



Department
for Work &
Pensions

PIP Assessment Guide

Part Three – Health Professional Performance

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

Updated on 03 April 2023

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

PIP Assessment Guide Part One – The Assessment Process

PIP Assessment Guide Part Two – The Assessment Criteria

PIP Assessment Guide Part Three – Health Professional Performance

This guide is **Part Three**, looking at **PIP Health Professional Performance**. In this guide you will find the processes and performance standards Health Professionals (are required to meet to carry out PIP Assessments.

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3. Health Professional Performance

3.0.1 This document sets out the processes to be followed by providers to ensure Health Professionals (HPs) carrying out Personal Independence Payment (PIP) assessments meet the required performance standards, including the requirements around competencies, training, approval audit and complaint handling.

3.1. Health Professional Competencies

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

- Be an occupational therapist, nurse, physiotherapist, paramedic, doctor: or
 - By exception, another registered health professional, providing the requirements set out at 3.1.2 are met, the individual continues to satisfy quality and probation processes, and only by individual, prior, written agreement with the Department.
- Be fully registered with the relevant licensing body (doctors must have a licence to practise)
- Have no sanctions attached to registration unless they relate to disability. In individual cases, this requirement may be waived subject to prior written agreement with DWP
- Have at least 2 years post full registration experience (this refers to either UK registration or equivalent overseas registration for non-UK HPs) or less than 2 years post full registration experience by individual, prior, written agreement with the Department
- Have passed a Disclosure and Barring Service check.

3.1.2 Before they are approved to carry out assessments, providers must be able to demonstrate that HPs:

- Have appropriate knowledge of the clinical aspects and likely functional effects of a wide range of health conditions and disabilities.

- Have appropriate skills in assessing people with physical health conditions, including history taking, observation and ability to perform a relevant examination.
- Have appropriate skills in assessing people with conditions affecting mental, intellectual and cognitive function, including history taking, observation and ability to perform a relevant examination.
- Are able to critically evaluate evidence and use logical reasoning to provide accurate evidence based advice
- Have excellent interpersonal and written communication skills that include the ability to:
 - Interact sensitively and appropriately, with particular regard for an individual's cultural background and issues specific to disabled people
 - Take a comprehensive, appropriately focused and clear history
 - Accurately record observations and formal clinical findings
 - Produce succinct, accurate reports in plain English, fully justifying conclusions from evidence gathered, and dealing appropriately with apparent conflicts of evidence and fluctuating conditions.

3.2. Training of Health Professionals

Initial training

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

Clinical Governance Quality Standards Framework

- 3.2.4 Providers will implement the Clinical Governance Quality Standards Framework (CGQSF) and provide evidence of compliance. The CGQSF is a systematic approach to continuously improving the quality of healthcare professionals work.

3.2.5 The CGQSF standards have been developed to be implemented at the levels: individual healthcare professional, their line manager and at an organisational level. There are three steps to gathering and reviewing CGQSF evidence against standards:

- **Step 1** – identify and document systems, processes and procedures in place against each CGQSF standard.
- **Step 2** – need evidence data - quantitative & qualitative behind step 1, that shows current status, any learnings and outcome, identifying good practice and gaps.
- **Step 3** – evaluate data trends over time that shows learnings identified & changes implemented, outcome, good practice and gaps.

3.2.6 The Authority may appoint an independent body to review CGQSF implementation by the providers to assure that the Framework is being implemented and monitored by relevant parts of DWP and providers with evidence showing similar standards, gaps identified, addressed and best practice shared. This is to demonstrate commitment to continuous quality improvement and provide assurance to the DWP Board, and the public, that regardless of which part of the UK the customer is assessed in, they would get similar standards of service from HPs.

The independent body may review and observe providers internal CGQSF processes, procedures and standards and identify any outliers against benchmark.

Refresher Training and Continuous Professional Development

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

3.2.8 Each HP should be given a personal training plan on an annual basis, containing details of the modules to be delivered to the individual and the timescales in which they will be delivered.

3.2.9 The Department may require that topics be included in the CPD programme.

Training Plans

3.2.10 Providers are required to undertake an annual Training Needs Analysis at organisational level to identify areas of training needs together with

priorities for implementation. The scope, objectives and methodology of the analysis will be subject to prior approval by the Department.

