



Northern Ireland

Public Services
Ombudsman

EVIDENCE

OWN INITIATIVE

R E P O R T

PIP and the Value of Further Evidence:

An investigation by the Northern Ireland Public Services Ombudsman into Personal Independence Payment

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Abbreviation	Meaning
AS	Additional Support
CAB	Citizens Advice Bureau
CRM	Customer Relationship Management
CRT	Customer Response Team
CST	Customer Service Team
DA	Disability Assessor
DfC	Department for Communities
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ESA	Employment Support Allowance
FE	Further Evidence
FME	Further Medical Evidence
GP	General Practitioner
GPFR	General Practitioner Factual Report
HAA	Health Assessment Advisor
HP	Health Professional
MR	Mandatory Reconsideration
MSE	Mental State Examination
MSK	Musculoskeletal
NIPSO	Northern Ireland Public Services Ombudsman
PA5	No Change of Advice Report
PA6	Change of Advice Report
PBR	Paper Based Review
PIP	Personal Independence Payment
PIP1	PIP initial claim form
PIP2	PIP Application form
PIPAG	PIP Assessment Guide
PIPSCS	PIP Computer System
SSA	Social Security Agency
SRTI	Special Rules Terminally Ill
TAS	The Appeals Service

Executive Summary



In June 2019, my Office commenced an Own Initiative¹ investigation into the role of further evidence in the administration of Personal Independence Payment (PIP) in Northern Ireland. This report sets out the findings and recommendations of that investigation.

PIP is a non means tested benefit for people of working age (16 – 64 years) intended to provide help toward some of the extra costs arising from having a long term health condition or disability. The Department for Communities (the Department) administers and awards claims for PIP, but the impact of a claimant's disability or health condition is assessed by Capita, a private sector contractor.

I chose to focus my investigation on examining the availability and application of further evidence in the administration of PIP. Further evidence in PIP is evidence which is additional to the claimant's PIP application form and any evidence that is gathered through a face to face consultation with a Disability Assessor. Sources of further evidence in PIP can include, but are not limited to:

- reports from health professionals involved in the claimant's care, such as a community psychiatric nurse or a general practitioner;
- evidence from those who support the claimant, such as care co-ordinators or key workers;
- prescription lists and care or treatment plans; and
- information provided directly by the claimant.

¹ Using powers set out in Section 8 of the Public Services Ombudsman Act (Northern Ireland) 2016.

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In my investigation I gave detailed consideration to a number of issues including:

- How the Department and Capita inform claimants of the role of further evidence in the PIP assessment process;
- How the assessment of further evidence is recorded and reviewed; and
- How the Department and Capita investigate and address complaints relating to further evidence.

I fully recognise that the delivery of PIP is sizeable with over 250,580 PIP claims registered since June 2016 when PIP began replacing Disability Living Allowance (DLA) in Northern Ireland.² I also recognise that significant work has gone into implementing PIP in a timely manner and that the Department through engagement has acted to introduce some initiatives unique to Northern Ireland which are not available in Great Britain.

Whilst I acknowledge and welcome the work undertaken, it is my role as Ombudsman to investigate and determine if systemic maladministration has occurred, report my findings and make recommendations. Had I not found systemic maladministration I would have reported this, as I have a role to reassure the public where it is right to do so. However, overall my investigation has made a finding of systemic maladministration having identified repeated failures which are likely to reoccur if left unremedied. It is therefore my view that there is more work to be done to improve the experience and outcomes for claimants, the robustness of decision making and public confidence in the system.

Methodology

My Investigating team:

- reviewed 100³ PIP case files and accompanying telephony records, testing the Department's and Capita's actions against the Principles of Good Administration⁴;
- made extensive enquiries to the Department and Capita;
- undertook site visits;
- engaged with a range of external stakeholders, and
- appointed an external advisor to review the investigative methodology used.

² *Personal Independence Payment Experimental - Statistics February 2021*, Department for Communities, Northern Ireland Statistics and Research Agency, published May 2021. Available from: <https://www.communities-ni.gov.uk/articles/personal-independence-payment-statistics>

³ The 100 cases included claims which had been through all stages of the PIP process, including Mandatory Reconsideration and submission of Appeal, and claims where the claimant had made a complaint to both Capita and the Department.

⁴ Published by the Parliamentary and Health Service Ombudsman on 10 February 2009. See Appendix A & B.

The qualitative nature of the investigation design has provided me with a very rich insight into the Department's (and Capita's) powers, policies, practices and culture. The briefings and site visits with the Department and Capita, the documentation of their policies, procedures and guidance, plus their detailed comments on my draft investigation report have provided me with a comprehensive understanding of how the processes are intended to operate, and how the various staff are meant to undertake their tasks in the performance of their roles.

The Principles of Good Administration

The Principles of Good administration propose a clear framework within which public bodies should seek to work. At the same time, the Principles of Good Administration help clarify the expectations against which my Office will measure performance.

Principles of Good Administration

Good administration by public bodies means:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Principles are intended to promote a shared understanding of what is meant by good administration and to help public bodies in the Ombudsman's jurisdiction provide a good public service to their customers.

I have set out below where my investigation found significant departures from the relevant principles of good administration which I consider to constitute systemic maladministration. I have also made a number of recommendations which, I hope, will help put things right.

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Getting it right

Central to '**Getting it right**' is getting the PIP benefit decision right first time. Focusing efforts on conducting a robust assessment of PIP claims, at the outset, is essential to delivering the right support for individuals at the right time and reducing any unnecessary stress. It also safeguards public resources, in terms of saving the time and costs associated with undertaking further examination of the same claims at another step or steps in the benefit decision process. It is estimated that PIP appeal costs, between April 2017 and March 2021, are nearly £14 million.⁵

PIP is a benefit designed to provide support to people who have a disability or are living with a long term health condition, some of whom are the most vulnerable members in our society. Vulnerable claimants may find it more difficult to access and navigate complaints and review mechanisms in the same way as other members of the public. It is therefore highly likely levels of unremedied injustice are significantly higher for these individuals than amongst the wider population.⁶

It is clearly explained throughout the PIP policy and application process that further evidence may form part of the decision taken in relation to a PIP claim. The importance of further evidence in PIP decision making is perhaps best illustrated by the fact that the Department refer to 'new' evidence as being the basis for the overturn of decisions in over 20% of mandatory reconsideration requests; i.e. additional evidence which was not available to the original decision maker.⁷ The Department also state that 'new' evidence is a significant factor in the overturn of decisions at appeal, for which there is currently a 63%⁸ success rate.

Unfortunately, the manner in which the Department gathers and collates the data relating to all aspects of further evidence (including its request, receipt and application in the decision making process), which I will detail under the principles of '**putting things right**' and '**Seeking continuous improvement**', leaves me uncertain as to the accuracy of the reasons, as presented by the Department, for the overturn of decisions. Based on the figures presented however, taking Mandatory Reconsiderations and Appeals together, there are at least 21,853 claimants of PIP for whom the eventual award entitlement was

⁵ *The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland*. Report by the Comptroller and Auditor General. 23 March 2021. Available at www.niauditoffice.gov.uk/publications/publications/management-and-delivery-personal-independence-payment-contract-northern-ireland

⁶ Gill, C. (2020) Chapter 5 'The Ombud and Own Initiative Investigation Powers' in 'A Manifesto for Ombudsman Reform' edited by Richard Kirkham and Chris Gill, Palgrave Macmillan

⁷ Assembly Question AQO 162/17-22 – February 2020. Available at <http://aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=295394>

⁸ AQW 13505/17-22 – February 2021. Available at <http://aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=324195>

not made at the earliest possible point in the process.⁹ Many more may have disagreed with the initial decision or Mandatory Reconsideration outcome, but felt unable to face challenging it further.

Despite the stated importance and value of further evidence to the benefit decision making process, as set out in the Department's own policy and procedures, and its reported significance in the overturn of decisions, it was surprising to learn, based on revised Capita figures, that further evidence was only requested in approximately 25% of the total number of PIP cases between August 2019 and April 2020.¹⁰

My investigation found that:

- At the Initial Review stage, further evidence was requested by Capita Disability Assessors in only 35 of the 100 claims that I examined. This figure includes both written and telephone requests. Whilst 10% higher than the overall 25% average, given the importance of further evidence to the PIP process it is lower than would be expected.
- Despite Disability Assessors having the ability to request further evidence at all stages of the PIP process, of the 96 claims routed for face to face consultation, further evidence was requested in only one case at the Assessment stage.
- The most commonly recorded indicator for deciding not to request further evidence was that it was unlikely evidence would be obtained within the timescale required.
- Capita's own written process, in respect of claims routed for a face to face consultation, almost acted as a deterrent to further evidence being gathered from other sources, despite claimants being left with the clear impression it would be an important part of the decision making in their claim.
- When evidence was requested from Health Professionals named by the claimant, the request letters sent by Capita were often poorly completed and did not specify what information was sought.

9 13,040 registered MRs from June 2016 until November 2020 resulted in New Decision & New Award. *PIP Experimental Statistics Supplementary Table (November 2020)*. Available at www.communities-ni.gov.uk/publications/personal-independence-payment-statistics-november-2020
8,813 PIP Appeals Successful, AQW 13505/17-22. Available at <http://aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=324195>

10 As set out in Chapter 8 of my report, Capita had provided the Department with inaccurate management information pertaining to 'further medical evidence', this inaccurate management information was initially provided to my investigation. Subsequently Capita provided revised management information for August 2019 to April 2020. This figure is based on the number of written requests made during this period and does not include requests made by telephone (the figures for telephony requests are not routinely collated by Capita).

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- In the face to face assessments, the evidence from the consultations was often the primary and in some cases the only source of evidence relied upon by the Disability Assessors when providing their advice to the Department.
- Disability Assessors did not explain or record why more reliance was placed on their observations at a face to face consultation than other available evidence from claimants, carers or professionals.
- In addition to passing quality audits, Capita use information about the number of assessment reports completed and submission times to decide bonuses for Disability Assessors. Time pressures and incentives have the potential to inhibit the appropriate use of further evidence to improve the quality of assessment advice.

Extract from Case Study 1, Chapter 2 on Initial Review Stage

Claimant F, whose primary condition is listed as Learning Disability, applied for PIP on 8 September 2018.

Award History:

DLA: Middle Care: Lower Mobility

First Tier Decision (14 November 2018): No Award, No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (5 December 2018): No change

2nd Mandatory Reconsideration (22 December 2018): Standard Daily Living (9): Enhanced Mobility (14)

This case identifies that evidence supplied by a health professional, whose contact details were provided by the claimant within the PIP2 application form, had a significant impact on the claim. In this case changing the decision from no award to Standard Daily Living and Enhanced Mobility. There are no records to confirm whether or not the health professionals provided on the PIP2 were considered by the Disability Assessor at the outset of the claim. An opportunity may therefore have been missed to request evidence at an earlier stage of the process in order to get the decision right first time.

Extract from Case Study 1, Chapter 3 on Assessment Stage

Claimant O, whose primary condition is listed as Multiple Sclerosis, applied for PIP on 10 June 2018.

Award History:

DLA Award: Middle Care: Higher Mobility

First Tier Decision (13 November 2018): No Daily Living (6 points):
Standard Mobility (10 points)

Mandatory Reconsideration (5 January 2019): No change

Lapsed Appeal (7 March 2019): Enhanced Daily Living (12): Enhanced
Mobility (20)

This case raises concerns that the Disability Assessor, at Assessment stage, did not appear to consider it relevant to seek evidence from identifiable health professionals to help improve the quality of advice. It reflects the risk associated with the policy and practice that indicates face to face consultations negate the need to consider and pursue other evidential opportunities.

Extract from Case Study 4, Chapter 3 on Assessment Stage

Claimant P, whose primary condition is listed as Parkinson's Disease, applied for PIP on 29 July 2018.

Award History:

DLA Award: Higher Care: Higher Mobility

First Tier Decision (12 October 2018): No Award, No Daily Living (0 points):
No Mobility (0 points)

Mandatory Reconsideration (24 November 2018): No change

Offer of Lapsed Appeal (24 December 2018): Standard Daily Living (9):
Enhanced Mobility (12)

It is alarming that no explanation was provided in the justification section as to why no apparent weight was given to the GP's evidence nor therefore were the contradictions in the evidence obtained by the Disability Assessor explained. If no weight was attributed because the evidence from the GP was deemed out of date, it is equally concerning that up to date evidence was not sought. In particular as the consultation findings contrasted so significantly with the impact reported by the claimant and the condition history.

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I also found that the Case Managers, who are the ultimate benefit decision makers, did not routinely request clarity from Capita Disability Assessors on assessment reports where advice was not properly explained. There was a failure to examine further evidence opportunities where the reported impact and assessment advice conflicted, even though claimants had pointed to sources of relevant evidence.

Decision making on whether or not to request further evidence was overwhelmingly deferred to Capita, despite Case Managers having the ability to request it and the responsibility to ensure the benefit decision is robust.

Extract from Case Study 2, Chapter 4 on First Tier Decision stage

Claimant AM, whose primary condition is recorded as Depression and Anxiety applied for PIP on 14 September 2018.

Award History:

DLA: Middle Care: Lower Mobility

First Tier Decision (1 December 2018): No Award, No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (31 January 2019): No change

Offer of Lapsed Appeal (5 April 2019): Standard DL (11): No Mobility (0)

The assessment report was received by the Department on the 24 November [2018]. Clarification was not sought from the Disability Assessor why the Disability Living Allowance (DLA) evidence was not referenced in the justification of their opinion. There are no records to demonstrate that the Case Manager examined the DLA evidence and gave proper scrutiny to the Disability Assessor's justification of their opinion against the existing evidence.

In my view, without such routine querying of obvious contradictions, inconsistencies and gaps in further evidence, there was often undue deference given by initial Case Managers to descriptors recommended in the Assessors' reports. Conversely, Case Managers, tasked with reviewing cases where an Appeal request had been submitted, requested further advice more frequently than Case Managers at earlier review stages, despite the fact that the evidential basis for the request was arguably the same at both stages.

Overall, despite the Department's and Capita's contention that further evidence has a key role in the PIP process, it was often the case that it was only at the last stage of the Department's Internal Process, following a claimant's submission of an appeal to the Tribunal, that the role of further evidence was elevated.

Extract from Case Study 5, Chapter 1 on Application stage

Claimant E, whose primary condition is listed as Epilepsy, applied for PIP on 19 July 2018.

Award History:

DLA: Middle care: Lower Mobility

First Tier Decision (14 October 2018): No award, Daily Living (4 points): Mobility (0 points)

Mandatory Reconsideration (27 November 2018): No change

Offer of Lapsed Appeal (13 January 2019): No Daily Living (4): Enhanced Mobility (12)

This case evidences how misleading communication, which provides inaccurate reassurance to claimants that their health professionals would be contacted, may impact on a claim. In this case it resulted in no further evidence being gathered by the claimant from the health professionals at the outset of the claim. Once the claimant became aware that health professionals had not been contacted they were able to access this information and provide it at a later stage, directly resulting in an award being made.

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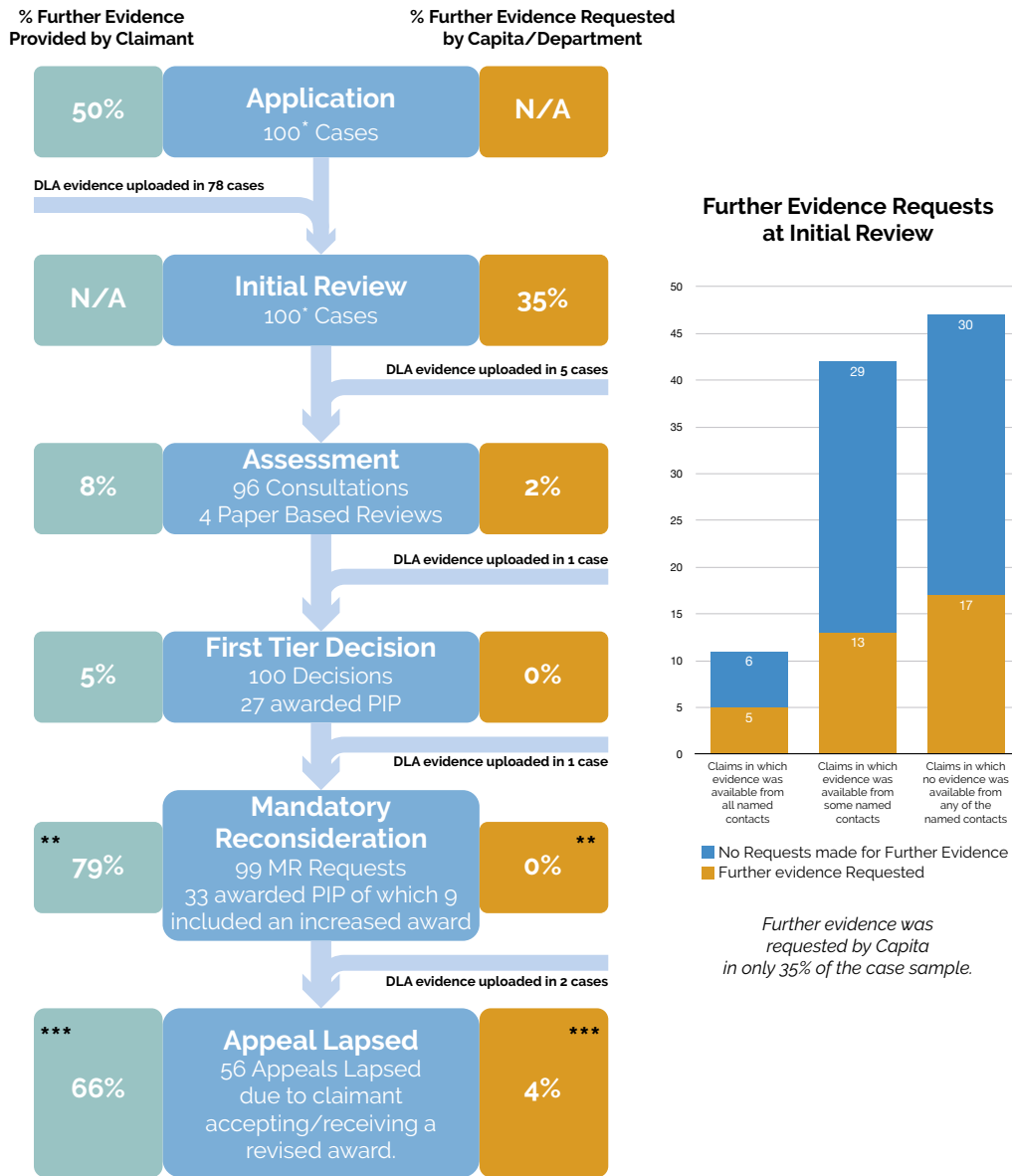
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The following diagram, illustrates how often evidence was requested by Capita/the Department or provided by the claimant in the case sample I examined. It also shows the breakdown of cases in which requests were not made to some or all of the health professionals named by the claimant as being best placed to provide advice on their condition.



Further evidence was requested by Capita in only 35% of the case sample.

* The investigation analysed all claims pertaining to 100 individuals however for the purposes of the diagram, in order to avoid duplication of instances, only one claim per claimant was represented. At the time of NIPSO drafting the report out of the 100 claims reported on - 1 of the claims had concluded at First Tier (initial) decision stage, 8 concluded after Mandatory Reconsideration and 91 had submitted an Appeal (of which of 56 lapsed following a revision of the decision by the Department, 26 went to Tribunal, 5 were awaiting a hearing, 3 were withdrawn and in one case an appeal was allowed but resulted in a new assessment.

** The % figure is based on the 99 MR requests.
 *** The % figure is based on the 56 Lapsed Appeals

Although claimants tended to submit further evidence with their appeal submission, I observed cases in which the same substantive information already existed in the claim file and/or additional evidence came from sources previously highlighted by the claimant but were not contacted by Capita or the Department. To describe such cases as overturned decisions on the basis of 'new evidence' is, in my view, misleading given that the evidence or the source of the evidence being relied upon as 'new' was often available from the very outset of the claims. It also masks that, at times, differing advice is provided by Capita to the Department on essentially the same information. I recognise that differing professional judgement can occur, on occasion, and does not necessarily represent a concern, however the reasons for it, and any wider or repeated inconsistency, should be carefully considered.

Extract from Case Study 3, Chapter 8 on Further Evidence Statistics

Claimant M, whose primary condition is listed as Arthritis, applied for PIP on 11 August 2018.

Award History:

DLA: Middle care: Higher Mobility

First Tier Decision (22 October 2018): No award, No Daily Living (2 points); No Mobility (0 points)

Mandatory Reconsideration (14 December 2018): No change

Offer of Lapsed Appeal (22 February 2019): Standard Daily Living (10); Standard Mobility (8)

This case evidences how the Department can determine that cases are overturned on 'new' evidence when the evidence was already available at an earlier stage of the process. The Appeals Case Manager had identified that evidence recorded within the assessment report indicated the claimant's functional restrictions. The GP factual report available prior to the face to face assessment also indicated functional restrictions. It is therefore disappointing that the categorisation of the reason of the lapsed Appeal is recorded as new evidence being received.

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The outcome of categorising overturned decisions in this way is that it provides an inaccurate reassurance to the public that the internal workings of the Department's decision making process are precise and robust, and that the evidence that ultimately results in an overturned decision is not available until much later in the process. It appears this line of thinking has taken hold to the point that it has been simply accepted by the Department as a fact outwith its control. An approach in line with the principle of **'Seeking continuous improvement'** would have however meant the Department exploring if this is in fact correct, and if so why it takes until the next or final stage in the process for the 'new' evidence to come to light.

This embedded thinking, as I will highlight later, gave rise to a significant and systemic departure from the principles of **'Putting things right'** and **'Seeking continuous improvement'** both in terms of the Department evaluating for itself as to why so many decisions were not right first time, and in how it responded to the complaints that further evidence was not properly considered or sought.

I found that in practice the value and application of further evidence to the PIP benefit decision was limited from the very outset of a claim. This was underpinned by the minimal, if any, records setting out the reasoning of how it was relied upon or otherwise by Disability Assessors and Case Managers. I do not, and nor would I think a claimant, consider the timeframe in which further evidence will be received to be acceptable as the sole relevant factor in determining whether or not it should be obtained.

Built into the system and culture, in my view, is a mind-set that useful further evidence should have been gathered by the claimant (despite the fact they are told not to gather it and to provide only what they already have) or that it is something that can be obtained 'later on'. There is a focus on taking the decision on the basis of the information available at the time, even where the information is undoubtedly incomplete, and then moving onto the next claim. The impact of this is that the onus is left on the claimant to keep challenging the decision. As I will explain below, in relation to the principles of **'Being customer focused'** and **'Being open and accountable'** often claimants had to do this 'in the dark' not knowing what, if any evidence, other than that obtained during the face to face consultation, had been requested and relied upon. This is unacceptable and puts claimants at a systemic disadvantage.

Extract from Case Study 5, Chapter 4 on First Tier Decision stage

Claimant AD, whose primary condition is recorded as Specific Language Impairment applied for PIP on 15 October 2018.

Award History:

DLA: Middle Care: Lower Mobility

First Tier Decision (11 March 2019): No Award, Daily Living (4 points):
Mobility (0 points)

Mandatory Reconsideration (2 April 2019): No change

Lapsed Appeal (2nd Mandatory Reconsideration) (25 June 2019):
Standard Daily Living (10): No Mobility (0)

This case evidences that the reasoning provided in the decision letter is difficult to understand and is not clear. The statement *'this information is the best available'* is questionable given no requests for further evidence or input was sought from the professionals whom the claimant listed as being best placed to provide advice on how the condition(s) affect the claimant. The letter does not inform the claimant that input or evidence was not sought from these sources.

Being customer focused

At its most basic level **'Being customer focused'** requires public bodies to provide services that are easily accessible to their customers. This is increasingly important for vulnerable citizens accessing a service designed to support them. As highlighted earlier, PIP is a benefit designed to support individuals who have a disability or are living with a long term condition. On this basis one might assume PIP would attract high numbers of claimants requiring additional support. Disappointingly, my investigation found that the Department's narrow interpretation of its own guidance on this issue meant that many vulnerable claimants may not in fact have been flagged as requiring additional support when adherence to the principle of **'Being customer focused'** may have warranted their inclusion. The approach by the Department on this very important issue, in my view, potentially limited its ability, as a public service, to treat people in accordance with their individual needs whilst responding flexibly to the circumstances of the case.

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Extract from Case Study 1, Chapter 1 on Application stage

Claimant A, whose primary condition is listed as Anxiety/Depressive disorder/Borderline personality disorder, applied for PIP on 19 July 2018.

Award History:

DLA: Middle Care: Low Mobility

First Tier Decision (17 October 2018): No Award, Daily Living (4 points): Mobility (0 points)

Mandatory Reconsideration (2 November 2018): No change

Appeal (23 June 2019): Standard Daily Living (8): Standard Mobility (10)

This case evidences that claimants who have a condition listed* within the Guidance (and have no Personal Acting Body) do not have the Additional Support marker applied on the basis that they may/will contact an informal support (such as an Advice Sector organisation). Without any guarantee that contact is made or that informal support is available or engaged with throughout the process, an opportunity is missed by the Department to provide vulnerable claimants with the appropriate support and flexibility afforded to those with the Additional Support marker.

It is of note that once the claimant had support from the Belfast Citywide Tribunal Service at Appeal, they were awarded PIP.

*The claimants' conditions included Bi Polar disorder, Obsessive Compulsive Disorder, Post Traumatic Distress Disorder, Schizophrenia, Learning Disability, Brain injury.

In '**Being customer focused**' policies and procedures should be clear, accurate, complete, and provide understandable information about the service. Specifically, public bodies should aim to ensure that customers are clear about their entitlements; about what they can and cannot expect from the public body; and about their own responsibilities. Key to all of this is that public bodies should communicate effectively, using clear language that people can understand and that is appropriate to them and their circumstances.

Contrary to this my investigation found a lack of openness and clarity in the Department's and Capita's communications to claimants about the role further evidence would play or had played in deciding their entitlement to PIP. Incomplete, and at times misleading, communications led some claimants to believe that the health professionals, whom they listed as being best placed to provide advice on their condition, would be or had been contacted when they had not. As mentioned earlier, further evidence is only requested in approximately a quarter of all PIP claims.

Varying communications in regard to the use of DLA evidence to support a claim for PIP also meant that some claimants were provided with different opportunities to select and review the evidence to be used. Claimants who initiated their PIP claim by telephone were asked only if they consented for their most recent DLA evidence to be used and were not provided with any details on what specific pieces of DLA evidence were available to the Department. In contrast, claimants who initiated their claim through the paper based alternative were given information on the different types of DLA evidence that could be used and asked to select which were to be used, as well as the option of being provided with a copy of the available DLA evidence to assist them in making their decision.

My investigation also identified that the various stages of review of PIP award decisions were not properly explained to claimants and many were not made aware of the impact additional evidence may have on claims after initial entitlement decisions have been made. Specifically I found:

- inadequate and inconsistent advice was provided to claimants on the Mandatory Reconsideration process; and
- claimants were not told of the Department's subsequent review of their claim, which automatically happens following a claimant's submission of an Appeal to the Appeals Tribunal. They often only became aware of this review if they received an offer of an increased award or were informed their Appeal had lapsed as the decision had been revised to the highest rate.

These issues had understandable implications for a claimant's ability to understand and challenge decisions at all stages of the process. Consequently, there was and remains a level of confusion among claimants on how further evidence is used to make PIP benefit decisions. This, as I have described earlier, puts claimants at a systemic disadvantage for progressing a review/appeal.

Extract from Case Study 1, Chapter 6 on Lapsed Appeals

Claimant AB [whose primary condition is reported as Fibromyalgia] submitted an Appeal request to the Appeals Service on 4 October 2018.

Award History:

DLA: Middle Care: Higher Mobility

First Tier Decision (19 July 2018): No award, No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (1 September 2018): No change

Offer of Lapsed Appeal (25 November 2018): Standard Daily Living (9): Standard Mobility (10)

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This case evidences the lack of communication provided to claimants prior to, and during, the lapsed Appeal process. In this case the claimant's evidence (which had already been provided at Mandatory Reconsideration) was twice referred [to Capita] for advice without the knowledge of the claimant. The claimant only became aware that the case was being reviewed by the Department when they received the offer of award letter - which provided significantly limited information. As a result the claimant assumed their award was overturned following their 'complaint'.

Being open and accountable

Public bodies should be open and truthful when accounting for their decisions and actions. They should state their criteria for decision making and give reasons for their decisions. Moreover, public bodies should create and maintain reliable and usable records as evidence of their activities.

As set out in 'Records matter', good record keeping tells us not only what has been decided but also why it has been decided.¹¹ Records not only provide evidence of the activity of the decision making process, they promote accountability and allow others to verify what has been done. Even when correct decisions are made, poor record keeping on the decision making process makes it difficult to convince others that the public body behaved properly.

Given the sheer volume of the PIP benefit claims to be processed, measures to increase efficiency are to be expected and in fact promoted where these do not adversely affect the quality of the benefit decision making. However, I found that record keeping across all stages of the claim process was poor and below the standard of what I would expect. This included, but was not limited to:

- a failure by the Department and Capita to create records on their systems of all the health professionals put forward by the claimant as being best placed to provide advice on their condition, as listed in their application for PIP;
- inadequate recording of Disability Assessors' decision making on the choice of assessment (i.e. why a face to face or paper based was selected), the considerations around requesting further evidence and its use in formulating their advice;
- an absence of records on how Case Managers weighed and evaluated all the evidence to decide entitlement or of the explanation provided

¹¹ *Records Matter. A view from regulation and oversight bodies on the importance of good record keeping records-matter-january-2020-digital-edition.pdf (nipso.org.uk)*

- when claimants requested an explanation call of the decision; and
- inadequate record keeping within the Department's complaint investigations.

As previously outlined I found the information provided to the claimants during the process to be inaccurate and incomplete. Not only was it strongly inferred that health professionals would be contacted in the claim (when more often than not, this did not happen), many claimants received correspondence from Capita that stated all health professionals whom they had listed had been contacted when this was not the case.

Extract from Case Study 6, Chapter 2 on Initial Review stage

Claimant K, whose primary condition is listed as Degenerative Disc disease, applied for PIP on 9 June 2018.

Award History:

DLA: Middle Care: High Mobility

First Tier Decision (14 September 2018): No Award, Daily Living (4 points), Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No Change

Offer at Lapsed Appeal (17 February 2019): Standard Daily Living (8): Standard Mobility (8) (offer declined)

Awaiting Appeal

A clinic face to face consultation was booked and the claimant was advised of the appointment date. No record was made to identify why further evidence had not been requested from the claimant's health professional(s), and no advice was provided to the claimant as to why this form of assessment was chosen.

In respect of the decision letters from the Department to claimants, which should provide the reasoning for the award outcome, I found the quality of explanation to be poor. I have read and reread a number of the letters sent to claimants that formed part of my investigation setting out the basis for the individual decision on their PIP claim. Having done so, I remain unclear as to what those reasons are.

I fully appreciate that PIP claimants will not always agree with the decisions the Department makes on their entitlement to benefit, but fundamental to any administrative decision making process, and at the heart of the principles of good administration, is that the claimant understands the decision and believes they have been fairly assessed. The ramifications of incorrect and/or poorly explained decisions, go far

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beyond those claimants directly affected. They contribute to a much wider perception of an unreliable opaque process which is at odds with the principle of '**Being open and accountable**'.

Acting Fairly & Proportionately

Public bodies should always deal with people fairly and with respect. They should be prepared to listen to their customers and avoid being defensive when things go wrong.

Whilst I welcome that the Department has been successful in providing support to a large number of claimants and that many have been satisfied with the PIP process, there are many individuals who have not had that experience. Concerns have been consistently raised by claimants, their Carers and family members, the Advice Sector and in Statutory and non-Statutory reports. Many of the issues I have raised are not new.

Within my investigation I have evidenced that there is a clear disparity between the policy intent regarding the role of further evidence and its use and application in reality. This gap does not provide for fairness, or support consistency in the quality of outcomes and experience for individuals.

Extract from Case Study 12, Chapter 5 on Mandatory Reconsideration stage

Claimant H, whose primary condition is listed as Fibromyalgia, had been awarded Standard rate PIP for both Daily Living and Mobility. Following a deterioration in condition, and further diagnosis of a new condition, the claimant applied for an unplanned intervention.

Award History:

PIP Award (13 Oct 2017): Standard Daily Living; Standard Mobility
Change of Circumstances (Unplanned Intervention) (May 2019): No award, No Daily Living (6 points); No Mobility (4 points)
Mandatory Reconsideration (18 June 2019): No change
Offer of Lapsed Appeal (31 August 2019): Standard Daily Living (10); Standard Mobility (10)

This case evidences that although contradictions arose between the assessment observations and the claimant's reported restrictions, and despite a specific request from a claimant for the Department to contact their health professional (as the health professional would only accept a request from the Department/another health professional) this was not requested either directly or indirectly by the Department. The claimant was instead advised that PIP don't request reports.

Acting fairly and proportionately is also a key principle for good complaint handling. To adhere to this principle, public bodies should investigate complaints thoroughly and fairly and should avoid taking a rigid, process-driven, 'one size-fits-all' approach to complaint handling.

Naturally, but not always, the benefit decision is often closely associated with the complaint issues raised by PIP claimants. I recognise that claimants must utilise the appeal mechanisms should they seek to dispute the award decision, however claimants also deserve to have their concerns about the process and treatment thoroughly examined. Although I recognise that the Department responded quickly to complainants and often invested effort in explaining policies and procedures, they rarely addressed the specific issues of complaint in a comprehensive manner.

My investigation found:

- The Department's overall standard of investigation into service complaints about Capita was inadequate.
- The Department relied on assurances provided by Capita that the issues had been investigated and addressed, as opposed to conducting its own enquiries. This extended to the Department's complaint response to the claimant being primarily based upon Capita's complaint response letters to the claimant and at times the Department did not have a copy of the claimant's original complaint.

Learning from complaints is a powerful way of helping to improve public services and build trust amongst the people who use the service. Regardless of the veracity of the complaint, I do not consider the manner in which the Department handles these complaints has the capacity to either improve services or build trust. Indeed, I believe it may have had the opposite effect, albeit unintentionally, of diminishing trust which can cause some claimants, and those who support them, to disengage from the complaints process.

Specifically, in respect of complaints raised about further evidence, I found both Capita and the Department to be lacking in how this issue of concern was investigated. When a claimant raised a complaint that an important piece of relevant evidence was not sought, the standard response was to state that the decision to request or not request further evidence is a clinical decision for the Disability Assessor. Given the potential seriousness of the issue raised, I do not consider it to be either fair or proportionate of the public body not to examine the specifics of a complaint about the gathering of evidence where this is clearly linked to the decision made on whether to award a benefit.

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Without investigation of this critical issue, the Department and Capita simply cannot establish whether the decision not to request was reasonable or indeed if the concern was valid or indicative of a wider problem.

There was also an inconsistency in the investigations of complaints about whether existing further evidence in a claim had been properly considered in the advice and decision; the scrutiny sometimes merely relying on the fact that the evidence was listed in the assessment report. As previously explained I found a distinct lack of records detailing the decision making surrounding the requesting and application of further evidence.

Extract from Case Study 2, Chapter 7 on Complaints

Claimant AJ's primary condition was recorded as Diabetes Neuropathy.. Within the complaint correspondence the claimant raises various issues, including their concern that no requests were made for further evidence. [No evidence had been sought from any of the six health professionals named by the claimant, nor had their DLA evidence been made available prior to Assessment and First Tier Decision.]

Award History

DLA: Highest Care: Low Mobility

First Tier Decision (25 February 2019): No Award, Daily Living (2 points): Mobility (0 points)

Mandatory Reconsideration (16 April 2019): No change

Appeal Decision (15 March 2020): No Award Decision Confirmed, Daily Living (4): Mobility (4)

It is acknowledged that the Department, made significant efforts in correspondence to provide reassurance to the claimant about the policy intent of the PIP benefit system assessment process. The Department outlined the quality standards set down for Capita as the Assessment Provider and explained the auditing mechanisms in place which it relayed provide confidence that the standards are delivered. It is notable and concerning however that at an operational level the Department did not address the case specific issues of complaint over and above providing the statement that Capita confirmed that the issues were investigated.

Putting things right

Where a decision is found to be incorrect, **'putting things right'** is a key duty for public bodies. This is essential for providing remedy to individuals but also for delivering services effectively and securing the confidence of service users. The case sample I selected included a large number of overturned decisions following submission of an appeal. I welcome the action taken by the Department to review and correct the decisions at that point of the process, however similarly to the decision letters at First Tier and Mandatory Reconsideration, the Lapsed Appeal notices provided little insight to the claimant as to the reasoning behind the change in decision.

I am also concerned that this may be indicative of an approach which considers that, as there are appeal mechanisms available to claimants in PIP, there is less onus to ensure all best efforts are taken at the outset to get the decisions correct. This approach ignores the added time, frustration and distress caused to claimants both financially and experientially, where the correct decision may have been reasonably achieved at an earlier stage. Critically, it is also a higher risk approach to the delivery of an essential benefit which is to support individuals, many of who are the most vulnerable members of our society, and who will invariably be further disadvantaged if the decision is not correct.

The principle of **'putting things right'**, relates not only to individual decisions but extends also to reviewing and amending any policies and procedures found to be ineffective or unfair. As outlined, opportunities for the Department and Capita to systematically improve the quality of assessment advice and decision making were lost due to incomplete analysis of the reasons for overturns in decisions. The limited analysis which was completed, was relied upon by the Department to provide a simple narrative that there is no maladministration in the system and decisions are only changed on the basis of 'new' evidence that the claimant provided late in the process. This narrative is likely to perpetuate rather than rectify deficiencies in the process.

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Extract from Case Study 3, Chapter 4 on First Tier Decisions

Claimant AN, whose primary condition is recorded as Schizophrenia applied for PIP on 5 October 2018.

Award History:

DLA: Middle Care: Lower Mobility

First Tier Decision (8 January 2019): No award, No Daily Living (2 points): No Mobility (0 points)

Mandatory Reconsideration (6 March 2019): No change

Offer of Lapsed Appeal (4 May 2019): Standard Daily Living (9): Standard Mobility (10)

It is of interest to note that subsequently a further letter was received from the Consultant Psychiatrist, however the content of the letter was the same as that of the first letter received prior to the assessment. A Department's Appeals Case Manager requested further advice from Capita. The information provided in the Consultant Psychiatrist's letter and the GP factual report (both of which were available during the initial assessment and decision) were relied upon in the change the advice. The Department subsequently revised their decision of entitlement and offered an award to the claimant which resulted in the Appeal lapsing.

I found the Department, as the duty bearer, failed to grasp risk areas around the handling of further evidence and its impact on service. This was observed in the Department's failure to recognise and proactively address inaccurate management information provided by Capita on the overall number of further evidence requests made in claims. The Department also provided inaccurate figures on the number of further evidence requests in response to Freedom of Information requests. The failure to effectively monitor this critical activity by the service provider impacted on the Department's ability to report accurate information, which is disappointing given the level of concerns raised by many parties about the issue of further evidence.

Another key opportunity for public bodies to **put things right**, not only for individuals but for the system, is through the operation of an effective complaints procedure through which complaints are investigated thoroughly, quickly and impartially. As discussed under the principle of **acting fairly and proportionately**, I found that the Department's overall standard of investigation into service complaints about Capita was inadequate and does not reflect their outward commitment to independently investigate complaints. The Department, at a governance

level, had not taken effective ownership of how reliably concerns about further evidence in the PIP process were addressed within the complaints system. This is a missed opportunity to tackle and remedy shortcomings at both individual and system levels.

Seeking Continuous Improvement

For public bodies, **seeking continuous improvement** must be more than a statement. For this principle to be realised, it involves regularly reviewing policies and procedures for effectiveness and also using the complaints system and feedback to improve services and performance.

I found however that the failure of the Department to **get it right** in the:

- scrutiny of further evidence in individual claims and management information,
- the incomplete analysis of why decisions are overturned and
- the ineffective complaints process,

hindered the Department's ability to improve. Although the Department has consistently advised it is committed to continuous improvement and has engaged with stakeholders, it has not properly utilised and reflected on the rich data that is available to it contained in the claims that it processes and the complaints that it receives.

Extract from Good Practice Case Study 15, Chapter 5 on Mandatory Reconsideration stage

Claimant AA, whose primary condition is listed as Cardiac, Raynaud's Syndrome, and Liver Problem, [was awarded PIP in 2016 had their entitlement reviewed in 2018. The claimant appealed the review decision that they were no longer entitled to PIP].

Award History

PIP (21 November 2016): Standard Daily Living (11 points): Enhanced Mobility (12 points)

Award Review (7 January 2019): No Award, No Daily Living (0): No Mobility (4)

Mandatory Reconsideration (24 February 2019): No Change

Offer of Lapsed Appeal (27 May 2019): Standard Daily Living (8): Standard Mobility (10)

This case has been highlighted as Good Practice due to the Appeal Case Manager's decision to question the inconsistencies in the assessment and request further advice from the claimant's health professional (despite the advice of the Telephony Advisors that this

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would not happen). As a direct result of the Appeals Case Managers request for further advice, and the receipt and review of the GP report, the claimant's award was overturned. The claimant was subsequently entitled to Standard rate Daily Living and Standard Mobility.

It is also of note that the Appeals Case Manager's request for further evidence highlighted the lack of recent evidence held as part of the necessity to gather further evidence. This is a practical observation which does not appear to be routinely applied by Case Managers. A number of the cases reviewed (where evidence was not requested) did not have recent evidence available on file.

I was also concerned to note that at times where the Department had reported implementing improvements in respect of previous reviews and recommendations, such as reviewing the clarity of its written material¹², some of the changes made by the Department were superficial and unlikely to have impact.

Through my investigation I have challenged the Department to comprehensively reflect on how communication can be improved and better decision making may be achieved. Whilst different professional judgements on the same information may on occasion occur, and relevant further evidence may not always be able to be obtained, it is clear that the inadequacies in requesting and applying further evidence must be tackled. I am also very clear, that although the failings identified span across both Capita and the Department, the duty to ensure improvements are made sits firmly with the Department, the public body with the responsibility to deliver PIP.

