider or HP has any concerns about the claimant or those who are within their care, in all cases, they should direct their concerns to the appropriate agencies, healthcare professionals and services who may provide further assistance to the claimant. Examples of these circumstances may be appropriate to:

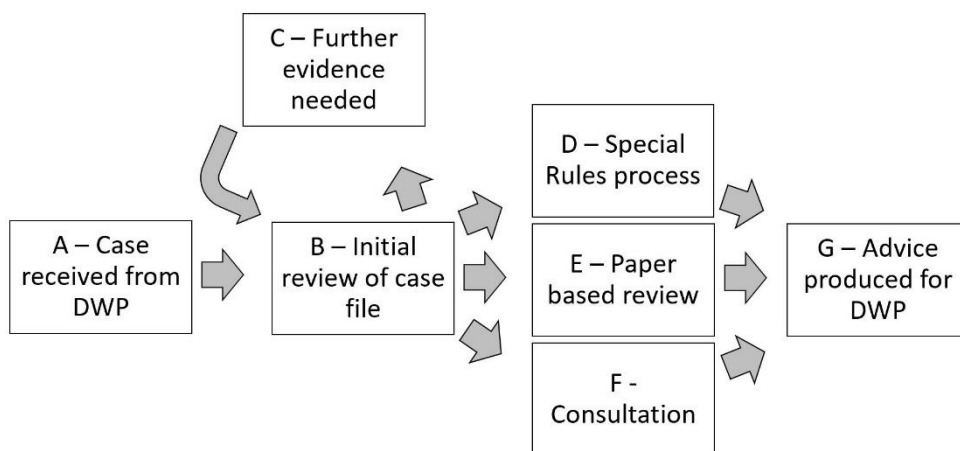
- A claimant with severe depression and anxiety, with children under 18 providing care and support to the claimant.
- During the assessment, the claimant states that they are experiencing psychological/emotional abuse in their home.
- A vulnerable claimant states that they are about to be made homeless, adding to, or exasperating existing conditions.

## 1.3 Carrying out PIP assessments

1.3.1 This section describes how to carry out the assessment. This includes the different processes for Special Rules cases, paper-based reviews and consultations, including guidance on when the different types of assessment should be used. This section also covers other areas on which HPs may be asked to provide advice.

### The PIP assessment process

#### The high-level assessment process



#### Case received into DWP

1.3.2 The claimant questionnaire and any evidence is 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 Assessment Tool (PIPAT) and/or the PIP Computer System (PIPICS)

1.3.3 Once this has been completed, the case will be referred via the PIPICS to the appropriate AP for them to complete on the PIPAT or clerically as appropriate

#### Case received from DWP

1.3.4 The PIPAT allows the AP to give advice to DWP in an electronic format

1.3.5 The following referrals will be sent to APs:

- Claims made under the Special Rules for End of Life (SREL) that are unable to be processed directly by the DWP.
- New claims
- Claims that are being reviewed and where a DWP CM is unable to make a decision without input from a HP. This includes, but is not limited to, reassessment of existing DLA claims and PIP claims where an agreed award review point is reached, or fresh evidence received
- Rework requests in relation to assessment reports
- Advice on other issues

### **Initial review of case file**

1.3.6 On receipt of a referral from DWP, the HP should 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 consultation will be required. –If the HP decides that this is required, they should also determine any difficulties the claimant may have attending a consultation and any reasonable adjustments which need to be put in place (home visit, BSL interpreter, ground floor consultation room, accessibility toilet)

1.3.7 Should the HP discover a case that appears to fall under the SREL provisions, it should be processed under the fast-tracked SREL arrangements.

1.3.8 APs should seek additional evidence from professionals involved in supporting claimants where HPs feel that would help inform their advice. The HP should contact the most appropriate person involved in the claimant's care. In some cases this might be a support worker or therapist rather than the GP. The HP should ideally wait for the return of any further evidence requested before deciding whether a consultation is needed.

1.3.9 APs may receive referrals from DWP for claimants who have a condition which means that they need additional support from DWP and the AP during the PIP application process. In these cases, the HP will need to consider the appropriate approach to completing the assessment (paper-based or

consultation). More information on claimants who require additional support can be found in Section 1.12 of Part One.

- 1.3.10 The HP should document a fully justified choice of further action taken during the initial review, including the justification for the assessment type required, providing this to DWP as part of the case documentation.
- 1.3.11 HPs should also consider the needs of vulnerable claimants. A vulnerable claimant is defined as “someone who has difficulty in dealing with procedural demands at the time when they need to access a service.” This includes life events and personal circumstances such as a previous suicide attempt, domestic violence, abuse, or bereavement. If a claimant has been in contact with DWP and has threatened self-harm or suicide, information about the incident will be included in the PIPCS – Medical Evidence screen comments box.
- 1.3.12 The HP should complete a PA1 – Review file note or an equivalent form or relevant IT system notes explaining the action taken on the case, how the decision was made on the type of assessment and the evidence used to support the decision.

## **1.4 Further evidence needed**

1.4.1 Additional evidence from professionals supporting the claimant should be sought where the HP feels it would help to inform their advice to DWP. The circumstances where obtaining further evidence may be appropriate include (but are not limited to):

- Where HPs feel that further evidence will allow them to offer robust advice without the need for a consultation – for example, because the addition of key evidence will negate the need for a consultation
- Where they feel that a consultation may be unhelpful because the claimant lacks insight into their condition
- Where claimants have progressive or fluctuating conditions
- Where they consider that a consultation is likely to still be needed but further evidence will improve the quality of the advice provided to DWP – for example, because the existing evidence lacks detail or is contradictory or to corroborate other evidence
- Where, in reassessment cases, further evidence may confirm whether or not there has been a change in the claimant's health condition or disability.

1.4.2 If a consultation has already been arranged and, following receipt of further evidence, the HP concludes that they can now advise DWP on the basis of paper evidence, the consultation should be cancelled.

1.4.3 If a claimant presents further relevant evidence during a consultation which is not already on PIPCS, the HP should always consider its relevance when completing their assessment report. Under normal circumstances the HP would make copies of the original evidence and hand the originals back to the claimant. In circumstances where it is not possible to copy the further evidence, perhaps during telephone or home consultations or where the claimant does not wish to part with the evidence, then it is permissible for the HP to make notes from the original further evidence documentation. The copy of the evidence or HP notes from the evidence should be sent to the CM with the completed report.

### **Sources of further evidence**

1.4.4 In the claimant questionnaire, claimants are encouraged to list the professionals who support them and are best placed

to provide advice on their circumstances. HPs should give consideration to the fact that in cases of complex conditions, knowledge and involvement of the GP may be limited, with specialist practitioners potentially better placed in some cases to provide useful evidence. HPs should consider which professionals identified can provide useful evidence. They should not simply request evidence from all professionals identified as standard.

1.4.5 The HP should consider the most appropriate evidence for the case under consideration. There are various sources of further evidence, including, but not limited to:

- A report from other health professionals involved in the claimant's care such as a Community Psychiatric Nurse (CPN)
- A report from an NHS hospital
- A factual report from a GP
- A report from a local authority-funded clinic
- Current repeat prescription lists
- Care or treatment plans
- Evidence from any other professional involved in supporting the claimant, such as social workers, key workers or 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
- An audiologist's report
- Contacting the claimant by telephone for further information.

### **Seeking further evidence from professionals**

1.4.6 DWP has three standard pro forma for use in seeking evidence in writing from (a) GPs, (b) hospitals and (c) other professionals. These pro forma are provided separately.

1.4.7 Where necessary, HPs may also seek evidence from professionals by telephone. Such telephone calls should be made by approved HPs, not by clerical staff.

1.4.8 A written record should be taken of any telephone discussions seeking further information and the content included in the assessment report provided to DWP or via the PIPAT. 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.

1.4.9 The HP should also clarify whether any information provided by the professional is Harmful or Confidential.

### **Harmful Information**

1.4.10 In all cases and on all forms the HP completes when giving advice, the HP should check their advice for any information which could be seriously harmful to the claimant's 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.