- 3.2.11 Providers are also required to supply the Department with a Training Plan setting out in detail the manner in which their training programme, both initial training and refresher training / CPD, will be delivered. This plan should be developed in co-operation with the Department and will be subject to Departmental approval.
- 3.2.12 Any subsequent changes to the Training Plan must be submitted to the Department for approval.
- 3.2.13 Providers must evaluate the effectiveness of their training and CPD programmes. The format and timescales of the evaluation should be agreed with the Department.

3.3. Approval / Revocation of Health Professionals

- 3.3.1 For clarity, all references in this section (Approval / Revocation of Health Professionals) to 'Acceptable' excludes Acceptable HP Learning Required and Acceptable Report Amendment required.
- 3.3.2 Before an HP can carry out PIP assessments they must go through a formal approval process to ensure they meet the Department's requirements in relation to experience, skills and competence. Failure to demonstrate that HPs have reached or maintained the necessary standards or co-operate with feedback and/or retraining will result in approval being refused/revoked.
- 3.3.3 Approval for an HP must be conferred by the DWP on behalf of the Secretary of State for Work and Pensions. This will, in turn, be based on the recommendation of providers who must provide evidence that the HP has demonstrated that they meet the required standards.
- 3.3.4 This section describes processes to be followed during the live-running of PIP assessment contracts.

Initial Approval

- 3.3.5 The initial approval process must be undertaken:
- For all new recruits
 - For all HPs who have not completed PIP assessments for 12 months or more
 - For all existing employees who have not worked on PIP before.
- 3.3.6 There are four stages in the initial approval process:
- **Stage 1 – Training.** This should involve all trainee HPs undergoing a DWP-approved training programme, which should include both theoretical and practical simulated assessments (including consultations, paper-based reviews and SREL advice) to ensure that they can meet the competence and knowledge requirements.
 - **Stage 2 – Assessment of Competence.** Once Stage 1 is complete, the provider should carry out an assessment of whether the trainee HP meets the required competence and knowledge standards. This should include written elements e.g. assessment reports and paper-based reviews and practical elements e.g. advice on SREL cases and assessing when assessments are appropriate and when further

evidence should be requested.

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

Full Approval

- 3.3.7 Providers will be able to seek full approval from DWP for an HP once that HP has shown an ability to consistently apply the competence standards by achieving the following number of consecutive Acceptable audit results at Stage 4:
- 5 reports produced following a consultation; and
 - 5 reports produced following a paper-based review including SREL (where descriptor advice is provided).
- 3.3.8 If the provider wishes to submit a HP for approval to carry out SREL referrals only, they may do so when the HP has achieved 5 consecutive Acceptable audit results for SREL cases. If the provider subsequently wishes to submit the same HP for approval to carry out paper-based reviews, the HP must achieve a further 5 consecutive Acceptable results following paper-based reviews on non-SREL referrals.
- 3.3.9 All cases which contribute to approval must be cases where advice is given either on a PA2, PA3 or PA4.
- 3.3.10 Providers with HPs who specialise in one area of assessment only will also be able to seek approval from DWP to carry out consultations, paper-based reviews or SREL. In these cases, HPs must show an ability to consistently apply the competence standards in their area by achieving the following number of consecutive Acceptable audit results at Stage 4:
- 5 reports following a consultation; or

- 5 reports following a paper-based review; or
- 5 SREL (where descriptor advice is provided).

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

Submitting HPs for approval

3.3.12 When the provider is satisfied that the HP has successfully completed all four stages of the approval process the following information should be sent to DWP upon request:

- The HP's name and work address.
- The AP's assurance that the relevant register has been checked for that HP's profession, they can confirm that they are registered and have two years post-registration experience.
- A list of the training the HP has completed and the dates that it was completed.
- A list of all the examinations/assessments the HP has completed, including dates and whether they have failed or passed. Where the HP had more than one attempt to pass a module, the AP should list the dates and the results in each instance.
- The dates of all the 5 consecutive assessment reports the HP has completed and the audit grade (Acceptable, Acceptable HP Learning Required, Acceptable Amendment Required, Unacceptable).
- Assurance from the clinical lead that he/she is satisfied the HP has reached the standard necessary to carry out PIP assessments.