¹² Review of the Personal Independence Payment Assessment Process, *Department for Communities' Interim Response*. November 2018. Available at www.communities-ni.gov.uk/publications/independent-review-personal-independence-payment-pip-assessment-process-northern-ireland-report

Conclusion

I fully recognise the work of the Department to implement PIP, the scale of the delivery and the introduction of initiatives, unique to Northern Ireland, with the aim of improving outcomes and claimants' experience. I also welcome that there are many individuals who have received support by being awarded PIP and note that some have received a higher level of monetary support than they received through DLA. I know however there are many other individuals for whom the system has not delivered as it should have done and my investigation has evidenced further improvements are required.

As the statutory body responsible for making the decision of entitlement and in aiming to get PIP outcomes right first time, the Department needs to place testing the sufficiency and strength of the overall evidence at the core of their decision making role. It must engage properly with claimants, on an individual basis, about where the best evidence to support their claim may be found and be proactive about bringing such evidence to light. Where aspects of its delivery are outsourced, such as in the undertaking of assessments by Capita, the Department must ensure the standards of service provision meets what the Department needs in order to make good decisions at the earliest opportunity possible.

To determine whether maladministration occurred I tested the actions of the Department and service provider Capita against the framework of the Principles of Good Administration. Having tested the actions, the evidence supports a finding of systemic maladministration. The issues I have reported do not point to 'one off' mistakes but instead support the need to fundamentally review how further evidence is obtained and applied in the PIP process and how this is communicated.

I am confident that the insight into the PIP process provided in my report along with my findings and recommendations will have a positive impact for the delivery of PIP to citizens in Northern Ireland.



Margaret Kelly

The Northern Ireland Public Services Ombudsman

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Recommendations

I have made 33 recommendations to the Department for improvement, which are set out in full in my report. My recommendations, summarised below under the Principles of Good Administration, centre on helping the Department to get the delivery of PIP to claimants right first time.

GETTING IT RIGHT

It is recommended that:

- The Department should be clear in its communication about where the responsibility lies for gathering further evidence in support of a PIP claim.
- The Department review Capita's policy for requesting further evidence at the Initial Review and Assessment stages and address any processes, time or bonus incentives that may act as barriers to pursuing further evidence to improve the quality of assessment advice. It should also ensure the quality of written request letters sent to claimants' health professionals is improved.
- The Department should ensure Capita's processes are compliant with guidance and service requirements, so that any unnecessary face to face consultations are cancelled and further evidence which is brought to consultations is properly considered.
- Training for Disability Assessors must emphasise the importance of explaining how all relevant evidence in a claim is evaluated when justifying the descriptor choices recommended in their assessment advice. The Department should review whether it properly applies the 'fit for purpose' criteria to assessment reports produced by Capita and enhance the auditing of further evidence criteria.
- The Department renew its own focus on the importance of further evidence for good decision making on PIP claims. Case Managers must be empowered to test the evidence (including Disability Assessor opinion) and seek further evidence (medical and non-medical) to ensure their decision making on PIP entitlement is robust.
- The electronic tool used to record the reasoning for decisions on PIP entitlement should be reviewed, given a reliance on pre populated and automated responses, and the limited amount of information that can be input. Case Managers need to make records about how they evaluate all relevant evidence in a claim and significantly improve the quality of explanations given to claimants in decision letters.

(Related recommendations 1.2, 1.4, 2.2, 2.4, 2.6, 3.1- 3.4, 4.1, 4.2, 5.6, 5.8, 6.3)

BEING CUSTOMER FOCUSED

It is recommended that:

- The Department review and improve its initial communication to claimants to provide clear and consistent information about the role of further evidence in the PIP process. Key information that should be clearly explained, includes how evidence to support a claim is gathered and the limited number of requests currently made by Capita to health professionals.
- The Department review its application of the Additional Support policy and consider further engagement with the Advice sector on providing support to vulnerable claimants.
- As well as improving the quality of the explanations provided in decision letters, the Department should provide claimants with a copy of their Assessment report along with the First Tier decision letter.
- The Department review and improve its communication to claimants on the Mandatory Reconsideration process, to include providing more detail about the provision of further evidence and update the Mandatory Reconsideration request form to be of assistance to claimants.
- The Department should consider the introduction of an acknowledgement letter to claimants who apply for a Mandatory Reconsideration, to include advice on further evidence which is specific to the claim and areas of dispute.
- The Department should include information, within the Mandatory Review notice, about the additional review stage conducted by the Department when an Appeal is submitted.

(Related recommendations 1.1-1.4, 2.3, 3.3, 5.2 - 5.4, 5.5, 6.1)

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BEING OPEN AND ACCOUNTABLE

It is recommended that:

- Record keeping must be significantly improved across the administration of PIP, including better quality recording of: the details of health professionals provided by the claimant; the reasoning for the choice of assessment; considerations on the value of pursuing further evidence; how all the evidence is evaluated in the decision making; explanations provided to claimants; and the actions taken to investigate complaints.
- The Department should ensure Capita revises their information pack so that claimants are accurately informed as to whether or not further evidence requests have been made to the claimants' health professionals and with whom contact has been made.
- The Department should make it clear to claimants that when a complaint is raised about Capita's service in respect of PIP assessments, Department Case Managers who are making a decision on the claim are not notified, nor do they have routine access to the complaint information.
- The Department should place an emphasis on making sure PIP information provided, in response to requests made by individuals and organisations, is clear and accurate. The relevant staff should be retrained accordingly.

(Related recommendations 2.1- 2.3, 2.5, 3.3, 4.1, 4.2, 5.1, 5.8, 6.3, 7.1, 7.3, 8.2)

ACTING FAIRLY AND PROPORTIONATELY

It is recommended that:

- There should be a clear policy on when Case Managers refer additional evidence received by the Department to Capita for further advice and ensure claimants are informed if it is referred or alternatively when a decision has been made not to refer.
- The Department should review the process by which it conducts its investigations into complaints about Capita service delivery. It is critical the Department sets out the standards of investigative action expected, as well as the administrative arrangements, for the thorough and independent investigation of these complaints.

- Both the Department and Capita should ensure complaint issues about further evidence are properly investigated and explain comprehensively to claimants as to why a complaint was or was not substantiated.

(Related recommendations 5.7, 7.1, 7.2)

PUTTING THINGS RIGHT

It is recommended that:

- The Department should review the robustness of its methods of monitoring statistics provided by Capita in respect of further evidence requests and response rate. Consideration should also be given by the Department to undertake its own collation of data in respect of this key activity.

(Related recommendation 8.3)

SEEKING CONTINUOUS IMPROVEMENT

It is recommended that:

- The Department should review the process for recording and analysing the outcome of PIP complaints to ensure learning and improvement. It should publish information about complaints, including the action taken to improve the service as a result of complaints, in a way that reaches claimants and other interested parties.
- The Department should review its current method of recording reasons for the overturn of awards decisions at Mandatory Reconsideration and Lapsed Appeal. It should continuously review and analyse the reasons to inform learning and improvement and report publicly to increase understanding.

(Related recommendations 7.3, 8.1)

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INTRODUCTION

About my Office - The Northern Ireland Public Services Ombudsman

As the Public Services Ombudsman it is my role to ensure that the people of Northern Ireland are served by a fair and efficient public administration that is committed to accountability, openness and quality service. My Office is entirely independent from the bodies that I investigate and my work is not subject to the direction or control of Ministers, the Secretary of State or the Assembly.

In accordance with the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act) I may investigate the actions of public bodies where it is alleged or suspected that maladministration has occurred.¹³ My investigations can also look at the actions of private sector providers to whom a public body has delegated functions of their service provision. My Office has been provided with strong evidence gathering powers which are fully utilised in order to thoroughly and impartially examine the issues of concern raised and deliver robust findings.

Maladministration is not defined in legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping. I am very alert to the significant impact that failings in public administration can have on individuals' lives and the extent to which such failings can seriously damage confidence in public services. Therefore in addition to delivering findings on whether maladministration has occurred, I place a strong emphasis on making recommendations which focus on **'putting things right'**, learning from complaints and improving public services for all.

About my Own Initiative Investigations

In addition to investigating complaints which are made to my Office by members of the public, the beginning of April 2018 saw the commencement of a new power to undertake investigations on my own initiative¹⁴ where I have a reasonable suspicion of systemic maladministration or systemic injustice¹⁵.

¹³ *Public Services Ombudsman Act (Northern Ireland) 2016*. Available at www.legislation.gov.uk/nia/2016/4/contents

¹⁴ Section 8 of the 2016 Act, *Power to investigate on own initiative*. Available at www.legislation.gov.uk/nia/2016/4/section/8

¹⁵ In a case where the matter is one which falls to be investigated under section 15(2)(b), 16(2)(b) or 17(2)(b) of the 2016 Act, that systemic injustice has been sustained as a result of the exercise of professional judgement.

My Office was the first of the Ombudsmen in the United Kingdom, who investigate maladministration, to acquire this new power. It is a reform which has been widely welcomed as a way to proactively focus investigative resources on issues of significant concern and does not require a complaint to have been made. It is a power designed to identify and address systemic failures which have the potential to affect the wider public, not just individual complainants and to ensure significant failings are addressed across sectors as a whole. It is a function that I believe is also critical to tackling service failures about which vulnerable individuals may be unable, or feel afraid, to complain.

To support the best use of the 'Own Initiative' function, in addition to forming a reasonable suspicion¹⁶ of systemic maladministration¹⁷, I assess the subject matters which are identified for potential investigation against published criteria¹⁸. My criteria for selecting subjects for potential Own Initiative investigations are:

One or more of the following -

- The issue of concern has been identified by the Ombudsman to be one of public interest;
- The issue of concern affects a number of individuals or a particular group of people;
- The investigation has the potential to improve public services;

AND

- The Ombudsman considers the investigation of the chosen issue is the best and most proportionate use of investigative resources.

I also consult as specified under the 2016 Act, with other oversight bodies and regulators, if I have formed the opinion that the subject matter is one they could potentially investigate also.¹⁹ This engagement helps me to gather information about other scrutiny work that may be ongoing or planned in respect of the issue of concern. The focus of this consultation is again to inform my decision making on whether to proceed to investigate and whether cooperation with one or more of these bodies could enhance the effectiveness of the investigation or reporting of the issue.

¹⁶ The threshold of 'reasonable suspicion' is subject of both a subjective test (that the Ombudsman has formed the suspicion) and an objective test. The objective test is supported by the information gathered (and recorded) during the assessment phase in the application of the decision framework/matrix and completion of the investigative proposal. There are no constraints on the potential sources of information from which the Ombudsman may form a 'reasonable suspicion' and may include information, intelligence and/or evidence.

¹⁷ Systemic maladministration does not have to be an establishment that the same failing has occurred in the 'majority of cases', instead it is an identification that the same issue/failing has **repeatedly** occurred and is likely to occur again if left unremedied; or alternatively, an identification that a combination or series of failings have occurred throughout a process which are likely to occur again if left unremedied.

¹⁸ Section 9 of the 2016 Act, *Criteria for own initiative investigations*. Available at www.legislation.gov.uk/niu/2016/4/section/9

¹⁹ Section 51 of the 2016 Act, *Consultation and co-operation with other ombudsmen*. Available at www.legislation.gov.uk/niu/2016/4/section/51

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Furthermore, I must submit a proposal to the public body I intend to investigate in which I set out the reasons for the proposed investigation and why I consider my published criteria has been met.²⁰ This step provides an additional opportunity to gather further information to inform my decision making about the value of commencing an Own Initiative investigation. It also presents a framework to engage with the public body at an early stage on the suspected failings in which they may put forward a settlement to address the issue of concern. Following response to my proposal, I may proceed to investigate, agree to a settlement (where one is put forward and I am satisfied it will remedy the issue) or continue to monitor the matter further.

The steps taken before an Own Initiative investigation is launched, is an iterative process to give careful thought to the subject matter and understand the areas of risk for service users, ensuring fairness and proportionality in the use of my Own Initiative powers to investigate issues of significant concern.

The Proposal to Investigate the Administration of Personal Independence Payment (PIP)

In January 2019 my predecessor, Marie Anderson, wrote to the Permanent Secretary for the Department for Communities (the Department) explaining that she was considering investigating the administration of PIP. PIP is a non means tested benefit for people of working age (16 – 64 years) intended to provide help toward some of the extra costs arising from having a long term health condition or disability.

PIP was introduced into Northern Ireland in June 2016, replacing Disability Living Allowance (DLA). The statutory framework for the introduction and delivery of PIP is set down under Part 5 of the Welfare Reform (Northern Ireland) Order 2015²¹, the PIP Regulations (Northern Ireland) 2016²² and the PIP (Transitional Provisions) Regulations (Northern Ireland) 2016²³.

The Department is the public authority with the statutory responsibility for making the decision on a claimant's entitlement to PIP. PIP is made up of two components, a 'daily living' component and a 'mobility' component. Each component has two rates; standard and enhanced. If a claimant is entitled to an award of PIP the claimant may be paid for one or both components.

²⁰ Section 29 of the 2016 Act, *Procedure for own initiative Investigation*. Available at www.legislation.gov.uk/ni/2016/4/section/29

²¹ *The Welfare Reform (Northern Ireland Order) 2015*. Available at www.legislation.gov.uk/nisi/2015/2006/part/5

²² *The PIP Regulations (Northern Ireland) 2016*. Available at www.legislation.gov.uk/nisr/2016/217/contents/made

²³ *The PIP (Transitional Provisions) Regulations (Northern Ireland) 2016*. Available at www.legislation.gov.uk/nisr/2016/227/contents

The claim process involves the claimant undergoing an Assessment. The assessment service for PIP is contracted out by the Department to a private sector provider called Capita who employ and train qualified health professionals as Disability Assessors to carry out the Assessments. The purpose of the Assessment is to provide advice to the Department on the overall functional impact of the claimant's health condition or impairment on their ability to carry out ten specific daily living and two mobility activities.

Following Assessment, the decision on a claimant's entitlement to PIP is made by a Department Case Manager. If the claimant does not agree with the decision they may request a Mandatory Reconsideration, a process by which the Department conducts a review of its decision. If following this review, the claimant remains dissatisfied with the Department's decision they may submit an Appeal to the Appeals Service requesting for their case to be heard by an independent Tribunal.

At the time of proposing the Own Initiative investigation in January 2019, the Department had processed almost 160,000 PIP decisions, which included both DLA reassessments and new claims.²⁴ Figures published by the Department at that time had indicated that as of August 2018, Mandatory Reconsiderations had been requested by claimants in approximately 26% of PIP decisions made since June 2016.²⁵ Approximately 10%²⁶ of all PIP determinations had proceeded to appeal and it was reported that approximately 55%²⁷ of the cases heard at Appeal had been successful in having the Department's decisions on entitlement overturned.

The proposed investigation by my predecessor had followed a spike in complaints to this Office and consideration of other information which caused concern, including the high numbers of PIP decisions by the Department which were overturned at Tribunal. Serious and recurring concerns about PIP had also been raised in the public domain and various sources reported that confidence in the treatment of vulnerable individuals and fairness in the delivery of the benefit, was low.

During the proposal stage, it was recognised that PIP had, and indeed continues to be, the subject of significant scrutiny and review both in Great Britain and in Northern Ireland. The implementation of PIP in Northern Ireland had already been the subject of an Independent Review in 2018 which was

²⁴ Response from Permanent Secretary to Ombudsman's proposal. 31 January 2019.

²⁵ 34 310 MRs registered out of 133, 670 clearances from June 2016 until August 2018. *PIP Experimental Statistics (August 2018)*. Available at www.communities-ni.gov.uk/articles/personal-independence-payment-statistics

²⁶ Response from Permanent Secretary to Ombudsman's proposal. 31 January 2019.

²⁷ *Welfare Reforms in Northern Ireland*. Report by the Comptroller and Auditor General. January 2019. Available at www.niauditoffice.gov.uk/publications/welfare-reforms-northern-ireland-0

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commissioned by the Department to report on the operation of assessment.²⁸ This had resulted in a number of significant recommendations, some of which had been accepted by the Department and a second Independent Review was planned for 2020, which has since reported.²⁹ The Comptroller and Auditor General for Northern Ireland had also advised during the consultation by my Office and in his report into welfare reforms in Northern Ireland that he subsequently planned to report on the Department's management of its contract with Capita and how well the contract has been delivered. The Comptroller and Auditor General, who has since published his report³⁰, has specifically not looked in detail at the processes for gathering further evidence in PIP benefit decision making and dealing with internal complaints.

Cognisant of these important pieces of work at the time of the investigation proposal, but also the scale of concern about the reported service failures and the impact on vulnerable individuals, a key consideration of my Office was to establish if an Own Initiative investigation would add value to the scrutiny of PIP. During the investigation proposal stage, information provided to my office from claimants, carers, advice and support organisations about their experiences and concerns, continued to be monitored. Additional information was also requested and obtained from the Department to inform the decision making on whether an investigation should be pursued and to scope the most effective area of focus should it proceed. My Office also engaged with Department officials to listen to and consider concerns they had raised on the proposed investigation.

During the same period several other areas of public service administration, distinct from PIP and in which systemic failings were suspected, continued to be assessed by my predecessor to determine if 'investigation of the chosen issue is the best and most proportionate use of investigative resources.'

The Decision to Investigate

In June 2019, following detailed consideration of the information available and the views of the Department, other oversight bodies, Members of the

²⁸ *Independent review of the PIP Assessment Process in Northern Ireland*. Independent Reviewer Walter Radar, June 2018. Available at www.communities-ni.gov.uk/publications/independent-review-personal-independence-payment-pip-assessment-process-northern-ireland-report

²⁹ *Second Independent review of the PIP Assessment Process in Northern Ireland*. Independent Reviewer Marie Cavanagh, 11 December 2020. Available at www.communities-ni.gov.uk/publications/second-independent-review-personal-independence-payment-pip-assessment-process-northern-ireland

³⁰ *The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland*. Report by the Comptroller and Auditor General. 23 March 2021. Available at www.niauditoffice.gov.uk/publications/publications/management-and-delivery-personal-independence-payment-contract-northern-ireland

Legislative Assembly and members of civil society, the then Ombudsman decided that her suspicion of systemic maladministration remained and that the criteria for launching the investigation into the administration of PIP was met.

My predecessor felt strongly that testing the actions of the Department and Capita in the delivery of PIP against a framework of good administration, provided a unique administrative justice lens to examine and potentially improve this area of public service delivery. The Principles of Good Administration are set out in full at Appendix A and the Principles of Good Complaints Handling at Appendix B. The principles outline that good administration by public service providers means:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

Furthermore it was considered that the powers of investigation held by my Office, presented a unique and robust investigative methodology to examine the issue of dispute by requiring the production of information and documentation. These evidence gathering powers allow for independent retrieval and examination of a selected sample of claims and complaints cases from source, separately from both the Department and Capita. Direct access to and impartial analysis of a substantial sample of cases which had been through the system, in addition to hearing the views of various stakeholders and reviewing policy, would provide robust and compelling evidence of how the administration of PIP operates in practice.

The Scope: The Availability and Application of Further Evidence in PIP

As with all areas of public administration that involve complex decision making, the collection and application of good quality evidence is critical to the accuracy, fairness and transparency of outcomes. When determining the scope of the Own Initiative investigation, it was identified that the availability and application of 'further evidence' in the administration of PIP was a significant and reoccurring issue of concern.

Further evidence in the administration of PIP is additional evidence to that which is gathered in a face to face consultation conducted by a Disability Assessor, it is evidence relevant to determining the functional impact of the claimants' condition or disability and can include medical or non-

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medical evidence. Sources of further evidence can include reports from or information provided by professionals involved in the claimants' care. The Department also advise that statements from carers or family members can also be considered.

My Office had observed confusion over who was responsible for gathering further evidence in the PIP process and concerns that evidence from those involved in the care of claimants, including health professionals and carers, was not being given proper weight in the Assessment and decision making on the outcome of the claim.

It was also notable that the Department reported that the receipt of new evidence in support of a claim, evidence which was not available to the original decision maker, was a significant factor in the overturn of decisions at Appeal.³¹ Although new evidence presented at Tribunal does not necessarily point to failings in administration, it did raise concerns about potential shortcomings in the evidence collection process and analysis prior to the case being heard at Tribunal, particularly given the high rate of overturn. Even though claimants in these cases ultimately received their correct entitlement, it should not be underestimated that the Appeal process can be lengthy and challenging to engage. My Office was also conscious of claimants, some of whom are the most vulnerable in society, may also feel unable to proceed to Appeal.

The former Ombudsman considered that the potential for systemic failings in the gathering and application of further evidence earlier in PIP process presented significant risks and implications to getting decisions right first time, treating claimants fairly and confidence in the public welfare system. The Ombudsman determined that an investigation scope which could comprehensively and systematically examine the specific issues pertaining to further evidence, had the potential to deliver findings and recommendations with real and meaningful impact. It was also considered that should systemic maladministration not be found, it would equally be valuable for the investigation to provide reassurance about the delivery of an important public service that was causing significant concern.

The Terms of Reference decided upon for the investigation are set out in Appendix C. The Own Initiative investigation would test the actions of the Department and Capita in administrating PIP against the framework of the Principles of Good Administration, with a focus on the availability and application of further evidence in the PIP benefit decision making and internal complaints processes.

³¹ *Response from Permanent Secretary to Ombudsman's proposal.* 31 January 2019

The Investigative Methodology

Focusing on the availability and application of 'further evidence' in the administration of PIP, my investigation set out to methodically examine this distinct issue through a significant body of cases of PIP claims alongside policy, guidance and system data. The methodology used in my investigation and reporting is set out in full at Appendix D.

It was essential to pursue enquiries and examine information which may point away from, as well as point towards failings or shortcomings in the gathering and application of further evidence in the administration of PIP. It was therefore important to consider the various stages of the PIP process for which the Department and Capita have the opportunity to correctly administer but also rectify or remedy issues pertaining to further evidence. The investigation included consideration of:

- The communication with the claimant, at the commencement of the claim, about the role of further evidence in the PIP process;
- The gathering and application of further evidence within PIP assessments;
- The application of further evidence within the decision making on the PIP application and how this is recorded;
- The communication with the claimant on what evidence was used and how the evidence was evaluated to reach the decision outcome on the PIP application;
- The role of evidence in mandatory reconsideration requests and lapsed appeals, and how this is communicated with the claimant; and
- The handling of complaints made by claimants about the gathering, use and application of further evidence in the PIP process.

The evidence sources used in my investigation are set out further in Appendix D and included:

- Research and review of relevant documentation including previous reports, legislation, Department and Capita policy, guidance, management information, contract and service agreements;
- Site visits to the relevant business areas and wider engagement with other public bodies, the advice sector and the public; and
- Examination of a case sample of PIP claims pertaining to 100 individuals and 48 final stage³² complaint files associated these claims.

The approach to the case sampling, which is also set out in Appendix D involved retrieval and examination of cases from two groups:

³² The complaints had been through all three stages of the internal complaints process (two stages with Capita and a third stage with the Department).

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- PIP claims lapsed³³ at Appeal; and
- PIP claims for which associated complaints had been through all three stages of the internal complaints process (two stages with Capita and a third stage with the Department).

These groupings of cases were identified as providing the best evidence to examine how the Department and Capita administered and addressed issues pertaining to further evidence at the different stages of the PIP process prior to being heard at Appeal.

It is recognised that there are limitations with respect to the number of cases the Own Initiative investigation could reasonably and proportionately examine, against the overall number of PIP claims processed. I am satisfied however that the combination of evidence gathered in my investigation, case specific and wider data, provided me with a deep understanding of the issue and is sufficient to determine whether maladministration occurred on a repeated basis.

The Report

Where I conduct an Own Initiative investigation, in addition to laying a report on the investigation before the Assembly, I must publish the report.³⁴ By publishing this report I can explain what my investigation found and the evidence upon which I have drawn a conclusion that systemic maladministration has occurred. This is a critical step to addressing the failings identified but it is only the start of the process to put things right and crucially get it right for the future. It is essential that the Department learn lessons and act on my recommendations to make changes and improve the delivery of this key benefit.

There have been some changes in the Department's delivery of PIP since my investigation commenced in June 2019, not least the suspension of face to face consultations as a result of COVID-19, however the issue I am reporting on remains current. In the last published figures by the Department out of the 240,040 decisions made from June 2016 until February 2021, Mandatory Reconsiderations were requested in approximately 30% of claims.³⁵ Approximately 11% of decisions are proceeding to Tribunal and the success rate of those heard, between April 2019 and January 2021, has risen to 63%.³⁶ The Department continue to

³³ A claim will lapse at Appeal, where following notification of the Appeal, the Department revise the award decision to the highest rate available or where it revised to the standard rate and the claimant accepts the offer of the revised award. The Appeal does not then continue.

³⁴ Section 45 of the 2016 Act. *Publication of reports on own initiative investigations*. Available at www.legislation.gov.uk/nia/2016/4/section/45

³⁵ 71,410 MRs registered out of 240,040 clearances from June 2016 until February 2021. *PIP Experimental Statistics*, published May 2021. Available at www.communities-ni.gov.uk/articles/personal-independence-payment-statistics

³⁶ AQW 13505/17-22. Available at <http://aims.niassembly.gov.uk/questions/printquestionssummary.aspx?docid=324195>

state that the receipt of new evidence in support of a claim, which was not available to the original decision maker, is a significant factor in the overturn of decisions at Appeal.

During the latter part of my investigation, the President of the Appeal Tribunals for Northern Ireland, advised that the provision of further medical evidence, especially by way of relevant medical notes and records, remains fundamental to Tribunal at its (judicial) adjudication stage.³⁷ He highlighted his view that the Department should have a more robust and structured way of receiving objective medical evidence from general practitioners and others prior to the Department's decision. I also noted with interest the findings of the Second Independent Reviewer who in December 2020 reported continuing concerns about the issue of further evidence and made findings in this area which I fully support.³⁸

I do of course recognise that the delivery of PIP by the Department is challenging and has involved considerable attempts to improve the service since it was first introduced. My investigation however did find evidence of systemic maladministration and my report contains significant criticisms of the Department and Capita in respect of their handling of further evidence in the PIP decision making and complaints processes.

I have laid out my report over eight chapters, to reflect the stages in which further evidence plays an important role in the administration of PIP and the process by which claimants pursue should they Appeal the decision:

- Application;
- Initial Review;
- Assessment;
- First Tier decision;
- Mandatory Reconsideration;
- Lapsed Appeals;
- Complaints; and
- Further Evidence Statistics.

These are also the stages, including governance, in which the Department had the opportunity to 'get it right', or 'put it right' by identifying and addressing shortcomings.

³⁷ Letter from the President of the Appeal Tribunals 11 September 2020

³⁸ *Second Independent review of the PIP Assessment Process in Northern Ireland*. Independent Reviewer Marie Cavanagh, 11 December 2020. Available at www.communities-ni.gov.uk/publications/second-independent-review-personal-independence-payment-pip-assessment-process-northern-ireland

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Within each chapter I have outlined the issues in which I have identified systemic maladministration. I have not included 'one off' errors or shortcomings identified³⁹, instead I have reported solely on issues where I found failings were repeated and of significant concern. I am confident that my investigation and this report which provides specific and detailed findings and recommendations, will serve to help deliver real improvements in the delivery of PIP.

Next Steps

My report has now been laid before the Assembly.

I have made 33 recommendations which I have asked the Department to implement. I expect the Department to provide me with an action plan within 6 months and I intend to publically report on the progress.

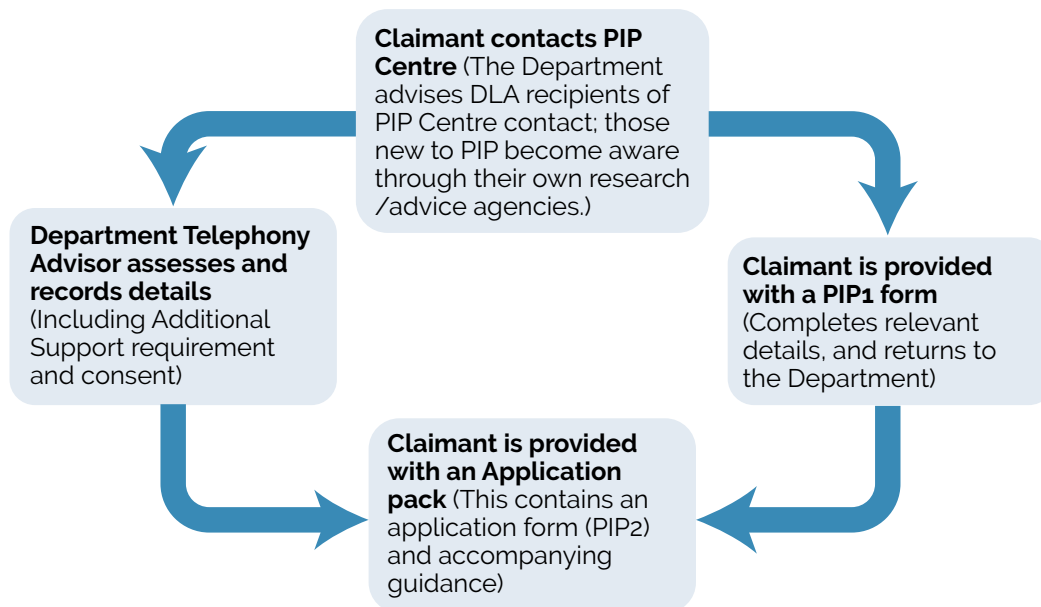
³⁹ During the course of the investigation NIPSO highlighted directly to the Department some cases in which 'one off' errors or shortcomings were identified so that the issues could be addressed at an early stage.

Chapter 1: Application

This chapter provides a general overview of the first stage of the PIP claim process, where an individual advises the Department of their intention to make a PIP claim and are subsequently provided with an application form (PIP2).

In the majority of cases this initial stage is undertaken by the claimant making contact with the Department's PIP Centre. During this call PIP Telephony Advisors undertake an assessment of the claimant's requirement for additional support, and record limited details to initiate the claim, including the contact details for the claimants' health professional(s) and consent to use their DLA evidence (where applicable).

In a minority of cases, where telephony is not the most suitable method of communication, this stage can also be completed in written form (PIP1).



Issue 1: Additional Support

At the outset of a PIP claim, determinations are made by Department telephony staff in regard to whether or not a claimants' condition and circumstances indicate the need for Additional Support (AS) in progressing their claim. This is only considered if the claimant does not already have a Personal Acting Body⁴⁰ (PAB) such as an appointee.

⁴⁰ an appointee, a Power of Attorney, 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).

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Department for Work and Pensions (DWP) guidance⁴¹ (the Guidance), followed by the Department, and the Department's PIP Handbook⁴², identify that a claimant with AS needs may not understand, or their condition may affect their ability to fully be aware of the consequences of not returning forms; not responding to a reassessment invite or reminder; failing to attend an assessment; and communications or decision notifications sent by the Department.

These documents suggest the need for proactive engagement with claimants throughout the process, not only to aid a claimant's compliance, but also to aid their understanding of Department communications and decisions, including the relevancy of the provision of further evidence.

The Guidance highlights:

'In particular, a claimant with AS needs may require support if they receive a decision where their benefit is disallowed or the level of their payments is reduced.'

The PIP handbook outlines the Department's first consideration of AS within the initial call, stating:

*'The claimant will not have to answer detailed questions about their health condition or disability, just some questions to establish if they have a mental, cognitive or learning impairment. This will help us establish if the claimant may need additional support through the claim process **[my emphasis]**.'*

My investigation identified that the Department's application of Additional Support does not fully align with the proactive support suggested by these documents. The Department advised my investigation:

*'The purpose of AS marker is to act as a safeguard in any case where a person has indicated mental health difficulties to **avoid the Department having to make unnecessary contact [my emphasis]** with them to establish if they had good reason for not returning their PIP2, which would delay the processing of a claim.*

The AS guidance advises:

Claimants identified as 'AS' who don't:

- *return the application form (PIP2) won't be disallowed automatically, but will be referred to the Assessment Provider (Capita) for an assessment;*

⁴¹ *Personal Independence Guide*, Section 2 Chapter 11. The Department confirmed that this policy continues to apply and is accessed by PIP staff via the Department's intranet.

⁴² pip-h <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/pip-handbook.pdf> (communities-ni.gov.uk) - Page 22

- *respond to a reassessment invite will be contacted by a case worker or visiting officer to complete a PIP1;*
- *attend an assessment the claimant will be contacted to find out the reasons for not attending before a good reason decision is made.'*

This restricted utilisation of the guidance fails to provide continued support throughout the process, and fails to recognise the value of communication with claimants who require AS in order to understand and engage in the process.

My investigation also identified concerns with how claimants are identified as potentially requiring AS.

As advised within the PIP Handbook, Department telephony staff initially determine whether AS is 'indicated' by considering a claimant's condition and whether they have support available. The Guidance states:

'If the claimant only has informal support for example a family member, friend, neighbour, or local support organisation such as CAB [Citizens Advice Bureau] it may still be appropriate to set the support marker...'

In contrast, the Department's telephony script (Appendix E), which was in place at the time the sample cases were assessed for PIP, identified that the AS marker would not be applied if a claimant advised that they would/ may contact an informal support. This is particularly concerning as the Department's telephony guidance also actively encouraged telephony advisors to advise claimants to seek 'informal support':

*'Advise the customer if they think they will need any help or support with completing the form to contact a local support organisation as soon as possible to arrange help.'*⁴³

As a direct result, claimants who had conditions listed within the Guidance, who simply indicated they would seek informal support following Department advice to do so, were subsequently recorded as not requiring AS.

This decision appears to be made without consideration as to whether or not the claimant has confirmed availability of the informal support, or the likely fluctuation in continued provision of informal support. The only required record for this decision was the insertion of the informal supports' contact details within the general contacts section of the Department's computer system (PIPCS). It is unclear what the purpose of this record is, as guidance does not suggest that the Department makes contact with these individuals/organisations to confirm whether support will be available.

⁴³ 'Telephony New Claim Data gather' Part 03, Section 27 20/6/2016- 2/5/2018. 3/5/2018 guidance updates 'customer' to 'claimant'.

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In response to my concern at this variation in written procedures the Department advised my investigation that the Guidance:

'does not apply to the telephony script, which is for Case Workers [telephony advisors]. The reason for this is that if a Case Worker has not applied the AS marker to a case, a Case Manager may apply it later in the process where they feel it is appropriate.'

I am concerned by the Department's response. It is unclear why the Department considers it appropriate that at the outset of the claim, where determination of AS is initially assessed, the Telephony Advisors should apply a different, more restricted approach than Case Managers.

11 claimants (with no PAB) within my case file review had conditions listed within the Guidance⁴⁴. In only one of these cases AS was marked as indicated on PIPCS. None of the other cases reviewed had an appropriate record identifying why AS had not been indicated, for example that appropriate, continuing informal support was confirmed to be in place. According to Department figures⁴⁵, as of February 2020, AS was recorded as indicated in only 11% (23,470) of all PIP claims.

Case Study 1 Additional support not indicated

Award History

DLA Award: Middle Care: Low Mobility

First Tier Decision (17 October 2018): No Award: Daily Living (4 points): Mobility (0 points)

Mandatory Reconsideration (2 November 2018): No change

Appeal (23 June 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant A, whose primary condition is listed as Anxiety/Depressive disorder/Borderline personality disorder, applied for PIP on 19 July 2018. Personality Disorders are listed within the Additional Support Guidance which states:

'If the claimant has a condition falling into one of the general categories outlined above or one of the specific conditions listed and no PAB, they are likely to meet the DWP [guidance applied by the Department] definition for AS and the context panel in PIPCS Application home page displays 'AS Indicated'.

⁴⁴ Bi Polar disorder, Obsessive Compulsive Disorder, Post Traumatic Distress Disorder, Schizophrenia, Learning Disability, Brain injury.

⁴⁵ Department for Community Personal Independence Payment (PIP) Experimental Statistics (February 2020) Cleared Claims (216,330); and Additional Support Confirmation status for PIP Claims in Payment (23,470 Additional Support not confirmed (indicated)) provided to NIPSO investigation in May 2020.

The claimant had no recorded appointee and no record was made within the 'Other person (external party)' contact section of PIPCS to indicate communication of informal support. However a record of the initial claim call notes that *'the claimant will get help from their CAB'*

The Medical Details section of the Department's computer system (PIPSC) records 'Additional support indicated: **No**'.

On 27 July 2018 the claimant's PIP2 application form was received by the Department. There is no evidence to suggest that the claimant had any support to complete the form.

On 31 July 2018 the claimant's DLA General Practitioner Factual Report⁴⁶ (GPFR) (22 July 2009) was uploaded advising of a long history of alcoholism, anxiety and depression with this affecting insight, judgement and awareness of danger.

On 17 Oct 2018 the claimant was advised that they were not entitled to PIP. The subsequent Mandatory Reconsideration on 2 Nov 2018 remained unchanged as the claimant provided no further evidence.

Department communication records indicate that without support the claimant struggled with the process:

A Mandatory Reconsideration note states:

'The customer states [claimant] has borderline personality disorder and this hasn't been taken into appreciation and [claimant] has PTSD and is a danger to [themselves].'

A communication record dated 19 March 2019 states:

'..Customer continually talked over the top of me explaining what is happening. Customer warned if [they] talked over the top of the C/W [Case Worker -Telephony Advisor] again the call would be ended. Call ended as customer continued to talk over the top of C/W even though warned the call would end if happened again.'

The claimant subsequently applied for an Appeal with the support of the Belfast Citywide Tribunal Service. At the Appeal Hearing on 23 June 2019 the Appeal Tribunal overturned the Department's decision and awarded the claimant Standard Daily Living and Standard Mobility.

This case evidences that claimants who have a condition listed within the Guidance (and have no PAB) do not have the AS marker indicated on the basis that they may/will contact an informal support. As a result,

⁴⁶ An advice request form sent to, and completed by a claimant's health professional.

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an opportunity may be missed by the Department to provide vulnerable claimants with appropriate support.

The Department's restricted viewpoint on the utilisation of AS was also evidenced within its response to my consideration of this Case Study:

'The fact they [claimant A] were originally disallowed PIP based on a review of the evidence is in no way related to the absence of an AS indicator on their case which as noted earlier is a safeguard to ensure forms are returned and in this case study the form was returned... In the Department's opinion this Case Study was processed in line with the guidance and provides no evidence that this claimant was adversely affected by not having the AS indicator applied to their case, as they returned their PIP2 form on time and were not required to attend an assessment, as it was completed by PBR [Paper Based Review]'

It is concerning that the Department focus on the return of forms and do not appear to acknowledge the distress evidenced within the claimant's phone calls as an 'adverse affect'. As suggested by the Guidance, had AS been applied this may have provided support to the claimant from the outset, including when they received 'a decision where their benefit is disallowed or the level of their payments is reduced'. This may have reduced their distress and may have enhanced their understanding of what was needed to engage with the process.

It is noted that once the claimant had support from the Belfast Citywide Tribunal Service at Appeal, they were awarded PIP.

Findings –

The Department's failure to appropriately apply, consider and record its reasoning for indications of AS in line with DWP guidance, evidences a failure to fulfil Principle 2 and Principle 3 of the Principles of Good Administration. As a result it is possible that vulnerable claimants requirement for AS would not have been appropriately assessed or applied, leading to a possible lack of understanding of the process or in some cases, disengagement.

Recommendations –

It is acknowledged that in November 2019 the Department amended its telephony script to allow the telephony advisors to apply the AS indicator in some cases where informal support was available. However it is noted that this related only to those claimants with a severe mental

health or behavioural condition, learning difficulty, developmental disorder or memory problems. The telephony script goes on to advise that the AS marker should be marked as 'No', if the claimant indicates they have/will seek informal support, for the following conditions: Severe depression - for which the claimant has been hospitalised, psychosis, schizophrenia, severe ADHD, Down's syndrome, Fragile X syndrome, severe autism, severe developmental delay, or any form of dementia Alzheimer's, Lewy body dementia, or vascular dementia, severe brain injury resulting in cognitive decline.

I also acknowledge that, following a Coroner's recommendation in Great Britain, DWP, and subsequently the Department, have amended the telephony script further from 10 May 2021. The new wording reads *'Do you have difficulty communicating with us? This could be things like sending information to us or understanding information that we send to you, due to your health condition or disability? For example, you may have a condition such as severe mental health or behavioural condition, learning difficulty, developmental disorder or memory problems. If the answer is yes then the potential additional support flag is indicated.'* However the listing of specified conditions indicates that the procedure may remain that the potential AS flag is still not applied for the conditions listed above, should the claimant indicate they have/will seek informal support.

I note that in March 2020 the Department introduced a revised telephony script which included the introduction of a free text field of 200 characters becoming available to Telephony Advisors where claimants identify that they normally ask for help to complete forms and understand letters. When this text box is completed it is automatically copied into Contact Notes of PIPCS. Although this will allow for the automatic recording of contact details of the claimants suggested support to PIPCS, the revised telephony script does not allow for any additional recording of the consideration given to the confirmed availability, or potential fluctuation, in support. Nor is any additional information provided to the claimant on the availability of AS from the Department.

The Department should consider:

- including reference to the support available from the Department's outreach service within the telephony script; and
- liaising with advice agencies/directly referring claimants with a listed condition (upon consent to do so) who suggest they will contact an advice agency to aid them with the PIP process.

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Issue 2: Communication

i. Telephone contact – Initial claim call

For the majority of claimants the opportunity for provision of advice on further evidence commences with the initial claim call. Some claimants may not fully read and/or understand subsequent correspondence and may depend solely on the advice provided by the Department's Telephony Advisors.

My telephony review of initial claim calls indicated a lack of advice being provided to claimants in regard to their own provision of further evidence. Instead advice/questioning about health professionals during the call, and subsequent requests for consent to make contact, placed an emphasis on the role of the Department and/or an external Assessment provider (Capita) to seek further evidence on the claimant's behalf. This communication led a number of the case file review claimants to believe that the Department/Capita would be responsible for gathering any further evidence to support their PIP claim.

This is particularly concerning as, on average, further evidence was only requested by Capita in 24.7%⁴⁷ of claims between Aug 2019 to April 2020⁴⁸. Within my case file review, further evidence was requested in 35% of cases.

My review of Mandatory Reconsideration calls illustrated that, following subsequent telephony staff advice to claimants to gather their own further evidence, a significant number of claimants expressed surprise and concern that their health professional(s) had not been contacted. It is of note that following this advice, 78%⁴⁹ of claimants within the case file review subsequently provided further evidence at Mandatory Reconsideration.