### **From Autumn 2016**

1.4.11 Where a claimant's condition has been deemed harmful and captured in the relevant screen in the PIPAT or PIPAT mobile, this Harmful Information will be included on either the assessment report form (fast-track paper review) (PA2), assessment report form (paper review) (PA3), assessment report form (consultation) (PA4) or supplementary advice note (change of advice) (PA6). The DWP and HPs will be expected to verify that this is the case.

1.4.12 Should Harmful Information other than the claimant's condition be present – either contained in supporting evidence or identified at a face-to-face consultation – this should be recorded separately on the Harmful Information note (PA7) or within the Harmful Information screens in the PIPAT or PIPAT mobile and clearly marked as "harmful". The HP should indicate where any Harmful Information is contained in an assessment report, for example: "the claimant is not aware of their condition and the PA X contains Harmful Information in supporting evidence" or "Part X of the GP Factual Report dated XXXX contains Harmful Information."

### **Confidential information**



1.4.13 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 DWP CM.

1.4.14 If the claimant states that they want to tell the HP something “in confidence” 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 CM making the decision on their claim would have no access to it.

### **Seeking further information from the claimant**

1.4.15 Where necessary, HPs may seek further information from claimants by telephone. Such telephone calls should be made by approved HPs, not by clerical staff.

1.4.16 HPs should identify who they are and the purpose of the call. A written record should be taken of any telephone discussion seeking further information, using the claimant’s own words as precisely as possible. This information should be included in the assessment report provided to DWP or via the PIPAT. 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**

1.4.17 The DWP currently pays for two specific forms of evidence: factual reports from GPs and SR1 forms completed by doctors who are registered with the General Medical Council (GMC).

1.4.18 APs are responsible for making payments for GP Factual Reports (GPFRs) where they have sought them, with the DWP reimbursing them the fees paid. SR1s will be sought and paid for by the DWP.

### **Late return of Further Evidence**

1.4.19 Where further evidence is received after the assessment has been completed and returned to the DWP, the evidence must be sent to the CM for consideration. If evidence is returned to the AP in error, it should still be forwarded to the DWP for scanning.

## 1.5 Paper-based reviews

1.5.1 HPs should carry out assessments using a paper-based review in cases where they believe there is sufficient evidence in the claim file, including supporting evidence, to provide robust advice to the DWP on how the assessment criteria relate to the claimant. It is vital all advice is sufficiently evidenced.

### Balance of probabilities

1.5.2 In some cases there may be sufficient information to advise on the majority of activities, but which leaves small gaps that it has not been possible to fill through obtaining FE or by contacting the claimant. In such cases, where the available information is consistent, the HP should consider whether they can use their own expert clinical knowledge of the condition(s), its severity and known impact in other areas to determine, on the balance of probabilities, the likely impact in the remaining areas. If they feel confident doing this and it would be in line with the consensus of medical opinion, then a paper-based review may still be possible, referring to such in the summary justification.

1.5.3 Apart from examination and informal observations that can only be obtained at a consultation, the HP must complete the paper-based review in line with the advice given in this guidance. HPs are required to advise on:

- Which of the descriptors in the activities set out in the assessment criteria are relevant to the claimant, taking due consideration of variability and reliability
- Whether the functional impact of the claimant's health condition(s) or impairment(s) has been present for at least three months and is likely to remain for at least nine months
- The appropriate time to review the claim, or indeed whether the claim will require a review, and whether the functional restriction identified in the report will be present at the point of any review
- Whether the claimant is likely to require additional support from the DWP in order to engage with future PIP claims processes.

1.5.4 The HP must – where appropriate – provide an overall summary justification or an individual justification for each descriptor choice to support the advice and provide the reasons for the advice. In cases of complex fluctuation, providing an

individual justification for each descriptor can help to ensure this is fully explored and advice justified.

### **Cases that should not require a consultation**

1.5.5 Although each case should be determined individually, the following types of case should not normally require a consultation:

- The claimant questionnaire indicates a low level of disability, the information is consistent, medically reasonable and there is nothing to suggest under-reporting
- The health condition(s) is associated with a low level of functional impairment, the claimant is under GP care only and there is no record of hospital admission. This advice applies even if the claimant maintains that they suffer from a high level of functional impairment – it is medically improbable that this is the case and a consultation is unlikely to add much useful additional information, since the clinical examination is likely to be unremarkable
- There is strong evidence on which to advise on the case and a consultation is likely to be stressful for the claimant (for example, claimants with autism, cognitive impairment or learning disability)
- The claimant questionnaire indicates a high level of disability, the information is consistent, medically reasonable and there is nothing to suggest over-reporting – (examples may include claimants with severe neurological conditions such as multiple sclerosis, motor neurone disease, dementia, Parkinson’s disease, severely disabling stroke)
- There is sufficient detailed, consistent and medically reasonable information on function.

### **Cases that are likely to require a consultation**

1.5.6 For cases where there is marked inconsistency, the claimed level of disability is unexpected based on the available evidence, or it has not been possible to gain sufficient further evidence, a consultation will be required.

## 1.6 The consultation

1.6.1 In the majority of cases, a consultation will be necessary to accurately assess the claimant's functional ability. This gives the claimant the opportunity to explain to the HP how their impairment or health condition affects them.

1.6.2 Consultations may be carried out at a range of locations, including an assessment centre, local healthcare centre or in the claimant's own home. This list is not definitive and the location should take into account the need to provide an appropriate venue to enable the claimant to attend the assessment.

1.6.3 This section contains guidance for HPs on how to carry out consultations, including giving a standard structure to consultations. However, HPs should be prepared to adapt their approach to the needs of the particular claimant, 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.

1.6.4 The relevant information required when offering advice on a consultation is set out in the clerical form PA4 or the relevant screens in the PIPAT.

1.6.5 Before starting the consultation, the HP should read the claimant questionnaire and all other evidence on file. It is also recommended that the HPs could also consult with clinical coaches or other experts prior to the assessment for advice and support on how conditions present and how this might affect function.

1.6.6 When speaking with the claimant, the HP should:

- Introduce themselves to the claimant and, if accompanied, their companion
- Explain the purpose of the assessment and what it entails – the HP should make clear to the claimant that the assessment is not a medical which involves diagnosis and treatment of their disability or condition. It should be explained that the assessment focuses on the effects of their health condition or impairment on their day-to-day life, looking at what

they can and cannot do in relation to the daily living and mobility activities

- To note: It is important that the HP ensures that valid verbal consent is obtained and recorded where appropriate.

### **Interview skills**

1.6.7 Throughout consultations, the HP should:

- Use clear language that the claimant will readily understand
- For sighted claimants, during face to face assessments, 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 towards the claimant from time to time
- When recording information on any computer systems, the HP should ensure that they look up frequently from the screen and maintain eye contact
- For blind and partially sighted claimants, the HP should explain what they are doing at each stage of the assessment.

1.6.8 The approach should be relaxed, 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.

1.6.9 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 allow the HP to develop the story the claimant is giving (for example, "So what happens after...").

### **Inconsistencies in the level of functional limitations**

1.6.10 Throughout the consultation, HPs should be evaluating what they are being told and checking whether the evidence is consistent. Inconsistencies could result in claimants either over or under emphasising the impact of their conditions and efforts should be made to avoid both. For example, is the level of functional impairment claimed in one activity compatible with that claimed in another? If a claimant can handle a toothbrush, it is unlikely they cannot handle kitchen cutlery. If a claimant cannot bend to put on their shoes, it is unlikely that they are able to wash below the waist.

1.6.11 When considering inconsistencies, HPs should bear in mind that some claimants may have no insight into their condition, for example claimants with cognitive or developmental impairments. In addition, variability in a condition may suggest findings which initially seem inconsistent. This should be explored through further questions to develop this detail.

### **History of conditions**

1.6.12 The HP should record a succinct and relevant history of all the health conditions or impairments that affect the claimant. The HP should record when the condition began and give brief details of changes since it began. In the case of fluctuation, the frequency and impact of periods of exacerbation and remission should be explored and recorded. If the diagnosis is unclear – the HP should record the condition as described by the claimant describing the symptoms, rather than trying to guess at the underlying pathology.