3.3.13 The DWP will review the HP's papers and approve them. DWP will maintain a database of approved HPs. If the status of the HP changes the AP should advise DWP as soon as possible.

Maintenance of Approval

3.3.14 The HP's on-going Approval is dependent upon the HP undertaking PIP assessment work for the provider and fulfilling the following criteria:

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

PIP assessment work includes any work that requires the HP to use their knowledge of PIP assessment policy in their regular role, for example direct functional assessment of claimants, consideration of claims at initial review and audit.

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

Revocation of Approval

- 3.3.16 The DWP reserves the right to revoke approval – both provisional and full approval – at any time where there is concern that an individual may no longer satisfy one or more of the required criteria. This is at the discretion of the DWP and is irrespective of any action that providers are undertaking.

- 3.3.17 Providers must consider whether the circumstances surrounding any revocation of approval warrant them informing the HP's professional body.

- 3.3.18 Revocation of an HP's approval should routinely be sought for a number of reasons:

- Termination of contract
- Resignation
- Deceased
- Change of job role no longer requiring approval
- Absence from work for 12 months

More information on these areas is covered below.

- 3.3.19 Providers should inform the DWP where any of the above apply, together with any relevant documentation if requested.

Absence from work

- 3.3.20 If the absence is for a period of **less than 3 calendar months**, the HP may resume their normal duties afterwards.

- 3.3.21 If the absence is for a period of **more than 3 but less than 6 months**, the HP should be subject to targeted quality audit on their return to ensure the required standards are being met. The number of assessments audited will be at the discretion of the provider.
- 3.3.22 If the absence is for a period of **more than 6 but less than 12 months**, the provider should return the HP to Stage 4 of the approval process, requiring them to undergo audit. As per Stage 4, the HP will be required to achieve 5 consecutive Acceptable reports produced following both consultations and paper-based reviews.
- 3.3.23 If the absence is for a period of **more than 12 calendar months**, providers should seek revocation of approval from DWP. To carry out PIP assessments in the future, the HP must go through the full initial approval process again.

Resignation, Deceased or Change of Role

- 3.3.24 When the HP informs the provider of their intent to leave or change role, the provider should then seek revocation of approval from DWP, stating the date of their final assessment.

Administrative processes

- 3.3.25 The detailed administrative processes to support the approval and revocation requirements have been shared separately with providers.
- 3.3.26 Providers must maintain a database detailing approvals / revocations of approval. The database content must be agreed with the Department and shared with it on request.

3.4. Quality Audit

- 3.4.1 Audit processes are in place for auditing justifications for initial review and the quality of assessments through:
- DWP Lot-wide audit (random sample); and
 - The provider - Approval-related audit (trainee), assessment report only.
- 3.4.2 Audit has a central role in ensuring that decisions on benefit entitlement, taken by DWP, are correct. It supports this by confirming that independent HP advice complies with the required standards and that it is clear and medically reasonable. It also provides assurance that any approach to assessment and opinion given is consistent so that, irrespective of where or by whom the assessment is carried out, claimants with conditions that have the same functional effect will ultimately receive the same benefit outcome.
- 3.4.3 Assessment reports subject to audit will be examined and graded Acceptable, Acceptable HP Learning Required, Acceptable Report Amendment Required and Unacceptable in accordance with the Quality Audit Criteria in section 3.5.
- 3.4.4 More detailed guidance on how justifications for initial review and assessment reports should be audited and the criteria to be used are set out in section 3.5.3.
- 3.4.5 The Department also recommends that providers undertake additional audit activity to ensure quality standards are being met, including:
- New entrant audit (recently approved)
 - Rolling audit
 - Targeted audit.

Lot-wide audit

- 3.4.6 The DWP Independent Audit Team carries out lot-wide audit, which is an audit of a controlled random sample from across each contract Lot, feeding in to routine performance reporting for DWP.
- 3.4.7 The sample should include SREL cases, paper-based review and consultation outputs, with supporting justifications for initial review. Forms PA5 and PA6 (Supplementary Advice) are not included in the lot-wide sample.

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

3.4.9 Providers' targets are for:

- 3% or less Unacceptable justifications for initial review/assessment reports; and in addition
- a minimum of 85% of assessment reports must be assessed as Acceptable or Acceptable HP Learning Required.