Case Study 2 Misleading communication affecting evidence gathering

Award History

DLA Award: Higher Care: Lower Mobility

First Tier Decision (4 March 2017): No Award (0 points)

Mandatory Reconsideration (28 March 2017): No change

Appeal (10 April 2018): Standard Daily Living (9): No Mobility (4)

⁴⁷ This figure does not include the 12000 calls made by Capita to health professionals during 2019. This figure is not included within Management information provided to the Department and is not considered a 'Key Metric'. It was provided as a one off report for the purposes of this investigation. The Department were unable to provide an appropriate breakdown of the calls, for example to identify how many were repeat attempts to make contact within one case.

⁴⁸ Taken from revised figures provided to NIPSO by the Department in June 2020 following identification by NIPSO that the figures previously provided were inaccurate.

⁴⁹ 31% of which was a supporting letter from the claimant or family member.

Claimant B, whose primary condition is listed as PTSD [Post Traumatic Stress Disorder], applied for PIP on 12 Nov 2016.

During the initial claim call the claimant was asked *'So which healthcare professional can best tell us about your health condition or illness and how it would affect you, for example a GP [General Practitioner], nurse or hospital doctor?' 'Any other healthcare professionals or social care professionals we could contact or would it mainly be your GP? And 'I am going to read you a statement about consent. So we may want to get information about your condition; we may want to contact your GP or other organisations. You don't have to agree but if you don't we may not have enough information to make a decision.'*

On the 2 December 2016 the claimant's PIP2 application form was received by the Department, which contained contact details for the claimant's GP. The claimant provided no further evidence.

On 17 December 2016 Capita's Disability Assessor recorded *'The claimant questionnaire has been reviewed. No additional information available at time of review. There is insufficient evidence available to confirm level of functional restriction claimed. Therefore a face to face assessment at clinic due to claimant condition will be required.'*

No request for evidence/advice was sent to the claimant's GP.

Following review of the face to face assessment report, the Department's Case Manager determined that the claimant was not entitled to PIP.

The claimant subsequently requested a Mandatory Reconsideration on 15 March 2017. The claimant's letter requesting an 'Appeal' identified their expectation that the Department had requested and reviewed their medical records. Statements include *'if you have seen my psych file...I'm sure you can see from my records...'*

On 23 and 24 March 2017 the Department's Mandatory Reconsideration Case Manager made an attempt to contact the claimant. The records suggest that on 24 March the Case Manager left a voicemail for the claimant enquiring whether they intended to provide further evidence. The claimant did not provide any further evidence.

On 28 March the Mandatory Reconsideration Case Manager determined no change should be made to the original award.

The claimant returned the Mandatory Reconsideration Case Managers voicemail on 21 April 2017 and expressed their surprise and concern

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that further evidence had not been sought by the Department:

Claimant: *There was a voicemail left on my house phone just asking if I wanted to submit more evidence. Can I just check when that decision was made; would my doctor's notes have been used?*

Telephony Advisor: *I can't see any GP reports on the system.*

Claimant: *So that decision can be made without any medical evidence?!*

Telephony Advisor: *The decision would have been based on the PIP2 that you would've filled in and the face to face assessment that would have been carried out.*

Claimant: *But not a doctor?*

Telephony Advisor: *The ones who do the assessments are health professionals, they may not necessarily be a doctor.*

Claimant: *OK, so I've lodged an appeal today so obviously I will have to take the GP reports and everything to the appeal. Is that the way that works?..'*

The claimant appealed the decision and was subsequently awarded Standard Daily Living and Nil Mobility at an Appeal Hearing on 10 April 2018.

It is unknown on what basis the Appeals Tribunal made their decision to overturn the award. However, this case evidences the confused and inadequate advice provided to claimants on further evidence gathering at the outset of the claim. The claimant only became aware of this following the Department's specific request to the claimant for further evidence at Mandatory Reconsideration.

As a result the claimant was unable to make an informed decision on the gathering and provision of applicable evidence at an earlier stage of the claim.

Findings –

The Department's repeated failure to provide open and clear communications to claimants, fully informing them of what to expect in regard to evidence gathering; evidences a failure of the Department to fulfil Principles 1, 2, and 3 of the Principles of Good Administration. As a result some claimants were misled that the Department/Capita would contact their health professionals. Claimants were therefore unable to make a fully informed decision in relation to their own provision of further evidence at an early stage of the process.

Recommendations –

The Department revised the telephony script in March 2020 to include further evidence advice to claimants:

'You will need to complete the form and return it with copies of supporting information that explains how your health condition or disability affects you carrying out day-to-day activities. By supporting information we mean things like social care plans, reports from health professionals, prescription lists, test results and statements from carers or family members.' Please only send photocopies, not originals.'

The telephony script should be reviewed further to include:

- Clear identification of where the responsibility lies in gathering further evidence in support of a claim;
- Advice on the impact the provision of evidence may have on their claim;
- Emphasis that in the majority of cases the claimants health professionals will not be contacted (provision of an average percentage of contact may be included); and
- Clarification that, where evidence is requested from a claimant's health professional, this request is undertaken by Capita, typically at the outset of the claim.

All PIP Telephony Advisors should be trained accordingly.

ii. Disability Living Allowance (DLA) evidence

At the end of the initial claim call, claimants of the former DLA are asked if they wish for their latest DLA medical evidence to be used within their PIP claim. The Department's procedure bulletin⁵⁰ (appendix F) suggests that if a claimant consents, a Telephony Advisor will create a task for the Department's Workflow team and 'note the details of the medical evidence to be used'. However none of the cases reviewed during my investigation recorded any details of medical evidence to be uploaded. A typical record stated:

'Customer would like for current DLA medical evidence to support PIP'

My telephony review also highlighted that the claimant was only asked if they wanted their most recent DLA considered, no further expansion or detail was provided on what specific pieces of evidence from their DLA claim where available, or what could/would be used. Nor was the claimant advised that they could see the contents of their DLA evidence prior to making a decision.

⁵⁰ PIP Bulletin 023, Re-use of DLA Medical Evidence/Requests for copies of DLA1, Issue date: 16/05/2017

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In opposition to this, my investigation identified that the paper based alternative to the initial claim call (PIP1) provides the claimant with a breakdown/list of all possible medical evidence the Department may hold within a DLA bundle (appendix G). Claimants are asked to tick which of these pieces of evidence they wish to be made available to their PIP claim. This includes an option for the full DLA bundle to be uploaded and, if required, a copy provided to the claimant before they decide which pieces of evidence should be used.

The level of information and opportunity provided to claimants, in regard to DLA evidence, is therefore dependent on what method the claimant chooses to apply for PIP.

The wording of the Department's procedure also suggests that its workflow team is directed to upload only medical evidence requested by the Programme Protection Unit (PPU)⁵¹. The Department refutes that this is the case, advising:

'The full Bulletin explains that the Workflow team look at the evidence on the DACS [Disability and Carers Computer System] computer system and identify any medical evidence document listed that supports the current award of DLA (not just PPU evidence).'

Although I am able to clearly identify the procedure bulletin's direction to the workflow team to 'scroll through each page of the case document item to identify any PPU requested medical evidence', I have not identified any statement to corroborate the Department's assurance that the bulletin advises its staff to identify any medical evidence.

Case Study 3 DLA evidence – variation in information and opportunity

Award History

DLA Award: Middle Care: Lower Mobility

First Tier Decision (21 Oct 2017): No award: No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (28 November 2017): No change

Appeal (17 September 2018): Enhanced Daily Living (15): Standard Mobility (10)

Claimant C, whose primary condition is listed as Learning Difficulties, applied for PIP on 17 July 2017.

⁵¹ Programme Protection Unit was a section within DLA whose role was to review DLA life awards; ensuring customers were receiving the right amount of DLA based on up-to-date medical evidence.

During the initial claim call the claimant was asked *'Who knows best about your health condition, GP, consultant or specialist nurse?'* and *'Do you give the department permission or someone acting on behalf of the Department permission to contact your GP?'* Following some confusion on the part of the claimant, the claimant's family member became involved in the call and advised of the GP and dietician's details and consented to the use of DLA evidence. The claimant's family member was not advised what pieces of medical evidence were available to the Department on the most recent DLA claim. They were not asked what pieces of evidence they wished to be used, nor were they advised that they could request a review of the available DLA evidence before making a decision.

On 5 August 2017 a GPFR, gathered during the claimant's previous DLA claim, was uploaded by the Department. The GP advised within the report that the claimant had *'Limited learning ability, needs supervision for all above, Performs no function without help and instruction.'* The GPFR was the only piece of DLA medical evidence uploaded on the claim.

The claimants application form (PIP2) was received on 11 August 2017. No further evidence was provided by the claimant.

Following review of the PIP2 and DLA evidence, the Capita Disability Assessor determined *'There is insufficient evidence available to advise the DfC [Department for Communities], therefore a face to face assessment is \ advised.'* Further evidence was not requested from either of the contacts provided by the claimant.

Following review of the face to face assessment report, which recorded no reference to the DLA GPFR in the descriptor justifications, the Department's Case Manager determined that the claimant was not entitled to PIP.

The claimant's family member requested a Mandatory Reconsideration and, with the assistance of the Citizens Advice Bureau (CAB), provided further evidence, including the claimant's statement of special educational need. Although the Department advised NIPSO that the GPFR was the only piece of medical evidence held from the claimants most recent DLA, it is of note that within the covering letter CAB highlighted their concern that not all parts of the DLA evidence had been considered:

'It seems contradictory that the assessor chose to use the original DLA application but not any of the original medical information/evidence that was provided at the time, e.g. the Educational statement and documentation.'

The further evidence was sent to Capita for review but was subsequently discounted. Capita's Disability Assessor noted on 21 May 2018:

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“The Educational Psychology report dated 1990...these are considered out of date and cannot be used as FME...The GP report dated 19/11/1996 is considered out of date evidence...”

The claimant appealed the decision and was subsequently awarded Enhanced Daily Living and Standard Mobility at an Appeal Hearing on 17 September 2018.

It is unknown on what basis the Appeal Tribunal made their decision to overturn the award. However, this case identifies the lack of information provided to claimants about DLA evidence including the opportunity for them to review what DLA evidence is available/will be used by the Department.

The telephony records also evidence the lack of clear, complete advice provided to claimants on further evidence gathering. As a result the claimant and their family were unable to make an informed decision on the gathering and provision of applicable evidence at an earlier stage of the claim.

Findings –

The Department's repeated failure to provide open and clear communications, fully informing all claimants of what to expect in regard to evidence gathering from their previous DLA claims, evidences a failure of the Department to fulfil Principles 1, 2, 3 and 4 of the Principles of Good Administration. As a result, claimants who apply through the paper based format are informed of their opportunity to request access to all of their DLA bundle and for this to be used to support their claim. Claimants who apply through the phone (majority) are not afforded the same information and therein the same opportunity.

Recommendations –

It is of note that Department telephony script and guidance⁵² prior to May 2018 included the following queries:

'Is there any other specific medical evidence from your DLA claim that you think might help?'

'Do you know what that evidence was when it was obtained?'

It is also of note that the Department previously advised claimants that some evidence may no longer be available:

⁵² 'Telephony new claim data gather' Chapter 03 Section 27, June 2016- 2 May 2018.

'We can obtain your DLA case and ensure this medical evidence is taken into account. Due to requirements under the Data Protection Act and our document retention procedures, previous evidence may not be available. If evidence is still on your case we will ensure that it is taken into account.'

It is unclear why this advice is no longer provided.

The Department should consider its previous telephony scripts and review and improve the DLA communication provided within the initial claim telephone script, in line with the PIP1. This should include:

- Advice on what types of evidence are available to the Department within the DLA bundle and confirmation from the claimant which pieces they wish to be used; and
- The Telephony Advisor recording the specific pieces of evidence requested by the claimant within the task to the workflow team.

All Telephony Advisors should be trained accordingly.

The Department should also review and improve guidance/training provided to the workflow team in identifying and uploading requested pieces of evidence from the DLA bundle in line with revised advice.

iii. Initial claim correspondence/communication

Following the initial claim call the Department provide claimants with application correspondence, alongside the PIP2 application form. In variance to the claim calls reviewed within my investigation, this correspondence includes helpful guidance on the types of further evidence claimants may provide, and the impact provision of evidence may have on their PIP claim.

However, direction is given that claimants should only provide information they already hold, re-emphasising the communication provided within the initial claim call that, if needed, further evidence will be sought on the claimants' behalf. This direction is also re-emphasised in the PIP Handbook⁵³ and the Department's advisory video⁵⁴.

*'Don't contact your GP or other professional for information as they may charge you. If more information is needed from your GP or other health professionals involved in your care, they **will [my emphasis]** be asked for it.'*
[extract from Advisory Video]

⁵³ PIP Handbook, 24 October 2019. Available at <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/pip-handbook.pdf>

⁵⁴ Personal Independence Payment - providing information to support your claim. Available at <https://www.youtube.com/watch?v=mnXTe4LCSJI&list=PLd6GQkE1fVSE4EHRIpks5NcxiBVGIGQ7v&index=4&t=0>

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'The claimant should only send in photocopies of things they already have available and shouldn't ask for other documents which might slow down their claim or for which they might be charged a fee – for example, from their General Practitioner. If we need this we'll ask for it ourselves using the contact details they provide on their form. That's why we need the claimant to tell us who is best placed to provide this evidence. It might also help if the claimant lets them know that we may contact them for information to help decide the PIP claim.' [extract from PIP Handbook]

The Department's repeated reference to claimants health professionals, the collection of their contact details, and the benefit of informing health professionals that contact may be made, conveys the importance of further evidence to the decision making process. However it also raises the possibility that some claimants may be falsely reassured that they do not need to gather additional evidence as this will be obtained on their behalf. Unsurprisingly my investigation identified that only **50%** of claimants, within the case file review, provided further evidence with their application.

Where claimants do send further evidence they already hold, this is often limited and dated. Although the PIP handbook advises that evidence does not have to be recent, the case file review identified several instances where items of medical evidence appeared to be discounted by Capita's Disability Assessors based on the date they were produced. This is a concerning practice, particularly for those claimants who have long standing conditions for whom there is no improved/variable outlook.

This restrictive advice is therefore likely to hinder the provision of useful further evidence from claimants at the outset of the claim.

It is also of note that the Department's communications on further evidence change significantly at later stages of the PIP process. In particular, the PIP Award Review⁵⁵ correspondence includes the following advice:

'Information you need to send us with your Award Review form

By sending us supporting information with your form, you may not need a face-to-face consultation with a health professional. We may be able to make a decision on your award more quickly and you'll continue to get the right award of PIP.

It's important you send us:

Information explaining how your health condition or disability affects you. Photocopies as we can't return original documents to you.

⁵⁵ A PIP award may be reviewed by the Department at any time. The Department will usually start to review a claim one year before an award ends. When the Department reviews a claim, they send the claimant a letter with a PIP review form.

Write your name and National Insurance number on the top of each document.

Collect your supporting information.

It's your responsibility to send copies of supporting information with this form to help us understand how your health condition or disability affects you now. The information sheet and this form give you examples of what you should send us.

Although it's your responsibility to send supporting information, occasionally we may ask the main health professional who knows about your condition for information. This may be your GP, hospital consultant or a specialist nurse. Please provide their details below.'

Claimants whose PIP awards are being reviewed are not advised only to send information already available, nor are they advised not to contact their health professionals. Instead this correspondence places emphasis on the claimant's responsibility to gather further evidence to support their claim. It also stipulates that health professionals will only be contacted by the Department/Capita 'occasionally'.

Despite the Department's reassurance⁵⁶ to my investigation that there is no difference between what the claimant is advised to do at Award Review stage, compared to when they make their initial application, I remain concerned with the variation in the further evidence communications.

Case Study 4 Evidence not requested from health professionals provided, later provided by claimant, decision overturned.

Award History

DLA: High Care: Higher Mobility

First Tier Decision (28 August 2018): No award (0 points)

Mandatory Reconsideration (4 November 2018): No change

Offer of Lapsed Appeal (4 February 2019): Standard Daily Living (11): Standard Mobility (10)

Claimant D, whose primary condition is listed as Asperger's, applied for PIP on 12 June 2018.

On 1 July 2018 the claimant's PIP2 application form was received by the Department with no further evidence. The PIP2 provided contact details for the claimant's GP and two social workers.

⁵⁶ Department response to NIPSO queries July 2020.

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On 7 July 2018 Capita's Disability Assessor recorded '*Items 1 to 2⁵⁷ of evidence have been reviewed. There is insufficient evidence to advise the DfC, however, due to the nature of the condition a home assessment is required.*' No requests for evidence were made to the claimants' health professionals.

Following review of the face to face assessment report, the Department's Case Manager determined that the claimant was not entitled to PIP.

With the assistance of CAB the claimant subsequently requested a Mandatory Reconsideration and advised they would be supplying further evidence.

On 24 September 2018 further evidence was received from the claimant, including letters from the claimant's GP and social worker. The Mandatory Reconsideration Case Manager chose not to share this evidence with Capita and determined that no change should be made to the original decision.

Following the claimant's request for an Appeal the further evidence received from the claimant was provided to Capita by the Department's Appeal Case Manager on 6 December 2018. Capita subsequently provided a change of advice report. However, this was not made available to the Department until 1 February 2019, despite its completion date of 7 December 2018.

Following receipt of the change of advice report (PA6) the claimant was offered an award of Standard Daily Living and Standard Mobility which was accepted by the claimant and the Appeal lapsed.

This case evidences how misleading communication, which provides an inaccurate reassurance to claimants that their health professionals would be contacted, may impact on a claim. In this case it resulted in no further evidence being gathered from the health professionals at the outset of the claim. Once the claimant became aware that this was the case, they were able to access this information and provide it at a later stage, directly resulting in an award being made.

⁵⁷ Items 1 to 2 are the application form and the claimants DLA GPFR

Case Study 5 Evidence not requested from health professionals, later provided by claimant, decision overturned.

Award History

DLA: Middle care: Lower Mobility

First Tier Decision (14 October 2018): No award: No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (27 November 2018): No change

Offer of Lapsed Appeal (13 January 2019): Enhanced Mobility (12): No Daily Living (4)

Claimant E, whose primary condition is listed as Epilepsy, applied for PIP on 19 July 2018.

The claimant's PIP2 application form was received by the Department on 18 August 2018. The claimant had provided contact details for their GP, Consultant Neurologist, and Psychologist. No further evidence was provided by the claimant.

On 24 August 2018 Capita's Disability Assessor recorded '*Items 1 to 2⁵⁸ of evidence have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.*' No requests for evidence were made to the claimant's health professionals.

Following review of the face to face assessment report, the Department's Case Manager determined that the claimant was not entitled to PIP.

On 27 October 2018 the claimant requested a Mandatory Reconsideration and advised they would send in further evidence. However, further evidence was not received within the required timeframe and the Mandatory Reconsideration Case Manager determined that the original decision should not be changed.

The claimant submitted an Appeal and on 28 December 2018 the Appeals Service provided the Department with a copy of the further evidence provided by the claimant. This further evidence was a letter (dated March 2018) from the claimant's Consultant Neurologist, a health professional referred to within the claimant's PIP2 application form.

The Department's Appeals Case Manager provided the letter to Capita who subsequently provided a change of advice report (PA6). As a result the Department offered the claimant an award of Enhanced mobility and the claimant's Appeal was lapsed.

58 Items 1 to 2 are the application form and the claimants DLA GPFR

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This case evidences how misleading communication, which provides an inaccurate reassurance to claimants that their health professionals would be contacted, may impact on a claim. In this case it resulted in no further evidence being gathered by the claimant from the health professionals at the outset of the claim. Once the claimant became aware that health professionals had not been contacted they were able to access this information and provide it at a later stage, directly resulting in an award being made.

Findings –

The Department's repeated failure to provide open, clear and consistent communications in regard to further evidence gathering evidences a failure of the Department to fulfil Principles 2 and 3 of the Principles of Good Administration. As a result claimants may be unable to make an informed decision on the provision of further evidence at the outset of their claim.

Recommendations –

The Department should review and improve all PIP application correspondence and advice videos in order to ensure that clear and consistent advice is provided, in line with the advice provided to claimants throughout the PIP process. This should include:

- Where the responsibility to gather evidence is placed;
- The types of evidence to be provided;
- The effect the provision of evidence may have on a claim;
- Caution that older pieces of evidence may not be considered relevant;
- The limited number of cases where health professionals will be contacted by Capita; and
- The decision and request for evidence from health professionals being undertaken by Capita (the assessment provider).

The Department should consider the following additions to the application pack which may act as reminders to claimants of their ability to provide additional evidence at this stage and to ensure that any additional evidence is correctly and efficiently allocated to an individual's case:

- Checklist of actions to be taken in the completion of the application form which would include the provision of additional information;

- Sheets of personalised Barcode/QR code stickers should be provided to the claimant to be used for any additional evidence provided by the claimant – (matching the personalised code printed on the individual claimants PIP2 application form); and
- Additional space to list additional evidence and comment box to advise why additional evidence has not been attached, this may include if further evidence will be sent at a later date (if applicable). This would also serve as an identifier to the Department and Capita if information goes missing/is unavailable on PIPCS.

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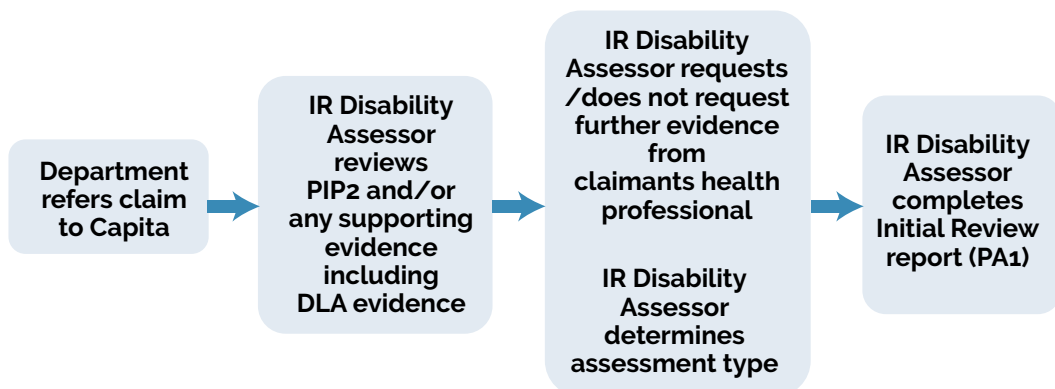
Chapter 2: Initial Review

This chapter provides a general overview of the second stage of the PIP claim process where an application form (PIP2) is received by the Department⁵⁹ and is referred to the assessment provider (Capita)⁶⁰.

Once a referral is received by Capita, an Initial Review Disability Assessor (IR Disability Assessor) will review the available information and make decisions on the requirement for further evidence from a claimant's health professional(s), and the most appropriate form of assessment (face to face assessment (F2F home or clinic), paper based review (PBR), special rules terminal illness (SRTI)).

If an IR Disability Assessor considers that a PBR can be undertaken they will retain the case for assessment. If it is determined that a face to face assessment is required, the case will be assigned to a Field Disability Assessor.

In the majority of cases, the Initial Review stage is the only stage of the PIP process where Disability Assessors will consider seeking further evidence/advice from a claimant's health professional(s).



⁵⁹ The Department do not review the application form at this stage of the process.

⁶⁰ Where an individual with an AS marker does not return an application form their case may also be referred to Capita without the PIP2.

Issue 1: Health professional⁶¹ contact details

Health professional contact details are first requested (and recorded) from claimants during the initial claim call, or within the PIP1⁶² form. Within both communications, claimants are reassured that they can also provide additional health professional contact details within their application form (PIP2). This is significant as many claimants may not have their health professional contact details readily available at the time of the call, and Telephony Advisors are limited to recording only two health professionals on PIPCS.

Despite the necessity of this additional stage, my case file review identified that where an additional health professional was provided on the PIP2 application form (68%⁶³ of cases reviewed) these were not recorded on either the Department's computer system (PIPSCS) or Capita's (CRM).

The Department advised my investigation that recording the health professionals provided within the PIP2, on either IT system, would be '*nugatory work*' as a copy of the PIP2 is available for review on PIPSCS.

This appears to be contradictory to Capita's practice to record all health professional(s) provided by the claimant during the initial claim phonecall/ PIP1 on CRM, despite these details already being held within PIPSCS. It is also in contrast to the standard practice of many public bodies, who consistently record details of any relevant parties within a dedicated contact section, regardless of whether or not the details already appear elsewhere on scanned documents within their IT systems. This practice ensures that the contact information is readily available to staff.

Aside from this departure in standard practice, I remain concerned that without any record to acknowledge that health professionals on the PIP2 have been reviewed, the Department are unable to definitively confirm whether or not these health professionals were included within the Disability Assessors consideration to request further evidence. It is of particular note that of the 34⁶⁴ cases where further evidence requests were sent, only 2⁶⁵ of these cases included requests to health professionals who were only provided on the PIP2.

61 Health professionals, as described by the Department, may include for example a GP, Hospital doctor, specialist nurse, community psychiatric nurse, occupational therapist, physiotherapist, social worker, counsellor, or support worker.

62 Paper based application for initial PIP claim.

63 In 5 of these cases the additional contact was from the same health facility.

64 In 34 cases further evidence was requested from health professionals, in 1 case further evidence was sought from a claimant's carer.

65 This figure excludes HP contacts who were previously recorded on the PIPSCS following the initial claim call.

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Case Study 1 PIP2 Health professional not recorded – further evidence from PIP2 health professional subsequently leads to overturned decision.

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (14 November 2018): No Award (0 points)

Mandatory Reconsideration (5 Dec 2018): No change

2nd Mandatory Reconsideration (22 Dec 2018): Standard Daily Living (9): Enhanced Mobility (14)

Claimant F, whose primary condition is listed as Learning Disability, applied for PIP on 8 September 2018.

On 22 September 2018 the claimants DLA GPFR (dated 2000) was uploaded. The GPFR referred to the claimant not retaining information and having a poor understanding of their condition.

On 1 October 2018 the claimants PIP2 application form, which was completed by the claimant's Social Worker, was received by the Department. The form contained contact details for both the claimants GP (General Practitioner) and Social Worker.

Only the contact details for the GP (which were provided within the initial call) were recorded on the Department's PIPCS and Capita's CRM. The GP contact details provided by the claimant were not the same GP who completed the GPFR 18 years prior. The Social Worker's contact details were not recorded. No evidence was available from either health professional provided by the claimant.

On 7 October 2018 a Capita IR Disability Assessor reviewed the PIP2 application and the claimants DLA evidence and recorded *'Items 1 to 2 of evidence have been reviewed. There is insufficient evidence available to inform the DfC [Department for Communities], therefore a face to face assessment is required.'*

No request for evidence was sent to the claimant's health professionals. The Disability Assessor made no record to detail their consideration of the need to request, or not request, further evidence from the health professionals provided by the claimant.

The Social Worker attended the face to face consultation with the claimant but there is no record of having been asked to provide input.

Following review of the face to face assessment report, a Department's Case Manager determined that the claimant was not entitled to PIP.

There is no record to suggest the Case Manager considered gathering further evidence from the claimant or their health professional to address inconsistencies and contradictions, despite contact details being available.

The claimant subsequently requested a Mandatory Reconsideration on 20 Nov 2018. The Department did not record if the claimant would be sending in further evidence therefore a decision was made to not revise the original decision on 5 December 2018. Three days following this decision the Department received a letter from the claimant's Social Worker outlining the functional impact of their condition.

The Department referred the Social Workers' letter to Capita who provided a change of advice report (PA6). As a result, the Department revised its original decision, awarding the claimant Standard Daily Living and Enhanced Mobility.

This case identifies that evidence supplied by a health professional, whose contact details were provided by the claimant within the PIP2 application form, had a significant impact on the claim. In this case changing the decision from no award to Standard Daily Living and Enhanced Mobility.

There were no records to confirm whether or not the health professionals provided on the PIP2 were considered by the Disability Assessor at the outset of the claim. An opportunity may therefore have been missed to request evidence at an earlier stage of the process in order to get the decision right first time.

Findings –

The repeated failure to appropriately record the contact details of all health professionals provided by the claimant, evidences a failure to fulfil Principle 1, 2 and 3 of the Principles of Good Administration. As a result claimants may be misled, and opportunities to gather relevant evidence (which may affect their claim) may be missed.

Recommendations –

The Department and Capita should review the process of recording health professional contact details. Immediate steps should be taken to ensure that additional health professionals on the PIP2 application form are recorded and considered.

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Issue 2: FME⁶⁶ required vs FME requested

Capita's IR Disability Assessors carry out a review of the claimant's application form and/or supporting information in order to determine what form of assessment⁶⁷ should be undertaken, and whether further evidence is required.

Capita's written process⁶⁸ for evaluating available evidence states:

'Following review of available evidence, the DA [Disability Assessor] will need to evaluate whether they have enough evidence to write a PBR or whether to send a referral for F2F...

When not to request FME

- *If we have already received either a GPFR [General Practitioner Factual Report], Consultant Report, care plan or other appropriate evidence but the evidence is inconsistent with the claimant questionnaire or the information provided is not sufficient enough for a PBR. A face to face assessment is appropriate.*
- *Where there is no high risk and no GPFR, Consultant Report, Care plan or other appropriate evidence the DA should, if safe to do so, send the referral for a Face to Face assessment.*

Please note – These scenarios are purely examples and are included for guidance. The reasons for requesting or not requesting FME may be non-exhaustive...'

I acknowledge that Capita has clarified that the scenarios are 'purely examples'. However, I am concerned that this guidance appears to suggest that Disability Assessors should not typically request evidence where there is none, or where inconsistent/insufficient evidence is available. I consider these are scenarios where further evidence is most likely to be required.

This process suggests that Capita Disability Assessors are directed that sufficient further evidence can be gained solely from a face to face assessment. This is evidenced by a statement within Capita's process document⁶⁹ which states:

'Further Evidence is not typically requested for assessments that are sent for F2F assessments [my emphasis], but there may still be additional evidence that arrives following the completion of Initial Review that will be available for the field based DA to review.'

⁶⁶ Further Medical evidence.

⁶⁷ Face to face (clinic or home) (F2F) or paper based assessment (PBR).

⁶⁸ Capita PIP Assessments Process manage initial review 2, Step 3.4.8.

⁶⁹ Capita PIP Assessments – Process Definition Document Manage face to face assessments, Additional Information (Page 13) Step 6.1, release date 20 Aug 2019.

I reviewed the implementation of this process within my case file review. Capita's system (CRM) contains four indicators within Capita's CRM where IR Disability Assessors can record that further evidence is required:

1. **Type of assessment required:** 100% of cases reviewed were categorised as '*PA1⁷⁰ – Review Filenote (FME Needed)*'
2. **Commentary within the PA1:** 98% of the cases reviewed used the phrase '*there is insufficient evidence...*'
3. **Assessment type reason code:** 93% of the cases reviewed were categorised as '*Insufficient evidence, unlikely to be obtained in timescale required*'
4. **FME Required: Yes/No:** 34% of the cases reviewed were categorised 'Yes.'

In 93% of the cases reviewed within my investigation the first three indicators identified that further evidence was required. However 68% of these same cases also listed '*FME required: No*'. Further evidence from a claimant's health professional(s) was subsequently only requested in 34% of the cases reviewed, in 1% of cases further evidence was sought from the claimant's carer.

In the main, these indicators were used only to record a decision to move to a face to face assessment, rather than a decision to request further evidence from a range of sources (face to face and health professionals). There were no further descriptive records within the CRM to identify why, when several references were made to insufficient evidence being available, further evidence was not requested.

I recognise that PIP is a functional assessment, and the face to face assessment may provide significant insight into functional capability. I also acknowledge the Department's repeated advice to my investigation that there is no mandatory/legislative requirement to seek further evidence, and its suggestion that it could be detrimental to make such requests to healthcare professionals who are already extremely stretched.

However the use of a process which actively discourages the obtainment of further evidence from other sources, and therein consideration of the benefit of further evidence from a claimants health professional(s), is concerning. Particularly as my investigation has identified that further evidence from health professionals often directly impacts on award decisions.

⁷⁰ Report type which identifies which form of assessment is required – face to face home/clinic or paper based.

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The Department advised my investigation that the referral to these four indicators had:

'conflated the need for 'further evidence' to complete the assessment and the need for further evidence to be supplied by a third party. It is not possible to compare the two i.e. that in 93% of cases needed more evidence, but only requested it from FE sources in [34]% of cases. This would assume that all 93% of cases that needed further evidence had a source to seek it from other than the claimant... the finding takes no account of the fact that in some cases, there are no other sources of FE available...there were no other healthcare professionals provided by the claimant who could be contacted that hadn't already provided evidence'

The majority of claimants provide health professional contacts when applying for PIP. In the cases reviewed by my office all claimants provided contact details of one or more health professionals as a potential source of further evidence.

I acknowledge that, at times, some form of evidence from the contacts provided by the claimant may have already been available to the IR Disability Assessor. I also acknowledge that in 11 of the 100 cases reviewed during my investigation, evidence was already available from all of the contacts provided. This evidence was typically obtained through the claimant's last DLA claim.

However, I am disappointed by the Department's suggestion that, if evidence (with apparent disregard to its content) is already available from a contact this eliminates their value as a potential source. Health professionals remain a valuable source of up-to-date evidence, should clarification or further information be required. For example, a considerable period of time may have lapsed since the claimant's most recent DLA claim, the claimant's functionality may have changed over that time. It is therefore likely that further up-to-date evidence from the same health professional would be of value.

Case Study 2 Same claimant, same information, differing decisions on the need to request further evidence.

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision written on Mandatory Reconsideration Notice (3 June 2018): No Award: No Daily Living (6 points): No Mobility (4 points)

2nd Mandatory Reconsideration (25 August 2018): No change
Offer of Lapsed Appeal (28 January 2019): Standard Daily Living (10)
Enhanced Mobility (12)

Claimant G, whose primary condition is listed as Learning Difficulty, applied for PIP on 8 Dec 2017.

On 14 Jan 2018 a Capita IR Disability Assessor reviewed the PIP2 application form and DLA evidence and recorded within the PA1 report:

'The claimant questionnaire and 1 additional document has been reviewed. There is insufficient evidence [my emphasis] to support the level of functional impairment claimed and a face to face assessment is required.'

The evidence available to the first Disability Assessor was as follows:

1. PIP2 Application form
2. GPFR⁷¹ 2014

The claimant provided contact details for their GP during both the initial phone call and within the PIP2 application form. Although the contact details were for the same GP practice the name of the GP provided by the claimant was different to the GP who had completed the GPFR over 3 years previously in 2014.

The further evidence indicators on CRM were completed as follows:

Type of assessment required: 'PA1 – Review Filenote (FME Needed)'

Assessment type reason code: 'Insufficient evidence, unlikely to be obtained in timescale required'

FME Required: 'No'

No request for evidence was sent to the claimant's health professionals.

The claimant subsequently failed to attend the face to face consultation, and following a period of review, 'Good reason' was eventually accepted by the Department. The claim was then resent to Capita for review.

71 GPFR is the report template sent by Capita to claimants health professional(s) to provide advice

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On the 20 April 2018 a Capita IR Disability Assessor had the following evidence available to review on PIPCS:

1. PIP2 Application form (same as above)
2. GPFR 2014 (same as above)
3. Copy of the original PA1 report as recorded above (classified as AP Assessment report where assessment could not be completed) with an attached list of appointment dates. (containing no additional functional or medical evidence)

Although the family member's letter advising of their reason for missing the original consultation was available to the Department, it would appear this letter was not available to the Disability Assessor as it is not contained within the attachments accessible to Capita from the PIPCS. It is also noted that the letter held no additional functional or medical evidence. It merely stated the family member had forgot about the appointment and had gone to the shops with the claimant.

The IR Disability Assessor recorded within the PA1 report:

*'The Claimant questionnaire and 2 additional documents have been reviewed. **There is insufficient evidence [my emphasis]** to support the level of functional restrictions reported. A face to face consultation is advised **FME has been requested [my emphasis].***

The further evidence indicators on CRM were completed as follows:

Type of assessment required: 'PA1 – Review Filenote (FME Needed)'

Assessment type reason code: 'Insufficient evidence, unlikely to be obtained in timescale required'

FME Required: Yes

The IR Disability Assessor completed a GPFR request with the following free text insertions:

'Information from your patients claim shows that they have the following health conditions/impairments:
GP factual report

In particular, I would like information on:

Please could you provide any information confirming condition and symptoms. If possible could you also comment on the functional restrictions in relation to daily activities.'

This case evidences the lack of clarity in relation to IR Disability Assessors' decisions to request further evidence from a claimant's health professional.

Two Initial Reviews of the same claimant were undertaken within 3 months, based on the same PIP2 application form and DLA evidence. In both cases it was identified and recorded that there was insufficient evidence; further medical evidence was needed and that it was unlikely to be obtained in the timescale required. However, the outcomes for each review differed significantly. Initially an IR Disability Assessor decided that further evidence should not be requested. Subsequently the second IR Disability Assessor decided that further evidence should be requested. There is no record to identify how these decisions were made or why the outcome differed.

Case Study 3 Insufficient evidence identified. Further evidence not requested.

Award History

DLA: Middle Care: Low Mobility

First Tier Decision (7 September 2017): No award (0 points)

Mandatory Reconsideration (13 Oct 2017): Standard Daily Living (8):
Standard Mobility (8)

Claimant H, whose primary condition is listed as fibromyalgia, applied for PIP on 27 May 2017.

On 6 July 2017 Capita's IR Disability Assessor reviewed the PIP2 application form and the claimant's *'how your conditions affects you'* diary. Within the PA1 report they recorded:

*'customer questionnaire reviewed **no additional evidence available**...insufficient evidence and therefore a face to face assessment is advised'*

The claimant provided contact details for their GP in both the initial call and the PIP2.

The further evidence indicators on CRM were completed as follows:

Type of assessment required: *'PA1- Review Filenote (FME Needed)'*

Assessment type reason code: *'Insufficient evidence, unlikely to be obtained in timescale required'*

FME Required: *'No'*

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No request for evidence was sent to the claimant's health professionals.

This case evidences that, although an IR Disability Assessor identified that insufficient evidence was available (in this case no available evidence from any professional at time of Initial Review) and that further medical evidence was needed, they determined that this would not be requested. There is no record to identify why this decision was made, although it appears to be in line with Capita's policy.

The Department advised my investigation that the record "*Insufficient evidence, unlikely to be obtained in timescale required*" in this case clearly indicates that, even where a healthcare professional has been identified, that the DA believes that evidence is not likely to be obtained without causing undue delay in determining the claimant's entitlement to the benefit. In such instances, the Department advised that the further evidence that is required can be gathered at the face to face assessment.

The Department do not recognise the apparent lack of detail in this description or how its repeated use within the cases reviewed has deemed it irrelevant to decision making records. As previously stated this category was used in 93% of the cases reviewed, including the majority of the 34% of cases where further evidence was requested from health professionals. It is therefore unclear how a record, which is repeatedly used in cases where evidence is requested, can also be considered a clear reasoning for not requesting evidence.

Findings –

The lack of appropriate decision making records made by IR Disability Assessors, evidences a failure to fulfil Principle 1 and 3 of the Principles of Good Administration. As a result the decision to not request further evidence is unclear, appears unreasonable, and in many circumstances, is contradictory.

Recommendations –

The Department should review Capita's policy for requesting further evidence and the categories used within Capita's CRM and implement change. The review should include consideration of:

- Reform of the guidance on when not to request further evidence;
- Additional descriptive records to include the consideration of requests for further evidence from the claimant's health

professional(s), particularly where it has been identified that insufficient supporting evidence has been provided or evidence is considered to be dated;

- Additional categories which reflect the decision not to request evidence from the claimants health professional(s); and
- Recording within the PA1 if further evidence has not been requested and why. Where further evidence has been requested, the health professionals should be listed. Case Managers (making a decision on the award) would then be in a position to decide whether the evidence relied upon is the best available, or whether there is an opportunity to gather further evidence to address any gaps/ discrepancies.

Issue 3: Communication

i. Initial information pack

My investigation identified that Capita's initial correspondence to claimants reassuringly provided advice that they can bring further evidence to the face to face consultation. It also included a standard statement when further evidence had been sought from the health professional(s) provided by the claimant:

'We have, or are currently waiting for, evidence from the contacts you have provided.'

The Department provided service specifications⁷² to my investigation which stated that Capita were required to not only inform the claimant that further evidence has been sought, but who it has been sought from:

'Where a written request for FME is made, the Contractor will update the claimant to notify them of this in order to keep the claimant informed of progress. The notification will also include details of the FME requested and from whom.'

However, despite the recorded statement appearing in reviewed Capita correspondence dated 2018 onwards, the Department advised my investigation that this specification was removed from the contract from 1 June 2017. The Department advised:

'It was felt that this was an unnecessary additional step as customers already provide their consent on their PIP2 application form for Capita to contact their HPs and they provide a list of who those HPs are.'

⁷² 'Amendments to the Specification Personal Independence Payment Assessment Service'; Information provided to NIPSO July 2019

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'It was therefore deemed an unnecessary step in the process, which may have resulted in claimants becoming concerned about why some of their healthcare professionals had not been contacted before they had even been assessed. It could also have led to claimants unnecessarily contacting their healthcare professionals to make enquiries regarding whether they had been contacted by Capita, if they had provided a reply and what its content would be.'

I acknowledge that this advice to claimants would be an unnecessary step if, in every case, Capita contacted all the health professionals provided by claimants. However my case file review identified that advice was only requested in 34%⁷³ of the reviewed cases. Furthermore, I have identified that not all health professionals are recorded and therefore may not be considered for the request of advice. It is therefore essential that claimants are advised if their health professional(s) has been contacted, along with details of who was contacted, fully informing their decision making regarding their own evidence gathering.

My investigation also identified that no alternative statement is used within Capita correspondence to advise claimants when their health professional(s) have not been contacted. Claimants therefore remain unaware that advice has not been sought in support of their claim.

Findings –

I acknowledge the Department's advice to my investigation that there is no contractual requirement for Capita to write to claimants after their case has been received for initial review or to advise them which of their healthcare professionals have or have not been contacted for further evidence. However I consider that the Department's failure to ensure that Capita's communications to claimants are open, clear and accurate, in relation to the request of further evidence from health professional(s), evidences a failure to fulfil Principle 3 of the Principles of Good Administration. As a result, claimants are misled in relation to which of their health professionals have been contacted, or they remain unaware that their health professional(s) have not been contacted. They are therefore unable to make a fully informed decision in regard to the need to gather/provide their own evidence.