1.6.13 The HP should record a brief summary of treatments or interventions, and how effective it has been, and whether any further intervention, such as physiotherapy or a surgical procedure, is planned. The HP should also include what relevant investigations have been carried out or planned for the future.

- 1.6.14 The HP should include 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 a specific period of time.
- 1.6.15 The HP must document the symptoms and history of the condition as described by the claimant. 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.
- 1.6.16 Where the claimant's clinical history is accurately detailed in either the claimant questionnaire or in supporting evidence, the HP may reference where it is recorded instead of reproducing this information in the assessment report.
- 1.6.17 All current medication, including "over-the-counter" medication, should be recorded in the report, unless it is fully documented on other evidence in PIPCS. For each medication record the frequency, dosage and purpose (where known) in full. Any relevant side effects which affect the claimant's functionality should be recorded here and an indication of the effectiveness of any treatment provided. The HP should also include details of any alterations to medication which have occurred since the questionnaire or supporting evidence was supplied.
- 1.6.18 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.
- 1.6.19 Where the claimant's current medication is accurately recorded in either the claimant questionnaire or in supporting evidence, the HP may reference where it is recorded instead of reproducing this information in the assessment report.

### **Social and occupational history**

- 1.6.20 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 had to make any modifications? Social and leisure activities undertaken by the claimant, as well as any they have given up or modified due to

their health condition or impairment, could also be mentioned here.

## **Employment**

- 1.6.21 The employment status of the claimant might be relevant and this should be explored and recorded as part of the evidence gathered in 'social and occupational history'.
- 1.6.22 If the HP identifies inconsistencies between work and information on the claimant questionnaire, the HP should question these inconsistencies and document the response.
- 1.6.23 The HP should record the occupation and the nature of the job for example, activities on a daily/weekly basis, including any reasonable adjustments made by the employer. They should also include information where the claimant has given up work or changed their job due to the functional limitations of their health condition or impairment.

## **Functional history including the 'typical day'**

- 1.6.24 Evidence gathered in the functional history is an important part of the assessment process as it should provide the CM with a clear picture of the claimant's day-to-day life.
- 1.6.25 The 'typical day' is a tool used to explore the claimant's perception of how they manage their daily living, and the nature and extent of the functional limitations resulting from their health condition or impairment. 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?
- 1.6.26 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.
- 1.6.27 As well as covering all the PIP activity areas, the typical day should also cover other activities such as housework, shopping and caring responsibilities for adults, children and



pets, and hobbies and pastimes – these details give additional supporting information about functional ability. For example, doing housework provides information about mobility, manual dexterity and fatigability. Doing crossword puzzles requires visual acuity, manual dexterity, concentration and cognitive ability. This section of the consultation must also explore the impact completing an activity may have on functional restriction immediately following and for the rest of the day. For example, if carrying out housework or walking outside would mean the claimant was unable to do anything else that day, this should be properly explored and recorded.

1.6.28 The functional history is the claimant's own perspective on how they manage the daily living and mobility activities. 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"; " manages to feed herself but needs to have meat cut up for her".

1.6.29 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 invite the claimant to talk through all the activities they carry out on most days, from when they get up to when they go to bed. The HP should do this by using open-ended questions and not just by asking a series of closed questions. The HP should encourage the claimant to expand on their answers 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 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, why they need help, who gives it, how often and for how long.

1.6.30 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. It is important to understand that more than one of these time frames for fluctuation may apply to an individual claimant. Information about variability is crucial in assessing the functional effects of the claimant's condition that apply on the majority of days and whether someone can carry out activities reliably, bearing in mind that advice will need to consider the impact of conditions over a year-long period. A "snapshot" view of the claimant's condition on a particular day at a particular time is not an adequate assessment.

### **Informal observations**

1.6.31 Informal observations are part of the suite of evidence used by CMs to help them determine entitlement to benefit. Informal observations are of importance to the consultation, as they can reveal abilities and limitations not mentioned in the claimant questionnaire, supporting evidence or during the history taking for the consultation. They may also show discrepancies between the reported need and the actual needs of the claimant. However it is important to balance informal observations with evidence from professionals who may have observed the claimant more regularly.

1.6.32 The HP should be making informal observations and evaluating any functional limitations described by the claimant from the start of the consultation. The HP cannot document any observations made outwith the consultation. The consultation starts at the point the claimant begins to converse with the HP on the telephone, enters the assessment centre or is met at their home and concludes when the claimant ends the telephone conversation, leaves the premises of the assessment or the HP leaves the claimant's residence. HPs may be able to observe relevant aspects of the claimant's appearance, for example how well kempt they are and whether they look under or over weight, during face to face consultation. This would be considered together with other factors such as their manner, hearing ability, walking ability during the history taking, through to the conclusion of the consultation. Informal observations should be recorded in the report, for example: "I observed them... and they appeared to have no difficulty with..."; "I saw him lean heavily on a walking stick when entering the consulting room".

- 1.6.33 HPs need be aware that it is possible that the assessment room may, for some claimants, provide an environment that appears to artificially enhance functional ability, for example for some claimants with hearing impairments. A home environment may also provide either an ideal, good or a very poor environment for testing functional ability, for example, depending on the level of background noise. HPs need to ensure that they explore claimants' functional ability in everyday life and in a variety of environments/situations that may not be ideal.
- 1.6.34 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 if the claimant 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 descriptor is most likely to apply.
- 1.6.35 HPs must also take into consideration the invisible nature of some symptoms such as fatigue and pain which may be less easy to identify and explore through observation of the claimant. HPs should be mindful that the level of analgesia used does not necessarily correlate with the level of pain. GPs are encouraged to avoid prescribing strong painkillers for long-term pain as the harms usually outweigh the benefits and there could also be specific reasons why painkillers aren't prescribed e.g. intolerance, or the use of other methods of pain relief. When pain is a significant symptom we would expect the claimant to be able to describe the location, type, severity and variability of the pain they experience and the impact it has on their daily life. The HP can assess the disabling effect of the pain by considering such description (where applicable) along with all other aspects of the case, e.g. disease activity/severity, effect on daily activities, treatment, pain relief, pain management strategies, examination findings and informal observations.
- 1.6.36 When considering mental health medication HPs should remember that not all claimants with a mental health condition will be on medication or receiving therapy. Severity of a mental

health condition does not necessarily correspond with the type or dosage of medication that the claimant is receiving. There are a number of reasons why a claimant may be unable or choose not to take mental health medication, for example, but not limited to:

- Poor compliance due to the nature of mental health condition
- Side effects or difficulty tolerating medication
- Lack of efficacy
- Preference for psychological therapy instead of medication
- Complicating factors e.g. excessive alcohol consumption

Therefore absence of medication does not automatically mean that the health condition is not severe. However, HPs should consider the type and context of certain medications, for example use of depot antipsychotic injections in psychotic disorders.

HPs should also take into account that some medications are used to treat different conditions, for example some antidepressants are also licenced to treat anxiety. HPs must also consider the use of other treatments such as psychological therapies.

## **Functional examination**

1.6.37 HPs may wish to examine areas of function relevant to the claimant's health condition or impairment. Such examinations should be tailored to the individual claimant and will vary depending on the nature of the disabling conditions present. Where there is clear and current evidence of a claimant's functional examination findings in a particular area, HPs do not need to conduct an examination of that area...

Functional examinations may cover one or more of:

- Mental functioning
- Vision
- Cardiorespiratory system
- Musculoskeletal system.

1.6.38 Before starting a physical examination, the HP must explain the procedure to the claimant, and obtain explicit verbal

consent to continue. The HP must explain to the claimant that they are going to carry out a functional examination but that it will be different from the clinical examination they might get at their GP's surgery. This is because the HP is not trying to make a diagnosis of their condition. The HP should note in the report that they have explained the procedure to the claimant and obtained their consent to proceed. Consent may need to be obtained at other points during the examination as the HCP should explain throughout what they are about to examine.