Approval-related audit

3.4.10 During Stage 4 of the HP approval process HPs should be subject to 100% audit to ensure that they are consistently able to apply the competence standards (see 1.37).

New entrant audit

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

Rolling audit

3.4.12 Rolling audit is an audit of the work of each HP on a regular basis to assess the quality of their work on a continuing basis, ensure maintenance of standards and for on-going approval.

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

Targeted audit

3.4.14 Targeted audit is audit activity triggered where a quality, rework or complaint issue has been identified to establish whether there is

evidence of an on-going problem or where it is felt that auditing should be carried out to ensure the required standards are met.

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

Experience of auditors

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

Live cases

- 3.4.17 Unless there are extenuating circumstances, audit activity should be carried out while cases are “live” and before they are submitted to DWP. As such all audit activity should be carried out swiftly to avoid delay to the case.
- 3.4.18 If a case is identified as requiring amendment after it has been returned to DWP, as the advice may be misleading, contact should be made with the relevant CM.

Feedback

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

Alteration of Acceptable Report Amendment Required and Unacceptable reports

- 3.4.20 Where assessment reports have been graded as Acceptable Report Amendment Required or Unacceptable, remedial activity should be taken before the case is submitted to DWP. Where possible, this activity should be taken by the HP who carried out the original assessment.
- 3.4.21 Where justifications for initial review have been graded Acceptable Amendment Required or Unacceptable remedial activity may apply to Provider processes following audit.
- 3.4.22 Any changes made to forms should be justified, signed and dated. It should be made clear that any changes are made as a result of audit activity.

3.4.23 Where necessary a new report form should be completed.

Maintaining records

3.4.24 Providers should keep records of all audit activity described in this section, including iterations of all audited reports. These records should be retained for a minimum period of two years.

3.5. Quality Audit Criteria

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

Areas to be audited for assessment reports

3.5.2 When auditing cases, providers should look at the entire case at the point at which it is finalised and due to be returned to the Department, considering both the final output and the processes followed.

3.5.3 Reports should be audited in four areas:

- Opinion
- Information Gathering
- Further Evidence
- Process

3.5.4 Attributes break the areas down into subcategories that must be considered.

Grading for assessment reports

3.5.5 Reports are graded as Acceptable, Acceptable HP Learning Required, Acceptable Report Amendment Required or Unacceptable in accordance with the following criteria

Areas	Attributes	Acceptable	Unacceptable
Opinion	Descriptor choice	- Clinically probable advice based on all the available evidence	- Clinically improbable advice such that the descriptor choice is highly unlikely and would lead to a wrong award if not changed
	Prognosis advice	<u>HP learning required:</u> - Clinically possible advice but evidence supports consideration of an alternative opinion or descriptor choice	
	QP/PT recommendation	<u>Report amendment required:</u> - Clinically improbable advice such that the descriptor choice is highly unlikely but would not lead to a wrong award if left unchanged;	
	SREL advice	- Clinically improbable prognosis advice- award	
	Reliability criteria		

		duration recommended considered to be too long/too short.	
		<p>Adequately justified</p> <p><u>HP learning required:</u> Justification which supports but doesn't fully explain the advice or the descriptor choice</p> <p><u>Report amendment required:</u> Justification which fails to support the advice or the descriptor choice but doesn't suggest an alternative award</p>	Justification which fails to support the advice or the descriptor chosen and would suggest an alternative award
Information gathering	<p>History (inc. variability)</p> <p>Examination</p> <p>Observations</p>	<p>Sufficient information gathered to support robust advice</p> <p><u>HP learning required:</u> Information gathered lacks detail but unlikely to have an adverse effect on advice</p> <p><u>Report amendment required:</u> Omission that has limited potential to change advice</p>	Major omissions such that advice cannot be relied on and correct award cannot be reasonably determined
Further Evidence	All relevant stages	<p>Sufficient further advice appropriately sought and referenced</p> <p><u>HP learning required:</u> Reference to relevant evidence incomplete; important evidence not sought or insufficient attempt to gather it; evidence requested from an inappropriate source</p> <p><u>Report amendment required:</u> In additional support needs case either: important evidence not sought or insufficient attempt to gather it</p>	Critical evidence not sought or insufficient attempt to gather it so that correct award cannot be reasonably determined
Process	<p>Case handling</p> <p>Usability</p>	Clear report which conforms with guidance and professional standards	Major omission or error (such as harmful information / unexpected findings / call to exam) with significant risk of