I note the Department's advice to my investigation that Capita record on their computer system the date and details of anyone they have contacted for further evidence and this information is available to the claimant should they request it. I also note the Department's advice that it can also be

⁷³ In an additional 1% of cases further evidence was requested from a claimant's carer.

provided to the claimant by the Department's Case Managers if a claimant subsequently requests an explanation of the decision on their claim. However I did not review any advice to claimants during my investigation, written or verbal, that this information is available upon request.

Recommendations –

The Department should liaise with Capita to revise their initial information pack to ensure that claimants are correctly and precisely informed as to:

- whether or not health professionals have been contacted; and
- The details of the specific health professionals who have been contacted (if applicable).

ii. General Practitioner Factual Report (GPFR) requests

When an IR Disability Assessor makes the decision to request evidence from a claimant's health professional(s) this is typically undertaken via a covering letter accompanying a blank advice template (typically referred to as a GPFR). The text within the letter is preset with the exception of two areas: *'Information from your patient's claim shows that they have the following health conditions'* and *'In particular, I would like information on'*. Free text boxes below these fields present an opportunity for an IR Disability Assessor to personalise the request in order to obtain the most relevant evidence for the individual claim.

However, the cases reviewed during my investigation identified a repeated failure to complete these fields with any due consideration. Some examples include:

- Information from your patients claim shows that they have the following health conditions/impairments:

Current diagnosis and functional ability.

In particular, I would like information on:

Current diagnosis and functional ability.

- Information from your patient's claim shows that they have the following conditions/impairments:

please confirm diagnosis, medication and functional restrictions.

In particular I would like information on:

see above.

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- Information from your patients claim shows that they have the following health conditions/impairments:

[blank]

In particular I would like information on:

Please provide up to date information on diagnosis, treatment, specialist input and functional restrictions.

- Information from your patient's claim shows that they have the following health conditions/impairments:

Diagnosed conditions, medications prescribed, functional restrictions.

In particular, I would like information on:

As above please'

Case Study 4 – Incomplete GPFR request, Failure to record contact details from PIP2 and poor communication

Award History

DLA: Higher Care: Low Mobility

First Tier Decision (20 September 2018): No Award: Daily Living (0 points): Mobility (0 points)

Mandatory Reconsideration (28 November 2018): No Change

Offer of Lapsed Appeal (28 January 2019): Standard Daily Living (11): No Mobility (0)

Claimant I, whose primary condition is listed as Paranoid psychosis/ depression and anxiety, applied for PIP on 12 May 2018.

On 26 June 2018 the claimant's PIP2 application was received by the Department

with contact details for the claimant's Psychiatrist and GP. Only the GP contact details are listed on PIPCS and CRM.

On the 5 July 2018 an IR Disability Assessor reviewed the claimant's application form and recorded '*Items 1 to 3 of evidence have been reviewed. There is insufficient evidence to advise the DFC, however due to nature of condition, a face to face within clinic setting is advised. Further medical evidence has been requested from all available contacts.*'

The IR Disability Assessor completed a GPFR to the claimant's GP but failed to complete the free text request sections:

'Information from your patient's claim shows that they have the following health conditions/impairments:

[blank]

In particular I would like information on:

[blank]'

No advice request was sent to the claimant's Psychiatrist, despite the record advising that evidence had been requested from 'all available' contacts.

Capita subsequently sent the claimant an initial information pack which advised *'We have, or are currently waiting for, evidence from the **contacts you have provided.** [my emphasis]'*

Following completion of Capita's assessment report, and review by Department Case Managers, the claimant was advised at both First Tier and Mandatory Reconsideration that they were not entitled to PIP.

Although the requested GPFR was not returned during assessment of the claim, the claimant subsequently met with their GP, who completed and returned the GPFR (sent on 5 July 2018) to the Department on 3 December 2018 along with a letter from the claimant's Psychiatrist (dated 5 June 2018) confirming diagnosis and providing observations.

Following review of this further evidence Capita provided a change of advice report (PA6), and the Department revised its decision. The claimant was offered Standard rate Daily Living (an additional 11 points).

This case evidences poor communication, to both the claimant and their health professionals, in regard to further evidence gathering.

The request sent to the health professional failed to include requests specific to the claimant. Although the cause of the GP's delay to complete the GPFR is unknown, it is possible it may have been impacted by the failure of the IR Disability Assessor to fully complete the request.

The communication to the claimant was inaccurate. The claimant provided details for both their GP and Psychiatrist, therefore the statement within the initial information pack wrongly reassured the claimant that both had been contacted. As a result the claimant and their family were unable to make an informed decision at an earlier stage in regard to the gathering of their own further evidence. Once the claimant and their family were aware that evidence had not been gathered from their health professionals, they were able to provide this information, subsequently overturning the Department's decision.

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Findings -

The repeated failure of the Department to ensure that Capita's IR Disability Assessors appropriately complete the request for further evidence from health professionals evidences a failure to fulfil Principle 1 of the Principles of Good Administration. As a result an opportunity may be missed to gather specific, appropriate and useful evidence from the health professionals.

Recommendations –

Following identification of this issue, the Department advised my investigation that in early 2019 Capita introduced an updated version of its CRM system, which prevented a Disability Assessor from completing a GPFR request with blank free text boxes. Guidance has also been re-issued to all Initial Review Disability Assessors in relation to completion of GPFR free text boxes.

Capita and the Department should review a random sample selection of GPFR requests within a 3 month timeframe of the date of this report in order to identify whether the action taken has remedied this issue.

It is acknowledged that the Department and Capita are continuing to work towards a short summary report following recommendations made by the Independent Reviewer, Walter Rader, in June 2018⁷⁴

[Recommendation 7: So that the relevant up-to-date medical information is available early in the PIP assessment process, the Department should reach agreement with the relevant professional bodies as to how they may best to obtain a GP Short Summary Report to support the PIP2 submission. This should be requested for every claim.]

However, in the absence/delay in this being implemented, focus should remain on the appropriate completion of the current request forms.

⁷⁴ *Personal Independence Payment, An Independent Review of the Assessment Process, Northern Ireland*. June 2018. Available at <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-independent-review-pip-assessment-process-june-2018.pdf>.

Issue 4: Assessment Choice

Within the Initial Review, IR Disability Assessors decide whether a claim requires a SRTI⁷⁵, a face to face assessment (F2F)⁷⁶ or a PBR⁷⁷. Where appropriate, an IR Disability Assessor can request further evidence from a claimant's health professional(s) before making a decision on the type of assessment required.

When a decision is made, the IR Disability Assessor records their assessment choice within a PA1 report and chooses the relevant category under 'Assessment type reason code'.

My investigation identified a lack of appropriate records explaining the IR Disability Assessor's assessment choice. In the majority of cases the only reason recorded within the PA1 to support a decision to proceed with a face to face assessment is 'insufficient evidence available'. Some examples taken from my case file review include:

'Items 1 to 2 of evidence reviewed. There is insufficient evidence to advise the DfC, however, due to the nature of the condition, a face to face assessment is advised. Further medical evidence has not been requested.'

'Items 1 to 31 have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face is required.'

'There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.'

'The claimant questionnaire was reviewed and there is insufficient evidence to provide a paper based report therefore a face to face assessment is required. Home assessment is required due to the nature of the claimant's condition.'

It is acknowledged that 'insufficient evidence' is a justified contributor to the decision for a face to face assessment. However, (as previously identified in Issue 2) where evidence is provided by either the claimant or the Department (DLA), there is no record of the IR Disability Assessor's reasoning why this is deemed insufficient.

The records also fail to provide any rationale as to why an immediate decision (often undertaken within an average of 9 minutes) is made to progress to face to face assessment, as opposed to awaiting further evidence from a health professional before making a decision.

⁷⁵ A fast tracked assessment if the claimants death could be 'reasonably expected' within the next six months.

⁷⁶ A face to face assessment requires a face to face consultation with the claimant to assess functionality.

⁷⁷ Paper based review is a desktop review of available evidence and any requested evidence, undertaken by an IR Disability Assessor. There is no requirement in this review to meet with the claimant face to face.

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The only other possible record to explain this decision is the categorisation '*unlikely to be obtained in timescale required*'. This may suggest that the IR Disability Assessor considered that further evidence would not have been obtained within the required Service Level Agreement (SLA) target timeframe in order to make a decision on assessment choice. However, my investigation identified that this category is used as a standard classification in the majority of claims (93% claims reviewed), including cases where evidence was requested. It is therefore not exclusively reflective of a decision to not request evidence.

Furthermore, my investigation identified that a six week period was typically available before the SLA required the assessment to be completed. Capita's target time for return of advice requests is 15 working days⁷⁸. It is therefore not 'unlikely' that a further evidence request could be sent, returned and the chosen assessment completed within this period. Particularly as a face to face assessment report is typically submitted on the same day/within a day of the consultation.

The Department disagree with my consideration, advising that my investigation:

'has not properly considered the evidence regarding time taken for the return of FE, the FE return success rates, the usefulness of FE that is returned or the requirements of the contract to provide appropriate notice of appointments, the opportunity for claimants to reschedule or the requirements to ensure a robust quality assurance process.'

It is acknowledged that time constraints and contract requirements may impact on the retrieval times of further evidence requests. However, in the majority of the cases I reviewed, the decision to request further evidence was made within the initial few days of the six week SLA commencing. If the Department feel that a six week period does not appropriately support the request and retrieval of further evidence, due to the issues outlined in its response, it should review the SLA timeframes.

The Department's response also raises concerns that the decision to request or not request evidence may not be based on the specifics of an individual case and whether additional evidence is likely to add value, but is instead based on a biased view of overall system issues. It is particularly concerning that there may be a default position that it is acceptable to not request further evidence from a Health professional in an individual case, because of previous unrelated cases having late or no response, or insufficient responses from other health professionals.

⁷⁸ Capita PIP Assessments CISPIP-pdd Process 3 – Manage Initial Review, version 1.7, Section 4.1.

Case Study 5 Assessment choice within SLA.

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (8 Oct 2018): No award: Daily Living (2 points), 0 points Mobility)

Mandatory Reconsideration (19 Nov 2018): No change

Offer of Lapsed Appeal (13 January 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant J, whose primary condition is listed as fibromyalgia, applied for PIP on 6 May 2018.

On 18 June 2018 the claimant's PIP2 application form was received by the Department, along with a supporting letter from claimant detailing the functional impact of their condition and advising that their GP had requested Capita contact them if advice was necessary. The claimant provided the contact details for three of their Consultants and a Doctor within the ICATS Department.

On 30 July 2018 an IR Disability Assessor reviewed the claimant's application form, additional evidence and the DLA report and recorded:

'Items 1 to 4 of evidence have been reviewed. There is insufficient evidence to advise the DfC, However due to the nature of the condition a home assessment is required.'

The 'Assessment type reason' on CRM was categorised as:

'Insufficient evidence, unlikely to be obtained in timescale required.'

The CRM also records the SLA required completion date to be 11 Sep 2018. Capita therefore had over 6 weeks to obtain any further evidence and complete the assessment.

No request for advice was sent to any of the claimant's health professionals.

A face to face consultation was booked and the claimant was advised of the appointment date. No record was made to identify why further evidence had not been requested from the claimant's health professional(s), and no advice was provided to the claimant as to why this form of assessment was chosen.

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Case Study 6 Assessment choice with no record why further evidence not sufficient.

Award History

DLA: Middle Care: High Mobility

First Tier Decision (14 September 2018): No Award: Daily Living (4 points), Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No Change

Offer at Lapsed Appeal (17 February 2019): Standard Daily Living (8): Standard Mobility (8) (offer declined)

Appeal: Awaiting Tribunal

Claimant K, whose primary condition is listed as Degenerative Disc disease, applied for PIP on 9 June 2018.

On 15 July 2018 the claimants PIP2 application form, along with a significant volume of further evidence, was received by the Department. The evidence included Consultant Rheumatology letters, Consultant Psychiatrist letters, MRI scans and medical information leaflets.

On 21 July 2018 an IR Disability Assessor reviewed the claimant's application form and additional evidence and recorded:

'Items 1 to 22 of evidence have been reviewed. There is insufficient evidence to advise the DFC, therefore a face to face assessment is required.'

The Assessment type reason on CRM was categorised as: *Insufficient evidence, unlikely to be obtained in timescale required.*

No record was made to detail why the available evidence was considered to be insufficient and no request for evidence/advice was sent to the claimants GP.

A clinic face to face consultation was booked and the claimant was advised of the appointment date. No record was made to identify why further evidence had not been requested from the claimant's health professional(s) and no advice was provided to the claimant as to why this form of assessment was chosen.

Case Study 7 Assessment choice with no record why further evidence not requested and no record of consideration of claimant's request for home visit.

Award History

First Tier Decision (6 Jan 2019): Standard Mobility (10 points) no Daily Living (6 points)

Mandatory Reconsideration (19 Feb 2019): No change

Appeal Decision (18 July 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant L, whose primary condition is listed as Osteoarthritis, applied for PIP on 20 Oct 2018.

On 19 Nov 2018 the claimant's PIP2 application was received by the Department with a request for a face to face consultation at home. The claimant also provided contact details for their GP, Occupational Therapist, Physiotherapist and Pain management clinic.

On the 26 November 2018 an IR Disability Assessor reviewed the claimant's application form and recorded:

'Items 1 of evidence have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.'

The Assessment type reason on CRM was categorised as: *Insufficient evidence, unlikely to be obtained in timescale required.*

No advice requests were sent to any of the claimant's health professionals.

A clinic face to face consultation was booked and the claimant was advised of the appointment date. No record was made to identify why further evidence had not been requested from the claimant's health professional(s), or whether the IR Disability Assessor had taken the claimant's request for a home consultation into account.

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Findings –

The failure to appropriately and clearly record the decision making in regard to the choice of assessment type evidences a failure to fulfil Principle 3 of the Principles of Good Administration. As a result, the decision to proceed with certain assessment types is unclear and, in some circumstances, does not take into consideration the requests of the claimant.

Recommendations –

The Department should review the assessment choice records within Capita's case referral system and implement change. The review should include consideration of:

- Additional descriptive records which identify why an assessment choice is made. This should include reference to any available evidence which does not support the claim;
- The removal of the use of the indicator '*unlikely to be obtained in timescale required*' as a standard reason code for face to face assessment choice;
- A review of its Service Level Agreement due to Capita's consistent determination that the timeframe to obtain further evidence is not adequate (as suggested by the standard use of the '*unlikely to be obtained in timescale required*' category); and
- Inclusion of the reasoning for the choice of assessment within the notification/appointment letter to the claimant.

Issue 5: Appropriate provision of resources

At Initial Review the IR Disability Assessor is tasked with:

- Reviewing all available evidence (PIP2 application form, DLA evidence and any other supporting information supplied by the claimant);
- Requesting further evidence where they deem it necessary;
- Determining the most appropriate form of assessment; and
- Completing a PA1 report form to evidence their considerations.

IR Disability Assessors are required to complete 20 Initial Reviews, alongside 2 Paper Based Reviews, daily.

My investigation identified that the majority of cases (those deemed to require face to face assessments) had an average consideration and write up time of 9 minutes at Initial Review. This could range from a case with 1 piece of evidence (PIP2 application form) taking a recorded 8 minutes to consider and write up, and a case with 22 pieces of evidence taking a recorded 11 minutes to consider and write up.

I acknowledge the Department's advisement to my investigation that all IR Disability Assessors are registered health professionals, with appropriate clinical expertise and training, who are accustomed to reading and interpreting medical information quickly and accurately. However the time taken to review the cases within my own case review, highlighted that the average time recorded for Initial Review could not be considered reasonable. An effective Initial Review, undertaking all of the required tasks, cannot reasonably be undertaken within 9 minutes.

Case Study 8 – Initial Review consideration and write up time.

Award History

DLA: Middle Care: High Mobility

First Tier Decision (14 September 2018): No Award: No Daily Living (4 points), No Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No Change

Offer at Lapsed Appeal (17 February 2019): Standard Daily Living (8): Standard Mobility (8)

(offer declined)

Appeal: Awaiting Tribunal

Claimant K, whose primary condition is listed as Degenerative disc disease, applied for PIP on 9 June 2018.

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On 21 July 2018 an IR Disability Assessor reviewed the claimant's application form and supporting evidence and recorded within the PA1 *'Items 1 to 22 of evidence have been reviewed. There is insufficient evidence to advise the DFC, therefore a face to face assessment is required.'*

The items available were as follows:

Item 1: DLA tribunal hearing advising that higher rate mobility and lowest care should be applied (2010)

Item 2: Consultant Psychiatrist report (1998) (4 pages)

Item 3: Medication leaflets

Item 4: outpatient results letter (2011) Consultant Respiratory physician (1 page)

Item 5: Lumbar spine results (radiologist) (2008)

Item 6: Medication labels

Item 7: PIP2 application form (as well as handwritten information on the form the claimant had provided additional typed sheets, for example in response to

- Section 3 they provided 40 lines of typed response (average of around 17 words per line);
- Section 5 13 lines of typed response;
- Section 6 21 lines of typed response;
- Section 7 7 lines of typed response;
- Section 8 4 lines of typed response;
- Section 11 4 lines of typed response;
- Section 13 76 lines of typed response;
- Section 14 68 lines of typed response;
- Section 15 36 lines of typed response; additional info 105 lines of typed response)

(approximate estimate 2,434 words)

Item 8: Consultant Psychiatrist report (1998) (2 pages)

Item 9: Consultant Rheumatologist report (1998) (2 pages)

Item 10: Consultant Rheumatologist report (1997) (3 pages)

Item 11: Psychiatric Report (1997) (3 pages)

Item 12: MRI scan results letter (2012)

Item 13: Consultant Rheumatologist report (2010) (2 pages)

Item 14: Medication leaflets

Item 15: Medication leaflets

Item 16: Medication leaflets

Item 17: Medication leaflets

Item 18: Medication leaflets

Item 19: MRI Radiology report (2012)

Item 20: Medication leaflets

Item 21: Medication leaflets

Item 22: Medication leaflets

Item 23: Document completed by Claimants GP in agreement with their stated issues. (3 pages 2010)

The consideration and write up time was recorded as 11 minutes.

Case Study 9 – Initial Review consideration and write up time.

Award History

First Tier Decision (6 Jan 2019): Standard Mobility (10 points) no Daily Living (6 points)

Mandatory Reconsideration (19 Feb 2019): No change

Appeal Decision (18 July 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant L, whose primary condition is listed as Osteoarthritis, applied for PIP on 20 Oct 2018.

On 26 Nov 2018 an IR Disability Assessor reviewed the claimant's application form and recorded within the PA1 *'Items 1 of evidence have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.'*

Only 1 item was available to the IR Disability Assessor, the PIP2 application form. It is estimated this document had approximately 1134 words to review.

The consideration and write up time was recorded as 8 minutes.

Case Study 10 – Initial Review consideration and write up time.

Award History

DLA: Middle care: Higher Mobility

First Tier Decision (22 Oct 2018): No award: (2 points Daily Living)

Mandatory Reconsideration (14 Dec 2018): No Change

Offer of Lapsed Appeal (22 February 2019): Standard Daily Living (10): Standard Mobility (8)

Claimant M, whose primary condition is listed as arthritis, applied for PIP on 11 August 2018.

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On 9 September 2018 an IR Disability Assessor reviewed the claimant's application form and supporting evidence and recorded within the PA1 *'Items 1-2 of the evidence have been reviewed. There is insufficient evidence to advise the DFC therefore a face to face assessment is required.'*

The items available were as follows:

Item 1: DLA GP factual report (2015) (4 pages), medication list (2015) (1 page) and a 'Statement from someone who knows you' (2015) signed by GP (1 page)

Item 2: PIP2 application form – it is estimated that this document had approximately 250 words to review.

The consideration and write up time was recorded as 9 minutes.

Case Study 11 – Initial Review consideration and write up time.

Award History

DLA: Middle Care: Low Mobility

First Tier Decision (18 September 2018): No award: Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (6 November 2018): No change

Lapsed Appeal (23 February 2019): Enhanced Daily Living (13): Enhanced Mobility (12)

Claimant N, whose primary condition is listed as Schizophrenia, applied for PIP on 17 May 2018.

On 15 July 2018 an IR Disability Assessor reviewed the claimants application form and recorded within the PA1 *'Items 1-4 of evidence have been reviewed. There is insufficient evidence to carry out a robust PBR and as both received medical evidences confirm that customer could attend an assessment (accompanied) the assessment has been locked to clinic.'*

The items available were as follows:

Item 1: PIP2 application form – it is estimated that this document had approximately 375 words to review.

Item 2: DLA Community Psychiatric Nurse factual report (2007) (4 pages)

Item 3: GP factual report (2018) (5 pages)

Item 4: Mental Health Resource Centre factual report (2018) (4 pages)

The consideration and write up time was recorded as 10 minutes.

Case Study 12 – Initial Review consideration and write up (over the average time – reason requested to explain).

Award History

DLA: High Care: Lower Mobility

First Tier Decision (4 Mar 2017): No Award (0 points)

Mandatory Reconsideration (28 Mar 2017): No change

Appeal Tribunal (10 April 2018): Standard Daily Living (9): No Mobility (4)

Claimant B, whose primary condition is listed as Post Traumatic Stress Disorder, applied for PIP on 12 Nov 2016.

On 9 June 2018 an IR Disability Assessor reviewed the claimant's application form and supporting evidence and recorded within the PA1 *'Items 1 to 24 were reviewed. There is insufficient information to advise the DFC. A face to face assessment is required.'*

The items available were as follows:

Item 1: PIP2 application form (2016) – it is estimated that this document had approximately 1900 words to review

Item 2: Capita Review Filenote – PA1 (2016)

Item 3: Capita Review Filenote – PA1 (2016)

Item 4: Capita Consultation report – PA4 (2016) (23 pages)

Item 5: Letter from claimant appealing decision (2017) (5 pages)

Item 6: Cover letter from claimant enclosing further evidence (2017)

Item 7: DLA GP factual report (2014) (4 pages)

Item 8: Notice of an Appeal with attached Mandatory Reconsideration Notice (2017)

Item 9: Cover letter from claimant enclosing further evidence (2017)

Item 10: Psychiatric outpatient appointment letter (2017)

Item 11: Appeal Service letter to PIP Appeals requesting appeal response (2017)

Item 12: DLA GP factual report (2014) (4 pages)

Item 13: Capita Supplementary advice note – PA6 (2017) (6 pages)

Item 14: Department response to Appeal Service (7 pages)

Item 15: Notification of response to Appeal Service (2017)

Item 16: Department letter to claimant advising that appeal response has been sent to the Appeals Service (2017)

Item 17: Letter from solicitors to claimant re Originating Summons (2017)

Item 18: Receipt for diesel (2017)

Item 19: Grievance meeting covering letter and notes (2016)

Item 20: Appeal Service letter to PIP Appeals providing further evidence (2017)

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Item 21: Letter from claimant to Appeals Service (2017)

Item 22: Letter to claimant from Department advising no change to decision following receipt of further evidence and information (2017)

Item 23: Additional information for the Tribunal form (2017)

Item 24: PIP2 (Intervention) form (2018) – it is estimated that this document had approximately 1500 words to review

The consideration and write up time was recorded as 40 minutes.

An additional field entitled 'reason for write up time' records '24 documents.'

This field does not appear on CRM when an IR Disability Assessor completes the review within the average timeframe (i.e. it does not appear if the input is between 4-20 minutes). This would suggest that expectations are placed on IR Disability Assessors to complete the Initial Review within this short timeframe.

Findings –

The inappropriate expectations, of the average handling time to complete an Initial Review, placed on IR Disability Assessors evidences a failure to fulfil Principle 1 of the Principles of Good Administration. As a result it is likely the IR Disability Assessors are unable to appropriately and efficiently complete their review, resulting in failures to identify additional health care professionals; low numbers of requests for further evidence and incomplete decision making records and advice requests.

Recommendations –

The Department should undertake a review of the Initial Review process, focusing on the average time taken to complete an Initial Review and the impact this subsequently has on the decisions to request further evidence. The Department should consider extending the time provided to IR Disability Assessors to consider, request and receive further evidence.

The Department should consider the time spent at the Mandatory Reconsideration stage overturning decisions based on new evidence (which would have been available for request at the outset of the claim) and how this time could be used at Initial Review to request sufficient further evidence to make decisions right 'first time'.

Chapter 3: Assessment

This Chapter examines the role and application of further evidence in the Assessment stage of the PIP claim process. Capita is contracted to undertake PIP assessments on behalf of the Department.

There are three different routes, determined at Initial Review, through which a claim may be assessed:

- Special Rules Terminal Illness;⁷⁹
- Paper Based Review; or
- Face to Face Consultation (within clinic or home).

Applying assessment criteria, a Disability Assessor provides advice to the Department on the overall functional effect of the claimant's health condition or impairment on their everyday life over a 12 month period.

The Disability Assessor is required to produce a report for the Department recommending descriptor choices on the claimant's ability to carry out ten daily living and two mobility activities along with clear explanation of the advice given. The recommended descriptor choices for each activity are automatically allocated a numeric score⁸⁰ by the PIP Computer System. A claimant's entitlement to PIP is subsequently determined by a Department Case Manager who decides which descriptor choices should be applied to each of the 12 activities. The rate of benefit is calculated on the total points scored for each component (daily living and mobility).

79 Individuals who identify themselves as terminally ill can seek to claim PIP under special rules for terminal illness (SRTI). Disability Assessors advise the Department on whether the claimant satisfies the SRTI criteria set out in legislation, that the claimant *'is suffering from a progressive disease and death in consequence of that disease can reasonably be expected within 6 months'*. If the criteria is met, the claimant will automatically receive the enhanced rate of the daily living component however entitlement for the mobility component is still assessed (if claimed).

80 *PIP Assessment guide Part 2: the assessment criteria*. Section 2.3 'Daily Living Activities'. Available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-2-the-assessment-criteria#daily-living-activities>

Section 2.4 'Mobility Activities'. Web document available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-2-the-assessment-criteria#mobility-activities>

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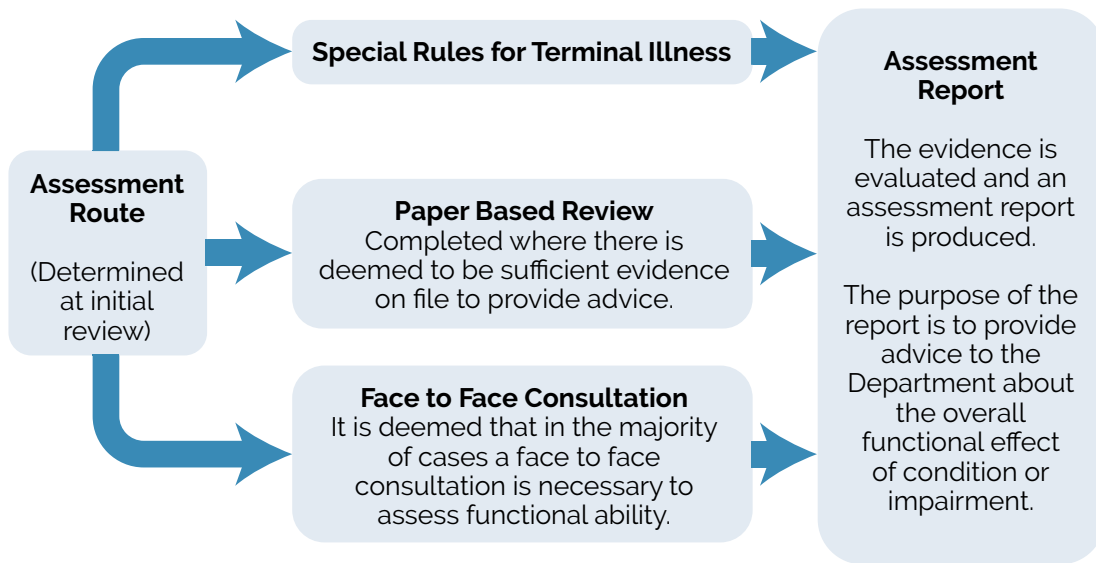
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The majority of PIP assessments completed on behalf of the Department by Capita are routed by way of a face to face consultation.⁸¹ In the case sample examined in my investigation, 96 out of the 100 claimants underwent a face to face consultation. Four of the claims were progressed by a paper based review and none fell under the special rules for terminal illness.

Issue 1: Pursuing Opportunities for Further Evidence at Assessment Stage

Gathering evidence through a face to face consultation with a claimant is a valuable method of informing the advice to the Department. This should not however exclude the pursuit of further evidence which may help improve the quality of the advice. Other sources of relevant evidence are particularly pertinent where the conditions reported by the claimant fluctuate, are progressive or if there is an indication that a claimant lacks insight into their condition. Further evidence can also be useful to test the reliability of observations [informal and examination] recorded in the consultation where they differ from what the claimant reports.

I identified an absence of Disability Assessors pursuing further evidence opportunities in face to face assessments. This appears to be as a direct result of Capita's policy and practice that further evidence is not typically requested for claims that are sent for face to face consultations.⁸² The approach taken by Capita, that in the majority of claims, a face to face consultation negates the need for further evidence, reflects in my view an

⁸¹ The Department advised NIPSO that from June 2016 until March 2021, 10.1% of claims were cleared by Paper Based Assessment.

⁸² Policy: *Capita PIP Assessments Process Definition Document Manage Face to Face Assessment*, CIS-PIP-PDD-6. Step 6.1. Practice: evidenced in Chapters 2, 3 and 8.

unrealistic expectation of what a consultation can feasibly achieve on its own. This presents a risk to the delivery of robust advice.

This position also significantly conflicts with the emphasis placed on further evidence during the application process, and thereafter, which not only creates an expectation that further evidence is likely to be requested by the Assessment Provider (Capita) but that it is important and somewhat central to decision making by the Department. Consequently, claimants attending consultations are more than likely to have expected the Disability Assessor to have obtained, or have attempted to obtain, more medical information or other forms of evidence than was the case. As previously highlighted, claimants were not informed if further evidence was not, in fact, requested from the health professionals they had listed in their PIP2 application forms. Furthermore, correspondence sent to claimants prior to consultation, inferred if further evidence was requested it was from all contacts listed by the claimant. This was not, however, accurate in many instances.

i. A responsibility beyond Initial Review

A face to face consultation, and the subsequent assessment report, is completed by a different Disability Assessor from the Assessor who completes the Initial Review of the claim. Capita advised my investigation that requests for further evidence can be made at any point of the process. Despite it being the responsibility of Disability Assessors at the Assessment stage to justify their advice to the Department, they did not, in turn, appear to question or review decisions made at Initial Review not to seek evidence to inform the advice. If, any such review did take place, it was not recorded.

It was clear that in practice Disability Assessors took a passive approach to identifying or following up further evidence opportunities which could improve the quality of their advice. Despite Capita's reassurance around the ability to request further evidence at any stage, I found that the decision to obtain further evidence was largely confined to the Initial Review stage, with no or limited evidence that Disability Assessors undertaking face to face consultations regarded it as a key consideration in preparing for consultations or formulating advice.

ii. Lost opportunities to request and obtain further evidence

Out of the 96 claims routed by way of face to face consultation, I found that further evidence was requested in only one claim during the Assessment stage (post the Initial Review).

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Prior to conducting face to face consultations, Disability Assessors are required to read the claimant questionnaire (PIP2 application form) and any other evidence available on file. These documents are viewable electronically via the Department's PIP Computer System (PIPICS). I observed, however, that where requests for further evidence were made at Initial Review and health professionals responded, the timeframes involved often meant responses were not received and uploaded onto the PIPICS prior to consultation. I also noted, in contrast to the PIP Assessment Guide (PIPAG), that when a face to face consultation is booked and further evidence is received prior to consultation, Capita do not review whether the assessment can progress by a paper based review instead.⁸³ This is because the Disability Assessor, conducting the assessment, does not review the further evidence until a short time frame before the consultation.

In preparation for the face to face consultation with the claimant, the Disability Assessor may research or seek advice about the reported condition and potential functional impact. Preparation also presents an opportunity for the Disability Assessor to consider the value of seeking further evidence or input (if not sought at the Initial Review) from the health professionals listed by the claimant as being best placed to advise how the condition affects the claimant.

Opportunities to pursue further evidence requests can also arise from information gleaned during the consultation. In addition to undertaking functional examinations and informal observations during the consultations, Disability Assessors interview the claimant about their history of conditions, social and occupational history, and employment and functional history. By exploring these areas directly with the claimant, further sources of potential evidence can be identified that were not previously contained within the PIP2 application form. Where consultation findings differ from reported impact or other existing evidence, Disability Assessors can revisit the value in seeking further evidence post consultation in order to address the inconsistencies when formulating their advice and completing the assessment report.

I welcome the approach taken by the Disability Assessor in the case where further evidence was sought at the Assessment stage. In this case the Disability Assessor had concerns following the face to face consultation that the claimant displayed a lack of insight into their mental health condition. The Disability Assessor contacted the claimant's General Practitioner (GP) whose contact details had been provided by the claimant

⁸³ *Variation to Contract: Sch7, p91*; Information provided to NIPSO July 2019.

in their application form but whose input had not been requested at Initial Review. The GP, who was contacted by phone, concurred with the concerns raised by the Disability Assessor and provided relevant further evidence which was utilised to improve the quality of advice in the assessment report.

I am concerned however that out of the remaining 95 claims routed by way of face to face consultation, no requests or contacts for further information were made with health professionals, carers or appointees during the Assessment stage. This is despite further evidence being requested in only 31 of these 95 claims at Initial Review and the assessments often involving contradictions between the consultation findings and functional impact reported by the claimant. Although some further evidence, for example DLA evidence, existed in most of the cases I examined, I found that opportunities to obtain additional evidence or input to address contradictions and improve the reliability of the advice to the Department were often not pursued.

iii. Barriers

A potential barrier to a Disability Assessor exploring further evidence is the extra time required to consider and pursue such evidence at the Assessment stage which does not appear to be built into the process.

It was noted that in the service requirements for PIP it was estimated that an assessment report, based on a consultation and completed by an experienced Disability Assessor, would take on average *16 minutes* to complete.⁸⁴ Although in the case sample reviewed the times recorded for completion of reports often extended past the estimated 16 minutes, this average provides an indication of the pressure associated with the completion of the report post the consultation.

I also note that in addition to Disability Assessors' assessment reports passing quality audits, Capita use information on the number of reports completed and submission times for reports to decide bonuses for Disability Assessors.⁸⁵ The current Capita internal service level agreement with Disability Assessors is for 75% of assessment reports to be submitted within twenty four hours of the consultation.

I am concerned by the Department's response to my investigation in respect of the issue of pursuing further evidence at the Assessment. The Department stated that to seek further evidence at the Assessment stage would introduce risk to the quality of the assessment report and would

⁸⁴ 'Personal Independence Payment (PIP) Assessment Service – Service Requirement', Para 11.12; Information provided to NIPSO July 2019

⁸⁵ Capita Performance Management and Forecasting, Document CISPIP- 15.

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disadvantage claimants by unnecessarily delaying the Department's decision regarding entitlement to benefit. The Department further stated, *'There is no requirement or practical benefit in requesting further evidence at the face to face assessment stage, other than for exceptional cases such as where vulnerability or lack of insight become apparent.'*

My findings have not suggested that seeking further evidence at the Assessment stage is necessary or proportionate in all cases. Indeed, there would be little value in doing so where consultation findings are consistent with the reported impact and evidence already held. However I did find a failure to pursue further evidence opportunities to address significant contradictions between consultation findings, the functional impact reported and existing evidence, including many cases in which sources of evidence had been pointed to by the claimant to support their claim and which had not been sought at the Initial Review stage⁸⁶. This included cases where individuals were vulnerable or a lack of insight should have been considered.

I also recognise the importance of getting support to individuals at the earliest opportunity. However the risk, as referred to by the Department, of taking time following a face to face consultation, for example to make enquiries with a claimants' carer or a health professional who knows them best, must surely be balanced with the need to improve the quality of the advice in order to get the decision right and the appropriate level of support for the individual. The Department also have failed to recognise that by not taking this approach, in addition to claimants not receiving the right level of support that they are entitled to at the earliest opportunity, many may receive no support at all. In the case sample I examined only 27 of the 100 claimants received a PIP award at the First Tier decision, yet at least 85⁸⁷ of the claimants were ultimately found to be entitled to a PIP award when the initial decision was overturned at a later stage either at Mandatory Reconsideration, Appeal or when their appeal was lapsed by the Department.

⁸⁶ Out of 47 claims in which no evidence was available, within the PIP claim file, from any of the contacts named by the claimant as being best placed to provide advice on their condition or disability, further evidence requests were made at Initial Review in only 17 of these claims. Out of 42 claims in which evidence was available from only some of the contacts named by the claimant, further evidence requests were made in just 13 of these claims at Initial Review. In identifying what evidence was available in the PIP claim files from the named contacts, my investigation also included the DLA evidence uploaded. It should therefore be noted that where evidence was available from a contact it may also not have been as relevant or current to the claimants' reported impact as what could potentially have been obtained had a request been made to that contact during the PIP process.

⁸⁷ 5 cases are awaiting to be heard at Appeal at the time of concluding my investigation (in 3 of these an award was made but the level of award is disputed).

Case Study 1 Further evidence not pursued to improve advice

Award History

DLA Award: Middle Care: Higher Mobility

First Tier Decision (13 November 2018): No Daily Living (6 points):
Standard Mobility (10 points)

Mandatory Reconsideration (5 January 2019): No change

Appeal Lapsed (7 March 2019): Enhanced Daily Living (12): Enhanced
Mobility (20)

Claimant O, whose primary condition is listed as Multiple Sclerosis (MS), applied for PIP on 10 June 2018. The claimant consented to their DLA evidence being used in support of the PIP claim, however, the DLA evidence was not uploaded onto the PIPCS.

The PIP2 application form submitted by Claimant O was received by the Department on 26 July. Claimant O also submitted a prescription list, a hospital appointment letter from a MS Nurse and a letter the claimant compiled to further outline the impact of the condition. Claimant O also listed their Neurologist, Occupational Therapist and Social Worker as the health professionals who are best placed to advise how the condition affects the claimant.

A Disability Assessor conducted an Initial Review of the claim on the 20 August and recorded, *'Items 1 to 2 of evidence have been reviewed. There is insufficient evidence to advise the DfC, however due to the nature of the condition a home assessment is required.'* No requests for further evidence or input were made to any of the health professionals listed by the claimant. The Initial Review is recorded as taking 9 minutes to write up.

As is standard procedure the claim was subsequently allocated to a different Disability Assessor to undertake the face to face consultation and complete an assessment report. The consultation took place on 13 October. The preparation time was recorded as taking 20 minutes, the consultation time as one hour and the assessment report as taking one and a half hours to write up.

The Disability Assessor made no requests for further evidence prior to submitting the assessment report. This is concerning given the consultation findings differed significantly from the functional impact reported by the claimant. The DLA evidence which the claimant had consented to be used as supporting evidence in their PIP claim remained unavailable to the Disability Assessor. The further evidence submitted by the claimant (prescription list and hospital appointment

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letter) was limited in respect of providing evidence of functional impact. Given the contradiction in evidence and the complexity of condition it would be reasonable to consider that the quality of advice could be improved by input from the health professionals listed by the claimant. There is no rationale recorded as to why seeking further evidence from these sources was not considered necessary.

The claimant subsequently submitted further evidence from a MS nurse at the Mandatory Reconsideration stage. After the claimant lodged an Appeal the Department returned the case to Capita for further advice in reference to the letter received from the MS Nurse at Mandatory Reconsideration. A change of advice note was issued by Capita and the Department subsequently revised the decision on the claimant's entitlement of an award.

This case raises concerns that the Disability Assessor, at Assessment stage, did not appear to consider it relevant to seek evidence from identifiable health professionals to help improve the quality of advice. It reflects the risk associated with the policy and practice that indicates face to face consultations negate the need to consider and pursue other evidential opportunities.

Case Study 2 Further evidence not pursued to improve advice

Award History

New Application (20 October 2018)

First Tier Decision (6 January 2019): No Daily Living (6 points): Standard Mobility (10 points)

Mandatory Reconsideration (19 February 2019): No change

Appeal Decision (18 July 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant L, whose primary condition is listed as Osteoarthritis, applied for PIP on 20 October 2018.

The PIP2 application form submitted by Claimant L was received by the Department on 19 November. The claimant did not submit additional evidence with the application but listed their GP, Occupational Therapist and Physiotherapist as the health professionals who are best placed to advise how the condition affects Claimant L. The claimant also provided contact details for the pain management clinic they attend.

A Disability Assessor conducted an Initial Review of the claim on the 26 November and recorded, *'Item 1 have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.'* No requests for further evidence were made at Initial Review which is recorded as taking 8 minutes to write up.

The claim was subsequently allocated to a different Disability Assessor to undertake a face to face consultation and complete an assessment report. The claimant was invited to attend a face to face consultation on 13 December.

The preparation time is recorded as 25 minutes and the consultation time is recorded as taking 50 minutes.

The consultation findings differed from the functional impact reported by the claimant. The only other evidence that existed at the time of the consultation, over and above that obtained during the consultation, was the claimant application. The Disability Assessor made no further evidence requests during the Assessment stage and completed the assessment report on 14 December. The write up time for the assessment report is recorded as taking 1 hour 25 minutes.

Given it is the role of the Assessment Provider to advise the Department on the overall functional effect of the claimant's health condition or impairment on their everyday life (over a 12 month period), it is disconcerting that no further evidence was sought to support or negate the impact reported, check the reliability of the consultation findings or even confirm the diagnosis reported.

Subsequently the Department's decision on award entitlement was overturned at Appeal. The reason for the overturn is unknown however this case demonstrates Capita's policy and practice that the consultation is considered in itself enough for Disability Assessors to base their advice. Despite the claimant providing relevant and pertinent sources of evidence in her application form, the opportunities to obtain relevant evidence were not pursued. There is also no rationale recorded as to why seeking further evidence from these sources was not considered necessary.

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Findings –

I found a repeated failure by Capita to seek further evidence during the Assessment stage of claims routed by way of face to face consultation. The approach at the Assessment stage to focus almost exclusively on gathering evidence through face to face consultations resulted in other opportunities to help improve the quality of the advice being ignored. This is contrary to Principles 1 and 4 of the Principles of Good Administration.

As a result advice provided to the Department by Capita on face to face assessments may not be based on all the relevant information which could potentially be available at the time of formulating the advice.