- 1.6.39 Any examination should be carried out in a professional and sensitive manner, aiming to avoid causing the claimant any distress. The HP should demonstrate movements and observe the claimant's range of movement. They should not move the claimant's limbs. 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.
- 1.6.40 The HP will never disturb underwear, never ask the claimant to remove their underwear, and never carry out intimate examinations (breast, rectal, abdominal or genital examinations).
- 1.6.41 Some examinations – for example, of the lower limbs – might be 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 they can while the claimant is sitting or standing.
- 1.6.42 Clinical findings from a musculoskeletal examination should be recorded in plain English, – for example 'able to place hands at the back of the head', 'able to reach above the head' – to help the CM understand the details of the examination. However, if findings are expressed as a measurement, the HP should put this into context for the CM by also describing the range with reference to the normal range of movement, for example he can turn his head to the right by 40 degrees, which is about half normal movement.
- 1.6.43 The assessment of mental function should be tailored to individual claimants and may take into account appearance and behaviour, speech, mood, depersonalisation/derealisation, thought, perception, cognitive function, insight and addictions.

Where cognitive difficulties are a common symptom of a relevant condition, these should be assessed.

- 1.6.44 If an area of function is examined, the HP must record all findings in the assessment report, even if function is found to be normal.
- 1.6.45 If any element of function is not examined at the consultation, the HP should record why this area was not examined rather than leave the section of the report form blank. For example: "She states she has no problems with speech, hearing, or vision". "He reported that bending would cause pain or worsening of his symptoms so movement of the spine was not assessed".
- 1.6.46 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 consultation**

- 1.6.47 Prior to concluding consultations, HPs should give claimants an overview of the findings they have taken from the consultation, including an indication of the fluctuation and variability of function they have recorded. Claimants should be invited to clarify any points and ask any questions they have about the assessment procedure, and asked whether there is anything else they would like to include. The HP should always attempt to respond to any issues or concerns they express.
- 1.6.48 No opinion on entitlement to benefit should be given by the HP. Claimants who ask should be reminded that it is for the DWP to decide entitlement. The report and all other evidence available will be used by the CM who will contact the claimant in due course.
- 1.6.49 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 and that the claimant can request a copy of their report from the DWP.
- 1.6.50 HPs should be ready to terminate consultations at any point should they become too stressful for the claimant.

### **Uncooperative claimants**

1.6.51 If the claimant is uncooperative during a consultation, the HP may terminate the consultation where they have gathered sufficient evidence to complete the assessment report and provide advice for the CM. If the claimant is persistently uncooperative or if they are clearly under the influence of alcohol or drugs, the consultation should be terminated and the case returned to the DWP, along with an explanation of why the consultation had to be terminated.

### **Companions at consultations**

1.6.52 Claimants have a right to be accompanied to a consultation if they so wish. Claimants should be encouraged to involve another person at 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.

1.6.53 On most occasions the claimant is likely to have one, or possibly two, companions. There may be very occasional circumstances where the claimant reasonably requires the support of more companions and this would be acceptable. If the HP has reason to believe that the companion(s) are attending for a reason other than to support the claimant, the HP has the right to decline the presence of the companion(s) at the assessment. These occasions are expected to be rare.

1.6.54 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. HPs should allow a companion to contribute and should record any evidence they provide. 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.

1.6.55 However, the involvement of companions should be handled appropriately by the HP. It is essential that the HP's advice considers the details given by the claimant and the companion and whether one or both are understating or

overstating the needs. 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.

- 1.6.56 HPs should use their judgement about the presence of companions during any examination. A companion should be in the room for an examination only if both the claimant and the HP agree. Companions should take no part in examinations.
- 1.6.57 The presence and involvement of any companion at a consultation should be recorded in the assessment report.

### **Audio recording of PIP consultations**

- 1.6.58 Upon prior request, providers have the facility to audio record telephone and face to face consultations. There is an expectation that this will remove or reduce the need for claimants to record consultations.
- 1.6.59 At a face to face assessment, the claimant must sign a consent form in which they agree to not use the audio recording for unlawful purposes. At a telephone assessment, consent should be captured verbally on the recording.
- 1.6.60 In some circumstances, claimants may wish to use their own equipment to audio record their consultation. The consent process above should be followed.
- 1.6.61 APs must publicise these conditions and include them in communications sent to claimants before they attend a consultation.
- 1.6.62 Video recording of consultations is not permitted. This is to ensure the safety and privacy of staff and other claimants.

### **Restrictions on claimants' use of recordings**

- 1.6.63 If it is only the claimant's personal data that is being recorded then there are no restrictions on the use the claimant can make of 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 consultations**



- 1.6.64 A claimant may make a covert recording of the consultation without the HP being aware. If the HP notices that a claimant is covertly recording their consultation, the restrictions above should be explained to the claimant.

### **Note-taking during the consultation**

- 1.6.65 Claimants and companions taking part in a consultation with the claimant are entitled to take notes for their own purposes. The claimant or companion may keep the notes and do not have to provide a copy to the HP, although the HP may record that notes were taken. The notes are for the claimant or companion's own purposes and are not an official record of the process.

### **Young people**

- 1.6.66 HPs may need to adapt their approach when assessing young people. Care should be taken, as always, to avoid creating stress or anxiety for 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.
- 1.6.67 Young people may attend a consultation with a parent or guardian. 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 and 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 for which the parent or guardian continues to assume responsibility. The HP should base their assessment on what the young person would be able to do if asked – that is, what they are functionally able to do – not the skills they have or haven't learned.

### **Unexpected findings**

- 1.6.68 Very rarely during the consultation, the HP may identify that the claimant appears to have a significant undiagnosed medical condition –. If the HP identifies such a condition, they have a responsibility to notify a suitable person involved in the claimant's care. This will usually be their GP.
- 1.6.69 The HP 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. If the claimant agrees, the HP should complete and send the relevant referral form to the claimant's GP, and give the claimant a copy.
- 1.6.70 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, they should seek the claimant's consent to telephone the GP or call an ambulance if appropriate. Such a telephone call should be followed up with a written notification to the GP. It is strongly recommended that the HP seek the claimant's consent to telephone their GP and inform them of the finding as soon as possible.
- 1.6.71 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. The HP should act within the guidelines, and be able to justify their actions. Procedures to follow and sources of support and guidance should be covered in HP training.

### **Home consultations**

- 1.6.72 Consultations may potentially be carried out at a variety of locations and some will need to be carried out at the claimant's home. 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 or cause significant distress to the claimant, – for example where the claimant is autistic, has severe physical disability or severe agoraphobia – the HP should, at a minimum, consider whether a home consultation is necessary.

1.6.73 When considering a request for a home consultation, HPs should consider:

- Whether another assessment type is more appropriate
- Whether the claimant has a medical condition that either precludes them from travelling, or makes it extremely difficult for them to travel
- The nature and severity of the condition
- The safety implications for a home consultation for the HP – for example, where the claimant has previously displayed unacceptable behaviour towards the DWP and this has been noted in their case file.
- Any accessibility issues related to the planned location of consultations.

1.6.74 The request for a home consultation may come from a GP or other healthcare professional involved in the claimant's care. When considering such requests, the HP should consider the points outlined above before making a decision on whether a home consultation would be appropriate.

1.6.75 HPs may also consider whether other options may be acceptable – for example, if travelling on public transport is the issue, could a taxi be considered?

1.6.76 Claimants are not required to provide evidence that would incur a fee to request a home consultation (unless they already have that evidence available). Where deemed necessary, they may be asked to provide other free of charge relevant evidence to support their request, for example evidence from a social worker, community nurse or carer that shows why a home consultation would be appropriate.

## **1.7 Special Rules for End of Life (SREL)**

- 1.7.1 These provisions were previously called Special Rules for Terminal Illness (SRTI), but this has now changed to 'Special Rules for End of Life' (SREL). The remainder of this section will refer to SREL rather than SRTI.
- 1.7.2 Claimants who identify themselves as nearing the end of life on the initial claim form can seek to claim PIP via the fast-track process known as SREL. If possible, the DWP will process the claim but where medical advice is required, the case will be referred to the AP for input. HPs will be required to advise on whether the claimant satisfies the SREL provisions (see below) and provide advice with appropriate justification to the DWP.
- 1.7.3 The criteria for SREL claims 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 12 months."
- 1.7.4 If the claimant meets the SREL provisions, they will automatically receive the enhanced rate of the Daily Living component. The claimant will not automatically receive the Mobility component and entitlement for this component will need to be assessed.