		<p><u>HP learning required:</u> Frequent spelling or grammar errors, use of jargon and unexplained abbreviations that are not in common use</p> <p><u>Report amendment required:</u> Omission or error (such as harmful information / call to exam) with minor risk of adverse consequence; directive advice on entitlement; unclear medical information critical to advice clarity</p>	harm to the mental or physical health of the claimant or others
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3.5.6 For the avoidance of doubt, a report must be graded:

- Unacceptable if the Unacceptable criteria applies to one or more of the Attributes.
- Acceptable Report Amendment Required, if none of the Unacceptable criteria applies and one or more of the Acceptable Report Amendment Required criteria Attributes apply.
- Acceptable HP Learning Required, if none of the Unacceptable nor Acceptable Report Amendment Required criteria applies and one or more of the Acceptable HP Learning Required Attributes apply.
- A report may only be graded Acceptable if none of the other criteria apply to any of the Attributes.

Grading for justifications for initial review

3.5.7 Justifications are graded as ‘acceptable’, ‘acceptable: HP learning required’, ‘acceptable: amendment required’ or ‘unacceptable’ in accordance with the following criteria.

Justification for case routing (initial Review)			
<ul style="list-style-type: none"> • Case routing decision • Rationale for case routing decision 	A		<ul style="list-style-type: none"> • Case routing correct based on all the available evidence and case routing decision is adequately justified • PBR preferred route but despite all efforts HP unable to obtain adequate evidence to support PBR and call to exam necessary
	AF		<ul style="list-style-type: none"> • Case routing correct and justification supports but doesn't fully explain the decision
	AA		<ul style="list-style-type: none"> • Case routing correct but justification fails to support the decision

	U	<ul style="list-style-type: none">• Case routing incorrect based on all the available evidence• Call to exam with significant risk of harm to the mental or physical health of the claimant or others• No justification given to explain case routing decision; or justification given is not medically reasonable or logical
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3.6. Rework

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

Rework Action

- 3.6.4 The action to be taken in relation to rework will vary on a case-by-case basis. Wherever possible, cases should be discussed with the original HP or referred back to them for further action to be taken.
- 3.6.5 In some cases it may be necessary for an additional consultation to be carried out, either with the original HP or a different HP. The impact of any such consultations on claimants should be considered when making the decision to carry out a repeat consultation. Where possible, further consultations should be avoided so as not to place extra burdens on claimants. However, this should not compromise the quality of the advice to DWP.
- 3.6.6 If clerical report forms are being used, Rework activity should result in the production of a new report form (PA2, PA3 or PA4).

Challenging Rework Reason

- 3.6.7 Any challenge to the reason DWP has returned a case to the Provider for rework must be made via the nominated rework Single Point of Contact (SPOC).

- 3.6.8 The Provider SPOC must contact the nominated DWP SPOC to make the challenge. The final decision on whether the case requires rework rests with DWP.

Feedback and Record keeping

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

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

- 3.7.1 The PIP assessment specification made clear that PIP Assessment Providers may receive feedback from Her Majesty's Courts and Tribunal Service (HMCTS) about the quality of the assessment reports. Providers should consider this feedback and take the appropriate action.
- 3.7.2 Where a medical member of an appeal tribunal identifies that an assessment report is below the standard expected of providers, they may consider giving feedback on the report to the provider in question. The criteria are that reports will be in line with requirements at paragraph 3.6.2.
- 3.7.3 Providers will need to work with the DWP and HMCTS to develop the processes for receiving this feedback.
- 3.7.4 Providers will also need to develop internal processes for recording referrals from HMCTS, action taken and responding to HMCTS. This should include processes for considering feedback from HMCTS, and where they agree that quality is not fit for purpose, steps to ensure that the feedback is passed to the relevant HP where appropriate and that any necessary improvement activity is taken.
- 3.7.5 Providers will also need to develop processes for liaising with HMCTS where they do not agree with the feedback received and for escalating any unresolved disagreements to the DWP who is the final arbiter on assessment quality standards.