Recommendation 3.1 –

The Department should review Capita's policy and practice for requesting further evidence and implement change.⁸⁸ The review should include:

- Clarifying it is the responsibility of the Disability Assessor, when providing advice to the Department, to be satisfied that requests for further evidence have been fully considered and pursued where appropriate;
- Introducing a section on the consultation report form for the Disability Assessor to complete on what requests, if any, have been made for further evidence, the date of request (if response received or update sought) and the rationale for deciding to make or not make further requests during the Assessment stage; and
- Addressing barriers in process, time and bonus incentives that may act to discourage Disability Assessors from pursuing further evidential opportunities to inform their advice.

The Department should set a requirement that Capita assigns the same Disability Assessor to a claim from the point of referral from the Department to the submission of the assessment report. This increases the accountability of the decision making on the role of further evidence in the assessment process and the advice given to the Department.

The Department and Capita should review their compliance with PIPAG in respect of cancelling unnecessary face to face consultations, if where following receipt of further evidence, it can be determined that a paper based review can be completed.

⁸⁸ Linked to Recommendation 2.2 (Chapter 2)

Issue 2: Further Evidence Presented at Consultation

A number of claimants, in the case sample reviewed, brought additional documents, including medical information, to their face to face consultations which they considered provided further evidence in support of their claim.

The PIPAG states that the Disability Assessor should always consider the relevance of additional evidence brought to the consultation and in normal circumstances the Assessor should make copies of the documents.⁸⁹ Where making a copy is not possible, for example because the consultation is taking place in a home setting, the PIPAG explains that the Disability Assessor should make notes from the evidence. Notes or a copy of the evidence should then be sent to the Case Manager with the completed report. The service requirements agreed for Capita's provision of assessments also reflect this procedure.⁹⁰

Capita's policy however does not instruct the Disability Assessor to make copies. It instead directs the Disability Assessor to review the evidence at the consultation and record notes directly into the report (if to be used in their advice).⁹¹ The policy was updated in 2019 to instruct that documents presented must also be noted within the 'Evidence Considered' section of the report. The claimant is provided with a self-addressed envelope for the evidence to be posted directly to the Department.

The Department advised my investigation that photocopying facilities are available in all assessment centres and are used to copy further evidence where there is a significant volume of new information that needs to be available to the Disability Assessor post the face to face consultation. A practice of photocopying documents presented by claimants at consultation was not however observed in the case sample reviewed in my investigation or reflected in the Capita policy documents provided.

I am concerned that Capita's procedure, which does not involve routinely making a copy of the documents, does not align with the PIPAG. The approach adopted by Capita fails to address the practicalities and challenges of evaluating further evidence at the point of consultation. It also diminishes the value of having all documents accessible to the Disability Assessor post the consultation, when the evidence should again be evaluated by the Disability Assessor to justify their advice in the

⁸⁹ *PIP Assessment guide Part 1: the assessment process*. Para 1.4.3. Web document available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-1-the-assessment-process#further-evidence-needed>

⁹⁰ *Personal Independence Payment (PIP) Assessment Service – Service Requirement*, Para 9.12; Information provided to NIPSO July 2019

⁹¹ Policy: *Capita PIP Assessments Process Definition Document Manage Face to Face Assessment*, CIS-PIP-PDD-6. Step 6.3.2 (v.2 & 2.1) and Step 6.4.2 (v.3)

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assessment report. As most assessment reports are completed with 24 hours of the consultation, documents brought to the consultation which are then posted to the Department are typically not available to the Disability Assessor prior to their completing the report.

I observed several complaints made by claimants that further evidence they brought to the consultation was not accepted by the Disability Assessor and not properly considered in the assessment. Although Capita and the Department explained the Disability Assessors had correctly followed Capita procedures, I understand why claimant confidence is affected by the policy adopted.

Findings –

Capita's policy on how Disability Assessors should handle additional documentary evidence brought to consultation appointments does not comply with the practice outlined in the PIPAG or the service requirements initially agreed with the Department. The procedure adopted is not in keeping with Principle 1 of the Principles of Good Administration.

I acknowledge that the intention of this procedure is that the Disability Assessor will consider any additional evidence provided at the consultation immediately and include this within their report. It is unrealistic that the Disability Assessor can appropriately review, consider and record its relevance at this point due to the pressure that a claimant will be present and awaiting the commencement of their face to face consultation.

Recommendation 3.2 –

The Department should ensure that Capita review their policy on how to handle additional documentation presented at assessment to align with the PIPAG and the agreed service requirements.

Issue 3: Evidencing Opinion

'Consultation report forms' are the assessment reports completed by Disability Assessors in claims which are routed by way of face to face consultations and are submitted to the Department as advice.

The assessment reports for the claims I examined included the following sections:

- List of all evidence considered alongside the consultation findings;
- History;
- Observations (Informal and Examinations);
- Health professional's **opinion** on daily living activities;
- Health professional's **opinion** on mobility activities; and
- Recommendation on review period choice⁹² and justification for choice.

Within the sections to record the health professional's opinion, the Disability Assessor must select descriptor choices and provide **justification** for their opinion on each of the ten daily living and two mobility activities.

i. Evaluating Further Evidence

Of significance and prevalence, in the case sample reviewed, was inadequate recording by Disability Assessors as to how further evidence was evaluated by them when justifying their advice on descriptor choices.

Guidance highlights that the assessment advice must be able to stand up to challenge and if opinion differs from information provided by the claimant, the Disability Assessor should draw on evidence to fully justify their advice. Evidence which can be used by the Disability Assessor to underpin their advice to the Department may include:

- Clinical history;
- Formal examination;
- Informal observations;
- The Disability Assessor's knowledge of the disabling effects of medical conditions;
- Treatment that the claimant receives; and
- Any other evidence available.⁹³

⁹² The Disability Assessor recommends when the claim should be reviewed, based on an assessment of when there is likely to be a significant change in the overall functional effect the main disabling condition.

⁹³ *PIP Assessment guide Part 1: the assessment process*. Para 1.8.19. Web document available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-1-the-assessment-process#completing-assessment-reports>

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As the primary purpose of the assessment report is to provide advice to Department Case Managers, who are not health professionals, the analysis of evidence should be clear. The PIPAG states a properly justified report should provide:

*'... 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 health professionals, clarification of any contradictions and an explanation of the HP's choice of evidence relied upon.'*⁹⁴

With specific reference to face to face assessment reports, I found the justifications in respect of the weighing of evidence to be generally poor. In 45 cases, despite further evidence being available and listed in the report as considered, the Disability Assessors made no reference at all to the further evidence within the justification sections for the descriptor choices. In some cases where further evidence was referenced there was no explanation as to why little or no weight appeared to be attributed to it. In many of the cases where the Disability Assessor's opinion differed significantly from the claimant, carer or other health professional's evidence there was no clarification provided on why more reliance was placed on consultation observations [informal and examination] than the other evidence available.

While there may have been sound reasoning behind the weighing of the evidence, including why some supporting further evidence was discounted, I found the recording on how further evidence was evaluated often unclear and at times absent. In addition to justifying to Case Managers the basis of the assessment advice, fully documenting rationale is an important accountability mechanism which if used properly can assist the Disability Assessor to check the quality of their own advice.

The Department when responding to my investigation advised that changes have been made to standardise the structure of summary justification sections of reports. The new structure contains four separate headings for Disability Assessors to complete when justifying their opinion:

- restrictions reported;
- recommendation and evidence used to support;
- reasons why reported restriction(s) are not supported by evidence (where applicable); and
- other descriptor(s) supported by some evidence and reasons why not advised.

94 *ibid*

This revised process, supported by training, became mandatory for Disability Assessors at the end of July 2020 with Capita implementing system changes and further training in November 2020. I welcome these changes as a step towards improving the recording of how evidence is evaluated in the provision of Assessment advice. If properly utilised, improved record keeping can help to identify gaps in the evidence that may be pursued to improve the advice and/or provide assurances that it is sufficiently robust.

ii. Lack of Specialist Input

In a number of the cases examined it was observed that Disability Assessors relied on a lack of regular specialist input in the claimant's care to negate the functional impact reported by the claimant. Whilst it is recognised that evidence of regular specialist input for assessment would be preferred, there appeared to be little or no consideration given to other reasons why it may not exist such as:

- Lengthy waiting lists;
- A lack of provision in specialist services;
- A reluctance to engage in specialist services, particularly in claims involving mental health: and
- Where individuals with disabilities or long term health conditions do not require regular engagement with specialist services due to the support they or their families have put in place.

It is concerning that claimants who have no regular specialist input in respect of their disability or health condition may be unfairly disadvantaged when advice is formulated by Disability Assessors if the wider context is not reflected.

iii. Prescribed Medication

I identified concerns in relation to appropriately checking and considering prescribed medication when evaluating the available evidence. In several cases prescribed dosage, potential effects or reason for prescribing was not acknowledged or accurately reflected in the evaluation of evidence.

This issue also appeared to be highlighted in Capita audits. In one assessment pertaining to a claimant who has fibromyalgia and chronic pain, the audit identified a failure to reflect the side effects of the medication the claimant was taking. The report was updated by the Disability Assessor following the audit and before being sent to the Department. Within this case it is also noted that the level of acute pain management medication was first described as 'moderate' by the Disability Assessor at the Assessment stage but later 'significant' by

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another Disability Assessor when providing further advice. In another assessment for a claimant whose primary condition was recorded as a learning disability, the Disability Assessor recorded that the claimant's medication was effective. However the claimant was not in fact taking any medication. This inaccurate input was identified during an audit and returned to the Disability Assessor to correct before the report was sent to the Department.

iv. Re-works

The Department and Capita have an agreed criteria against which assessment reports are to be considered contractually 'fit for purpose'. The criteria includes that assessment reports must be '*comprehensive, clearly explaining the medical issues raised, fully clarifying any contradictions in medical evidence*'. If this criterion and/or other listed criteria⁹⁵ are not met, the Department has the discretion to return the assessment report to Capita for what is referred to as a 're-work'. In addition to producing a new assessment report, Capita must financially reimburse the Department with a service credit. The volume of 're-works' directed are also used as one of the measures⁹⁶ of meeting quality standards in the process.

The Department advised my investigation that in 2018 it had identified cases that should have been returned to Capita as reworks but were incorrectly being returned as requests for advice. A PIP Bulletin was issued to Case Managers in January 2018 by the Quality Assurance Manager (QAM) team to highlight the issue and provided clear instructions on what should be categorised as a re-work and the process to return the assessment report to Capita as a re-work. Following the issuing of the bulletin the Department observed a significant increase in the cases returned to Capita by Case Managers for re-work.⁹⁷

I welcome the action taken by the Department at that time however I remain concerned about this issue. Within the cases examined (many of which post-date the issuing of the bulletin), there appeared to be insufficient consideration given to applying the 'fit for purpose' criteria where contradictions in evidence, including medical evidence, were not clarified or explained in the assessment reports. The Department for the most part addressed apparent inadequacies in the comprehensiveness

⁹⁵ Re-works can also be requested in relation to presentational issues such as a report being free of jargon or medical abbreviations and being clearly presented, legible and concise.

⁹⁶ The Department advised NIPSO that the primary measure of the quality of assessment reports is the lot wide audit conducted by Capita and that the Department's Health Assessment Advisor (HAA) Team also undertakes audits to provide additional clinical reassurance. Between September 2016 and the end of February 2021, the HAA Team audited 1.6% of cases *cleared* by Capita.

⁹⁷ The statistics on reworks show that from January 2017 to December 2017 - 267 cases were referred to Capita for rework. Following issue of the bulletin - 942 cases were referred for rework between January 2018 and December 2018.

of the reports by requesting further advice from Capita instead of considering a 're-work'.

In one case identified, where a 're-work' was directed of the assessment report, this occurred at the Appeal stage, following a complaint. The rework had not been considered as a course of action by the Case Managers at First Tier or Mandatory Reconsideration who had simply accepted the advice report.

An apparent hesitancy or confusion on behalf of the Department to determine, at their discretion, whether an assessment report is 'fit for purpose' was further illustrated in another case in which the claimant had lodged a complaint and an Appeal. In that case a Department Health Assessment Advisor (HAA) identified clear concerns about the quality of the assessment and that these concerns should have been identified in the Capita audit undertaken on the assessment report. The HAA and a Department Official concurred on a course of action to return the case to Capita for 'rework/advice' to 'close the gap'. The Department however sought advice from Capita on the case to address the apparent inadequacies and there is no record of why it was not considered further for a 're-work'. Following new advice from Capita the Department offered the claimant a new award and the Appeal lapsed.

The Department has highlighted that the outcomes for claimants are the same whether a case is returned to Capita for advice or as a rework. I acknowledge this is correct, however I consider that the proper application of the criteria for re-works and monitoring of this feedback is important for good governance of the service provided by Capita.

Case Study 3 Existing evidence and inconsistencies not adequately addressed in advice

Award History

DLA Award: Higher Care: Low Mobility

First Tier Decision (20 September 2018): No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (28 November 2018): No change

Offer of Lapsed Appeal (28 January 2019): Enhanced Daily Living (11): No Mobility (0)

Claimant I, whose primary condition is listed as Paranoid Psychosis, Depression and Anxiety applied for PIP on 12 May 2018. The claimant gave consent for their DLA evidence to be used and the Department uploaded a GP factual report (GPFR) from 2015 onto the PIPCS. The DLA

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evidence confirmed diagnosis and provided some insight into functional impact of the condition.

The PIP2 application form was received by the Department on 26 June 2018. The application was completed by a member of the claimant's family who is also recorded as their carer and provided information on how the condition affects the claimant's day to day life. A Consultant Psychiatrist and GP were listed as the health professionals who are best placed to provide additional information on how the condition affects the claimant and their contact details were provided.

A Disability Assessor conducted an Initial Review of the claim on the 5 July 2018 and recorded, '*Items 1 to 3 of evidence have been reviewed. There is insufficient evidence to advise the DFC, however due to nature of condition, a face to face within clinic setting is advised. Further medical evidence has been requested from **all available contacts [my emphasis]**.*' Two of the three items referred to in the Initial Review were however duplicates of the 2015 report from the GP. A check of Capita's records show that evidence was requested from the claimant's GP but not the Consultant Psychiatrist in contrast to the statement that further medical evidence was requested from all available contacts.

The claim was subsequently allocated to another Disability Assessor to undertake the face to face consultation and complete an assessment report. The consultation took place on the 1 September 2018 and the claimant was accompanied by a family member (carer). The preparation time was recorded as taking 15 minutes, the consultation 25 minutes and the assessment report write up time as 45 minutes.

In completing the assessment report, the Disability Assessor recommended descriptor choices of A for all activities (resulting in no points if accepted). The consultation findings contrasted significantly with the reported impact by the family member (carer).

To justify their opinion on descriptor choices the Disability Assessor relied primarily upon their informal observations and functional examinations at consultation. The Disability Assessor appeared however to be selective in referencing the evidence provided by the claimant and the family member (carer). For example, information that the claimant watches football and plays the PlayStation was referenced as evidence of '*demonstrating good cognition, concentration and patience*' yet there was no reference in the justification to other relevant information recorded in the claimant's social and occupational history such as: that the claimant did not attain their GCSEs; attended specialist behavioural school for

last of their schooling years; left a course due to mental health and was unable to continue with driving lessons as became overwhelmed.

Of significant concern was also the failure to address the evidence contained within the 2015 GP report, which was not referenced at all within the summary justifications compiled by the Disability Assessor. This is despite the 2015 GP report providing supporting evidence of diagnosis, functional impact and information on the claimant 'lacking insight' into their condition. A reported increase in the dosage of the claimants' prescribed medication from that date was also not referenced. The contradictions in the evidence were not addressed in justifying the opinion.

The advice provided by the Disability Assessor was agreed with by the Case Managers at both the First Tier and Mandatory Reconsideration stages. When requesting the Mandatory Reconsideration the claimant's family member (carer) wrote to the Department and described the Disability Assessor as having been attentive and understanding at the consultation when explaining the symptoms. The family member (carer) however commented, *'I myself feel the score you awarded [name of claimant] on all the areas was as if it was someone else you were scoring.'*

Following receipt of further medical evidence (a GPFR and letter from the Consultant Psychiatrist confirming the reported functional impact was ongoing) at the Appeal stage, the Department subsequently revised its decision of entitlement and offered an award to the claimant which resulted in the Appeal lapsing.

This case suggests the initial assessment report, in failing to address the inconsistencies in the evidence which existed at the time of assessment or explain why some of the evidence appeared to be discounted, did not meet the standards as set out in the PIPAG that a properly justified report must provide 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 health professionals, clarification of any contradictions and an explanation of the HP's choice of evidence relied upon.'

Nor does it appear to meet the 'fit for purpose' criteria agreed between the Department and Capita for reports to be *'comprehensive, clearly explaining the medical issues raised, fully clarifying any contradictions in medical evidence.'* There is no record of either Capita or the Department raising the inadequacies identified in the assessment in this case or deriving any learning from it.

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Case Study 4 Existing evidence and inconsistencies not adequately addressed in advice

Award History

DLA Award: *Higher Care: Higher Mobility*

First Tier Decision (12 October 2018): *No Daily Living (0 points): No Mobility (0 points)*

Mandatory Reconsideration (24 November 2018): *No change*

Offer of Lapsed Appeal (24 December 2018): *Standard Daily Living (9): Enhanced Mobility (12)*

Claimant P, whose primary condition is listed as Parkinson's Disease, applied for PIP on 29 July 2018. The claimant gave consent for their previous DLA evidence to be used and the Department uploaded a GP report from 2005 onto the PIPCS. This report provided evidence on the functional impact of the condition on the claimant at that time and about the progressive nature of the diagnosis.

The PIP2 application form submitted by Claimant P was received by the Department on 20 August 2018. The claimant provided information in the application about how their condition affected them. Claimant P identified their Consultant Neurologist, Parkinson's nurse and GP as the health professionals who are best placed to provide additional information on how the condition affects the claimant and provided their contact details.

A Disability Assessor conducted an Initial Review of the claim on the 26 August 2018 and recorded, *'Items 1 to 2 of evidence have been reviewed. There is insufficient evidence to advise the DfC, however, due to the nature of the condition a home assessment is required.'* No requests for further evidence were made at Initial Review which was recorded as taking 9 minutes to write up.

The claim was subsequently allocated to another Disability Assessor to undertake a face to face consultation and complete an assessment report. The consultation took place on the 18 September 2018, and the assessment report completed. The preparation time was recorded as taking 10 minutes, the consultation 33 minutes and the report write up time as 50 minutes.

The Disability Assessor recommended descriptor choices of A for all activities (resulting in no points if accepted) relying primarily upon consultation observations (informal and examination) to justify their opinion. The consultation findings contrasted significantly with the impact reported by the claimant.

Of significant concern is the failure of the Disability Assessor to address the evidence contained in the 2005 report from the GP which described how the condition, progressive in nature, impacted on the claimant's functionality in a number of relevant activities. Although the GP report was listed as considered alongside the consultation findings it was not referenced once within the justification section.

It is alarming that no explanation was provided in the justification section as to why no apparent weight was given to the GPs evidence nor therefore were the contradictions in the evidence obtained by the Disability Assessor explained. If no weight was attributed because the evidence from the GP was deemed out of date, it is equally concerning that up to date evidence was not sought. In particular as the consultation findings contrasted so significantly with the impact reported by the claimant and the condition history.

Furthermore, the reliance on observations and examination findings to refute the functional impact reported by the claimant was contradictory, given the Disability Assessor also recorded within the report that the claimant *'was not observed to mobilise at the time of the assessment'*.

The advice by the Disability Assessor was accepted without question by the Case Managers at First Tier and Mandatory Reconsideration stages. The advice, was however, queried by a Case Manager at Appeal stage in a request for further advice from Capita:

This customer is [age and gender of claimant] with Parkinson's disease diagnosed [prior to 2000]. Please see GP report of 2005. GP had noted in this report [the claimant] has difficulty with cooking, washing and dressing due to left sided stiffness, pain and tremor which would correlate with [the claimant's] statement to the AP [Assessment Provider]. As Parkinson's disease is a progressive condition and customer has had disabling symptoms as far back as 2005 (as described by GP) is it not reasonable that due to stiffness, pain and tremor [the claimant] would have difficulty with daily living tasks and walking? I note customer reports it takes a lot longer for [them] to carry out tasks and there are some tasks [they] would not attempt if [their] tremor was exacerbated for example cooking and washing. I also note customer reports [their] condition is affected by fatigue – the fact that [their] assessment was carried out at home at 10.45am may have a bearing on how [they] performed at assessment. Can you also consider that [the claimant] was not observed to mobilise therefore we have no information on [their] gait, speed and manner of walking? I would suggest an aid would be appropriate for Act 1, 2, 4, 5, 6 and possibly E for Act 12.

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A change of advice note was subsequently issued by Capita and the Department revised their decision of entitlement offering an award to the claimant which resulted in the Appeal lapsing.

This case raises concerns that the assessment report, in respect of evaluating evidence, does not meet the standards as set out in the PIPAG for a properly justified report or appear to meet the fit for purpose criteria. While the advice was ultimately queried by a Department Case Manager at Appeal stage it is concerning that this was not done at earlier decision stages or that consideration did not appear to be given to engaging the 're-work' process. In addition to getting the entitlement decision right first time, addressing the inadequacies earlier is an essential part of meeting the relevant quality standards within the service level agreement and could therefore help to identify any associated performance issues and learning for improvements.

Case Study 5 Inadequacies in evidencing opinion not queried

Award History

New Application

First Tier Decision (17 February 2019): No Daily Living (0 points): Standard Mobility (0 points)

Mandatory Reconsideration (29 March 2019): No change

Offer of Lapsed Appeal (23 June 2019): Standard Daily Living (8): Standard Mobility (8)

Claimant Q, whose primary condition is listed as Small Fibre Neuropathy, applied for PIP on 18 October 2018.

The PIP2 application form submitted by Claimant Q was received by the Department on 2 December 2018. The claimant provided contact details for their Consultant Neurologist and GP. The claimant also submitted letters from the Consultant Neurologist to the GP and an up to date prescription list.

A Disability Assessor conducted an Initial Review of the claim on the 10 December and recorded, '*Item 1 [sic] have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.*' No requests for further evidence were made at Initial Review which is recorded as taking 8 minutes to write up.

The claim was subsequently allocated to another Disability Assessor to undertake a face to face consultation and complete an assessment report. The consultation took place on the 3 February 2019 and the

assessment report completed. The preparation time was recorded as taking 20 minutes, the consultation as 55 minutes and the report write up time as 1 hour and 30 minutes. The report was the subject of an audit by Capita and was subsequently received by the Department on 11 February.

Within the 'justification for descriptor choice' section of the assessment report in respect of five of the activities, the following statement was included:

*'The restrictions reported **are/are not [my emphasis]** supported by the evidence from SOH [Social and Occupational History] which indicates motivated.'*

The rudimentary failure to specify whether the restrictions were or were not supported by the evidence was not queried in the Capita audit of the report prior to submission to the department nor by the Department Case Managers at First Tier, Mandatory Reconsideration or Appeal stages.

Following receipt of further medical evidence at the Appeal stage the Department subsequently revised their decision on entitlement and offered an award to the claimant which resulted in the Appeal lapsing.

This case raises concerns that the assessment report, in respect of evaluating evidence, does not meet the standards as set out in the PIPAG for a properly justified report or appear to meet the fit for purpose criteria. It is also concerning that obvious inadequacies in explaining how the evidence was evaluated to support descriptor choices were not identified by either the Capita audit or the Department.

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Findings –

I found the justification of advice in face to face assessment reports tended to be poorly recorded with respect to how further evidence was evaluated. Existing further evidence was often not referenced in the justifications and contradictions not highlighted. Explanations were lacking as to why observations [informal and examination] were preferred over a claimant's account or third party evidence of functional impact, such as evidence available on file from carers or other health professionals. These repeated failures are contrary to Principles 1 and 3 of the Principles of Good Administration.

The lack of proper explanation on the evaluation of further evidence can indicate poor quality advice and/or open the advice up to challenge. This can result in lowering stakeholder confidence in the system as well as impacting on decision making on entitlement.

Recommendation 3.3 –

I welcome the new structure for summary justifications introduced for assessment reports and that Disability Assessors have been provided training on the completion of the justifications. The Department should utilise the findings of my investigation and ensure that Capita's training to Disability Assessors demonstrates the importance of clearly explaining how all the evidence in a claim is evaluated to justify advice on descriptor choices. Disability Assessors should be reminded it is essential to highlight contradictions in evidence and fully explain why more reliance is placed on some evidence than others.

The Department should review whether it properly applies the 'fit for purpose' criteria to assessment reports received from Capita. Case Managers should be reminded that the Department has the sole discretion on determining whether advice or assessment reports are fit for purpose and to direct 're-works'.

Where the Department identifies clear omissions and failures in the assessment process and subsequent decision making at First Tier and Mandatory Reconsideration, claimants should be informed of these and the actions the Department is taking to address these in the future.

Issue 4: Auditing of Further Evidence Issues in the Assessment Process

Capita have an extensive programme of auditing assessment reports to test the quality of Disability Assessors' advice. The audits I examined in my investigation focused on grading the assessment reports and provided feedback on the following criteria:

- Opinion;
- Information Gathering;
- Further Evidence; and
- Process.

Despite my investigation repeatedly identifying that consideration was often not given at Assessment stage to obtaining further relevant evidence to inform assessment reports, out of the 39 reports audited none identified gaps in respect of *gathering* further evidence.

Although two of the reports audited were given a grade 'AA' (in respect of the 'further evidence' section) along with a grade rationale *'In additional support needs case, either important evidence not sought or insufficient attempt to gather it'*, the audits in these cases did not in fact identify a gap in the gathering of evidence. The failing in one case related to recording procedures around evidence considered and the other identified that evidence, which was on file, had not been appropriately considered by the Disability Assessor in the justification of the advice.

In the remaining 37 reports audited, a grade 'A' was given in respect of meeting the 'further evidence' section, with a grade rationale that *'sufficient further advice [was] appropriately sought and referenced'*. This is despite that in 25 of these cases there were no requests made for further evidence at the Initial Review stage and further evidence was sought in only one case during the Assessment stage.

The audits did not appear to examine the decisions made about requesting further evidence at Initial Review or whether this decision making was reviewed during the Assessment stage. This again reflects the approach taken that requesting further evidence is a responsibility discharged at Initial Review and moreover, the policy and practice that further evidence is not typically requested by Capita for claims that are sent for face to face assessments.

In respect of evaluating further evidence, and the recording of the justification of recommended descriptors (which is considered within the 'opinion' section of the audit), I observed varied approaches to standards

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expected. I was concerned to note that in a number of audits where contradictions in existing evidence were not properly evaluated in the report, Disability Assessors were advised to simply negate the further evidence with the consultation observations [informal and examinations]. Little or no consideration appeared to be given to what attempts could be made to address or explore the contradictions further. The audits did not challenge why the Disability Assessor had not attempted to obtain additional input or discuss the apparent contradictions with the health professional or other source who provided it.

The Department initially responded to my investigation that the 'further evidence' section of the audit criteria within the PIPAG, for face to face assessments, is based on whether the Disability Assessor has listed all evidence within the report. In a further response the Department confirmed that a report is considered unacceptable where '*Critical evidence [is] not sought or insufficient attempt to gather it so that correct award cannot be reasonably determined*' but stated that this consideration is most relevant in cases completed by paper based review, where in the Department's view critical evidence from other Healthcare Professionals is most likely to be required.

The Department again put forward that '*there is not a requirement*' in the PIPAG to gather or seek further evidence at, or post, the face to face consultation and stated '*where a face to face consultation takes place and the correct award can reasonably be determined, **with or without the presence of further evidence [my emphasis]** and providing no amendments are required, then the report will be of an acceptable standard*'.

I find the Department's response to be a limited interpretation of how the area of 'further evidence' should be graded within the audit and fails to value the important role that further evidence can play in improving the quality of advice and getting the decision right first time, regardless of what way a claim is routed. The PIPAG's description⁹⁸ of how this area is expected to be graded outlines considerations about whether 'important evidence' is sought (at all relevant stages) as well as if it is referenced. Furthermore it does not differentiate between paper based reviews and face to face consultations in this regard.

I fully acknowledge, as previously stated, that gathering evidence through a face to face consultation with a claimant is a valuable method of informing the Disability Assessor's advice to the Department however it should not negate the need to consider sourcing other 'important

⁹⁸ PIP Assessment guide Part 3: the assessment process. Para 3.5.5. Available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-3-health-professional-performance#quality-audit-criteria>

evidence'. Regardless of whether the claim is routed by paper based review or face to face consultation, as demonstrated in this investigation, relevant further evidence as well as consultation findings is often found to be critical to reasonably determining the correct award.

The Department further advised my investigation that in September 2019, Capita introduced a sample audit of Initial Review decisions as a distinct activity outside of the audit of assessment reports. The Department stated this is an additional auditing function which Capita is not contractually required to undertake and that between 22 May 2020 and 31 March 2021, 595 audits were completed representing 1.3% of Initial Reviews undertaken during that period. I welcome this increased scrutiny and further encourage there to be a practice of reviewing decision making about further evidence across all stages (Initial Review and Assessment) with the aim of producing the best quality advice to the Department.

Case Study 6 Weaknesses of audit in addressing further evidence

Award History

DLA Award: *Middle Care: Low Mobility*

First Tier Decision (18 September 2018): *No Daily Living (0 points): Standard Mobility (0 points)*

Mandatory Reconsideration (6 November 2018): *No change*

Lapsed Appeal (23 February 2019): *Enhanced Daily Living (13): Enhanced Mobility (12)*

Claimant N, whose primary condition is listed as Schizophrenia applied for PIP on 17 May 2018.

The PIP2 application form submitted by Claimant N was received by the Department on 5 June 2018. The claimant gave consent for their DLA evidence to be used. The claimant also provided contact details for a number of health professionals whom they considered as best placed to provide advice.

The claimant provided information about why they considered attending a face to face assessment would be distressing. A request for further evidence was sent by Capita to Claimant N's GP and Community Mental Health Team on 15 June. In the letter to the GP, the Disability Assessor recorded that in particular they would like information on whether the patient could attend a face to face assessment. Responses were received from the GP and Community Mental Health Team which were uploaded to the PIPCS on 24 June and 2 July respectively.

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A Disability Assessor conducted an Initial Review of the claim on the 15 July and recorded, *'Items 1-4 of evidence have been reviewed. There is insufficient evidence to carry out a robust PBR [paper based review] and as both received medical evidences confirm that customer could attend an assessment (accompanied) the assessment has been locked⁹⁹ to clinic.'* The Initial Review was recorded as taking 10 minutes to write up.

The claim was subsequently allocated to another Disability Assessor to undertake a face to face consultation and complete an assessment report. The consultation took place on 3 August. The assessment report completed following consultation was subject of audit on 7 August.

In respect of meeting the 'Further Evidence' criteria, a grade 'A' was given with the grade rationale that *'sufficient further advice [was] appropriately sought and referenced'*. Feedback on referencing further evidence was recorded against the 'Opinion' criteria in respect of the selection of descriptor choices:

*Activity 1,4 6 – recent FE [Further Evidence] from CPN [Community Psychiatric Nurse] indicates [claimant] needs prompting, please acknowledge this in the summary justification for each of these activities **and then negate it [my emphasis]** using evidence from the MSE [Mental State Examination] and SOH [Social and Occupational History] which indicates stable mood and motivation.*

*Activity 11 – you have stated "The HOC lacks a condition to support difficulty with calculating money" however, considering the nature of schizophrenia, it is possible that the customer would have difficulty with this. 11A is appropriate but please remove this statement from the summary justification. Also, please acknowledge the recent FE from the CPN in this summary justification **and negate it [my emphasis]** with the SOH and MSE.*

A further audit report was produced on 10 August. A grade 'A' was given in respect of the 'Further Evidence' criteria and feedback recorded against the 'Opinion' criteria:

*Current descriptor choices are reasonable. **It is good practice to include any recent FE that indicates a restriction in summary justification and then use evidence at assessment to negate this [my emphasis]**. Recent CPN report indicates need for prompting however, based on evidence gathered at assessment and GPFR which reports stable mood, current descriptor choices are not unreasonable.*

⁹⁹ 'Locked' refers to the Disability Assessor's decision that the face to face consultation can only take place in a clinic setting and not in the claimant's home.

The amended assessment report was submitted to the Department. The claimant was not offered an award at First Tier or upon the Mandatory Reconsideration.

At the Appeal stage, further evidence was provided by the Community Psychiatric Nurse which was largely reflective of the previous information provided. The Department returned the case to Capita with the evidence from the Community Psychiatric Nurse to seek additional advice. A change of advice note was issued by Capita. The Department revised the offer of award to the claimant and the Appeal lapsed.

This case raises concerns where a contradiction arose in the evidence available for the assessment, the Disability Assessor was advised that it was good practice to negate recent further evidence sources with evidence derived from consultation. Whilst it is indeed reasonable that significant weight should be applied to consultation observations [informal and examination], there should be proper consideration given to why it is preferred over other evidence, particularly where the source of evidence may have a more extensive and specialist knowledge about the impact of the condition on the claimant. Furthermore, this case evidences that no consideration was given to encouraging the Disability Assessor to test the contradictions in the evidence further by returning to the source of the evidence, the Community Psychiatrist Nurse, to explore the issues.

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Findings –

Audits of assessment reports gave inadequate scrutiny to the quality of Disability Assessors' decision making on whether further evidence requests or additional input from evidence sources should be pursued to inform the advice to the Department. The lack of scrutiny on this critical issue demonstrates a failure to meet Principle 1 of the Principles of Good Administration.

As a result the grading on 'further evidence' criteria may provide inaccurate reassurances about the quality of assessment reports and miss opportunities to encourage and embed good practice on the gathering and use of 'further evidence' to provide reliable and robust advice.

Recommendation 3.4 –

Given the availability of further evidence is a significant factor in the overturn of Department decisions at Appeals it is recommended that the Department and Capita enhance the auditing of 'further evidence' criteria.

The Department should review the audit programme implemented by Capita to ensure testing and grading in respect of 'further evidence' is comprehensive for cases routed by face to face consultations, as well as paper based reviews. This should include robust scrutiny at both stages (Initial Review and Assessment advice) of a Disability Assessor's decision making and recording of:

- What further evidence requests or additional input could reasonably be considered to improve the quality of advice and what consideration/action was taken by the Disability Assessor to pursue it; and
- How available further evidence was evaluated and the analysis recorded to justify opinion.

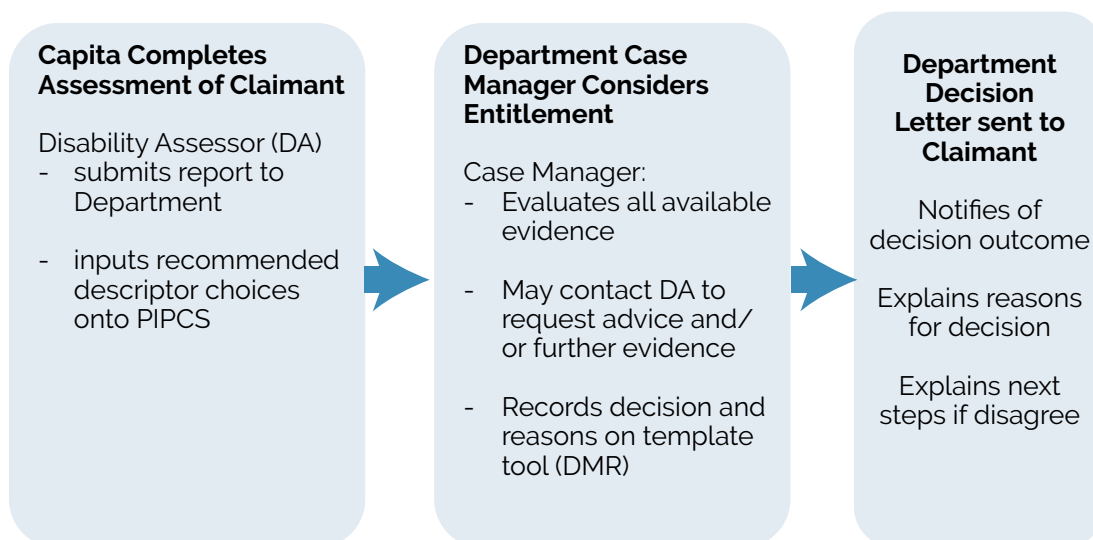
Chapter 4: First Tier Decision

This Chapter looks at the Department's consideration of further evidence in the First Tier decision making process on PIP entitlement and the communication with the claimant of the evaluation of the further evidence in the claim.

The statutory requirement to deliver the PIP benefit system and the decision on a claimant's entitlement rests with the Department. Once a claimant is assessed by the Assessment Provider (Capita), it is the responsibility of the Case Manager, acting on behalf of the Department, to determine the outcome. Case Managers do not have a clinical or social care professional background but are trained 'decision makers' who are instructed to approach the determination objectively by:

- *Considering the evidence,*
- *From that evidence, establishing the facts of the case,*
- *Applying the law to those facts.¹⁰⁰*

Once the decision is made, the Case Manager writes to the claimant with notification of entitlement. The notification (decision letter) informs the claimant of the descriptor choices selected for each of the daily living and mobility activities, the reason for the decision and the steps they can take should they disagree.



100 Department Advice for Decision Making Guide, Chapter A1: Principles of decision making and Evidence A1301, September 2017.

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Issue 1: Considering the Evidence for the Decision

After the claimant has undergone an assessment, the Capita Disability Assessor submits their report to the Department. The Department's computer system, the PIPCS, is populated with the Disability Assessor's recommended descriptor choices on each of the ten daily living and two mobility activities considered in a PIP claim.

Although the Disability Assessor provides recommendations, it is advice only and it remains the responsibility of the Case Manager to independently examine *all* of the evidence provided/gathered in the claim prior to making the decision. Similar to the Disability Assessor when formulating their advice, the Case Manager must also address any inconsistencies or gaps in the evidence when making their decision. To do so the Case Manager is at liberty to go back to the Disability Assessor on particular points.

The evidence available to the Case Manager at this stage of the process includes:

- the PIP2 application form (containing the claimant's own account of the impact of their condition and their needs);
- any additional information or evidence provided by the claimant;
- any evidence requested by Capita;
- the evidence gathered during the face to face consultation (where one has taken place); and
- the advice given by the Disability Assessor in the assessment report.

Case Managers make their decisions on a claimant's entitlement to PIP on the balance of probability.¹⁰¹ Evaluation of the evidence can be a challenging task and requires consideration of many factors, including but not limited to, whether the available evidence is:

- relevant;
- reliable;
- opinion or fact; and
- complete.

An important aspect of the Case Manager's analysis of the evidence is to consider whether the evidence is the best available and/or sufficient to make a fair and objective decision.

¹⁰¹ *Department Advice for Decision Making Guide*, Chapter A1: Principles of decision making and Evidence A1340, September 2017.

i. The Need for More Evidence?

Throughout my investigation I found significant contradictions and tensions between the reported onus placed on claimants to provide evidence and the responsibility of the Department (and Capita) to gather evidence to inform decision making.

Reflection on the Department's guidance of the '*principles of decision making and evidence*' is particularly pertinent to considering the duties placed on the Department and its Case Managers in this matter. The guidance for Case Managers outlines that when making a decision on the balance of probability:

*'Claimants must supply all information and evidence required in connection with the decision. The decision maker should do as much as possible to see that all the necessary evidence is brought to light.'*¹⁰²

I note the responsibilities on Case Managers, to ensure evidence is brought to light, was further highlighted, when the guidance on understanding the burden of proof, was updated in April 2019 to include:

*'Initially the burden [of proof] lies with the claimant to prove that the conditions for a claim or application are satisfied but the decision maker should do as much as possible to ensure that the claimant has every opportunity to provide all relevant evidence **and where the information is available to them rather than the claimant, then they must take the necessary steps to enable it to be traced [my emphasis].'***¹⁰³

Although the Department contend that claimants are given every opportunity to provide relevant evidence in the PIP process, conversely claimants are advised to only provide evidence that they already have. As I have previously highlighted this is likely to deter claimants from seeking additional evidence to support their claim. Furthermore although claimants are asked to provide the details of health professionals from whom relevant evidence may be sought, requests for further evidence are often not made by Capita in assessments.

Case Managers have an important role at the decision stage to review whether there is value in seeking further evidence, in particular where there is a conflict between the needs reported by the claimant and the Disability Assessor's recommendation. Evidence should be pursued where it is necessary and proportionate and given the potential serious impact on a claimant of reaching the incorrect decision in the first instance, it is

¹⁰² Department Advice for Decision Making Guide, Chapter A1: Principles of decision making and Evidence A1342, September 2017.

¹⁰³ Department Advice for Decision Making Guide, Chapter A1: Principles of decision making and Evidence A1405, April 2019.

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right to expect that Case Managers should be satisfied that all reasonable efforts were made to obtain relevant evidence from sources pointed to by the claimant. As aptly presented in a training slide by the Department, it is the role of the Case Manager to:

'Ensure that the customer's individual circumstances have been considered and that they have been treated fairly and given a chance to voice their side of the story. This includes customers in vulnerable situations and customers that need additional support to complete their claim.'

In none of the claims I examined did the Case Manager communicate directly with the claimant prior to making their decision. Therefore the 'voice' of the claimant is primarily captured in the account they provide in the PIP2 application form, the sources of evidence that claimants point to (the health professionals and other active participants involved in their care) and the information they provide at a face to face consultation. I found, however, little assurance in the cases I examined that Case Managers examined what further evidence had been sought/not sought to date and the value of requesting further evidence to improve the quality of the decision. Out of the sample of 100 cases reviewed, no requests for further evidence were made by Case Managers prior to making the First Tier stage decision, other than in a case where it was identified that DLA evidence had not been uploaded onto the PIPCS at an earlier stage in error.

I recognise that in most of the cases I examined, that some further evidence, such as DLA evidence, already existed in addition to the PIP2 application form and the assessment report. Given the significant differences in the Disability Assessors' advice to the Department and the functional impact reported by the claimants in many of these cases, I would however have expected consideration to have been given by Case Managers to the value of seeking additional further evidence to explore the contradictions, particularly in instances where the claimant had pointed to a source of relevant evidence that had not been obtained.