### **Referral procedure**

- 1.7.5 If the claimant states that they are nearing the end of life when applying for PIP, they will be advised by the DWP to obtain an SR1 form from their GP, consultant, specialty doctor, hospice doctor or senior specialist nurse. The DWP will wait 7 working days for the SR1 to be returned before making a referral to the AP.
- 1.7.6 The SR1 form is the preferred medical evidence for a DWP SREL claim and has replaced the DS1500. However, SREL referrals may continue to include DS1500 forms and these should be considered in the same way as SR1 forms. We anticipate that in time the DS1500 will be phased out once the national transition to SR1 forms is complete.

- 1.7.7 BASRiS (Benefits Assessment under Special Rules in Scotland) is the Scottish Government's replacement for the SR1 and DS1500. Where a BASRiS form has been provided, DWP should treat it as 'other medical evidence' and refer the claim to the AP for review in all cases.
- 1.7.8 The referral sent to the AP via the PIPCS will include the initial claim details together with the SR1 or other medical evidence if any has been submitted by the claimant.
- 1.7.9 The SR1 gives factual information about the claimant's condition; whether they are aware of their diagnosis/prognosis; details of any treatment received, ongoing or planned; and the date from which the claimant is thought to have met the SREL criteria.
- 1.7.10 SREL referrals will not contain the claimant questionnaire 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 the AP. This will include details of the claimant's key supporting health professional and basic information about their mobility.
- 1.7.11 All SREL claims will be clearly flagged. SREL referrals must be completed and returned to the DWP within two working days.
- 1.7.12 Consultations are not required where a claim has been referred under the SREL provisions.

### **HP advice in SREL claims**

1.7.13 In SREL claims, HPs are required to advise on:

- Whether they consider, on balance, the claimant is or is not nearing the end of life as per 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.

1.7.14 The HP must provide a summary justification to support the advice to the DWP. Failure to provide this may result in the advice being returned for clarification or rework.

1.7.15 If the claimant is already in receipt of PIP and the case has been referred under SREL as a change of circumstances, the HP must include an indication of when the claimant was first

thought to meet the SREL criteria. Failure to provide this information may result in the advice being returned for rework.

1.7.16 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 12 months, they should advise accordingly.

1.7.17 The relevant information required when offering advice on SREL claims is set out in the PIP Assessment Tool or clerical form PA2.

### **Further evidence in SREL claims**

1.7.18 If there is insufficient information in the claim file to confirm that the claimant is nearing the end of life and consent is clearly indicated on the file, the HP should telephone the clinician identified by the claimant in PIPCS. When making telephone contact with a GP or other clinician, 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.

1.7.19 If no SR1 has been provided and there is no additional medical evidence, a telephone call to the relevant clinician will always be required.

1.7.20 If the HP is unable to contact the clinician identified in PIPCS, then they should try to contact another relevant clinician involved in the patient's care. On rare occasions, it may not be possible to contact the GP or other relevant clinician to obtain advice. In such cases the HP may need to seek advice from another person, for example (this list is not exhaustive):

- A third party (where noted on the claimant's case) in order to obtain the necessary evidence
- The practice nurse
- The practice administrative staff for support with contacting relevant clinical staff. (Note: information should only be requested from administrative staff if all other sources of evidence have been unsuccessful).

1.7.21 The HP must ensure that the claimant has given consent for the person they phone to share information. It is important to

remember that GPs and specialists are responsible for any information divulged by the administrative staff and HPs must ensure that the person they speak to has the authority to provide the information. The HP must record the telephone conversation in their notes, indicating who has given that person the authority to speak on their behalf.

- 1.7.22 All telephone conversations should be recorded and include all relevant clinical information gathered by the HP. The information gathered forms part of the suite of evidence and should be included in the assessment report provided to the DWP and referenced in their advice.

### **Contacting claimants in SREL claims**

- 1.7.23 Every effort should be made to provide advice in SREL cases. If the HP cannot obtain further evidence from the GP or other clinician, the HP should by exception consider contacting the claimant. Where the claim has been made by a third party, the HP should contact the third party, rather than the claimant, as the claimant may not be aware of their prognosis.
- 1.7.24 The claimant or their representative may be able to provide updated information on where they are having their treatment and who is treating them. This may be enough to enable the HP to gather further medical evidence or advise whether the claimant satisfies the criteria for SREL. The claimant or their representative may also be able to provide updated information on treatment received or planned. HPs are expected to use their professional knowledge, skills and judgement to determine what questions are appropriate to ask about treatment.
- 1.7.25 Should the HP fail to obtain an unequivocal answer about prognosis or whether the claimant is nearing the end of life, their advice to the CM must be founded on the balance of medical probability, which should if possible be evidence-based. In exceptional circumstances a written request for further evidence can be issued.

### **Referrals of claimants already in receipt of benefits via SREL**

- 1.7.26 In PIP SREL referrals, the DWP will check for an Employment and Support Allowance (ESA) or Universal Credit (UC) claim under SREL. If the information is available, the CM

will transcribe the decision and any justification, word for word, into the medical evidence screen of the PIPCS.

- 1.7.27 The HP will be asked to consider the ESA/UC evidence when providing advice to the DWP.
- 1.7.28 Where it is felt that this is still insufficient, the HP would be asked to contact the clinician that the claimant has identified on the claim form, to obtain information in order to advise the DWP.

### **SR1 form received without a claim form**

- 1.7.29 Any SR1 forms received directly by APs should not be considered. Unsolicited SR1 forms should be sent urgently to the DWP, with an explanation as to the reason why the AP is sending the form.

### **Claimant questionnaire or further evidence suggests SREL applies in standard claims**

- 1.7.30 If evidence that a claimant meets the SREL criteria is uncovered following receipt of the claimant questionnaire or additional evidence in a non-SREL claim, then advice should be given to the DWP that the claimant fulfils the criteria for SREL and the case should then be treated as a SREL referral. The assessment report must be completed and returned to the DWP using the work queue for SREL within two working days from that point. The advice should fully justify why the claim is being treated under the SREL process.
- 1.7.31 Should an HP identify that a claimant is likely to meet the SREL conditions during a consultation and the claimant is aware of their condition, the HP should treat the case as a SREL referral.
- 1.7.32 In a small number of cases, the claimant may not be aware that they are nearing the end of life. In these cases, the AP and the DWP must ensure the claimant is not inadvertently advised of their prognosis. Before treating a standard claim under the SREL process, the HP should take steps to discreetly gain an understanding of the level of knowledge the claimant has about their own condition and prognosis. For example, if the evidence comes from the claimant's GP, the HP should telephone the GP to confirm whether the claimant is aware. In the event that a claimant is not aware of their prognosis, it must



continue to be treated as a standard claim. The HP should not change the claim to a SREL claim.

**Author has misunderstood the purpose of the SR1 form**

1.7.33 Occasionally, the HP will encounter a case where the contents of the SR1 reveal that the author has completely misunderstood its purpose; for example, where there is no implication that the claimant is nearing the end of life. The HP should still make enquiries to clarify whether the person meets the SREL criteria and return the assessment report to the DWP with any supporting evidence, stating whether the claimant is nearing the end of life as per the prescribed definition.

## **1.8 Completing assessment reports**

1.8.1 The assessment report is sent electronically through the PIPAT or clerically, where appropriate, using the following clerical forms:

- PA1 – Review file note (where used)
- PA2 – Review report form (Special Rules for End of Life)
- 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.

1.8.2 Copies of all the forms are provided separately.

1.8.3 The nature of the information required in reports varies depending on the nature of the activity. Reports produced during consultations require the most content, as HPs will need to record the discussion, observed findings and conclusions from the consultation.

### **Choosing descriptors**

1.8.4 For each activity area, the HP should use evidence to choose one descriptor 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.

1.8.5 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 whether they can do so:

- Safely
- To an acceptable standard
- Repeatedly
- In a reasonable time period.

