Personal Independence Payment Factual Report

Guidance on completing your report

Background

Personal Independence Payment is a benefit for people who face the greatest barriers to leading independent lives. Entitlement is based on the impact of the individual’s impairment or health condition(s) on their everyday life, be it physical, sensory, mental, intellectual, cognitive or developmental.

If you have been sent a Factual Report for completion, it means we need further information about your patient’s medical condition(s) and the impact their condition(s) have on their day-to-day life in order to decide this claim.

Important notes about completing your report

The person making the claim may, at any stage, request a copy of this report to be sent to them by the Department for Work and Pensions.

To ensure compliance with ‘Rehabilitation of Offenders Act 1974’, your report should not contain any reference to criminal convictions, whether spent or not, unless the information is directly relevant to your patient’s condition or disability.

This report is not subject to the Access to Medical Reports Act 1998. The patient does not need to read it before it is returned.

General guidance on completing your report

Record relevant information based on your knowledge of the patient and their medical records. It is not necessary to interview the patient to complete this form.

Write down facts rather than opinion. We require an objective report - please only include information about symptoms that are recorded in the patient’s records and information about disabling effects that you or another healthcare professional have directly observed.

It may be helpful to your patient to enclose any relevant correspondence contained in your patient’s file, for example recent consultant letters, letters from the Community Mental Health Team etc. Please ensure that any third party information is removed. Third party information is any sensitive information that refers to someone other than the claimant, for example the claimant’s family.

Complete all sections as fully as possible but write “not known” if appropriate. “Not known” can be helpful.
Relevant information is anything that relates to health conditions or disabilities which impact on an individual’s functional ability

**Guidance on completion of section on effects of the disabbling condition**

The assessment for Personal Independence Payment considers the claimant’s ability to carry out a series of everyday activities.

In this section, please provide information on the claimant’s ability to carry out the relevant activities, if you are able. The relevant activities are:

- Managing their health conditions and treatment
- Communicating
- Reading and understanding information
- Walking or moving around
- Getting somewhere on their own
- Making simple budgeting decisions
- Preparing, cooking and eating food
- Washing, bathing and using the toilet
- Dressing and undressing

Write what has been observed by yourself or another healthcare professional. For example; self care – “rose unaided from a chair in surgery, no bending difficulty noted.” Getting around – “walks slowly with marked right sided limp using a walking stick, not breathless or very breathless when attends surgery for routine check.”

Please only include observations, not opinions.

**Examples**

Here are examples of information that is particularly useful to us for the following conditions.

- **Respiratory conditions** including asthma and COPD – exercise tolerance, **recorded** variability, peak flow readings (including serial readings), spirometry results, treatment and compliance – prescriptions requested regularly / when was last prescription, oral steroids and hospital admissions in last 12 months.

- **Ischaemic Heart Disease** – investigations including results of formal exercise testing, exercise tolerance, clinical findings, response to treatment including nitrates, treatment compliance, hospital admissions in last 12 months.

- **Musculoskeletal conditions** – **recorded** symptoms, recorded history of falls, detailed clinical findings including range of joint movements, treatment including planned surgical treatment with dates, response to treatment and compliance - prescriptions requested regularly / when was last prescription.
• **Mental health conditions** – documented history of self harm, self neglect, detailed mental state findings, history of admissions – voluntary or compulsory, regular prescriptions and last one ordered.

• **Sensory impairment** – visual and auditory acuity