A lack of requests by Case Managers for further evidence to be obtained at the decision stage, and a failure to record deliberations and considerations, may in part be a result of the PIP process guidance stating (under the Section on 'Medical Evidence') that evidence gathering is the responsibility of the Assessment Provider (Capita).¹⁰⁴ A Case Manager may however, in consultation with a Disability Assessor, discuss the need for 'further evidence' to be obtained. I am concerned that this has been translated into the custom and practice of Case Managers limiting their role in examining whether further evidence (medical or non-medical)

¹⁰⁴ Department Advice for Decision Making Guide, Chapter A1: A1524, September 2017.

is needed to ensure their decision is robust. I noted that the service requirements agreed between the Department and Capita outlines that the *'Authority [the Department] may exceptionally mandate the Contractor [Capita] to obtain a specific piece of FME [further medical evidence].'*¹⁰⁵ I find it difficult to reconcile an established practice of Case Managers rarely/ infrequently requesting or identifying potentially helpful further evidence given the clear responsibility the Department has to ensure there is sufficient evidence to get the decision right.

A further contributor to Case Managers seemingly not examining the need to request further evidence may also be that they, like the claimants, were not clearly or accurately informed by Capita as to whether requests were pursued or discounted during the assessment process. As previously highlighted where Disability Assessors made requests for further evidence at Initial Review stage, the notes available to Case Managers (PA1s) indicated all health professionals listed by the claimant had been contacted when this was often incorrect and misleading. I find it contrary to good administration and effective decision making that Case Managers are not provided with this information prior to making their decision.

I am also concerned that there appears to be little governance as to how often requests for further evidence are sought after an assessment is completed. Upon the introduction of PIP it was an agreed service requirement for Capita to provide the Department with monthly statistics on the *'Number of requests to the AP [Capita] from the DfC, to request further medical evidence, after an assessment report has been complete.'* Upon identifying the figure to be reported as zero for each month, from June 2016 until July 2019, my investigation was informed the number of requests from the Department had not in fact been recorded until July 2019. Figures recorded in the months from July through to November 2019 ranged from one to 19 requests.

ii. Further Evidence held by the Department in Other Benefits

In addition to Disability Living Allowance there are other benefits a claimant may have applied for, such as Employment Support Allowance (ESA), which could potentially provide other relevant sources of evidence to the PIP claim. This evidence is available to the Department where the claimant provides their consent that it can be used. I noted that ESA medical reports were sought and considered by Case Managers in a number of claims at the Mandatory Reconsideration stage but this did not occur at First Tier.

¹⁰⁵ *'Personal Independence Payment (PIP) Assessment Service – Service Requirement'*, Para 9.14; Information provided to NIPSO July 2019

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The Department advised my investigation that there is currently no IT interface to allow Case Managers to view either ESA or Universal Credit reports and stated that requesting and uploading evidence from other benefits is not a simple or straightforward process. The Department put forward that to do this at First Tier decision making stage would delay providing the claimant with an outcome on their claim and potentially delay essential financial support that they require in a timely manner. The Department however proceeded to advise that a Change Request is underway to make these reports electronically available to Case Managers at the First Tier decision making stage.

I welcome this development. Whilst I recognise there may be limitations of evidence obtained in a different benefit I consider there should be a consistent approach to providing the opportunity to use this evidence during the First Tier decision making process.

iii. Testing Opinion Against Evidence

Significant weight is given by Case Managers to the advice given by the Disability Assessor in the assessment report. The advice should not be accepted, however, without scrutiny. Ultimately it is for the Case Manager to be satisfied that the Department's decision is supported by the evidence.

To explore the opinion provided, Case Managers may contact Disability Assessors to:

- Seek clarification on the advice;
- Query inconsistencies; and/or
- Discuss the need for more evidence.

The Advice for Decision Making Guide states that a Case Manager is also entitled to reject the Disability Assessor's opinion where there is evidence which raises a strong inference against the opinion.¹⁰⁶ Further guidance on the process however means that in practice Case Managers must first seek the input (or escalate the case to) the Department's Quality Assurance Manager and/or the Health Assessment Advisor. The process also involves the Department returning to Capita to attempt to reconcile the difference.

For the Disability Assessor's opinion to be accepted by the Case Manager and relied upon in the decision, the Case Manager must be satisfied that the Disability Assessor has addressed any conflicting evidence. Part of the process of testing the completeness of the opinion provided by the Disability Assessor, is that the Case Manager must check whether

¹⁰⁶ Department *Advice for Decision Making Guide*, Chapter A1: A1522, September 2017.

the Disability Assessor has considered all of the existing evidence when formulating their advice. Case Managers do this by checking that the evidence available on the PIPCS is listed in the assessment report as having been considered by the Disability Assessor. My investigation has found that Case Managers do not record these checks on the claim file.

The Case Managers must also examine if the Disability Assessor justified their recommended descriptor choices in the assessment report, by referencing the evidence, clarifying any contradictions and explaining the choice of evidence relied upon. Case Managers may seek advice from Department Quality Assurance Managers (QAMs)¹⁰⁷, and where a clinical perspective is required, the Department's Health Assessment Advisors (HAAs) can be asked for input.

In Chapter 3 I outlined my concerns about what I found to be inadequate recording by Disability Assessors on how further evidence was evaluated when justifying their advice on descriptor choices. I was therefore concerned to note only one of the cases I examined recorded that a Case Manager sought advice from a QAM on the opinion provided by the Disability Assessor prior to making the First Tier decision on entitlement. I found no records in the other cases to suggest advice was sought and therefore received from the Department's QAMs and/or the HAAs in the First Tier decisions. I am concerned that this indicates a lack of scrutiny by the Case Managers of the Disability Assessors' justifications, and/or undue deference to their opinion.

iv. Further Evidence Received after the Assessment

When further evidence is received by the Department after the assessment is completed, the Case Manager must consider whether additional advice is required from the Assessment Provider prior to making the decision on entitlement. Case Managers are instructed in their training that if the new evidence is contradictory to information in the assessment report that the Case Manager will need to contact the Disability Assessor for further clarification.

I identified ten cases in which further evidence received by the Department, after the assessment report had been produced but prior to the Case Manager's decision, was not referred to Capita. In nine of these cases there was an absence of records to support that the Case Managers had evaluated the evidence and actively made a decision not to seek further advice, indicating the evidence may have been overlooked at that stage. In four of these cases, when further evidence was referred to

¹⁰⁷ The Department informed my investigation that on average QAMs receive 300 queries per month from Case Managers.

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Capita for advice at a later stage, primarily by Appeal Case Managers, the evidence contributed, at least in part, to a change in the award decisions and the lapsing of Appeals.

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The Department, when responding to my investigation, stated that the evidence had not been overlooked explaining that a system 'task' is created when further evidence is received which is added to the Case Manager's work queue. The Department also provided reasons as to why it was considered reasonable and appropriate for the Case Managers in these cases not to refer the further evidence received after assessment to Capita for further advice. In the absence of contemporaneous records of how the evidence was evaluated, it remains unclear how the Department is confident the evidence was not overlooked. It is also concerning that the Department in their response stated there is '*no legislative or procedural requirement*' for Case Managers to make such contemporaneous records.

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v. Recording the Process of Evaluating the Evidence

I am concerned at the lack of records detailing the key activities undertaken by Case Managers to evaluate the evidence in the claims. The records did not detail what evidence the Case Manager considered, how the Disability Assessor's opinion was checked or how the sufficiency of the evidence was tested. In the absence of these records it is difficult to determine what, if any, scrutiny was applied to the further evidence by Case Managers in their decision making.

Chapter Five

The Department pointed to the decision letters completed by Case Managers as being a sufficient record, however as I outline later in this Chapter, I found that the letters I examined repeatedly failed to account for how further evidence was considered in the decision making.

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Case Study 1 Further evidence not considered prior to decision.

Award History

DLA: Low Care

First Tier Decision (18 September 2018): No Award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No change

Offer of Lapsed Appeal (21 January 2019): Standard Daily Living (11): No Mobility (0)

Claimant AL, whose primary condition is listed as Mental Health/ Depression, applied for PIP on 15 June 2018. The PIP2 application form was submitted by Claimant AL and the claimant provided the contact details of their General Practitioner (GP) as the health professional best placed to advise how the condition affects them.

A Disability Assessor conducted an Initial Review of the claim on the 16 July and recorded, *'Items 1 to 1 of evidence have been reviewed. There is insufficient evidence to advise the DfC, however due to the nature of the condition, a face to face within a clinic setting is advised. Further medical evidence has been requested from all available contacts.'* The Disability Assessor sent a GP Factual Report (GPFR)¹⁰⁸ request to the claimant's GP.

The claimant attended a face to face consultation on the 6 August 2018. The consultation findings differed from the functional impact and needs reported by the claimant. The Disability Assessor submitted an assessment report to the Department on the same date recommending descriptor choices of A for all activities (resulting in no points if accepted).

On 7 August, the day following the submission of the assessment report, a GPFR completed by the claimant's GP and dated 5 August was received by the Department and uploaded onto the PIPCS. The GP provided information about Claimant AL's health conditions including that the claimant had suffered from chronic and severe mental health problems for over 20 years. The GP also provided his opinion that an assessment would result in deterioration and considerable risk to their patient. (The face to face consultation had already taken place and the assessment was completed by the date the GPFR was received).

The Case Manager made a decision on the claimant's entitlement to PIP on 18 September 2018, which accepted the Disability Assessor's recommended descriptor choices and the claimant was awarded no

¹⁰⁸ GPFR is the report template sent by Capita to claimant's GP to provide advice

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points. There is no record of the Case Manager's consideration of this evidence provided by the GP prior to making the First Tier decision on 18 September 2018. The further medical evidence was not sent to Capita for further advice and there is no record of the Case Manager considering seeking further input from the GP. It is unclear if the evidence was simply overlooked by the Case Manager or if the Case Manager considered no further input/advice was required.

The absence of records in this case suggests a lack of due diligence by the Case Manager at First Tier decision making stage to examine all the available relevant evidence and seek to explore inconsistencies in the evidence prior to making their decision on the claimant's entitlement.

Of considerable note is that following the decision the Department received a letter from the GP in which it stated '*[Claimant AL] has been my patient for [more than 25 years] and I cannot understand how you took no cognisance of the mental health disabilities which were outlined in my report. I feel you urgently need to review your assessment of disability.*'

There was no advice sought from Capita on this letter or the GPFR by the Case Manager at the Mandatory Reconsideration. The information in the initial GPFR was however later relied upon by a Disability Advisor in providing a change of advice when a Department Appeals Case Manager queried the evidence after an Appeal was lodged. Following the change of advice the claimant was offered an award of PIP and the Appeal lapsed.

Case Study 2 Consideration of evidence, and scrutiny of opinion, unclear

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (1 December 2018): No Award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (31 January 2019): No change

Offer of Lapsed Appeal (5 April 2019): Standard Daily Living (11): No Mobility (0)

Claimant AM, whose primary condition is recorded as Depression and Anxiety applied for PIP on 14 September 2018. The claimant consented to their DLA evidence being used in support of their claim. The DLA evidence uploaded on to the PIPCS included two GPFRs completed in 2015 and a '*statement from someone who knows you*' completed in 2014. The GPFRs had confirmed diagnosis but provided limited information on functional impact. The statement was completed by a Scheme Manager

for a housing association which offers accommodation and support for individuals recovering from alcohol and drug misuse problems. The Scheme Manager had provided information on the 'intensive support and motivation' that Claimant AM had required from staff to carry out daily living tasks during their residency and described the level of support as higher than most of the other residents.

The PIP2 application form submitted by Claimant AM was received by the Department on 18 October and listed a number of physical conditions alongside the Depression and Anxiety. In Section 1 of the PIP2 application form which is entitled 'About your health professionals', Claimant AM listed their GP as the professional best placed to advise how the condition affects them. In the additional information section of the PIP2 application form it is recorded:

'Vulnerable adult, neglects [their] health, health will deteriorate. Previously homeless, unable to pay rent, ended up on hospital due to poor health and was evicted from home. Received care from [named housing and support scheme] and was rehoused to be close to family, needed care and support. Struggles to ask for help and does not receive the help [the claimant] needs.'

A Disability Assessor conducted an Initial Review of the claim on 25 October 2018 and recommended the claim was progressed by way of a face to face consultation. A request for further evidence was sent to the claimant's GP, however the GPFR form was returned to the Department not completed. Given the various references in the PIP2 application form to the Housing Support Scheme having provided the claimant with support, consideration could have been given to seeking the claimant's consent to contact this potential source of further evidence. No request was made for input from the Housing and Support Scheme staff.

Claimant AM attended a face to face consultation on 18 November. The claimant was accompanied by a family member, however no information was obtained from the family member. The consultation findings differed from the functional impact and needs reported by the claimant. In completing the assessment report, the Disability Assessor recommended descriptor choices of A for all activities (resulting in no points if accepted by the Case Manager). Although the DLA evidence was listed in the assessment report as considered by the Disability Assessor, there was no reference to it within the justifications for the recommended descriptor choices. There was no explanation why the evidence appeared to be discounted or given no weight e.g. If it was discounted because it was a number of years old.

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The assessment report was received by the Department on the 24 November. Clarification was not sought from the Disability Assessor why the DLA evidence was not referenced in the justification of their opinion. There are no records to demonstrate that the Case Manager examined the DLA evidence and gave proper scrutiny to the Disability Assessor's justification of their opinion against the existing evidence.

On 1 December 2018 the Case Manager agreed with the descriptor choices recommended by the Disability Assessor resulting in no award of entitlement. The Department issued a decision letter on 2 December notifying the claimant that they were not entitled to an award of PIP.

Subsequently, further evidence submitted from the Scheme Manager, as well as an ESA Medical Report, was relied upon by Capita in a change of advice when further advice was sought by a Department's Appeals Case Manager. The Department revised their decision of entitlement and offered an award to the claimant which resulted in the Appeal lapsing.

It is important to note that, unlike the DLA process where the claimant was asked upfront to consider submitting 'a statement from someone who knows you', the PIP process asked the claimant only to provide information/evidence they already had. The claimant would therefore not have considered it necessary to gather up to date evidence from the Scheme Manager. The claimant had however provided sufficient information in the PIP2 application form to point toward the Housing and Support Scheme as being a potential source of evidence which could have been considered at the First Tier decision making stage given the conflicting evidence.

Case Study 3 Consideration of evidence, and scrutiny of opinion, unclear.

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (8 January 2019): No DL (2 points): No Mobility (0 points)

Mandatory Reconsideration (6 March 2019): No change

Offer of Lapsed Appeal (4 May 2019): Standard Daily Living (9): Standard Mobility (10)

Claimant AN, whose primary condition is recorded as Schizophrenia applied for PIP on 5 October 2018. The claimant consented to their DLA evidence being used in support of their claim. A GPFR and a hospital report from 2003 was uploaded onto the PIPCS confirming diagnosis and indicated the claimant had limited insight into aspects of their condition.

The PIP2 application form submitted by Claimant AN was received by the Department on 5 November 2018. Within the form it is recorded that two family members provide support with daily living and mobility activities. Claimant AN also gave the details of their GP and Consultant Psychiatrist as the health professionals best placed to advise on how the condition affects the claimant.

A Disability Assessor conducted an Initial Review of the claim on 10 November 2018 and recommended the claim was progressed by way of a face to face consultation. A request for further evidence was sent to the claimant's GP and Consultant Psychiatrist and responded to by both professionals. The responses provided evidence of diagnosis (confirming it was severe and chronic), treatment and medication (including regular review) and some information on the claimant's social isolation, that the claimant finds social interaction very stressful and is vulnerable to changes in situations. In their letter the Consultant Psychiatrist stated they could provide extra information if needed.

Claimant AN attended a face to face consultation on 28 December. The consultation findings differed from the functional impact and needs reported by the claimant. The Disability Assessor completed an assessment report which was the subject of a successful internal Capita audit. In completing the assessment report, the Disability Assessor recommended descriptor choices of A for all activities with the exception of the activity '*engaging with others face to face*' for which the Disability Assessor recommended descriptor choice B, that the claimant needed 'prompting' to be able to engage with other people.

Although the DLA evidence, recent GPFR and Consultant Psychiatrist's report was listed in the assessment report as considered and provided evidence supporting the claimants reported needs, the Disability Assessor did not refer to the evidence when justifying their opinion. No further evidence or input was requested from the Consultant Psychiatrist in response to their offer, nor was input requested from the two family members who were recorded as providing support.

The assessment report was received by the Department on the 4 January 2019. The Case Manager did not seek any clarification from the Disability Assessor on their advice. There are no records to support that the Case Manager considered all the evidence in the claim when making their decision or gave consideration to seeking further evidence from the Consultant Psychiatrist and/or family in attempt to address the inconsistencies in the existing evidence. On 8 January a Case Manager agreed with the descriptor choices recommended by the Disability

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Assessor and the claimant was notified of the decision that they were not entitled to PIP.

It is of interest to note that subsequently a further letter was received from the Consultant Psychiatrist, however the content of the letter was the same as that of the first letter received prior to the assessment. A Department's Appeals Case Manager requested further advice from Capita. The information provided in the Consultant Psychiatrist's letter and the GPFR (both of which were available during the initial assessment and decision) were relied upon in the change of advice. The Department subsequently revised their decision of entitlement and offered an award to the claimant which resulted in the Appeal lapsing.

Case Study 4 Good Practice Example: Testing the Evidence

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (21 November 2016): Standard DL (11 pts) Enhanced MOB (12 pts)

Claimant AA, whose condition is recorded as Cardiac, Raynaud's Syndrome, and Liver Problem applied for PIP on 28 August 2016. Claimant AA was asked to attend a face to face consultation with a Disability Assessor on 15 October 2016. Following the consultation the Disability Assessor completed an assessment report which was the subject of a successful internal Capita audit.

The assessment report was received by the Department on 20 October 2016. A subsequent note on the PIPCS records that the Case Manager spoke to the Department's Quality Assurance Manager about the advice which resulted in clarification being requested from Capita.

The query that was forwarded by the Case Manager to Capita on 14 November 2016 stated: *'Please clarify descriptor 12 and possibly also review 1, 4, 5 & 6. Customer was observed to be extremely SOB [shortness of breath] walking very short distances and also SOB at rest. AP has stated customer could walk 50-200 metres in a timely manner. 50 to 200 metres is considered to be the distance customer is required to be able to walk in order to achieve a higher level of independence such as the ability to get around a small supermarket. Can this descriptor be applied if customer was observed to be extremely SOB walking a very short distance within the home? As [claimant] is also SOB at rest, would more help (rather than just aids) possibly be required with washing/dressing and dress/undressing considering customer is short of breath at rest and has chest pain? Please clarify.'*

In response to the query, further advice was issued by a Disability Assessor to the Department changing the advice on the recommended descriptor choices. The Case Manager accepted the new advice and sent a decision letter to the claimant on 21 November 2016.

This case has been highlighted as Good Practice. The Case Manager scrutinised the evidence available and identified inconsistencies between the Disability's recorded observations and justification of their recommended descriptor choices. The Case Manager returned to Capita to explore the inconsistencies and query the advice fulfilling their responsibility as a Case Manager to be satisfied with the evidential basis for the decision.

Findings –

I consider the repeated failure by the Department to demonstrate that further evidence is adequately considered and/or pursued in the decision making process is contrary to Principles 1, 2 and 4 of the Principles of Good Administration. As a result the quality of decisions can be impacted and claimants may not receive the appropriate support for their needs.

It is recognised that decision making to determine PIP entitlement is a complex task. The decision making process and outcome are however both best served by having a strong evidential base. Testing the sufficiency and strength of the evidence should be at the core of decision making which seeks to get the decision right first time.

Recommendation 4.1 –

The Department should review and renew the focus given in the decision making process to the importance of the role and application of further evidence by:

- Reviewing whether the guidance and processes in place supports the Case Managers to be empowered in practice, in their role as decision makers, to test the evidence (including Disability Assessor opinion) and seek further evidence (medical and non-medical) where necessary;
- Allocating Case Managers sufficient time and resources to thoroughly examine the evidential base (recognising the time and cost benefits of getting decisions right first time);
- Providing regular training and workshops for Case Managers on the

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principles of evidence based decision making;

- Introducing an electronic template for Case Managers to record their evaluation of the evidence for each descriptor choice (including detailing what evidence was reviewed, the weighing of the evidence and any action taken to address gaps or inconsistencies) which forces entries to be made prior to saving the electronic record;
- Ensuring advice or input by Quality Assurance Managers and the Health Assessment Advisors is routinely sought and recorded in the claim file; and
- Ensuring there is robust governance of how often further evidence is sought and obtained during the decision making stage (management information can be used to explore the impact of the further evidence and whether it should have been sought at an earlier stage of the process).

Issue 2: Decision Letters

Case Managers use an electronic tool called the Decision Maker's Reasoning (DRM) Template to create reasons to support their decision, through a combination of selection options and free text (Appendix H). This is then used to form part of the case records and the decision letter sent to the claimant. The DRM includes:

- A standard introduction
- Some set fields
- Dropdowns with some pre-set sentence construction.

There are also free text fields which can be used by the Case Manager to provide more detailed reasoning where the Case Manager disagrees with the functional needs reported by the claimant. Although the decision reasoning should be personalised and written to help the claimant understand what the Case Manager has decided and why, the guidance on using the DRM also states it minimises the amount of manual input required.

In my investigation I found the decision letters sent to the claimants, for the most part, to be difficult to understand and lacked personalisation. The majority of the letters I read provided limited insight into the evidential basis for the decision that was reached. This causes me significant concern given these letters are the basis upon which a claimant will decide to contest or accept the decision made on their entitlement.

i. Overview Justifications

The Department advised my investigation that in March 2017, Case Managers were directed to complete ‘*overview justifications*’ instead of ‘*detailed justifications*’. Whilst I welcome efforts to review the accessibility of decision letters for claimants I am concerned, an overview justification should not result in less clarity for claimants.

Unlike in other benefits, PIP decision letters do not advise claimants that they may request a ‘statement of reasons’.¹⁰⁹ This is because PIP decision letters should, in addition to notifying the claimant of the decision, provide sufficient information on the decision making, so as to fulfil the function of a ‘statement of reasons’. I found that the decision letters reviewed in my investigation, for the most part, did not fulfil this function well.

ii. Evidence Considered

Within the case sample examined in my investigation, the decision on the claimant’s entitlement or otherwise to PIP was provided upfront in the letters. This was followed by a section entitled ‘*How I made my decision*’ in which the Case Manager explained, ‘*I looked at all the information available to me, including: ...*’

It is my view that this section of the letter was often not completed adequately. Typically the letters did not list all of the evidence (or all the categories of evidence) available in the claim file and considered by the Case Manager. This is disappointing given the intent behind this section is to inform the claimant as to what evidence was available to the decision maker and provide reassurance that it was factored into the decision reached. Failure to detail the actual evidence obtained and thereafter considered means it remains unclear to the claimant as to what evidence was taken into account by the Case Manager in formulating their decision. Where evidence provided by the claimant was not listed, it may have suggested to the claimant that it was not considered. In the absence of any other records which detailed what the Case Manager considered in their evaluation of the evidence, I also could not be reassured as to whether all evidence was appropriately examined in these cases.

Furthermore, unless it was listed, the claimant remained unaware as to whether further evidence was sought and obtained by the Department and/or Capita to inform the decision making. As outlined in Chapter 2, claimants were not informed at the Initial Review stage of the assessment when a decision was taken not to request further evidence from health professionals they had listed as sources of evidence. In the cases where

¹⁰⁹ Department *Advice for Decision Making Guide*, Chapter A1: A1117, September 2017.

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evidence was sought, the letter in the initial claim pack from Capita had suggested it was sought from all health professionals listed by the claimant when this was often not the case. By not listing, in the decision letter, all of the evidence available (even in summary form), claimants who disagree with the decision are not placed in an informed position to set out potential gaps in the evidence in their request for a Mandatory Reconsideration.

The lack of care in completing this section extended in one case to the Case Manager listing multiple times that information was provided from the claimant's GP by telephone advice. In fact the phone calls related to the Disability Assessor contacting the GP surgery on multiple occasions to establish the status of a GPFR. The manner in which this section was completed would have inferred greater engagement and input was sought and obtained from the GP in the process than was in fact the case.

In response to my investigation the Department advised that in 2018 it had put further controls in place to ensure Case Managers list all the evidence they have considered on the decision letter provided to claimants. As the majority of the letters I examined, in which this issue was observed, were compiled in 2018 and 2019, the Department was asked for further information on these controls. The Department responded the control put in place in 2018 involved a check being added to the QAMs quality checking guide that meant '*evidence missing/incorrect information on draft decision letter*' would be identified as a '*minor error*'. The Department proceeded to advise, a further instruction was in fact issued to Case Managers in 2020, when errors in this regard were identified as still occurring. I consider it essential that the Department remains alert to this reoccurring error, given its importance in demonstrating what evidence the Case Manager based their decision making.

iii. Information is the Best Available

A pre scripted standard introductory paragraph in the letters under 'My decision', the section in which the Case Manager explains the reasoning behind the decision, stated:

*I made my decision using information about your health condition or disability including details of **any [my emphasis]** treatment, medication, test results and symptoms. This information is the **best available [my emphasis]** and enough to decide how much help you need.*

I found that the use of this standard statement was not appropriate in many cases, given the decision not to request further evidence in many claims, and may contribute to complacency around the efforts to obtain

relevant evidence in the PIP process. In the absence of the claimant being informed exactly as to what evidence was requested and/or available to the Case Manager when they made their decision, the claimant may infer that all potential sources of medical evidence they pointed to were pursued (and potentially obtained) when this was not the case. Furthermore the statement lacks personalisation and consideration of an individual's circumstances, for instance claimants with disabilities not considered as medical conditions.

iv. Explanation

In completing the DMR, and constructing the letter to the claimant, the Case Manager should provide robust supporting reasons for their decisions. The explanations provided to the claimant should be comprehensive and clear to allow claimants, some of whom may be vulnerable, to understand how the decision was reached. This is necessary so that the claimant is sufficiently well informed to either accept the decision or choose to challenge the decision through the Mandatory Reconsideration process. Claimants can request a copy of the assessment report and an explanation call of the decision but for most claimants the decision letter is the primary method by which the Department accounts for its decision making.

The Department advised my investigation that the Information Technology (IT) system used in PIP decisions, limits how much information Case Managers can provide in their overview justifications and that Case Managers cannot refer to each piece of evidence they considered that relates to each activity. The Department also highlighted that the number of characters Case Managers can use in reference to each component, daily living and mobility, is limited to 600 characters (including spaces). I am concerned about the impact these IT limitations on Case Manager input, may have on the quality of both the recording and communicating of the reasons for decisions.

I found that in the majority of the claims I examined, the decision was not clearly explained to the claimant in the decision letter. In many of the decision letters I read I found that, the sentences were unwieldy and at times incomprehensible. For example, a decision letter to a claimant whose primary condition is recorded as Paranoid Psychosis/Depression and Anxiety, contained the following sentence:

*I decided you can prepare and cook a simple meal for one person unaided, eat and drink unaided, either manage medication or therapy or monitor your health unaided, **or you do not need to [my emphasis]**, wash and bathe unaided, dress and undress unaided, express and understand verbal*

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information unaided, read and understand basic and complex information either unaided or using glasses or contact lenses, engage with other people unaided and make complex budgeting decisions unaided.

Case Managers are encouraged to reference the Disability Assessor's observations [both those made informally and those arising as a result of examinations] in their letters to support their decision making in the claim on functional ability¹¹⁰. Often when observations were referenced in the letter, it was not explained that they were observations from the consultation. It was also often not clear what descriptor choices or activities the observations were being applied to in the reasoning behind the decision. In some cases the observations included had no obvious relevance to the difficulties reported by the claimant. For example, in a decision letter the Case Manager stated, *'You walked unaided at normal pace and gait. You displayed good power and pincher grip'*, yet the claimant whose primary condition was recorded as Schizophrenia had not reported any physical restrictions.

I was concerned to note that in some cases Disability Assessor's opinions were inappropriately presented by the Case Manager as statements of fact or diagnosis. For example, in a decision letter to a claimant the Case Manager stated,

'Your mood is stable and you have no memory, cognitive or intellect restrictions.'

Of significant concern and similar to the issues raised regarding the assessment reports, was a lack of clear referencing of the further evidence by Case Managers in the decision letters. The reasoning was primarily based on consultation findings and often the Disability Assessor observations [informal and examination] without addressing conflicting evidence and the reason why certain evidence was preferred. While the reasoning may have been sound, a failure to refer to other existing evidence and the analysis of the evidence may infer to the claimant the Disability Assessor's opinion is given undue weight regardless of the content of other sources of evidence.

v. Attributing Evidence Accurately

The decision letters reviewed in my investigation typically concluded the *'My decision'* section of the letter with a sentence that stated, *'This is consistent with...'* and then listed a number of items such as:

'... your medical history, your description of a typical day, informal observations at your face to face consultation, how you engaged with

¹¹⁰ Department Guidance on Decision Making Reason Template Tool P8

the assessor, the available evidence, the information you provided about how your disability affects you, your mental state and musculoskeletal examination results and your visual test results.'

I found that in most cases there was inaccurate attribution in the concluding statement. This included, but was not limited to, the decision reasoning not being consistent with the claimant's description of their typical day. While in some claims care was taken to accurately reflect what evidence the decision reasoning was consistent with, I found often this statement undermined rather than explained the evidential basis for the decision.

Case Study 5 Explanation of Decision Not Clear

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (11 March 2019): No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (2 April 2019): No change

Lapsed Appeal (2nd Mandatory Reconsideration) (25 June 2019): Standard Daily Living (10): No Mobility (0)

Claimant AD, whose primary condition is recorded as Specific Language Impairment applied for PIP on 15 October 2018. The claimant through their appointee (a family member) consented to their DLA evidence being used in support of their claim. The claimant's appointee sought an extension to submit the PIP2, explaining there was a number of challenges to obtaining the evidence, including that the claimant's needs are *'not really a medical problem'*.

The PIP2 application form submitted by Claimant AD was received by the Department on 15 December. The appointee reported the claimant has special needs due to a Specific Language Impairment, Dyspraxia (verbal, oral, developmental), Dyslexia, Sensory Problems and Anxiety (social and generalised). Within the PIP2 application form the appointee provided the details of the claimant's GP, School Special Educational Needs Co-ordinator and a Learning Teaching Support Specialist. The appointee also submitted several items of further evidence, dated between 2017 and 2018, including the claimant's statement of special education needs, speech and language therapy reports and psychological advice report.

A Disability Assessor conducted an Initial Review of the claim on 22 December and recommended the claim was progressed by way of a face to face consultation. No requests were made for further evidence or input from the professionals listed by the appointee.

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Claimant AD and their appointee attended a face to face consultation on 21 January. The consultation findings contradicted the level of help the claimant and their appointee reported was needed to complete the daily living and mobility activities. The assessment report was received by the Department on 1 March 2019 and on 11 March the Case Manager agreed with the descriptor choices recommended.

A decision letter was issued to the appointee on 13 March notifying the claimant that they were not entitled to PIP. The decision that the claimant has not been award PIP was provided upfront in the letter. Under the section '*How I made my decision*', it is recorded:

'I looked at all the information available to me, including:

- *the 'How your disability affects you" form [PIP2 application form].*

I used this information to look at whether you can carry out 12 activities and the amount of help you need. A score is given for each of these activities.'

The letter proceeds to provide the score for each activity, the total score and decision. To explain the reasoning the letter stated under '*My decision*'

I made my decision using information about your health condition or disability including details of any treatment, medication, test results and symptoms. This information is the best available and enough to decide how much help you need. You said you have difficulties preparing food, taking nutrition, managing therapy or monitoring a health condition, washing and bathing, managing toilet needs or incontinence, dressing and undressing, communicating verbally and making budgeting decisions. I decided you can prepare and cook a simple meal for one person unaided, eat and drink unaided, either manage medication or therapy or monitor your health condition unaided, or you do not need to wash and bathe unaided, manage your toilet needs or incontinence unaided, dress and undress unaided, express and understand verbal information unaided and make complex budgeting decision unaided. You said you have difficulties reading and understanding signs, symbols and words and engaging with other people face to face. I decided you need prompting to read or understand complex information and engage with other people.

You said you have difficulty planning and following journeys. I decided that you can plan and follow the route of a journey unaided. You said you also have difficulty moving around. I decided you can stand and the move more than 200 metres. You have no cognitive or intellectual impairment. You are not prescribed any medication and have no specialist input. You were

able to complete the musculoskeletal examination and showed good use of your lower and upper limbs and good grip. This is consistent with your medical history, your description of a typical day, informal observations at your face to face consultation, the information available at your face to face consultation, how you engaged with the assessor, the available evidence, the information you provided about how your disability affects you, your mental state and musculoskeletal examination results. I have considered what your needs are on the majority of days. I cannot consider awarding you PIP for any help you need for anything not covered by the daily living or mobility activities.

This case evidences that the reasoning provided in the decision letter is difficult to understand and is not clear. The statement *'this information is the best available'* is questionable given no requests for further evidence or input was sought from the professionals whom the claimant listed as being best placed to provide advice on how the condition(s) affect the claimant. The letter does not inform the claimant that input or evidence was not sought from these sources.

The use of automation to select the needs reported by the claimant and descriptor choices determined by the Case Manager resulted in long and unwieldy sentences that are difficult to read and comprehend. The letter lacks personalisation and where reference is made to the consultation findings and observations, they are not placed in that context. Within the reasoning provided it is unclear which of the activities that the consultation findings are being relied upon to explain why the decision is different from the needs reported. The statement *'You have no cognitive or intellectual impairment'* appears to be presented as fact and is inappropriate. It is unclear why prescribed medication, or lack of, is relevant to the reported needs and it's difficult to understand the basis for the statement *'you have no specialist input'*.

The concluding statement *'this is consistent with'* is contradictory. Many of the items which are listed as being consistent with the Case Manager's reasoning, present information which differs, not least the claimant's (and appointee's) account of the impact of the condition as detailed in the PIP2 application form.

Of significant concern is that the letter does not place the claimant in an informed position as to how the further evidence provided to support the claim was evaluated in the reasoning or indeed if it was considered at all. The evidence provided by the appointee was not listed in the letter as being considered under the section *'My decision'* nor is it specifically referred to in the reasoning provided.

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Findings –

I found the Department's decision letters repeatedly failed to account for how further evidence was considered in the decision making and presented significant challenges to claimants' understanding of the evidential basis for the decisions. It is not in dispute that 'decisions' were recorded, but what was presented as 'reasons' by the Department I found for the most part to be absent of the necessary standard required in good public administration specifically Principles 2 & 3 of the Principles of Good Administration.

My investigation has identified that an over reliance on automation in the use of the DMR may have led to the situation I have uncovered in relation to poorly recorded reasoning for decisions and confusing explanations to claimants. Claimants were not sufficiently informed as to what evidence existed in their claim. Where it was decided by Case Managers that the evidence did not support the needs reported by the claimant, the letters provided limited, if any, insight into why consultation findings/evidence were preferred over conflicting further evidence. As a result the claimant, the individual at the centre of process, is not placed in an informed position to understand the decision or to identify the evidential areas of dispute.

Recommendation 4.2 –

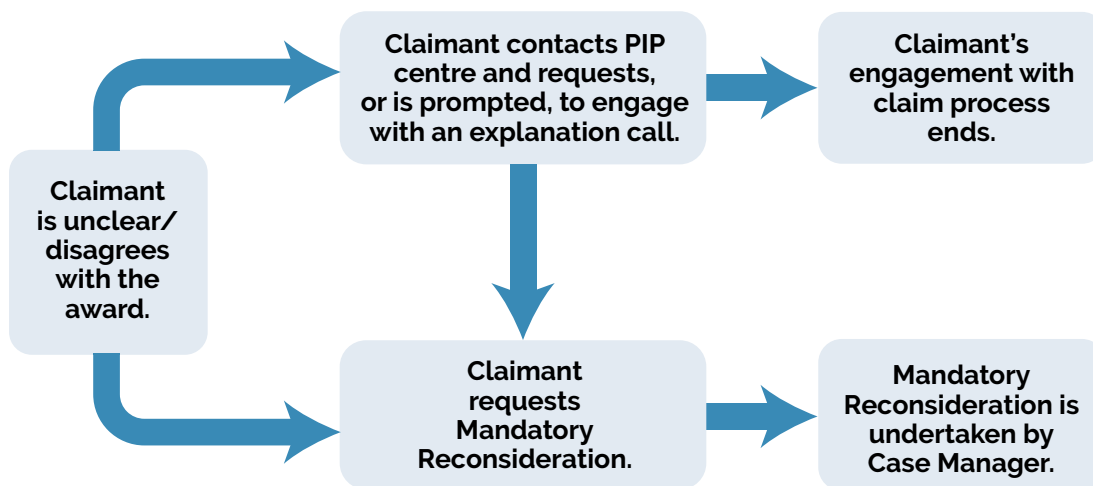
The Department should review how decisions are recorded and communicated with claimants to include:

- Reviewing whether the DMR is fit for purpose given the reliance by Case Managers on pre populated and automated responses and whether character limitations placed on Case Managers' input may contribute to the lack of personalisation and customisation on further evidence in the 'reasoning' for decisions;
- My previous finding included a recommendation to introduce recording the evaluation of the evidence for each descriptor choice. This could be used to help Case Managers provide more robust and individualised reasons in their decision letters;
- Decision letters should detail what further evidence was considered when making the decision, what evidence was requested and what was obtained. Evidence types may need to be grouped but it should be sufficient in detail and description to allow the claimant to understand and identify what evidence was available to the decision maker; and
- Reviewing standardised terminology and statements in respect of the evidence gathered and considered, such as *'best available'* and *'consistent with'* to ensure their use is accurate and legitimate in the individual claim.

Chapter 5: Mandatory Reconsideration

The Mandatory Reconsideration process occurs when a claimant requests a review of an award. The process involves a Mandatory Reconsideration Case Manager reviewing the evidence available at the time of the decision, along with any further evidence subsequently provided. This information is used to determine whether the original award should be revised.

It is a legal requirement¹¹¹ for claimants to undergo a Mandatory Reconsideration with the Department before they can challenge their PIP award at Appeal.



Issue 1: Explanation Call

Prior to a Mandatory Reconsideration, the First Tier decision letter advises that if a claimant requires further explanation of a decision, they can request an explanation call. This is not a compulsory step in the review or appeal process. However, having identified a significant deficiency in the explanations provided to claimants within the decision letters reviewed as part of this investigation, I consider this to be a valuable step in the PIP process.

¹¹¹ The Universal Credit, Personal Independence Payment, Jobseeker's Allowance and Employment and Support Allowance (Decisions and Appeals) Regulations (Northern Ireland) 2016, Regulation 7 (2) 'In a case to which this regulation applies, a person has a right of appeal under Article 13(2) of the 1998 Order(19) in relation to the decision only if the Department has considered on an application whether to revise the decision under Article 10 of that Order.'

Explanation calls were requested in 21 of the cases reviewed during my investigation. These requests were made following both First Tier and Mandatory Reconsideration decisions. I noted the following from my review:

- In 38% (8) of the 21 cases reviewed, the calls were not returned within the Department's internal benchmark of 48 hours.
- In 86% (18) there was no record of the provided explanation.

The Department advised my investigation:

'The Department does not consider it necessary to make written records of explanation calls as they are audio-recorded. There is no added further value in Case Managers making written notes of what they discussed with a claimant during an explanation call... Explanation calls are not used in the Mandatory Reconsideration process and as such, to spend time writing up details of what a Case Manager discussed with a claimant during an explanation call would be nugatory work and serve no meaningful purpose. The Mandatory Reconsideration Case Manager can listen to the explanation call where they feel it is necessary to do so...'

The Department's reasoning that written records would serve no meaningful purpose is concerning. It is also at odds with its own computer system (PIPICS) having a dedicated 'Explanation' section to allow for written detail of explanation calls to be recorded. It is unclear why, if the Department consider written records to be unnecessary, its procedural guidance states that the Case Manager must update this PIPICS explanation section after the phone call¹¹².

The Department's advisement that explanation calls are not used within the Mandatory Reconsideration process, is also both surprising and concerning. Particularly as the Department's procedural guidance stipulates that the Mandatory Reconsideration Case Manager must link the explanation call to the Reconsideration record¹¹³. It is unclear why the Case Manager must search for an explanation and link it to the reconsideration if it is not to be used within the Mandatory Reconsideration process.

In my view, the records of explanation calls are very relevant to the Mandatory Reconsideration process as they may inform the Case Manager of:

- issues which have already been raised by the claimant;
- areas where further evidence may be required;
- explanations already provided; and/or

¹¹² Section 09 Chapter 02 'Claimant wants decision explaining – Explanation call'

¹¹³ Section 09 Chapter 01 'Overarching processes for all Reconsideration skill sets'

- gaps in the explanation which may then need further discussion/ explanation within the Mandatory Reconsideration call/decision letter.

Although I acknowledge that the Department advised that explanation calls are audio recorded, the review of these records is inhibited both by the requirement of Case Managers to request access through their line manager, and more fundamentally by the Department's culture that explanation calls are not used within the Mandatory Reconsideration process. I therefore consider that written summary notes of the explanation provided to the claimant, which would be easily accessible to all Case Managers throughout the process, is both necessary and relevant.

I am also disappointed that, in response to my concerns regarding adherence to the 48hour internal benchmark to return explanation call requests, the Department placed emphasis on the fact that this is not a legislative requirement and that the 'majority' of calls were returned within this period. The Principles of Good Administration consider a public body's adherence, not only to legislation and published policy, but also to internal policies and targets. The figure of 38% represents a significant number of cases where the internal target – which is communicated externally to claimants – was not met. At the very least, this figure should prompt the Department to re-evaluate how it communicates the expected timeframe to claimants.

Case Study 1 Delay in provision of requested explanation call and lack of record of explanation

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (18 November 2018): Enhanced Mobility (12 points): No Daily Living (6 points)

Mandatory Reconsideration (1 December 2018): No change

Offer of Lapsed Appeal (8 Feb 2019): Enhanced Mobility (12): Standard Daily Living (8)

Claimant R, whose primary condition is listed as Epilepsy, applied for PIP on 14 September 2018. Following Capita's paper based review, the Department notified the claimant on 18 November 2018 that they had been awarded Enhanced Mobility and Nil Daily Living.

The claimant subsequently applied for a Mandatory Reconsideration but was advised on 1 December 2018 that no change had been made to their award.