- 1.8.6 The HP must also take into account that most health conditions or impairments can fluctuate over time. The HP should consider ability and fluctuations over a 12 month period to present a coherent picture.
- 1.8.7 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.

### **Claimants applying for PIP from outside the UK**

- 1.8.8 For claimants living outside the UK (known as exportability cases) –a slight change to the process is required.
- 1.8.9 Exportability cases are identifiable by the fact that the claimant's address will be outside the UK and there will be a PIP2 (exp) with the case. In these cases, the HPs do not need to consider entitlement to the Mobility questions 11 and 12 on the PA3. If the PA3 requires a response to the Mobility questions at activities 11 and 12, the HP should select 'A' (zero points) and type the comment 'N/A – Exportability Case'. This will reduce the amount of time the HP spends providing advice on these cases as the mobility aspects do not have to be considered.

### **Evaluation and analysis of evidence**

- 1.8.10 It is essential that the CM is made aware of the evidence the HP has used to complete the assessment report. The HP must acknowledge that they have considered all the available evidence when formulating their advice.
- 1.8.11 All evidence must be interpreted and evaluated using medical reasoning, considering the circumstances of the case and the expected impact on the claimant's daily living and/or mobility. When weighing 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 effect on their daily life.

1.8.12 The HP's advice and justification must provide a clear explanation as to why more reliance has been placed on some evidence than 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 describes their circumstances and the impact of their health condition or impairment
- Further evidence – for example factual report from the GP, hospital report, other health and social care professionals involved in the claimant's care
- Consultation – the history, informal observations and clinical findings
- Statements from family/carers/friends.

### **Summary justification**

1.8.13 Report forms should contain where appropriate an overall "summary justification" or an individual justification for each descriptor choice providing a succinct summary for the CM of the evidence obtained and used in the HP's consideration and the reasons for descriptor choice. Where there is a complex, fluctuating condition strong consideration should be given for individual justifications being required.

1.8.14 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.

1.8.15 If the HP's opinion on descriptor choice differs from information provided by the claimant, the HP should draw on evidence to fully justify their advice to the DWP.

1.8.16 When a third party provides evidence – for example, a carer or health professional – the HP should evaluate the strength of the opinion being expressed. The HP's evaluation could 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.

## **Variability**

1.8.17 In some health conditions, the level of disability varies over time. These conditions are characterised by periods of remission and relapse or "good" days and "bad", during which the level of functional impairment can change for example multiple sclerosis or chronic fatigue syndrome. When advising on descriptors and justifying advice, the HP should consider the functional effects of the claimant's health on the majority of days.

1.8.18 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 type, 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 CM to understand the claimant's circumstances and the consequences of their health condition or impairment

## **Requirements of a justified report**

1.8.19 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; referencing evidence used to support descriptor choices, explanations where the HP's opinion differs from those of the claimant, carers or other healthcare professionals, clarification of any contradictions and an explanation of the HP's choice of evidence relied upon
- The evidence that underpins the HP's advice can include:
  - Clinical 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?**

1.8.20 The consultation report is primarily for CMs, 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.

## **1.9 Prognosis**

- 1.9.1 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. CMs will decide whether these conditions are met but need advice from the HP on how long the condition has been present and how long it is likely to last.
- 1.9.2 The CM 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 is 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.
- 1.9.3 Where a condition can fluctuate significantly over a period of time consideration should be given as to when a review would be appropriate.

### **Advising on prognosis**

- 1.9.4 Advice must be, logical, take into account current advances in medical care, be medically consistent and should reflect the evidence on likely prognosis from the claimant's professionals where available.
- 1.9.5 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 claimant to adapt given sufficient time or with appropriate treatment and/or support, thereby reducing the effects on functional ability. HPs should consider whether there is evidence that such an adaptation or adjustment has taken place.

- 1.9.6 If there is more than one relevant functional condition, the prognosis should take account of the effects of all conditions and the added impairment resulting from any interactions that may occur.
- 1.9.7 Age is not a medical cause of incapacity but it can be an indicator of disease progression. 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 other multiple pathologies who loses the lower leg because of complications due to diabetes is more likely to struggle.
- 1.9.8 Advice on prognosis 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**

- 1.9.9 After the CM 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 CM decide on the type of award.



## 1.10 Award Review dates

1.10.1 The HP will be asked to provide advice on when it would be appropriate to review the claimant's claim to PIP. Advice should be based on the HP's assessment of when there is likely to be a significant change in the overall functional effect of a claimant's main disabling condition(s). The HP should use the free text box to clearly describe why they have selected the review point and the potential change to the claimant's level of functional impairment that may lead to a review being necessary. The HP should use the following guide when considering review points:

### No Review Required

1.10.2 It would be appropriate for the HP to select the "no review required" option in the following circumstances:

- Where, in the HP's assessment, the claimant's level of functional impairment is such that the case manager is likely to consider that they do not meet the threshold for an award of PIP.
- Where the HP considers the claimant has a level of functional impairment that they will likely improve to the point where there is little or no functional limitation present, for example after treatment, surgery or medication. In such cases a short award period with no review required should be advised. The HP should indicate the duration of such treatment and the date at which there is likely to be little or no functional limitations present for a minimum of 9 months and up to a maximum of 2 years.

1.10.3 In the following instances it would be appropriate to recommend an ongoing award:

- Where the HP considers there to be no likely change to the functional impairment
- Where the claimant has functional impairment which is not likely to substantially change in the long-term, allowing for short-term periods of functional change in the case of fluctuating conditions
- Where the claimant has very high levels of functional impairment in both daily living and mobility components likely to reach the threshold for an enhanced/enhanced award, and in which their needs are only likely to increase, such as with progressive conditions

1.10.4 The following are illustrative examples of when it may be appropriate to advise “no review required”:

- No review required - “His learning disability has been present since birth and his functional limitations are unlikely to change now. He lives in supported accommodation and there has been no change to his functional ability in the last few years. A review is not likely to be considered necessary.”
- No review required – ‘The claimant has motor neurone disease with high levels of functional impairment in the daily living and mobility activities. He requires significant support from his carer and his needs are only likely to increase due to the progressive nature of his condition.’

1.10.5 The HP should clearly outline their reasons for selecting the “no review required” option using the free text box – for example “the claimant’s level of functional ability is stable and will not improve or deteriorate in the long term” or “the claimant is due to undergo surgery and it is likely they will no longer experience their current functional limitations in X months.”

### **Specification of a Review Period**

1.10.6 The following are illustrative examples of review periods which may be appropriate:

- 12 month review- ‘The claimant has a combination of physical and mental health conditions causing significant functional limitation. They are due to undergo surgery within the next 9 months, after which an 8-12 week recovery period is anticipated. It is likely that the claimant will not experience their current physical functional limitations post-recovery period. However, their mental health conditions are likely to persist.’
- 3 year review –‘She is experiencing limitations to her functional ability due to severe depression and anxiety, which she has had for a few years. She is under the mental health team who are treating her with combination therapy, including several medications and psychological therapy. Although the condition has been present for a few years there may be some change in functioning in the future so a review of 3 years would be appropriate.’

- 5 year review – ‘His autism spectrum disorder was diagnosed in early childhood and will be lifelong. He is aged 16 and attends a supported education centre where he is learning independent living skills and undergoing travel training, with the hope of attending college in the future. There is unlikely to be any change in functioning in the shorter term, but with time, maturity and learning his functional ability is likely to change so a review in 5 years would be appropriate.

1.10.7 The HP is asked to confirm whether the functional restriction is likely to be present at the recommended point of review.

1.10.8 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 CM that the case will need to be reviewed to determine the correct level of any on-going entitlement. In these cases, the CM is likely to arrange for a review before the end of the claim.

1.10.9 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, someone with osteoarthritis of the hip who is expected to have a hip replacement in the next few months where a full recovery is likely in a relatively short period of time. In these cases, the CM is likely to make a fixed term award of benefit.

1.10.10 The ‘Not applicable’ box should be selected where the HP considers that there is no health condition or impairment affecting function present on the majority of days over the 12 month required period.