3.8. Complaints

3.8.1 A complaint is an expression of dissatisfaction about the services delivered by providers which originates from a claimant. They may be made verbally or in writing by the claimant or their representatives.

3.8.2 Providers should put in place processes to effectively manage complaints.

Serious Complaints

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

- Assault / injury during the course of an assessment
- Inappropriately intimate examinations
- Abuse relating to any protected characteristic under the Equality Act 2010
- Theft or fraud
- Criminal activity.

3.8.4 Providers should develop processes to manage Serious Complaints separate to the overall complaints processes, with escalation routes to appropriately senior staff.

3.8.5 Where a Serious Complaint is made against an HP, the DWP should be informed immediately. Providers should also consider suspending the HP from carrying out PIP assessments until any investigations into the complaint have been completed.

3.8.6 Providers should liaise with the DWP on the outcome of any investigation into a Serious Complaint. If a Serious Complaint is upheld, providers should consider:

- Liaising with the relevant professional body (General Medical Council, Nursing and Midwifery Council, Health Care Professions Council etc.).

3.9. Fees for further evidence

- 3.9.1 DWP pays fees for General Practitioner Factual Reports (GPFRs) from GPs and SR1 forms completed by doctors who are registered with the General Medical Council (GMC).
- 3.9.2 Fees are not paid by DWP for other sources of evidence, such as Hospital Factual Reports from NHS hospitals and clinics; Local Authority funded clinics; or factual reports / GPFRs completed by professionals other than GPs or Consultants.
- 3.9.3 For many years the Department has not accepted “Treasury fees”, which doctors often quote.
- 3.9.4 The DWP sets its own fees for factual reports and information where a fee is payable and providers should not negotiate individual fees with doctors (GPs or hospital staff). Payment for evidence other than the GPFR or SR1 should be discussed with the Department on a case-by-case basis.

General Practitioner Factual Reports

- 3.9.5 As independent contractors, GPs are permitted to receive a fee for completing GPFRs and providing factual information unless the information required is included in their contractual agreement.
- 3.9.6 Where it is permissible to pay a fee, this should be the standard fee that the Department pays – currently £33.50 for a GPFR and £17.00 for an SR1 completed by a GP (although providers will usually not need to seek SR1 from GPs). If the GP’s surgery is VAT registered, VAT should also be paid in addition to the appropriate fees.

Hospital Factual Reports

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

- 3.9.10 The responsibility to provide factual reports lies with the hospital, and requests should be addressed to the hospital as opposed to a particular member of staff - though the requests may specify the type of information that would help (e.g. from a physiotherapist).
- 3.9.11 No fee is payable to the person completing the report.
- 3.9.12 Sometimes hospital staff state that they are not contracted to carry out this work on behalf of the hospital. If so, they should ask the hospital to arrange for someone else to complete it on behalf of the hospital.

Rejecting requests for payment

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

3.10. The principles of good report writing

Clarity

3.10.1 Good quality reports should:

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

Clear English

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

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

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

Appropriate language

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

3.10.5 Reports should not include terms which could cause offence. Appropriate language should be used when describing the claimant, for example "overweight" or "obese" as opposed to "fat". Unless it is

essential to the determination of the claim, any information that may be construed as a value judgement should be avoided in advice. For example, comments about the claimant appearing dishevelled are inappropriate, unless they are part of the evidence supporting a level of self-neglect due to mental health problems.

Explanation of technical terms

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

The avoidance of medical jargon

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

“SOB++ JVP↑ Ankle oed. R=L AF Δ ?CCF”

- 3.10.9 Such jargon may not be understood by the DM or the next HP to read it and should be avoided.

Avoidance of internal contradiction

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

Correctness

3.10.13 Correctness embraces a number of principles:

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

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

Completeness

3.10.15 It is very easy to miss out a key factor in a consultation. Good preparation is important and it can be helpful to write down a checklist of all the salient aspects of the case before embarking on the consultation.

Facts versus opinion

3.10.16 A fact is a verifiable statement about the claimant – for example, “He takes salbutamol as required for asthma”.

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

3.10.18 Facts provide strong evidence for opinions because they are verifiable. Facts should be used to support descriptor choice. Opinions are most robust if they are based on fact – for example, “In my opinion, his asthma is mild, he takes salbutamol as required for most of the year, adding in inhaled steroids only during the hay fever season”; “She is not safe unless she is supervised while cooking, as she has several times burnt saucepans by forgetting them on the hob”.