On 3 December 2018 the claimant contacted the Department and requested an explanation call. The notes on the Department's PIPCS record:

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'T/C RECD[Received] FROM CUST REG [regarding] EXPLANATION CALL. ADVISED TASK SET UP AND COULD TAKE 48 HRS.'

On the 7 December 2018 the claimant contacted the Department as they had not received an explanation call. The Department's PIPCS¹¹⁴ records: *'advised case has been referred to case manager for callback'*

On the 14 December 2018 the Case Manager returned the claimant's call. The 'Explanation' section within PIPCS records:

'CUSTOMER WANTS EXPLANATION OF DECISION, [Claimant] TAKES MULTIPLE SEIZURES ON A REGULAR BASIS, CUSTOMER GETS NO WARNING BEFORE SEIZURE AND HAS EVIDENCE OF HARM [They] HA[VE] DONE TO [Themselves] DURING SEIZURES. Claimant will be appealing decision. [Claimant] states [claimant] has evidence from GP [General Practitioner] regarding choking whilst taking nutrition and the amount of seizures [claimant] has been having. Advised [claimant] to send this in and we can look at it.'

This case evidences a significant delay in provision of the explanation call (11 days from request to call) in spite of assurance that a call would be undertaken within 48 hours. Despite the claimant contacting the Department when no call was received, it was still a further seven days before the call took place.

The case also highlights that although a note of the explanation call was undertaken there is no descriptive record as to what 'explanation' was provided by the Case Manager in regard to the Department's decision at First Tier or Mandatory Reconsideration. The note merely records statements made by the claimant, and advice that the Department will look at further evidence if the claimant provides it.

Case Study 2 Delay in explanation call and lack of record of explanation

Award History

First Tier Decision (6 Jan 2019): Standard Mobility (10 points): No Daily Living (6 points)

Mandatory Reconsideration (19 Feb 2019): No change

Appeal Decision (18 July 2019): Standard Mobility (10): Standard Daily Living (8)

Claimant L, whose primary condition is listed as Osteoarthritis, applied for PIP on 20 Oct 2018. On 6 Jan 2019 the claimant was advised within

¹¹⁴ PIPCS is the Department's computer system for PIP.

their First Tier decision letter that they had been awarded standard rate Mobility and no Daily Living.

The claimant subsequently requested a Mandatory Reconsideration, and on 19 February 2019 they were advised that there was no change to their original award.

On 5 Mar 2019 the claimant's carer contacted the Department to query the decision. The Telephony Advisor stated that they would request a callback from the Case Manager as they did not make the decision. The Telephony Advisor also stated that the call should happen within 48 hours.

On 8 Mar 2019 the claimant's carer contacted the Department as the explanation call had not happened. The Telephony Advisor stated they would send an email to the relevant team. The carer also requested that a complaint be lodged in regard to the delay in the explanation call being undertaken. The Communications records state:

'TC from claimants carer ..- extremely annoyed that no one has contacted him within the 48 hrs. He has also requested a complaint be lodged..'

The 'Explanation' section of PIPCS holds no record of an explanation call.

However a record within the notes section of the system dated 8 Mar 2019 states:

'Explanation call completed (appeals phones not recorded which I explained and was happy to proceed). Carer was not happy with the fabrications in the Assessment report and stated PIP guidelines were not followed. [They] ha[ve] lodged a complaint which is being dealt with separately and I have advised that a response to this will be made in 10 working days. [They] stated that [they] w[er]e told by CM [Case Manager] on a phonecall on 5 Mar that [they] could contact the DM [Decision Maker/ Case Manager] and the decision would be changed before appeal. I advised this was not the case and can get call listened to. I asked if [they] could provide any medical evidence to support the claim, which [they] felt [they] shouldn't have to, therefore next stage is appeal. I have advised the benefits of the appeal process and customer agreed [they] would take it to the appeal stage.'

The Department subsequently responded to the carer's complaint identifying that the delay was not what should be expected:

'I can advise I have established that there was a slight delay before the Case Manager's first attempt to contact [Claimant's carer] on 8 March 2019 at 09.06am. I appreciate that this has caused inconvenience and

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I apologise for the delay. This is not the level of service that PIP aims to provide nor is it the level of service which you have a right to expect and I apologise to you and [Claimant's carer] for any inconvenience this may have caused.'

This case evidences a delay (although slight) in provision of the explanation call and highlights a failure to record any 'explanation' of the Mandatory Reconsideration decision to the claimant. As in previous records the note records the claimants/carer's statements but no advice as to how the award was made. Again the focus of the call appears to be that the claimant should send in further evidence, without any guidance on what specific evidence would be required to support their claim.

Case Study 3 Delay in explanation call and lack of record of explanation

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (22 October 2018): No Award: No Daily Living (6 points): No Mobility (0 points)

Mandatory Reconsideration (3 December 2018): No change

Offer of Lapsed Appeal (1 Mar 2019): Standard Daily Living (11): No Mobility (0)

Claimant S, whose primary condition is listed as ADHD [Attention Deficit Hyperactivity Disorder] /Behavioural Problems, applied for PIP on 9 June 2018. On 22 October 2018 the Case Manager reviewed the Assessment report and additional documents and determined that the claimant was not entitled to PIP.

The claimant's appointee subsequently requested a Mandatory Reconsideration and advised they would be sending in further evidence.

On 5 November 2018 a letter was received from the claimant's appointee advising of issues with reading, writing, not understanding signs, learning and behavioural disabilities. This was accompanied with a GP letter which stated *'I have known [claimant] for a number of years and am in possession of [their] complete medical record. I have studied the copies of the reports and have also studied the points raised in [their] appeal. I am happy to confirm to the appeals panel that [claimant's] account is an accurate one and represents [their] true level of debility...If you have any further queries please do not hesitate to contact me.'*

The Case Manager referred the further evidence to Capita who provided a no change to advice report (1 December 2018) which stated *'Evidence provided after assessment are a hand written letter from the customer and a letter from GP. GP does not provide any medical information. There is no advised change to descriptors.'* On 3 December the claimant was informed that there was no change to the original decision.

On 20 December the claimant's appointee contacted the Department and requested an explanation call.

The 'Explanation' section of PIPCS holds no record of an explanation being provided.

However there is a record within the 'Notes' section of PIPCS dated 24 December 2018 which states:

'Contacted Appointee, passed security, Advised appointee that FME received had been considered in reconsideration decision, advised that I would re-issue an amended decision letter to reflect this.'

This case evidences a delay (although slight) in provision of the explanation call and highlights a failure to record any 'explanation' of the Mandatory Reconsideration decision to the claimant. As in previous records the note records the claimants'/carers' statements but no advice as to how the award was made other than to confirm further evidence was considered (which, notably, was not confirmed within the decision letter).

Findings –

The Department's repeated failure to appropriately record the content of explanation calls, and its failure to appropriately manage the expectations of claimants in regard to the return of an explanation call, evidences a failure to fulfil Principles 1 and 3 of the Principles of Good Administration. As a result it is unclear whether the advice provided to claimants allowed claimants to make a fully informed decision in regard to whether or not their award was appropriately considered. The delays in response undoubtedly also added to the frustration of claimants at a period of already heightened distress, having not received the award they felt their circumstances warranted.

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Recommendation 5.1–

The Department should ensure that appropriate records are made by Case Managers to evidence any explanation of decisions provided to the claimant.

- Department guidance, on the appropriate recording of explanations provided to claimant's, should be reviewed and updated to reflect any required changes; and
- Staff should be retrained accordingly.

Issue 2: Awareness

If a claimant wants to challenge the Department's award they can request a Mandatory Reconsideration, with or without first undertaking an explanation call. The Department advised my investigation *'The process is clearly outlined and defined on decision letters to claimants and on the Department's website.'*

My review of Mandatory Reconsideration request calls raised concerns with the Department's assurances on the robustness of the information available to claimants prior to making a Mandatory Reconsideration request call. In particular the calls from claimants following receipt of their decision letter, identified a lack of awareness as to how they could participate with the process and support their request for a review.

'Telephony Advisor: Are you planning on sending in any further medical evidence or information to support the Mandatory Reconsideration?'

Claimant: 'As in what way, like from a Doctor?'

Claimant K

'Telephony Advisor: Will you be able to send in any further medical evidence? It would be better if you can send something in from your GP or someone medical.'

Claimant: I thought this would be in my medical notes.'

Claimant AL

Telephony Advisor: Will you be able to provide additional information, further evidence, to give them something new to look at?

Claimant: They've already got medical evidence, I think. They've already written to my GP. They have it.

Telephony Advisor: So you won't be able to provide any more?

Claimant: Well, if they want more they can write again.

Telephony Advisor: You wouldn't be able to provide it?

Claimant: So I have to provide the medical evidence? Where would that normally come from, GP?

Claimant AK

Claimant carer: It says on the Government website that some Mandatory Reconsiderations take a few weeks, some several months...But it also says that the person making the decision will ring you to discuss it and then send out a reconsideration letter and obviously we haven't received a letter or phone call yet...'

Telephony Advisor: I don't know why it says that on website as that doesn't happen...I'm sure they can call the customer if they feel they need to ...'

Claimant L

I therefore considered the information readily available to claimants on the Mandatory Reconsideration process.

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i. Advice within decision letters

In 2018, the PIP Independent Reviewer, Walter Rader¹¹⁵, commented within his report:

'The Review's understanding of the PIP assessment¹¹⁶ process comes as a result of an extended period of engagement with Departmental and Capita staff. It included having access to operational sites to witness the process in action. It was only with the benefit of this exploration of PIP, including drilling down into the systems and procedures, that the Review was able to understand the PIP assessment process in its entirety. It is not unreasonable to draw the conclusion that a claimant, who does not have the benefit of such access, would struggle to understand the PIP assessment process.'

Rader subsequently made the following recommendation:

'Recommendation 4:

- (A) *The Department should review written material, particularly (i) the initial letters to claimants (ii) the subsequent decision letters to claimants, ensuring clarity of message and the avoidance of jargon*
- (B) *The Department should develop simple straightforward material describing the PIP assessment process.'*

As part of my investigation, and in order to consider what improvements had been made, I queried what amendments to correspondence had taken place since 2018. In response the Department advised of a number of nominal changes including changes to addresses, phone numbers, paragraphs to explain General Data Protection Regulation (GDPR), etc. An exception to this was the Department's advisement that 'enhancements' had been made to the Mandatory Reconsideration paragraph within the First Tier decision letter *'to provide customers with advice about providing more information.'*

The Department further advised:

'The wording in this paragraph was amended to emphasise to the customer if they have more evidence it should be provided as it might change the decision. This was to encourage customers to provide more evidence at the earliest opportunity, mindful that the vast majority of PIP decisions overturned at appeal are due to new evidence being made available to the tribunal panel which wasn't previously made available to the Department.'

¹¹⁵ *Personal Independence Payment An Independent review of the Assessment Process*, Walter Rader June 2018 Pursuant to Article 94 of the Welfare Reform (Northern Ireland) Order 2015. Available for review at <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-independent-review-pip-assessment-process-june-2018.pdf>

¹¹⁶ The accompanying flow chart within the report identifies the review considers the PIP assessment process to be initial application, evidence gathering, Capita Decision on form of assessment, Capita assessment, Decision Outcome, Reconsideration and Appeal.

I note the paragraph prior to revision advised:

'You can ask us to reconsider our decision

Tell us if you think we've overlooked something, or you've more, information that affects the decision. Do this within one month of the date of this letter. When we've looked at what you've told us we will send you a letter to tell you what we've decided and why. We call this letter a 'Mandatory Reconsideration Notice'.

The paragraph following revision advised:

'You can ask us to reconsider our decision

Tell us if you have more information, or if you think we have overlooked something which might change the decision. Do this within one month of the date on this letter. We will look at what you tell us and send you a letter to tell you what we have decided, and why. We call this letter a Mandatory Reconsideration Notice.'

I am concerned by the Department's claim that these '*enhancements*' provide claimants with advice about providing more information. The changes made to this paragraph relate solely to the placement of wording. No additional advice on further evidence is provided.

I am also concerned that there appears to be an expectation that this short paragraph is sufficient to publicise and explain the Mandatory Reconsideration process, particularly as it does not advise:

- the required form of contact (i.e. whether to contact via letter/phone/ either);
- that contact could be made using the details provided on the first page of the letter; or
- the importance of the provision of further evidence, the required time period for this to be provided once a Mandatory Reconsideration is requested, or that an extension may be requested.

ii. Advice available on the Department's website

An online review of the Department's website also highlights a lack of readily available, easily accessible, advice to claimants about the Mandatory Reconsideration process. When the web address www.communities-ni.gov.uk is input, the following screen comes up following a scroll down the initial page:

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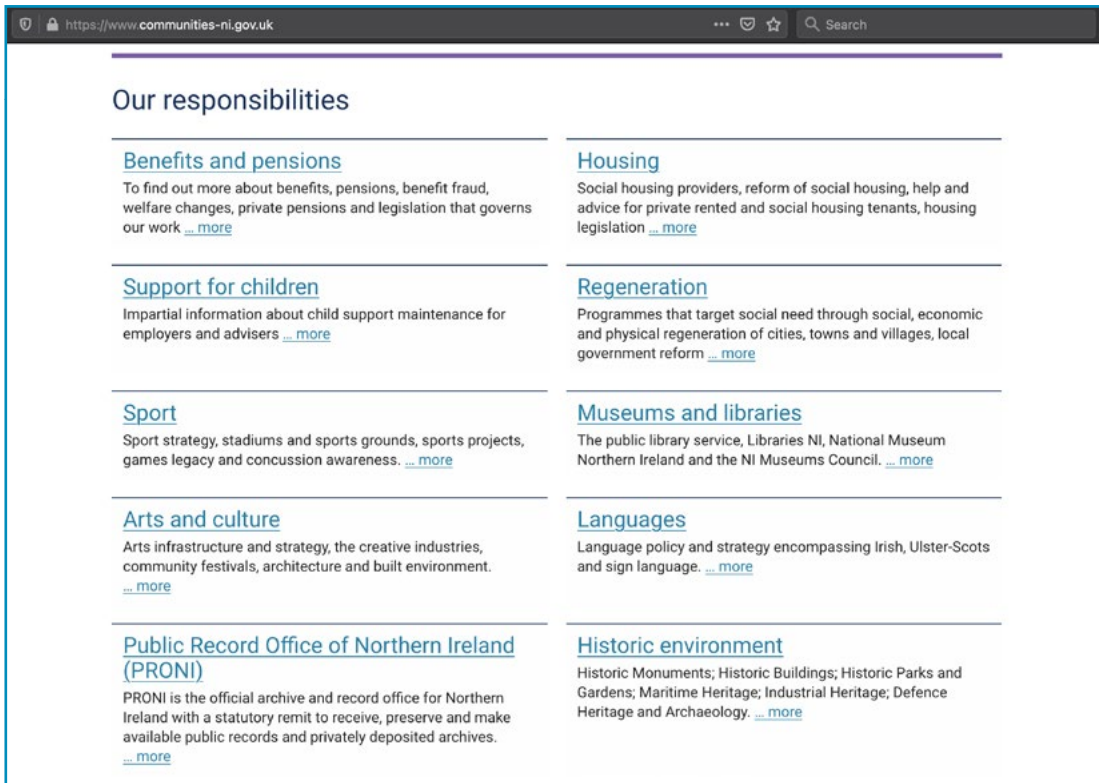
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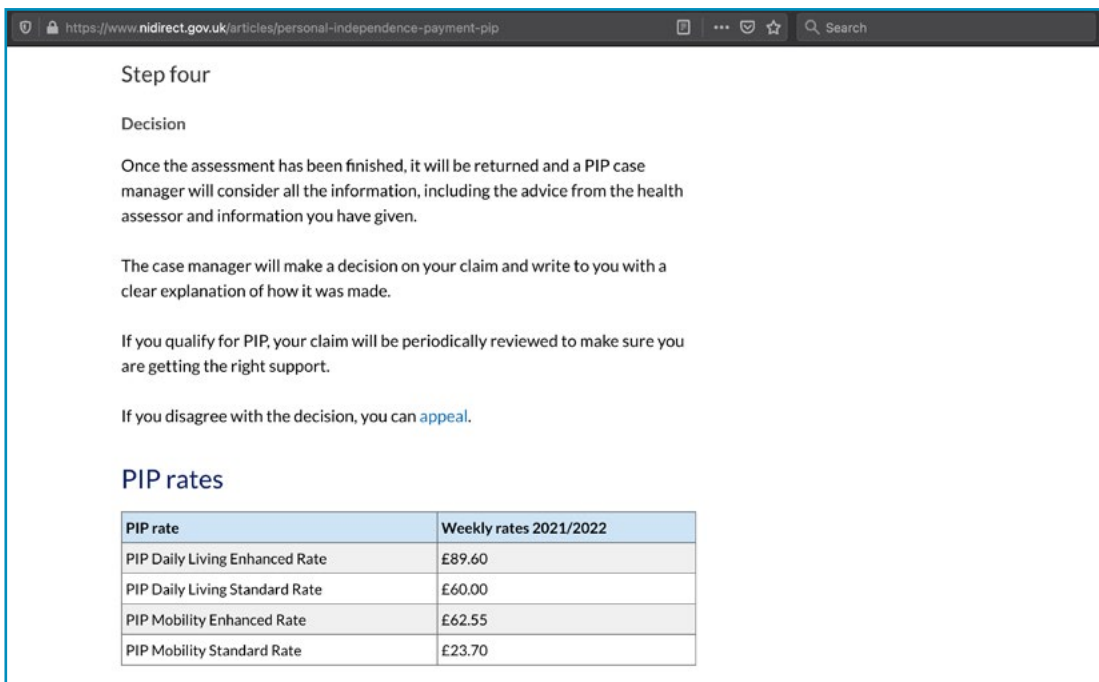
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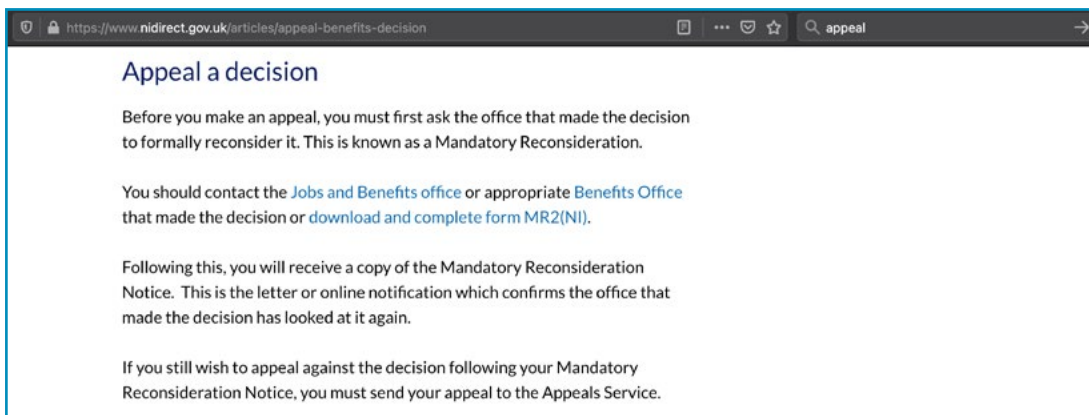


From here several screens and links must be accessed to reach an A-Z list of benefits, which includes PIP. When the PIP link is clicked, the user is redirected to the NIdirect government website, which refers only to the ability of a claimant to Appeal a PIP decision:



No reference is made to the necessity to first undertake a Mandatory Reconsideration, or the difference between Mandatory Reconsideration and Appeal, nor is any advice provided on how the claimant can best support their request with additional evidence.

A hyperlink on the word 'Appeal' is provided to a further generic Benefit Appeals page, however only basic information on Mandatory Reconsideration is provided:



Alternatively, if a user/claimant attempts to use the search function on the Department's website, a search of 'Mandatory Reconsideration' produces 36 items¹¹⁷:

- 1 link to Mandatory Section 75 training;
- 16 links to PIP statistics;
- 15 links to housing related matters;
- 1 link to DFC Privacy notice;
- 1 link to compensation recovery;
- 1 link to Employment and Support Allowance Questions and answers; and
- 1 link to Appeals service and Appealing decisions.

The majority of these links are unrelated to Mandatory Reconsideration and none of them provide specific advice on the PIP Mandatory Reconsideration process. The Appeals service page provides general advice on the Appeals Service and a further link to the NIDirect website.

¹¹⁷ Search undertaken 13 April 2021.

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iii. Online information videos

It is acknowledged that the Department suggested¹¹⁸, within their response to Walter Rader's Statutory Independent Review, that the provision of online information videos would aid claimants understanding of the PIP process. The NI Direct website provides a link to these videos.

A review of the video entitled 'Key things to know about your PIP decision' identifies limited information about the Mandatory Reconsideration process. Again, no information in relation to how a claimant should support their request for a review is included:

'If you disagree with the PIP decision, you can call the PIP centre to talk it through.'

'If you're still not happy with the decision, you can ask for the decision to be looked at again. This is called a 'Mandatory Reconsideration'.'

'If you are still not happy with the decision after the Mandatory Reconsideration, you will have the right to appeal to an Independent Tribunal.'

'Your Mandatory Reconsideration notification will tell you how to appeal to an Independent Tribunal.'

The Department advised my investigation:

'There is no necessity in these short videos, which are intended as a general overview of each stage of the process only, to go into more detail about the Mandatory Reconsideration process. It would also be misleading to advise "how a claimant should support their request", as there is no legislative or procedural requirement for them to provide further evidence in support of their request.'

I am disappointed and concerned by the deficiency in accessible advice on Mandatory Reconsideration and the Department's consideration that no further detail or advice is required. This has undoubtedly contributed to the lack of awareness and claimant confusion identified within my case file and telephony review, which will likely continue if not addressed.

¹¹⁸ *Review of the Personal Independent Payment Assessment Process Department for Communities' Interim Response* November 2018. Available here <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-interim-response-to-pip-independent-review.pdf>

Case Study 4 Lack of awareness of Mandatory Reconsideration process

Award History

DLA: Higher Care: Higher Mobility

*First Tier Decision (11 November 2018): Enhanced Mobility (12 points):
Standard Daily Living (9 points)*

Mandatory Reconsideration (6 December 2018): No change

Appeal (26 August 2019): Enhanced Mobility (12): Standard Daily Living (10)

Claimant T, whose primary condition is listed as chronic neck, back and shoulder pain, applied for PIP on 21 August 2018. Following Capita's face to face assessment, the Department advised the claimant on 11 November 2018 that they had been awarded Standard Daily living and Enhanced Mobility.

On 20 November 2018 the claimant's partner contacted the Department to request a Mandatory Reconsideration. An extract of the telephone call is provided below:

Telephony Advisor: *I can get a reconsideration started from today. [Claimant] will have a month from today to provide anything in writing that [they] wish to be considered or looked at or anything you don't agree with.*

Claimant's partner: *What way do we do that?*

Telephony Advisor: *Can you put it in writing and put it to the address on the letter. Is it everything you need looked at?*

Claimant's partner: *Can I not do it on the phone?*

Telephony Advisor: *You can, or writing, whatever you want.*

[Claimant's partner discusses some issues with managing treatment, etc.]

Telephony Advisor: *If there is anything else you can think of when you come off the phone you can send it in.*

Claimant's partner: *I don't know what I can send in.*

Telephony Advisor: *Like what you are telling me point by point. Sometimes people send in a doctor's letter. It's up to you.*

Claimant's partner: *Does that go to the Tribunal then?*

Telephony Advisor: *No it goes to another Case Manager to look over it and they might change it before it goes to Appeal....You will have up to 17 December to get that sent in...'*

The claimant subsequently wrote to the Department outlining issues with points awarded. On 6 December 2018 the claimant was advised that following the Mandatory Reconsideration the decision had remained unchanged.

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This case evidences the lack of awareness of the Mandatory Reconsideration process, including what is required of claimant's to engage in the process, prior to the claimant having to contact the Department for advice.

Case Study 5 Confusion with Mandatory Reconsideration

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (19 November 2018): Standard Daily Living (8 points): Standard Mobility (10 points)

Mandatory Reconsideration (3 January 2019): Standard Daily Living (8): Enhanced Mobility (12)

Claimant U, whose primary condition is listed as Osteoarthritis/fibromyalgia/Right hip Bursitis/Sciatica, applied for PIP on 19 July 2018. Following a Capita Face to Face assessment on 4 November 2018, a Department Case Manager determined that the claimant was entitled to Standard rate in both Mobility and Daily Living.

The claimant contacted the Department on 26 November as they wished to query the award. Extracts of telephone call are provided below:

'Telephony Advisor: We can raise it as an appeal and we ask you to send in any further medical evidence. If you have any further medical evidence that you might have. Do you want me to do that?

Claimant: Yes.

Telephony Advisor: So what you need to do is a letter in as to why you want a reconsideration and any further medical evidence. If you have any further medical evidence they give you 28 days. Do you want me to tick that box for you?

Claimant: What do I do now love?

Telephony Advisor: You have 28 days from today to get further medical evidence and a wee covering letter on what you think wasn't taken into account. You could go to Citizens Advice centres or do it yourself.

Claimant: And I just post it in?

Telephony Advisor: You just post it in to Limavady.'

The following day the claimant contacted the Department again. Extracts of telephone call are provided below:

'Telephony Advisor: [Queried whether had already rang].

Claimant: I did and [Telephony Advisor] told me could appeal over phone but I didn't understand.

Telephony Advisor: *Did they not set it up over the phone then?*

Claimant: *No, they said it would await more documents.*

Telephony Advisor: *Yes, they set it up yesterday. We call that a Mandatory Reconsideration.*

Claimant: *Yes, I said I'd see my doctor. He has sent everything – I don't have an appointment till next week.*

Telephony Advisor: *You have 28 days.*

[Further discussion about DLA payments and mobility car].

Telephony Advisor: *You will be asked to return that.*

Claimant: *What, with the Appeal lodged?*

Telephony Advisor: *No, it's not an appeal. We call it a Mandatory Reconsideration. It's a review of a decision.'*

On 1 Dec 2018 the claimant contacted the Department again. Extracts of telephone call are provided below:

Claimant: *I had phoned for a full Assessment report and said to look through it and if not happy to phone back.*

Telephony Advisor: *So you received decision letter?*

Claimant: *I have.*

Telephony Advisor: *So you are not happy? So you want a Mandatory Reconsideration?*

Claimant: *What's that?*

Telephony Advisor: *The decision will be looked at again.*

Claimant: *I think that's already been done?*

Telephony Advisor: *It was registered on the 25th, Thursday of last week, and will you be sending further medical evidence?*

Claimant: *That's the problem, I can't get an appointment with the doctor till 23 December but I've asked my housing association to send a letter out.'*

The following day (2 December 2018), prior to a decision on the Mandatory Reconsideration, an Appeal request was received by the Department from the Appeals Service, along with evidence supplied by the housing association.

This case evidences the confusion which can arise between Mandatory Reconsideration and Appeals. Resulting in the claimant contacting the Appeals Service before the Mandatory Reconsideration had been completed.

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Findings –

The Department's failure to provide clear, complete and easily accessible advice on Mandatory Reconsideration, and their apparent failure to appropriately implement timely improvements relating to Rader's 4th recommendation, evidences a failure to fulfil Principles 2, 3 and 6 of the Principles of Good Administration. As a result some claimants remain confused/uninformed at this stage of the PIP process – which may ultimately impact on their claim.

Recommendation 5.2 –

I welcome the Department's introduction of Mandatory Reconsideration calls (Outbound Reconsideration Calls) in July 2019. Although NIPSO has not reviewed any recordings of these calls - as they were not in place at the time the cases reviewed were assessed for PIP - the Department has advised that the purpose of the call is to explain the process and get a better understanding of the reasons why the claimant disagrees with the decision made, and to establish if further evidence is going to be provided in support of the Reconsideration request. However I note these calls only take place after a Mandatory Reconsideration request has been made.

I also welcome the Department's advisement that it is committed to collaborating with DWP in the continuous improvement of PIP letters and leaflets and are continuing to work with DWP colleagues as a key stakeholder to review all communications with claimants in order to make further improvements in line with the recommendation in the Rader's report.

As part of this review the Department should examine the correspondence and communications provided in regard to the Mandatory Reconsideration process. The review should include:

- Inclusion of more detailed advice on the Mandatory Reconsideration process within the First Tier decision letter, including advice on the provision of further evidence and expected timeframes for provision of the same. The Department should consider including the (already available) Mandatory Reconsideration Guidance¹¹⁹ notes with the First Tier decision letter;

119 <https://www.nidirect.gov.uk/sites/default/files/publications/Mandatory%20reconsideration%20notes%20-%2009.01.19.pdf>

- Consideration of the introduction of the Mandatory Reconsideration request form (Appendix J) already in place for Mandatory Reconsideration for DWP. This form could be provided to claimants with the First Tier decision letter or upon request for Mandatory Reconsideration, as standard. I am aware that the Department have a Mandatory Reconsideration request form in place (Appendix I). However it is unclear how often this form is utilised for PIP (it was not viewed or referred to within any of the cases reviewed). The form could also be improved, as unlike the DWP version, it does not contain prompts for further evidence; and
- Consideration of the introduction of an alert/heading on PIPCS to clearly identify at what stage of the process a claimant is at for the benefit of Telephony staff.

Issue 3: Claimant participation

i. Telephony request vs Letter request

As previously highlighted, limited information is provided to claimants in regard to how to request a Mandatory Reconsideration. Within the final pages of the First Tier decision letter (typically page 5/6) claimants are advised that if they wish to request an explanation they can phone or write to the Department¹²⁰. However, no subsequent provision of advice on the method of contact for the request of a Mandatory Reconsideration¹²¹ is provided. Nevertheless my case file review identified that requests for a Mandatory Reconsideration were, typically, made during a telephone call¹²² to the Department.

My telephony review identified that during these calls, clear communications were provided to claimants to gather further evidence from their health professionals to support their Mandatory Reconsideration¹²³.

In the majority of Mandatory Reconsideration request calls reviewed as part of my investigation, the claimant was asked, '*Are you sending in further evidence?*', followed by the Telephony Advisor suggesting the types of evidence they could provide (frequently a GP letter). If claimants advised that they intended to seek further evidence, they were typically provided with a 4 week period before a decision would be made on their claim. If further evidence was not received within a 2/3 week period the claimant was contacted or sent a reminder letter.

¹²⁰ If a case is disallowed the first page also contains a statement '*If you disagree with our decision you can ask us to look at it again. You must do this within one month of the date of this letter.*'

¹²¹ Extract Mandatory Reconsideration paragraph, page 6.

¹²² 45% requested MR via telephone a further 19% requested through both telephone and letter.

¹²³ Chapter 1, page 5.

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I acknowledge and welcome the provision of advice by Telephony Advisors at this stage of the process. I have included a Good Practice Case Study at the end of this issue to illustrate how helpful these interactions can be.

However, my investigation identified that claimants who provided a written request for a Mandatory Reconsideration were not provided with the same information as those who made a telephone request. Upon receipt of a letter requesting a Mandatory Reconsideration, no further information was provided to the claimant. As a result, claimants who sent in their request via letter may have remained unaware of the responsibility placed on them to provide further evidence. They may also not have been afforded the additional 4 week period to gather additional evidence, unless the claimant advised within the letter that they intended to send in further evidence.

Case Study 6 Good Practice example: Telephone Advice

Award History

DLA: Middle care: Higher Mobility

First Tier Decision (13 November 2018): No Daily Living (6 points): Standard Mobility (10 points)

Mandatory Reconsideration (5 Jan 2019): No change

Appeal Lapsed (7 Mar 2019): Enhanced Daily Living (12): Enhanced Mobility (20)

Claimant O, whose condition is listed as Multiple Sclerosis (MS), applied for PIP on 10 June 2018.

On the 7 July 2018 the claimant contacted the Department to request a Mandatory Reconsideration. Below is an extract taken from the script of the call:

Telephony Advisor: *What we do for a reconsideration is a Case Manager will look at your claim - also will give you another opportunity to send in further evidence to help support your claim - that mostly will be from medical professionals. Just to let you know the information that we did use when making your decision: PIP2 form you filled out, included some additional information, medication, Handwritten letter and only other thing your Assessment report. Nothing else gathered, so that gives you the opportunity to get in contact with your GP and see if there is any further evidence they can give you to support the claim. Have a look at the points awarded and decide what areas not happy with - that's the area you are going to target with that evidence [Explains further the process]. Also if you*

want to, put in a letter to explain your issues. Want a copy of the face to face report? You can look at it and argue if there is any parts not accurate [send out today]. You in the meantime can start getting in contact with any Health Professionals if you can [explains time limitations]. As the saying goes, the more the merrier, so if you can.

Claimant: So much going on, I'm the worst person in the world for neglecting myself, neglected so much of my MS symptoms before diagnosis [expands] because I don't necessarily speak to my GP doesn't necessarily mean that I am not experiencing any problems [expands].

Telephony Advisor: The thing, for this benefit especially, is getting the medical backing up for it. Do in future – I know you are thinking I don't want to annoy people but then it has it all on record for you.

Claimant: [Explains about just getting on with it]. Hard to prove something if I haven't been ringing the MS nurse or not ringing the GP – just the way I am.

Telephony Advisor: Try for future. Everybody's award is reviewed. If things happen like that do contact them – it may not be just ringing them on the day – it may be that they do wee reviews with you through the year. Keep a record of the things you want to talk to them about and make sure they have it on your records – in a few years' time when it comes to doing your review that's more information to support that it is still ongoing and they can confirm it is still ongoing with you. Make that priority for the future.

Claimant: [Concurs]

Telephony Advisor: The more people you can talk to the better – GP – MS nurse or if you have a therapist – anyone at all who helps with your condition – do get information from anyone at all.

Claimant: I had rang them and they said you [sic] s can contact them if you want to but they can't necessarily provide anything.

Telephony Advisor: It's not necessarily we contact everybody's doctor or medical professional.

Claimant: I supplied all the phone numbers [unclear].

Telephony Advisor: The reason we ... we have more than 5000 a month in for this benefit so we don't write out to everybody's doctor's - we would only really contact people's doctors if we feel we need information clarified or some more detail on information. The onus is, for this particular benefit, is definitely put on yourself to try and see what you can get. It may be the decision you are still not happy with – you may have to go to the Appeal and then again the appeals people will try and get information from your doctors. We are well aware that there are some doctors that point blank refuse to give anything to anyone and there's nothing we can do about it.

Claimant: My consultant and social workers said feel free to give them my numbers and put them straight through to me.

Telephony Advisor: The details there, but it's not necessarily that they will do it for everybody.

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Claimant: *What do you say if they don't give it to you?*

Telephony Advisor: *We just say put the note forward that you have tried to get this information and even at that, there's doctors we write out to and they still send it back empty – they put a note on saying we don't fill these out and that's it. Then when it comes to the Appeal stage they'll do a bit more digging – you'll probably find you will get something under FOI [Freedom of Information] which takes up to 30/40 days to get the information – that's the other one a lot of people use because it's the only way they get around it with their doctor. It's your details you would think you can get it.*

Claimant: *Just a nightmare, terrible.*

Telephony Advisor: *Good thing is, nearly done with transfers from DLA so it does have to be done unfortunately... This is your chance to get everything you can, on top of what we have, to help change our mind quicker rather than have to go through an appeal...'*

This case has been highlighted as Good Practice due to the level of information and advice provided to the claimant by the Telephony Advisor. As a result the claimant provided further evidence which (aside from delays in referral for advice on the part of the Department) directly resulted in the overturn of the original award, providing the claimant with an enhanced PIP award.

Findings –

The Department's repeated failure to be open and clear in fully informing claimants of what to expect during the Mandatory Reconsideration process, evidences a failure of the Department to fulfil Principles 2, 3 and 4 of the Principles of Good Administration. As a result, a limited number of claimants who requested Mandatory Reconsideration via letter may not have been afforded the same opportunity as those who requested via telephone.

Recommendation 5.3 –

As previously acknowledged the Department introduced Reconsideration Calls in July 2019. The Department advise that within these calls, the issues under review are discussed with the claimant at the outset. Further evidence prompts are also provided.

However, claimants may opt out of receiving a Reconsideration call, and only a limited number of attempts to make contact with the claimant will be made, therefore it is essential the Department introduce a form of

communication which reaches all claimants and provides a consistent message.

The Department should consider the introduction of an acknowledgement letter to claimants who apply for a Mandatory Reconsideration. This letter should include:

- An acknowledgement of the request along with details/confirmation of what the claimant has disputed (where this has been provided);
- Further advice/confirmation on what types of further evidence a claimant could provide. Where appropriate, tailored advice should be provided in regard to specific evidence which would support the claimants reconsideration, for example if the Assessment report advises that no medical evidence was available to support certain descriptors this should be highlighted to the claimant;
- A specified return date for further evidence (if applicable);
- Specific guidelines on when or if an extension to the 4 weeks will be provided and how this will be considered by the Mandatory Reconsideration Case Manager; and
- Provision of the Mandatory Reconsideration request form (if applicable).

ii. Time

My telephony review identified variation in the advice, provided to claimants by Telephony Advisors, in regard to the time period available to gather further evidence in support of their Mandatory Reconsideration.

In some cases Telephony Advisors stated that further evidence should be provided within one calendar month, with some being provided a specific date. Others advised that further evidence should be provided within 3 weeks, as it could take up to 10 days for any additional information to be viewable on the PIPCS system. In a limited number of cases claimants were provided with a reassurance that the four weeks could be extended upon request. However, not all claimants were advised that, as this was a discretionary decision on the part of the Mandatory Reconsideration Case Manager, this was not always guaranteed.

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Case Study 7 Variant communications on time available to request further evidence

Award History

DLA: Higher Mobility: Lower Care

First Tier Decision (25 June 2018): Standard Mobility (10 points): Standard Daily Living (8 points)

Mandatory Reconsideration (26 August 2018): No change

Claimant V, whose primary condition is listed as Scoliosis, was advised on 27 June 2018 that they had been awarded Standard rate Daily Living, and Standard rate Mobility.

On 14 July 2018 the claimant contacted the Department to request a Mandatory Reconsideration. The claimant was advised they had 28 days to provide further evidence. An extract of the telephone call is provided below:

Telephony Advisor: *You have 28 days from today to send in further evidence [you don't have to]*

Claimant: *I will have to see my doctor.*

Telephony Advisor: *Perfect up to 12 August 2018 to get in – fresh eyes to look at all the information and any additional evidence sent in.'*

This case evidences the advice to claimants that they would be provided with 28 days to send in further evidence.

Case Study 8 Variant communications on time available to request further evidence

Award History

PIP Award (13 Oct 2017): Standard Daily Living (8): Standard Mobility (8)

Change of Circumstances (Unplanned Intervention)(May 2019): No award: No Daily Living (6 points): No Mobility (4 points)

Mandatory Reconsideration (18 June 2019): No change

Offer of Lapsed Appeal (31 August 2019): Standard Daily Living (10): Standard Mobility (10)

Claimant H, whose primary condition is listed as Fibromyalgia, had been awarded Standard rate PIP for both Daily Living and Mobility. Following a change in circumstances (hospital admission for three weeks and new diagnosis) the claimant applied for an unplanned intervention¹²⁴. On 2 May 2019 the claimant was advised they were no longer entitled to PIP.

¹²⁴ When a claimant has a change in their circumstances they can apply for an unplanned intervention, which entails a review of their award.

On 9 May 2019 the claimant requested a Mandatory Reconsideration and a copy of their Assessment report. The claimant was advised they had 28 days to provide further evidence *'Any delay let us know, we will contact the Reconsideration team to let them know.'*

On 16 May the claimant contacted the Department as they had not received a copy of the Assessment report. The claimant requested an extension to their Mandatory Reconsideration. The Telephony Advisor stated *'7 June -I'll put a note on, that's all I can do.'*

On 20 May the claimant contacted the Department to advise they had still not received the Assessment report. The Telephony Advisor stated that it had been printed on both the 9 and 16 of May. An extract of the telephone call is provided below:

'Claimant: *Can I ask for additional time, can I?*

Telephony Advisor: *Yes, I'll put it down now.*

Claimant: *How long am I allowed?*

Telephony Advisor: *I am asking for two weeks for you.'*

On 25 June 2019 the claimant contacted the Department as they had received their Mandatory Reconsideration Notice (dated 18 June 2019). The claimant advised *'I posted evidence on Monday – recorded delivery. The letter is dated 18 June – prior to my time being up. I was given two extra weeks by [Telephony Advisor], why has the decision been made before time up?' The claimant also stated 'what's the point in saying you can have time if they don't let you.'*

This case evidences the lack of clear communications in regard to possible extensions of time to gather further evidence. It also highlights the distress felt by the claimant as a result.

It is of note that in this case, the claimant complained to the Department about these miscommunications. In response, the Department again provided the claimant with inaccurate advice: *'I should explain that customers are given 4 weeks from the decision notification being issued to request a mandatory reconsideration and to supply further evidence in support of a claim.'*

This is inaccurate or at best misleading, claimants are provided with 4 weeks from the date of the decision letter to request a Mandatory Reconsideration. Once they request a Mandatory Reconsideration, if they advise they intend to send in further evidence, they are provided with a further 4 weeks to gather the same.

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Case Study 9 Variant communications on time available to request further evidence

Award History

DLA: Higher Care: Lower Mobility

First Tier Decision (7 November 2018): No Award: No Daily Living (2 points): No Mobility (0 points)

Mandatory Reconsideration (11 January 2019): No change

Appeal (23 November 2019): Enhanced Daily Living (12): Enhanced Mobility (14)

Claimant W, whose primary condition is listed as Crohn's Disease, applied for PIP on 23 July 2018 and was subsequently advised they were not entitled to an award.

On 13 November 2018 the claimant contacted the Department to request a Mandatory Reconsideration and a copy of the Assessment report. The Telephony Advisor stated that the claimant had 4 weeks to send in further medical evidence.

On the 16 November the claimant contacted the Department again to query whether they could stop the Mandatory Reconsideration as they needed more time to gather further evidence. An extract of the telephone call is provided below:

'Claimant: I wanted an Appeal. Can you take it off?

Telephony Advisor: Is it Appeal or Mandatory Reconsideration?

Claimant: I just rang this number. I want more time to gather evidence.

Telephony Advisor: If we cancel Mandatory Reconsideration now you can't do another one. You would have no right of Appeal. You have 4 weeks, 10 December to get further medical evidence.

Claimant: I was afraid they would make the decision without anything.