## 1.11 Award Reviews

- 1.11.1 From 27 June 2016, claimants who are due to have their award reviewed will be sent a new form (AR1) for completion which will be returned to the DWP. This new document has been designed to focus on the information to be checked at the award review stage and to determine whether there have been any relevant changes in the claimant's condition(s) or needs across all descriptors since their current PIP award began. The aim of this measure is to reduce the impact of repeat assessments on claimants and on APs where a decision can be made by a DWP CM.
- 1.11.2 The AR1 will be returned to the DWP by the claimant and, where possible, a proportion of planned award reviews will be completed by DWP CMs, who will compare the new information against the evidence from the previous assessment. DWP CMs undertaking award reviews will complete new learning and have on-site support from healthcare professionals employed by DWP and will also be able to contact the claimant and / or carer for further information where necessary.
- 1.11.3 Where the DWP CM is unable to make a decision and more evidence is required, the case will be sent to the AP to be dealt with as business as usual. The case will include form AR1 and any additional information obtained by the CM (see the medical evidence screen in PIPCS.) For any award review case referred to the AP, all relevant supporting and further evidence will be visible.
- 1.11.4 The HP will attempt to complete a paper based review if possible, or arrange a face-to-face assessment where required.
- 1.11.5 DWP CMs will undertake paper-based award reviews in cases which contain the Additional Support (AS) marker and where the AR1 has been completed by the claimant and returned to DWP. Where the AR1 has not been completed and returned, the claim will be sent to the AP who should attempt to contact the claimant and arrange an assessment. Should the AR1 be subsequently received by the DWP, it will be tasked to the document received work queue for the appropriate AP (More information on the Additional support marker is in the following section).

## **1.12 Identifying claimants who require additional support with the PIP process**

1.12.1 Many claimants with mental, intellectual or cognitive impairments will be able to engage with the PIP application process.

1.12.2 Some claimants may have a Personal Acting Body (PAB), such as:

- an appointee:
- a Power of Attorney or Guardian:
- a Deputy:
- a Corporate Other Payee or Corporate Appointee:
- a Tutor (under Scottish law):
- a Curator bonis or judicial factor (under Scottish law):
- a Guardian (under Scottish law).

A PAB is a person formally nominated to act on their behalf, who will ensure that the claimant is supported throughout the process. Where a claimant has a PAB they would not be classified as requiring additional support from DWP. These people already have appropriate support.

1.12.3 In some cases however, claimants may not be able to engage effectively with the claims process, due to reduced mental capacity or insight – for example, they may not understand the consequences of not returning a claim form and not have a PAB to help them. In the PIP journey, such claimants are considered to require additional support from DWP and elements of the PIP claims process have been adapted to provide further support for this group.

1.12.4 During the gathering of initial claim information, claimants who are identified as requiring additional support from DWP will have an Additional Support (AS) marker attached to their case on PIPCS. Using the information available to them, HPs will need to consider the most appropriate approach to completing the assessment for these claimants, be that paper based review or consultation.

1.12.5 During all consultations, if the AS marker has not already been added on PIPCS, HPs should identify if a claimant who does not have a PAB requires the AS marker to help them

engage with the PIP journey, especially where there is a mental health, intellectual or cognitive impairment. If the HP believes that the AS marker should be applied this should be indicated in the advice given to DWP.

1.12.6 Examples of health conditions that may affect mental capacity and may potentially mean the claimant could struggle to engage with the PIP journey include (but are not limited to):

<i>Health conditions (note: these conditions may occur in addition to or be exacerbated by physical health conditions)</i>	Examples
Mental health condition	Severe Depression (evidenced by, for example, previous hospitalisation for depression, intensive support from community-based mental health teams or significant input from a psychiatrist or other mental health practitioner). Bipolar disorder Post Traumatic Stress Disorder (PTSD) Obsessive Compulsive Disorder (OCD) Psychosis Schizophrenia Personality disorders
Behavioural condition	Attention Deficit Hyperactivity Disorder (ADHD) Conduct disorder
Learning disability	Down syndrome Fragile X syndrome
Developmental disorder	Autistic Spectrum disorder Developmental delay Speech or language disorders
Dementia or cognitive disorder resulting in cognitive decline	Alzheimer's Dementia with Lewy bodies Vascular dementia Dementia associated with other conditions such as Parkinson's disease Severe brain injury resulting in cognitive decline

## 1.13 Requests for Supplementary Advice

1.13.1 CMs may make requests for supplementary advice at any stage in the decision-making process. The supplementary advice option will be used where the report overall is fit for purpose but there is a need for some aspects to be clarified further.

1.13.2 Reasons for supplementary advice might be (but are not limited to):

- Further evidence having been received from the claimant after the assessment report has been returned to the Department
- Help 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 a diagnosis, the use and significance of medication, the interpretation of functional examination findings, the significance of special investigations and the nature of surgical or other treatments
- Requesting non-prescriptive advice of a general nature on the likely functional restrictions arising from a specific health condition or impairment
- Requesting advice on whether a claim is being made for “substantially the same condition” as a previous claim
- To inform a fraud investigation (such requests are likely to be rare).

1.13.3 Supplementary advice may also be requested for a reconsideration where the claimant challenges a decision made about entitlement to PIP, or for the early revision of a decision as part of the appeals process. The CM will re-examine the facts of the case, the law and any other issues which applied when the decision was made. The purpose of the reconsideration is to try and resolve disputes without the need for an appeal. The HP may be asked for advice on further evidence from the claimant and may request further evidence before providing advice to the DWP.

1.13.4 HPs should answer questions posed by the CM but must avoid giving any prescriptive advice that refers to possible benefit entitlement, as final decisions rest with the CM. Advice should be clear, succinct, justified and in accordance with the consensus of medical opinion.

- 1.13.5 Where consideration of Supplementary Advice results in the HP changing their previous advice to the DWP, this should be clearly flagged.
- 1.13.6 Requests for Supplementary Advice may be made to APs by telephone and/or through the PIPCS and/or the PIPAT, depending on the nature of the request. Requests for advice through the PIPCS should be responded to using clerical forms PA5 or PA6.
- 1.13.7 HPs should use clerical form PA5 to provide supplementary advice that does not affect the descriptor choices or advice on prognosis in the original report. For example, it may be 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 additional information does not change the original advice.
- 1.13.8 If there are changes to the descriptor choice, the HP should complete clerical form PA6 to highlight the evidence used to support 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, for example prognosis.
- 1.13.9 Where the assessment was completed using the PIPAT, it will be necessary to create the appropriate supplementary advice on the PIPAT and once submitted a PA5/PA6 will be output to the DWP.



## 1.14 Advice on substantially the same condition

1.14.1 One area that HPs may be asked to advise on is whether a repeat claim for PIP is being made for “substantially the same condition” as an earlier claim.

1.14.2 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. Repeat claims to PIP by individuals who have developed a new condition will be treated as entirely new claim and have to fulfil the Qualifying Period of three months.

1.14.3 In some cases, however, a fixed term award of PIP may have been given where it was anticipated that there would be an improvement in the claimant’s functional ability (for example due to treatment), but where, following the PIP award ending, the claimant’s needs either continue, or increase. 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. In these cases entitlement to PIP may again be triggered and the claimant may re-apply.

1.14.4 In most cases it should be possible for CMs to identify those cases where a claim has been made for substantially the same physical or mental health 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 health conditions and considering the evidence of the case.

1.14.5 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 - for example mitral valve disease / mitral stenosis
- Whether the original diagnosis has been amended but the underlying impairment and functional effects remain the same – for example 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 deterioration 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, resulting in mobility problems.

**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 Z has diabetes and depression with agoraphobia. His diabetes was not well controlled and he had become depressed. He was awarded the Daily Living and Mobility components, both 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.