3.10.19 When the HP evaluates the opinion of a third party that provides evidence – for example, a carer or health professional - the HP should evaluate the strength of the opinion being expressed. The HP’s evaluation should include the level of expertise of the individual offering

the opinion; their direct knowledge of the claimant; and whether it is medically reasonable. An unsupported opinion will carry no weight, whereas an authoritative, well-justified opinion from an expert source will carry far more weight, especially if it is supported by factual evidence. The HP should also consider whether the third party is acting impartially or as the claimant's advocate.

3.11. Sample Quality Audit Proforma



Department
for Work &
Pensions

Key	
A	Acceptable
AF	Acceptable with Feedback
AA	Acceptable with Amendments
U	Unacceptable

Case routing			
<ul style="list-style-type: none"> Case routing decision Rationale for case routing decision 	A		<ul style="list-style-type: none"> Case routing correct based on all the available evidence and case routing decision is adequately justified PBR preferred route but despite all reasonable efforts HP unable to obtain adequate evidence to support PBR and call to exam necessary
	AF		<ul style="list-style-type: none"> Case routing correct and justification supports but doesn't fully explain the decision
	AA		<ul style="list-style-type: none"> Case routing correct but justification fails to support the decision
	U		<ul style="list-style-type: none"> Case routing incorrect based on all the available evidence Call to exam with significant risk of harm to the mental or physical health of the claimant or others No justification given to explain case routing decision; or justification given is not medically reasonable or logical
Opinion			
<ul style="list-style-type: none"> Descriptor choice Prognosis advice QP/PT recommendation Terminal illness opinion Reliability criteria Justification 	A		<ul style="list-style-type: none"> Clinically probable opinion based on all the available evidence and adequately justified
	AF		<ul style="list-style-type: none"> Clinically possible advice but evidence supports consideration of an alternative opinion or descriptor choice Justification which supports but doesn't fully explain the advice or the descriptor choice
	AA		<ul style="list-style-type: none"> Clinically improbable advice such that the descriptor choice is highly unlikely but would not lead to a wrong award or major error in duration if left unchanged Justification which fails to support the advice or the descriptor choice but doesn't suggest an alternative award
	U		<ul style="list-style-type: none"> Clinically improbable advice such that the descriptor choice is highly unlikely and would lead to a wrong award. Justification which fails to support the advice or the descriptor chosen and would suggest an alternative award
Information gathering			
<ul style="list-style-type: none"> History (inc. variability) Examination Observations 	A		<ul style="list-style-type: none"> Sufficient information gathered to support robust advice
	AF		<ul style="list-style-type: none"> Information gathered lacks detail but unlikely to have an adverse effect on advice
	AA		<ul style="list-style-type: none"> Omission that has limited potential to change advice
	U		<ul style="list-style-type: none"> Major omissions such that advice cannot be relied on and correct award cannot be reasonably determined
Further Evidence			
<ul style="list-style-type: none"> All relevant stages 	A		<ul style="list-style-type: none"> Sufficient further evidence appropriately sought and referenced
	AF		<ul style="list-style-type: none"> Reference to relevant evidence incomplete Important evidence not sought or insufficient attempt to gather it Evidence requested from an inappropriate source
	AA		<ul style="list-style-type: none"> In additional support needs case, either important evidence not sought or insufficient attempt to gather it
	U		<ul style="list-style-type: none"> Critical evidence not sought or insufficient attempt to gather it so that correct award cannot be reasonably determined
Process			
<ul style="list-style-type: none"> Case handling Usability 	A		<ul style="list-style-type: none"> Clear report which conforms with guidance and professional standards
	AF		<ul style="list-style-type: none"> Frequent spelling or grammar errors, use of jargon and unexplained abbreviations that are not in common use

	AA	<ul style="list-style-type: none"> • Omission or error (such as harmful information) with minor risk of adverse consequence • Directive advice on entitlement • Unclear medical information critical to advice clarity
	U	<ul style="list-style-type: none"> • Major omission or error (such as harmful information / unexpected findings) with significant risk of harm to the mental or physical health of the claimant or others