## 1.15 Consent and Confidentiality

### Consent

- 1.15.1 The department collects consent on behalf of GPs to allow them to share medical records. It cannot be assumed that in an individual case consent has been given or that consent previously given remains valid. Thus, in every case and before each instance that information is obtained or released, checks should be made to ensure valid consent is held. If the data is sensitive/ special personal data, UK GDPR sets a higher standard for 'consent' which is explained further below (paragraph 1.15.5).
- 1.15.2 Consent may be written, verbal and in certain circumstances given by a third party.
- 1.15.3 For consent to be lawful under Data Protection Legislation, (Data Protection Act 2018 and UK GDPR) it must be informed, freely given, specific and unambiguous and as straightforward to withdraw as it was to give in the first place.
- 1.15.4 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 and it must be a positive opt-in –for example 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 CM 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.
- 1.15.5 UK GDPR defines special category data, and if consent is being used as a condition for processing the data, the consent must be 'explicit consent'. Special category data includes the following (Article 9 (1) UK GDPR):

- Personal data revealing racial or ethnic origin
- Personal data revealing political opinions
- Personal data revealing religious or philosophical beliefs
- Personal data revealing trade union membership

- Genetic data
- Biometric data (where used for identification purposes)
- Data concerning health
- Data concerning sex life
- Data concerning a person's sexual orientation

1.15.6 For consent to be explicit it must be affirmed in a clear statement. If Providers are required to gain consent, claimants do not have to write the consent statement in their own words; Providers can use their own words. However, claimants must clearly indicate that they agree to the statement- for example by signing their name or ticking a box next to it. In the case of sensitive/special information, the claimant must be fully aware of the nature and content of the information being processed.

1.15.7 Consent to contact third parties to allow them to share information will be sought by the DWP during the initial information gather – regardless of whether the claimant applied for PIP 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 the DWP and APs should always check that this has been provided.

1.15.8 Should claimant consent not have been provided at the initial claim stage, it can be sought verbally by APs over the telephone.

### **Timescales for consent applying**

1.15.9 Depending on how it is worded, 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.

1.15.10 Consent can be withdrawn by claimants at any time in the claim.

1.15.11 In any case where consent is over 2 years old, action should be taken to confirm that it still reflects the claimant's wishes.

1.15.12 It is good practice to check that there is valid consent every time further evidence is sought.

## **Consent to a physical examination**

1.15.13 Attending a consultation does not mean that the claimant has given consent to a physical examination. At every stage of the proceedings the claimant should be advised as to what is going to happen and agree to it happening.

## **Appointees**

1.15.14 In cases where claimants have a named third party as an appointee, this could be due to the claimant being unable to manage their own affairs as a result of a serious mental health condition or cognitive / learning disability. Exceptionally, an appointee may also feature where a claimant is physically, but not mentally impaired, for example, if they have had a stroke which has resulted in a significant impact on their functional ability.

1.15.15 An officer acting on behalf of the Secretary of State will authorise an appointee to become fully responsible for acting on the claimant's behalf in any dealings with DWP or its contracted APs. This includes:

- Claiming benefits including completing and signing any claim, providing consent to obtain further evidence and providing information to the HP on the functional impact of the claimant's health conditions
- Collecting/ receiving benefit payments
- Reporting changes in the claimant's circumstances, or changes in their own circumstances that the DWP may need to know – for example a change of name or address.

1.15.16 An appointee can be either a named individual, or an organisation (usually with an advocacy role), known as a corporate appointee.

1.15.17 Where a claimant has an appointee, this will be flagged in the initial referral to the AP. Where an appointee has been nominated to represent the claimant, the claimant must not be instructed to attend a consultation by the AP. This is because they have been deemed incapable of engaging directly with the DWP or its contracted APs. Instead, and only if a consultation is deemed necessary, the AP must send the invite to the appointee only. However, it should be noted that the named appointee, be this a corporate or individual appointee, can nominate another person to represent them at any consultation.

That said, the HP should make every effort to obtain evidence in order to conduct a paper-based review in these circumstances.

- 1.15.18 A consultation cannot go ahead if the appointee or their representative does not accompany the claimant. If they do not turn up then normal Failed To Attend (FTA) action is taken – the DWP will investigate the conduct of the appointee
- 1.15.19 The appointee should be considered in line with guidance about companions being present at consultations. 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.

### **Power of Attorney (PoA)/Deputy**

- 1.15.20 Where the claimant has told DWP that they want an attorney to act for them, the attorney's details will be on the DWP system (CIS) if it is a PIP claim. Those details will go through to the Provider and the invite letter should be sent to that person only. It must be the claimant who attends any consultation. If the claimant attends on their own then the assessment can go ahead if the claimant has capacity. The issue here is that the DWP may not know whether the power of attorney is a Lasting PoA, which must be registered whilst the donor has capacity, then once registered it remains valid even if capacity is lost – but DWP is not always told. If capacity has been lost then the expectation is that the claimant would be accompanied. The attorney should be aware of this and if acting responsibly should not let the claimant attend on his own. They themselves do not have to attend. They can nominate someone else to accompany the claimant.
- 1.15.21 If the claimant has a deputy then that means they have lost capacity. The invite letter must go to the deputy who will arrange for the claimant to attend. As with appointees, the deputy can nominate another person to accompany the

claimant. The claimant must not be assessed if they are on their own.

## **Proof of consent**

- 1.15.22 Proof of consent given by claimants need not be routinely sent by APs when requesting further evidence. Proof of consent is not necessary needed before information is released by hospitals, trusts and clinics funded by the NHS or local authorities.
- 1.15.23 The position that proof of consent is not required is supported by the GMC, 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’.
- 1.15.24 If GPs, consultants and doctors request proof of consent they should be reminded of the GMCs advice. If they still require something in writing, the HP should email them a letter providing assurance that consent is held and quoting the GMC advice.
- 1.15.25 Occasionally a HP may be asked to provide evidence that consent is held in the form of the claimant’s signature before the information is forthcoming. GMC guidance is clear that if a doctor insists on a copy of the original claimant consent then DWP must provide it. In such cases the AP should contact the Department for information.
- 1.15.26 In standard claims it may be appropriate to obtain further evidence from an alternative source should proof of consent be an issue.
- 1.15.27 In cases treated under the SREL process, a telephone call to a different clinician 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 clinician involved in the claimant’s care again. If the clinician involved in the claimant’s care remains unwilling to provide the information, an appropriate alternative person - for example their consultant - should be telephoned.

## **Consent in third party claims**

1.15.28 The Welfare Reform Act 2012 (Section 82) creates special provision for a third party to make a claim on behalf of a disabled person without their knowledge.

1.15.29 Further information relating to the claim may be required and, due to the tight timescales involved in processing such 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 SREL.

1.15.30 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".

1.15.31 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**

1.15.32 Personal information held by the 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.

1.15.33 The 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, APs 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 the required retention period and periodically review the data you hold and erase and anonymise when no longer required.
- Do not make personal information available for commercial use without the claimant's permission.

### **Telephone conversations**

1.15.34 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 should be contacted using the telephone contact number on file.

1.15.35 Personal information should never be left on answering machines or voice-mail facilities.

### **Releasing information to a claimant or third party**

1.15.36 Other than information about their appointments with the HP or an update on their current position in the assessment process, it is not the role of the AP to release information to the claimant. It is also not appropriate for the provider to release information to a third party such as the claimant's representative, appointee, attorney or MP. Anyone making a request must be advised that requests for information should be made to the DWP.

## 1.16 Glossary

<b>Abbreviation</b>	<b>Definition</b>
ADHD/ ADD	Attention Deficit Disorder
AP	Assessment Provider
AS	Additional Support
BSL	British Sign Language
CD	Compact Disk
CIS	Customer Information System
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
DLA	Disability Living Allowance
CM	Case Manager
DPA	Data Protection Act
DRS	Document Repository System
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
FE	Further Evidence
GMC	General Medical Council
GP	General Practitioner
GPFR	General Practitioner Factual Report
HP	Healthcare Professional
HMCTS	Her Majesty's Courts and Tribunal Service
NHS	National Health Service
OCD	Obsessive Compulsive Disorder
PA1	Review file note (where used)
PA2	Review report form (Special Rules for End of Life)
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
PIP	Personal Independence Payment
PIPAT	PIP Assessment Tool
PIPSCS	PIP Computer System
PTSD	Post -traumatic Stress Disorder
SAM	Service Assurance Manager
SENCO	Special Education Needs Co-ordinator
SREL	Special Rules for End of Life
SRTI	Special Rules for Terminal Illness
SR1	Medical Evidence form for a SREL claim
TI	Terminal Illness