Telephony Advisor: No, if you say you are getting evidence in, they give you 4 weeks. If you need longer we can put a note on the system. They can't hold off forever, but 1 or 2 weeks.

Claimant: OK.'

On 20 November 2018 the claimant contacted the Department as they had not received a copy of the Assessment report. The Telephony Advisor advised 'We can make a note on the system if the report is late that you need more time.'

On 26 November 2018 the claimant contacted the Department to advise that they were awaiting a letter from a Consultant. An extract of the telephone call is provided below:

'Claimant: *I put in for appeal. I have more information. Can you put it down to make sure my claim isn't looked at until I get this back?*

Telephony Advisor: *It's a reconsideration, not an Appeal. I'll put a note on. We would normally say to you to have the information in by 3 weeks because it can take a week for it to get scanned onto the computer system and the CM will look at it again in 4 week's time. I'll put note on, I can't guarantee that [Case Manager] will hold off. 3 December for information in.'*

On 6 December a reminder letter about sending in further evidence (PIP2008) was sent to the claimant (this was not held on the file provided to NIPSO). The letter advised the claimant to reply by 13 December 2018.

On 9 December 2018 the claimant contacted the Department. A note of the call on PIPCS states:

'cust said they will not be able to meet 13/12/2018 deadline for FME for recon - the doctors advised [them] two weeks ago that it will take four weeks to compile copies of [their] med records as requested. I advised CM not obliged to wait after the deadline but I will make a note of [their] request for more time --- also advised that if FME is received after a decision has been reached it will be checked to see if it would have affected the decision'

This case evidences the lack of clear communications in regard to the time provided to gather further evidence and possible extensions of time. Within one call the claimant was advised that they had 4 weeks to gather evidence, in a later call advice was provided that typically 3 weeks is provided, as the information has to be uploaded on to the system. The claimant was advised of three different dates – 3 December, 10 December and 13 December.

In some of the calls, assurance was given that extra time may be provided, at other times the claimant was advised that although a note can be put on the system there was no guarantee the Case Manager would wait. After several contacts being made the claimant was eventually told that the further evidence would still be looked at – even after a Mandatory Reconsideration decision had been made.

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Findings –

The repeated failure to provide clear, consistent communication to claimants on the provision of evidence, is contrary to Principle 1, 2 and 3 of the Principles of Good Administration. As a result claimants may be confused and misled in relation to the time provision for gathering and returning further evidence in support of their Mandatory Reconsideration.

Recommendation 5.4 –

As previously recommended¹²⁵ the Department should consider the introduction of an acknowledgement letter to claimants who apply for a Mandatory Reconsideration which will provide claimants with additional information on the time provision for evidence gathering.

The Department should also retrain Telephony Advisors in line with this communication in order to ensure a consistent message is provided to all claimants.

iii. Assessment report

A significant number of claimants within my case file review, requested a copy of their Assessment report as part of their Mandatory Reconsideration. In many of these cases, an extended period of time elapsed between request and receipt of the report.

The Independent Reviewer previously recommended:

'Recommendation 14: The Department should put in place arrangements for a copy of the assessor's report to be made available to claimants along with the decision letter.'

The Department did not agree with this recommendation, highlighting¹²⁶ the high number of claimants who do not question their original award.

In my view, given the lack of appropriate explanation provided within the First Tier decision letter¹²⁷, a claimant's review of the Assessment report, cannot be undervalued. It is a necessary aid in informing claimants how decisions have been made, and what potential further evidence may be required to support their Mandatory Reconsideration. For claimants

¹²⁵ Recommendation 5.3.

¹²⁶ *Review of the Personal Independent Payment Assessment Process Department for Communities' Interim Response* November 2018.

¹²⁷ Refer to Chapter 4, Issue 2.

to know what further evidence is required, they first need to know what evidence has already been obtained/utilised/discounted in deciding on the award. Any delay in provision of the Assessment report is therefore likely to impact on the time available to gather further evidence.

The Department advised my investigation that an extension can be considered if the delay in receiving a copy of the assessment report specifically delays a claimant in providing further evidence. To do this a claimant would have to be aware that this request would be considered and would have to request an extension on that basis. No written communication provided to the claimant explains the possibility of this extension, or indeed the ability to request an assessment report. Nor at any point in Case Study 10 or 11 were the claimants verbally advised that they could request an extension to their Mandatory Reconsideration due to the delay in receipt of their Assessment report.

Case Study 10 Delay in provision of Assessment report

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (14 September 2018): No Award, No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No Change

Offer at Lapsed Appeal (17 Feb 2019): Standard Daily Living (8): Standard Mobility (8) (offer declined)

Appeal: Awaiting Tribunal

Claimant K, whose primary condition is listed as Degenerative Disc Disease, applied for PIP on 9 June 2018 and was subsequently advised that they were not entitled to PIP.

On 21 September 2018 the claimant requested a Mandatory Reconsideration and a copy of the Assessment report.

On 29 September the claimant contacted the Department as the Assessment report had not been received. The claimant was advised it had not been issued.

On 6 Oct the claimant rang to advise that they had received the report, today, and had issues with it. The claimant also advised that they wanted their comments on the Assessment report recorded within the Mandatory Reconsideration. The claimant wrote to the Department on 7 October 2018 advising *'I feel the assessor's report is not fit for purpose and it appears that this is what the Decision Maker [Case Manager] has relied upon the most in her/his consideration for my non-award.'*

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This case evidences the significance placed on the Assessment report for the purposes of supporting a Mandatory Reconsideration, and the significant delay that can be experienced by claimants when they request a copy of the same. In this case potentially taking 16 days out of the 4 weeks provided to gather further evidence.

Case Study 11 Delay in provision of Assessment report

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (12 October 2018): Standard Daily Living (8 points): No Mobility (4 points)

Mandatory Reconsideration (7 November 2018): No change

Appeal (2 March 2019): Enhanced Daily Living (12): Enhanced Mobility (14)

Claimant X, whose primary condition is listed as Osteoarthritis, applied for PIP on 19 July 2018, and was subsequently awarded Standard Daily Living and no Mobility.

On 18 October 2018 the claimant contacted the Department to request a copy of the Assessment report. Following discussion with the Telephony Advisor the claimant also requested a Mandatory Reconsideration.

On 27 October the claimant contacted the Department to query where the Assessment report was. The Telephony Advisor stated that it would be with the claimant within a few days.

On 29 October 2018 the Department received a letter from the claimant highlighting discrepancies in the Assessment report.

This case evidences the significance placed on the Assessment report for the purposes of supporting a Mandatory Reconsideration, and the significant delay that can be experienced by claimants when they request a copy of the same. In this case potentially taking 9 days out of the 4 weeks provided to gather further evidence.

Findings –

The repeated failure to provide easy access to the Assessment report within an appropriate timeframe evidences a failure to fulfil Principle 2 of the Principles of Good Administration. As a result, a claimant's ability to request relevant further evidence may be impacted/limited, as any delay in receipt of the Assessment report may reduce the time available to identify relevant further evidence and gather the same.

Recommendation 5.5 –

I note the Department advised, in its response to the Independent Review, (November 2018¹²⁸) that improvements were to be undertaken to PIP communications to clearly highlight to everyone they can request a copy of their Assessment report should they wish to do so. To date I have not seen these amendments making their way into the communications.

Given the importance of the Assessment report, and the difficulties for claimants accessing their report, the Department should now reconsider their response to the Independent Reviewer's recommendations and provide all claimant's with a copy of their Assessment report along with their First Tier decision letter.

Issue 4: Decision Making

i. Mandatory Reconsideration Case Managers request for further evidence

As previously highlighted¹²⁹, Case Managers do not directly request further evidence from a claimant's health professional(s) or active participants in the claimant's care. The Advice for Decision Making guide¹³⁰ states:

*'Note: For Personal Independence Payment it will fall to the Health Professional to determine what, if any, further evidence is required.'*¹³¹

A1526 The decision maker should decide the claim in the light of all the evidence including the Health Care Professional or Health Professional's report.'

My case file review confirmed that Mandatory Reconsideration Case Managers adhere to this guidance, as I found no instance where further evidence was directly, or indirectly, requested by Mandatory Reconsideration Case Managers as part of their reconsideration.

However, it remains the responsibility of a Department Case Manager to review and consider a claimant's PIP claim, including further evidence, in order to decide on an award. There is therefore an expectation that Case Managers should be capable of independently identifying gaps in information; contradictions between further evidence and the Assessment

128 *Review of the Personal Independent Payment Assessment Process Department for Communities' Interim Response* November 2018

129 Refer to Chapter 4, Issue 1 i.

130 Department's *Advice for Decision Making Guide, Chapter A1, Principles of decision making and evidence*, September 2017.

131 *Social Security (Northern Ireland) Order 1998, art 12(2) & art 19; 2 R(I) 14/51 A1526*

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report; and any deficiencies' in the Disability Assessors analysis. These expectations of the role are confirmed by the Advice for Decision Making guide providing emphasis on the requirement for Case Managers to appropriately consider, and gather, further evidence. The guidance states:

'A1342 ...The decision maker must do as much as possible to see that all the necessary evidence is brought to light.

A1524 ...For Personal Independence Payment evidence gathering is the responsibility of the Health Professional. On receipt of the Health Professional's assessment the decision maker may, in consultation with the Health Professional, discuss the need for further evidence.

A3067 Decision makers are not bound by what the previous decision maker concluded about the facts, but they need to consider cases thoroughly and conscientiously in order to make the reconsideration process a reality. In particular they must make sure that all existing evidence is looked at carefully and, where necessary, further evidence obtained.

A3070 Where further evidence or information is required from the claimant in order to deal with an application for revision, the claimant is notified what information or evidence is required, and given one month to supply it. The one month period can be extended where the decision maker thinks it is reasonable to do so¹³²'

Despite my case file review identifying cases where claimants had stated that they were unable to request information, and/or letters from health professionals encouraging contact from the Department, this did not result in a Mandatory Reconsideration Case Manager (directly or indirectly) requesting further evidence from a health professional. It cannot be determined whether or not requests to these additional health professionals would have had an impact on the award, however, it remains the case that an opportunity may have been missed to gather relevant further evidence.

Where claimants were informed to provide further evidence this was typically undertaken by a Telephony Advisor and only in general terms, for example *'You could provide a letter from your GP'*. Any specifically 'required' evidence was not identified and was not requested by a Mandatory Reconsideration Case Manager.

There was, however, a notable exception identified within my case file review. Following a Mandatory Reconsideration decision and a claimant's

¹³² *The Universal Credit, Personal Independence Payment, Jobseeker's Allowance & Employment and Support Allowance (Decisions & Appeals) Regulations (Northern Ireland) 2016, reg 20(3)(a) & reg 20(3)(b)*

subsequent Appeal request, an Appeals Case Manager was identified to request further evidence via Capita (Lapsed Appeals will be considered in more detail in Chapter 6). I have included this as a Good Practice Case Study.

Case Study 12 Further Evidence not requested by Mandatory Reconsideration Case Manager

Award History

PIP Award (13 Oct 2017): Standard Daily Living (8): Standard Mobility (8)

Change of Circumstances (Unplanned Intervention)(May 2019): No award: No Daily Living (6 points): No Mobility (4 points)

Mandatory Reconsideration (18 June 2019): No change

Offer of Lapsed Appeal (31 August 2019): Standard Daily Living (10): Standard Mobility (10)

Claimant H, whose primary condition is listed as fibromyalgia, had been awarded Standard rate PIP for both Daily Living and Mobility. Following a deterioration in condition, and further diagnosis of a new condition, the claimant applied for an unplanned intervention.

At the time of the request for an unplanned intervention the evidence available to Capita and the Department included evidence provided for the claimants first PIP claim, which related to their condition prior to the new diagnosis:

- Claimant and family member letters;
- Psychotherapist GPFR (2012);
- OT report (2017);
- Physiotherapy report (2017).

The claimant additionally provided the following when they applied for the unplanned intervention:

- Unplanned intervention PIP2 application form (2019);
- Consultant Neurologist report (2018).

The claimants PIP2 listed details of their Neuro physiotherapist, Consultant Neurologist, GP and Occupational Therapist.

On 2 April 2019 a record on Capita CRM evidences a call made by the Disability Assessor to their support line. This service is utilised when the Disability Assessor needs guidance on a claim. It is recorded that the Disability Assessor queried the apparent confictions between their observations and the restrictions reported by the claimant:

'..new condition reported, indicating high level restriction, however not observed at time of assessment and MSK declined...'

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The advice provided:

'given the information at the time of the assessment, descriptor choices are not improbable, however ensure all information has been considered and utilised to robustly justify choices.'

No referral to available further evidence was made within the justification for the chosen descriptors in the Assessment report.

No further evidence was requested from the health professionals by Capita or the Department despite contradictions/inconsistencies in evidence. It was subsequently determined that the claimant was no longer entitled to PIP.

On 3 May 2019 the claimant rang to enquire about the progress of their claim. The claimant was advised over the phone that a decision had been made and the claim had been disallowed. An extract of the telephone call is provided below:

Claimant: *I had a Face to face in February – haven't heard anything.*

Telephony Advisor: *It's with the Case Manager. The letter was issued yesterday..your PIP will end.*

Claimant: *[Shocked] They've taken it off me?![Very upset] I feel physically sick. I gave my consultant's letter. I've gave everything in. I've a new condition and they've taken it off me. It's disgusting. It's beyond a disgrace.'*

On the 9 May 2019 the claimant rang to request a Mandatory Reconsideration request. An extract of the telephone call is provided below:

'Telephony Advisor: *Will you be sending in further evidence?*

Claimant: *I am going to have to. I can't get a report from new neuro physio, they said because I'm not a professional I can't request it. Can you request it – that report?*

Telephony Advisor: *We at PIP don't request reports. Capita make the decision whether to request or not.*

Claimant: *How do I do it then?*

Telephony Advisor: *I'll put in your notes 'might be able to get GP report'. Keep us informed –Any further evidence has to be sent in 28 days...'*

There is no record to evidence that the Case Manager considered this request and no request for further evidence was made.

This case evidences that although contradictions arose between the assessment observations and the claimant's reported restrictions, and despite a specific request from a claimant for the Department to contact their health professional (as the health professional would only accept a request from the Department/another health professional) this was not

requested either directly or indirectly by the Department. The claimant was instead advised that *'PIP don't request reports'*.

Case Study 13 Further Evidence not requested by Mandatory Reconsideration Case Manager

Award History

DLA: Higher Care: Higher Mobility

First Tier Decision (9 November 2018): Standard Daily Living (8 points):
Standard Mobility (10 points)

Mandatory Reconsideration (29 December 2018): Standard Daily Living (9):
Enhanced Mobility (12)

Claimant Y, whose primary condition is listed as 2 slipped discs in neck and 4 in lower back, applied for PIP on 6 August 2018. On 19 August 2018 the claimant's DLA GPFR (dated 2003) was uploaded. Further evidence was not requested by Capita or the Department from any of the health professionals provided by the claimant.

It was subsequently determined that the claimant was entitled to Standard rate (both Daily Living and Mobility) PIP.

On 16 November 2018 the claimant contacted the Department to request a Mandatory Reconsideration. An extract of the telephone call is provided below:

'Claimant: *I asked my Doctor for medical evidence, they said Doctors don't do that anymore; said you send out a form to them. Is that the way it is done?*

Telephony Advisor: *At start of an application Capita would send out a written request because they do the assessments. At this stage, when you ask for a decision to be looked at again, the onus is on you to provide additional medical evidence.'*

Claimant: *Have you stated that to my GP?*

Telephony Advisor: *the evidence used was the application and anything sent with the form and DLA.*

Claimant: *If you had my DLA, I was on high, how did my benefit go down?*

Telephony Advisor: *You have submitted a Mandatory Reconsideration?*

Claimant: *Yes.*

Telephony Advisor: *You can get further evidence we haven't seen before to confirm condition.*

Claimant: *Are you saying [GP] sent in a report about me?*

Telephony Advisor: *No, I'm not saying that.*

Claimant: *Can I get that letter off my doctor?*

Telephony Advisor: *I'm not your doctor.'*

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On 7 December 2018 the claimant contacted the Department and advised they were struggling to get further evidence. An extract of the telephone call is provided below:

'Claimant: *I can't get my hands on paperwork. Can you advise me? I'm in a predicament. I phoned OT [Occupational Therapist]. They said you have to go through data protection. Is there any other way of getting this?*

Telephony Advisor: *Sometimes health professionals don't like giving it to the claimant, sometimes they are more likely to give it if we ask. We don't normally ask but I can put a note on the case to say these people can be contacted if they need more information.*

Claimant: *Yes. It's as if they can't acknowledge me as I'm not someone with the authority to ask for it.*

Telephony Advisor: *Do you want to give me the names?*

Claimant: *Yes, Burns Ward, RVH; Knockbreda Health. [They] seemed to have a report. Would they be the right people to contact? It was them gave me urgent referral.*

Telephony Advisor: *Names?*

Claimant: *No, I don't know. It was around August time I was in Royal Victoria Hospital. I don't know where to get information for you.*

Telephony Advisor: *Anyone from Knockbreda?*

Claimant: *Occupational Therapist, is [Name provided].*

Telephony Advisor: *I'll make a note of what you've told me today.*

Claimant: *I keep sending things in and I don't know if it's enough.*

Telephony Advisor: *The more we have the better. Put your NINO [National Insurance Number] on top of everything you send in.'*

The Telephony Advisor did not advise whether this was or was not sufficient information to allow for contact to be made with the OT.

There is no record to evidence that the Mandatory Reconsideration Case Manager considered the request. No request for further evidence from the claimant's OT or GP was made.

The claimant subsequently provided further evidence from their GP (same GP as listed within the PIP2) which was referred to Capita resulting in a change of advice report (PA6). The claimant was provided with an overturned award of Standard Daily living and Enhanced Mobility. It is unknown whether – had a request been made by the Case Manager to the OT - this would or would not have had an impact on the award decision.

This case evidences that although a claimant requested the Department contact their health professional to confirm functional restrictions, as they were unable to do so, this was not requested either directly or

indirectly by the Department. The claimant was advised that Capita request medical evidence at assessment stage and that the onus was now on them to provide additional evidence, despite subsequently acknowledging *'Sometimes health professionals don't like giving it to the claimant, sometimes they are more likely to give it if we ask...'*

It is therefore of particular note that the Department advised my investigation: *'It is also unclear as to why the [Ombudsman's] investigation believes that the Department or Capita would have greater success in obtaining further evidence than a claimant who is contacting their own OT.'*

Case Study 14 Further Evidence not requested by Mandatory Reconsideration Case Manager

Award History

DLA: Lower Care: Lower Mobility

First Tier Decision (3 April 2018): No Award: No Daily Living (6 points) No Mobility (0 points)

Mandatory Reconsideration (17 May 2018): No change

Offer of Lapsed Appeal (4 October 2018): Standard Daily Living (8): No Mobility (4)

Claimant Z, whose primary condition is listed as back pain, applied for PIP on 9 January 2018. The claimant's PIP2 application form listed contact details for the claimants GP. Although the claimants DLA form, which had been completed by their family member in 2004, was available there was no available medical evidence from any health professional.

Following Capita's face to face assessment, an internal Capita audit identified that the Disability Assessor's original descriptor choice of 12d (20 to 50 metres) for activity 12 'Moving around' should be reviewed, the DA was asked to instead consider 12a – which was subsequently selected.

The Department considered the final Assessment report, and determined that the claimant was not entitled to PIP.

On 15 April 2018 the claimant requested a Mandatory Reconsideration. Within the letter the claimant disputed that they had no lower limb restriction and advised the Department to check this with their Doctor:

"In January '08 I got a hip replacement which restricts my physical movements and in October 2016 I had a scan done on my lower back (MRI/lumbar spine) you can check this with my doctor!"

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The Mandatory Reconsideration Case Manager referred the letter to Capita on 6 May 2018:

'Please see handwritten letter from customer although this is not medical evidence does this have any impact on the disallowance. Customer speaks of having MRI scans and lower limb restriction?'

On 11 May the Department received a 'no change of advice' report (PA5) from Capita (dated 7 May 2018). The claimant's Doctor was not contacted.

On 17 May 2018 the Department advised the claimant, within a Mandatory Reconsideration Notice, that there was no change to the award.

This case evidences that although a claimant requested the Department contact their Doctor to confirm functional restrictions this was not undertaken by either the Department or requested by the Department through Capita.

It is of note that once the claimant provided further evidence from their health professionals (consultant radiologist) when requesting an Appeal, the award was overturned by the Department and the Appeal was lapsed. The claimant was awarded Standard rate Daily Living and was awarded 4 points for activity 12 (12b).

It is unknown whether – had a request been made by the Case Manager to the GP - this would have or would not have had an impact on the award decision.

Case Study 15 Good Practice Example: Appeals Case Manager request for further evidence

Award History

PIP (21 November 2016): Standard Daily Living (11 points): Enhanced Mobility (12 points)

Award Review (7 January 2019): No Award: No Daily Living (0 points) No Mobility (4 points)

Mandatory Reconsideration (24 February 2019): No Change

Offer of Lapsed Appeal (27 May 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant AA, whose primary condition is listed as Cardiac, Raynaud's Syndrome, and Liver Problem, applied for PIP on 28 August 2016 and was awarded standard rate Daily Living and Enhanced Mobility.

Following an award review in 2018 it was deemed that the claimant was not entitled to PIP.

The claimant requested a Mandatory Reconsideration on 12 Jan 2019. The claimant emphasised on multiple occasions that their GP was more than willing to provide information if contacted. On the 24 Feb 2019 the claimant was sent a Mandatory Reconsideration Notice advising that there was no change to the award.

The following day the claimant contacted the Department querying whether a decision had been made. An extract from the call is detailed below:

Claimant: *Are they refusing me?*

Telephony Advisor: *Yes, a disallowance.*

Claimant: *Can you tell me what they are refusing me on?*

Telephony Advisor: *[Pulls it up] It'll not say anything specific.*

Claimant: *I'm going to end up in hospital – worried sick.*

Telephony Advisor: *I'll read you summary 'unfortunately at this stage we are unable to contact medical professionals on your behalf. The onus lies with the claimant to provide any medical evidence that they wish to have considered...' [Explains in the letter]. You have posted further evidence from Dr X yesterday – they may well take another look at that, I will put note on the system, that [that] was posted yesterday.*

Claimant: *I don't know how ill you have to be because I'm worse than when I was first awarded it. [Expands on his condition].*

Telephony Advisor: *They may well look at this again, based on the further evidence.*

Claimant: *[Shaking - tribunal query?]*

Telephony Advisor: *Yes, if you want to go to appeal. I cannot guarantee but if there is evidence from a medical professional they may well look at that again but can't say for definite – you are best to lodge [an] appeal whenever you get the paperwork out to you. You have a lot of evidence there (refers to rheumatology, cardiology, audiology).*

Claimant: *Why can you not ring the GP – my GP said if they need anything tell them to get in contact with me.*

Telephony Advisor: *But, as it says in the letter I read out, the onus is on the customer to obtain the evidence, the decision makers will not, at this stage they will not contact on your behalf, it would be up to yourself to gather the information.'*

The claimant contacted the Department again on the same day and spoke to a different Telephony Advisor. An extract from the call is detailed below:

'Claimant: *[Discussed his condition] I wrote a letter into yourselves to say the doctor said if they want to ring me, just tell them to ring me and I'll fill in all the information.*

Telephony Advisor: *They won't ring. It would be handy if he could fill in a*

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letter and you send it in because they won't ring him...and when you go for an appeal they will see that letter also.'

On 1 March 2019 the Department's Appeals Case Manager raised an advice query with Capita as follows:

*'Please can you advise if claimant's GP was contacted for evidence? Claimant disputes much of what is stated in the Assessment report. Claimant remains on the same medication as in 2016 and has urgent input from a number of specialists including rheumatology, gastroenterology and critical care. [Claimant] is extremely stressed about [their] health and lives in fear of having another heart attack. Claimant feels [their] condition is getting worse and has urgent referrals to cardiology as a result. [Claimant] states on the day of an assessment [claimant] had taken all [their] medications which would have masked symptoms. [Claimant] relies heavily on friend for help in the majority of daily activities. **Given the inconsistencies between the claimant's reported difficulties and the findings at assessment, could [their] GP be contacted for current evidence regarding restrictions [my emphasis].** There is no recent medical evidence held and taking into account recent referrals to cardiology, it may be useful to obtain this.'*

On the 29 March 2019 Capita sent a GPFR (General Practitioner Factual Report) request to the claimant's GP. This was completed and received by the Department on 14 April 2019. This report was referred to Capita on 17 May 2019. In response Capita provided a change of advice report (PA6) to the Department (signed 18 May 2019 uploaded 26 May 2019) recommending descriptor choices which provided the claimant with an award of Standard Daily Living and Mobility. The Department subsequently offered this award to the claimant, who accepted the same and the Appeal was lapsed.

This case has been highlighted as Good Practice due to the Appeal Case Manager's decision to question the inconsistencies in the assessment and request further advice from the claimant's health professional (despite the advice of the Telephony Advisors that this would not happen). As a direct result of the Appeals Case Managers request for further advice, and the receipt and review of the GP report, the claimant's award was overturned. The claimant was subsequently entitled to Standard rate Daily Living and Standard Mobility.

It is also of note that the Appeals Case Manager's request for further evidence highlighted the lack of recent evidence held as part of the necessity to gather further evidence. This is a practical observation which does not appear to be routinely applied by Case Managers. A number of the cases reviewed (where evidence was not requested) did not have recent evidence available on file.

Findings –

The Department's repeated failure to utilise Case Managers' ability to request further evidence at Mandatory Reconsideration stage, either directly or indirectly, is outwith Principle 1 of the Principles of Good Administration. Claimants may be adversely impacted as a result.

Recommendation 5.6 –

The Department should provide a refresher training session on the ability of the Department to request further evidence for all staff (both Case Managers and Telephony Advisors). The training session should include:

- Emphasis on the importance of First Tier Case Manager's giving full consideration of the need for further evidence alongside the Assessment providers report in order to get the decision right first time;
- Identification that it is possible for all Case Managers to request further evidence through Capita;
- Encouragement to use this function where there is conflict/gaps in evidence;
- Encouragement to use this function where there is limited medical evidence available or no recent medical evidence; and
- The use of Good Practice examples, such as the case study provided, to illustrate the effective use of this function.

The Department should also introduce a feedback template where award decisions are overturned at Mandatory Reconsideration and Lapsed Appeal. This template should include:

- The reason for overturn of the award;
- Whether a different approach was taken by previous Case Managers, and why the variation in approach occurred; and
- Whether any action taken could have been undertaken at an earlier stage of the process.

The Department should use the template to provide individualised feedback to the Case Managers involved in order to promote learning and discussion.

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ii. Referral of further evidence to Capita

When further evidence is received by the Department, Case Managers have discretion in regard to whether or not referral to Capita for further advice is undertaken. The Advice for Decision Making Guide¹³³ states:

'A1523 Where a decision hinges on a medical issue the decision maker must seek advice from Medical Services or the Health Professional if they have any doubt about

- 1. whether the evidence is sufficient to make a decision, or*
- 2. how it should be interpreted.'*

The training provided to Case Managers in relation to the referral of further evidence also states:

'If further medical evidence is received after the assessment has been completed but before the decision is made, the CM [Case Manager] needs to consider if the new evidence makes a difference and if it needs referring to the AP for advice. The CM should consider if the new evidence fits with the descriptor the HP [Health Professional] has chosen. Where evidence is received that is contradictory to information in the AP [Assessment Provider] report; the CM will need to contact the HP for further clarification.'

Although this advice illustrates what the Case Managers should consider in regard to the receipt of medical evidence, it would appear that no corresponding direction for other forms of evidence, which may not be medical, have been provided. This is of particular note as the Second Independent Reviewer, Marie Cavanagh, commented on claimant concerns with the Department's, and Capita's, consideration of claimant/carer evidence:

*'Additionally, evidence has been received indicating concerns about the lack of consideration given to relevant non-medical evidence. Where evidence has been provided by claimants and their families there is an overwhelming view that the evidence is disregarded or ignored.'*¹³⁴

These concerns may be validated by my investigation's identification of instances where Mandatory Reconsideration Case Managers did not refer evidence to Capita as it was considered to be 'non-medical'. For example, in Case Study 20, in response to the claimant's complaint that their letter was not considered, the Department wrote to the claimant and advised:

¹³³ Department's Advice for Decision Making Guide, Chapter A1, Principles of decision making and Evidence, September 2017.

¹³⁴ PIP A Second Independent Review of the Assessment Process (communities-ni.gov.uk) Page 10

'I can confirm your letter was considered when we completed your last decision. However, as you did not supply medical evidence from a health professional we could not forward your letter to our assessors. If you want to forward medical evidence to support your claim we can look at your case again or you can go to the next step in the PIP process and appeal you decision...'

The Department's response contradicts its advisement to my investigation that 'medical evidence', as defined within its procedural guidance¹³⁵, can be first hand from the claimant or reported by a relative or carer. It is also in opposition to the action taken by the Case Manager in Case Study 18 where non-medical evidence was referred to Capita for advice (and notably increased the award).

Unfortunately, a lack of records explaining Case Managers decisions to refer or not refer further evidence has meant that I am unable to ascertain whether variations in approach were justified. The Department advised my investigation: *'There is no requirement legislatively or in the relevant guidance for Case Managers to record why they have or have not referred a particular piece of evidence for further advice.'* I am concerned by the Department's response, which echoes its responses to previous record keeping issues. In particular I am concerned that in the case of non-referral of further evidence, a lack of records meant that it was often unclear whether the evidence was overlooked, or whether a well-reasoned decision was made that referral was not necessary.

It is evident from these cases, and the Case Studies below, that the incomplete advice, the wide discretion afforded to Case Managers, and the lack of any requirement for decision making records has resulted in significant variation in Case Managers decisions. As a result, in some cases, evidence which had been available at earlier stages of the process was not referred to Capita until it was reviewed by the Appeals Case Manager, subsequently leading to a change in award.

The Department advised my investigation:

'It is normal procedure for an Appeals Case Manager when preparing an appeal response to do this, even when a Mandatory Reconsideration Case Manager has not considered it necessary. Appeal tribunals often direct the Department to seek advice on further evidence where advice has not been previously sought. This means an adjournment of the tribunal and a delay in a decision being made for the claimant. To avoid such adjournments, an Appeals Case Manager may decide to seek that advice ahead of the tribunal hearing. This should not be taken as an indication that the Appeals Case Manager places more weight on the evidence than the Mandatory Reconsiderations Case Manager...'

¹³⁵ Part 08, Chapter 3 'Previewing the evidence'

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'The Department also does not accept there is any variation in approach or lack of consistency regarding referring further evidence for advice, other than the infrequent occasions when two different Case Managers may come to a different conclusion regarding the importance or relevance of a particular piece of evidence, which is not evidence of any malpractice or maladministration. It is a judgement call by a Case Manager as to whether one piece of evidence should prevail over another regarding the weight attributed to it.'

The Department's unwillingness to accept there is a variation in the approach of Case Managers is concerning. It is apparent that while the Department has adopted a standard approach following submission of an Appeal (to refer evidence if it has not previously been referred regardless of its considered merit) this procedure has not been implemented, or considered necessary, at earlier stages of the process, despite the impact this may have on an award. I am alarmed that had the claimants in the cases I reviewed not requested an Appeal, this evidence would not have been referred, and the award would have remained unchanged.

Case Study 16 Lack of procedure in place for referral of further evidence to Capita

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (19 July 2018): No Award, No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (1 September 2018): No change

Offer of Lapsed Appeal (25 November 2018): Standard Daily Living (9): Standard Mobility (10)

Claimant AB, whose primary condition is listed as fibromyalgia, applied for PIP on 10 March 2018.

On 29 March 2018 the Department uploaded the claimants DLA GPFR (dated 31 October 2015) confirming their conditions, reports of low mood and confirming functional issues reported by claimant.

On 24 May 2018 a GPFR (requested by Capita 1 May 2018) was received by the Department. The report advised *'Please see patients note, per orthol[paedic] letters 4 yr history bilateral anterior knee pain, reports locking swelling giving way with pain. Effects of disabling condition on day to day life – may be affected by chondromalacia, fibromyalgia, asthma, IBS.'*

On 11 June 2018 the GP sent a further letter requesting a home visit due to severe anxiety and panic attacks.

Following a face to face assessment at home the Case Manager reviewed the Assessment report and determined that the claimant was not entitled to PIP.

The claimant subsequently requested a Mandatory Reconsideration, and on 10 August 2018 the Department received a letter from the claimants GP advising of the use of aids such as toilet seat, bath rails shower seat pill box and crutches. The letter also referred to the claimant's referral to counselling and attendance at a rheumatology outpatient clinic.

On 1 September 2018 the Mandatory Reconsideration note on PIPCS recorded '*FE [further Evidence] received reconsidered and not revised decision.*' A Mandatory Reconsideration Notice was sent to the claimant advising there was no change to the award. The claimant subsequently requested an Appeal.

On 11 October 2018 an Appeals Case Manager requested that Capita review the GP letter which was received prior to the Mandatory Reconsideration decision. In response Capita completed a change of advice report which stated:

'As per phone call FME [Further Medical Evidence] was submitted by the customer but the Case Manager did not send it to API[Assessment Provider]...taking in to consideration the FME regarding [claimant] physical condition some restrictions may be present given the nature of [claimant's] condition suggesting that 1b 4b 6b and 12b would be advised.'

Although this provided the claimant with additional points, it did not provide them with an award. The claimant was not informed of this change.

On 26 October the Department received correspondence from the Appeals Service.

On 17 November 2018 the Department's Appeals Case Manager returned to Capita for second time and queried '*customer not scored for aids [claimant] is prescribed*' [as referred to within the GP letter provided prior to the Mandatory Reconsideration decision]. In response Capita provided a further change of advice report which stated '*In view of the GP evidence, the following descriptors are reasonable 1a,2a,3b,4b,5b,6b,7a ,8a,9a,10a,11a,12d.*'

This change of advice resulted in the provision of an offer of award of standard Daily living and Standard mobility, which the claimant accepted.

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This case evidences how the lack of consistency in approach to referring evidence to Capita, and the failure of Mandatory Reconsideration Case Managers to question inconsistencies in advice, can impact on a claimant. In this case failure to refer evidence at Mandatory Reconsideration resulted in a considerable delay in the eventual referral and instatement of a PIP award.

This case also evidences the Good Practice of a limited number of Case Managers (typically Appeals Case Managers) who appropriately question the advice provided by Capita's Disability Assessor based on evidence from the claimant's own health professional. In this case directly resulting in a change in award.

Case Study 17 Lack of procedure in place for referral of further evidence to Capita

Award History

DLA: Higher Care: Higher Mobility

First Tier Decision (1 May 2017): No award: No Daily Living (4 points): No Mobility (4 points)

Mandatory Reconsideration (23 July 2017): Standard Daily Living (8): Standard Mobility (10)

Claimant AC, whose primary condition is listed as Asthma, applied for PIP on 21 February 2017. Although the claimant was previously on DLA they were not asked if they wanted previous DLA medical evidence to be taken in to account.

Following Capita's face to face assessment the Department advised the claimant on 1 May 2017 that they were not entitled to a PIP award.

On 8 May the claimant's representative contacted the PIP Centre to advise they had just received the letter and requested a Mandatory Reconsideration. An extract of transcript of the telephony recording is provided below:

'Telephony Advisor: Does [claimant] want everything looked at again? If they look at everything again they can take all the points off [claimant]. [Claimant] can lose points as well as gain points. Do you want me to ask them to look at everything again?

Claimants Representative: They would have to do something. Would you be able to tell me if the doctor sent something in? I phoned up our doctor to ask did you get a form to fill in from PIP. He said I haven't looked at them this month; I don't know how to fill them in. Can I tell them you haven't got anything?

Telephony Advisor: For this you really need to be sending more information if you can get it. You know, more medical information...I'm going to say you

are sending in further medical evidence. You have a month to get further medical evidence to us...Try and get as much medical evidence as you can.'

On 20 May 2017 a GPFR dated 13 May 2017, and a prescription list was received by the Department. This was not forwarded to Capita.

25 May 2017 the claimant contacted the Department and advised they had requested further medical evidence from the Doctor who advised they would send it over to PIP, if PIP made a request for it. **'Therefore [claimant] does not have further medical evidence but wants GP contacted and to proceed with Mandatory Reconsideration.'** The claimant was not advised that medical evidence had recently been received from the GP.

On 3 June 2017 the claimant contacted the Department as they had received a reminder letter advising that the Department was yet to receive any further evidence. The claimant again reiterated that the GP will not provide any further evidence. The claimant was not advised that medical evidence had recently been received from the GP.

On 26 June 2017 the claimant was asked whether they wanted medical evidence from their last DLA claim considered. The claimant consented.

On 14 July 2017 all further evidence, including the DLA and the recent GPFR was referred to Capita for further advice.

'GP factual report is available on system following assessment....Please advise if the available information would impact upon the previous decision.'

On 17 July 2017 a change of advice report (dated 15 July 2017) was received in the Department. Recommending descriptors which provided the claimant with an award of Standard Mobility and Standard Daily Living.

On 23 July 2017 the Department issued the Mandatory Reconsideration notice and advised the claimant they were entitled to Standard Mobility and Standard Daily Living.

This case evidences how the lack of consistency in approach to referring evidence to Capita can impact on a claimant. In this case failure to refer evidence at the point it was received resulted in a considerable delay (approximately 2 months) in the eventual referral and instatement of a PIP award. There is no record to identify why this delay occurred, whether it was overlooked or whether it was considered unnecessary to refer. The lack of policy on referral and the lack of procedure to record any considerations mean that this cannot be determined.

The case also evidences the Department's failure to consider the claimant's DLA evidence in the first instance.

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Case Study 18 Lack of procedure in place for referral of further evidence to Capita

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (11 March 2019): No award: No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (2 April 2019): No change

Lapsed Appeal [2nd Mandatory Reconsideration] (25 June 2019): Standard Daily Living (10): No Mobility (0)

Claimant AD, whose primary condition is listed as Specific Language Impairment, applied for PIP on 15 October 2018. Following Capita's face to face assessment the Department advised the Claimant on 11 March 2019 that they were not entitled to PIP.

On 19 March 2019 the claimant's appointee advised they had just received the letter and requested a Mandatory Reconsideration. It was recorded '*customer will not be sending in any form.*'

The following day (20 Mar) the claimant's appointee contacted the Department. An extract of the telephony script is provided below:

Claimant's appointee: *I was kind of shell shocked yesterday and [Telephony Advisor] asked me what I wanted looked at and I just said all of it but I was going to write out a wee letter and draw attention to the bits I disagree with.*

Telephony Advisor: *That is fine [gives advice on Mail Opening Unit address.]*

Claimant's Appointee: *I don't need to tell them that before they look at it again?*

Telephony Advisor: *No, see when you registered the Mandatory Reconsideration did you tell them you were going to be sending in evidence?*

Claimant's Appointee: *No, I was shell shocked. [Telephony Advisor] said what do you want reconsidered and I said all of it really, there is bits, like communication, mixing with people and reading that I really felt [claimant] should have scored.*

Telephony Advisor: *There's going to be note on so the Case Manager is aware that evidence is going to come in.*

Less than two weeks later, (not the 4 week provision given to gathering evidence) on 2 April 2019, a Mandatory Reconsideration notice was sent to the claimant advising that no changes were made to the award.

On 7 April 2019 a letter from the claimant's family member, outlining areas of dispute was received by the Department. A further cover letter was issued to the claimant by the Department on 12 April advising the letter had been received but there was no change to the decision.

On 26 April 2019 the claimant's appointee rang asking for an update on Mandatory Reconsideration. An extract of the telephone call is provided below:

'Claimants Appointee: *I received a letter which was sent out almost immediately as soon as I said I wanted to reconsider but they didn't wait for the information to come in – they went ahead and sent a letter without the additional information. I explained all of this and the guy said..*

Telephony Advisor: *And on the 11th they made the decision and wrote out to you.*

Claimants Appointee: *But I haven't received it.*

Telephony Advisor: *14 days we allow for a letter to get out – that would be today – have you had post today?*

Claimants Appointee: *Yes*

Telephony Advisor: *I'll request a duplicate out to you.*

Claimants Appointee: *I'm very unhappy about how they've come to that decision when I have drawn attention to all the points.*

Telephony Advisor: *The letter should give you that information and how you can go about appeal.'*

On 9 May 2019 the claimant requested an Appeal.

On 18 May the Department's Appeals Case Manager raised an advice request with Capita:

'Please see letter received 7/4/19. Whilst I acknowledge this is not additional medical evidence it contains fairly robust evidence from a close family member. I would be very grateful if you would consider if the information would have any bearing on the current assessment and descriptor choices.'

On 19 May 2019 Capita completed a change of advice request (PA6) date stamped by the Department Mail Opening Unit as 26 May 2019. Although the PA6 notes the family letter disputing descriptor choices, it does not specifically reference it in the weighing up of evidence for descriptor choices.

On 24 June 2019 the claimant was sent a further Mandatory Reconsideration Notice [it is unclear why this was not a lapsed Appeal offer as claimant was at Appeal stage and case was provided by the Department as a lapsed Appeal] advising that they were entitled to

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Standard Daily Living and no Mobility. There was no reference within this letter to the impact the additional letter provided by the family member had on the award. The letter only referred to evidence obtained during the face to face assessment and further evidence being received.

This case evidences how the lack of consistency in approach to referring evidence to Capita can impact on a claimant. In this case failure to refer evidence at the point it was received (7 April 2019) resulted in a considerable delay in the eventual referral and instatement of a PIP award (24 June 2019). There is no record to explain why the evidence was not referred upon receipt other than the letter identifying it had been received but there was no change.

Case Study 19 Lack of procedure in place for referral of further evidence to Capita

Award History

DLA: Higher Care: Lower Mobility

First Tier Decision (4 September 2018): No Award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (20 October 2019): No change
Offer of Lapsed Appeal (18 February 2019): Enhanced Mobility (12);
Enhanced Daily Living (15)

Claimant AE, whose primary condition is listed as ADHD [Attention Deficit Hyperactivity Disorder], applied for PIP on 10 June 2018. Capita undertook a face to face assessment on 4 August 2018 which provided 0 points.

On 24 August 2018 a completed GPFR was received in the Department from the claimant's Consultant Paediatrician. This further evidence was not forwarded to Capita for review by the Case Manager. There is no record to evidence the consideration of referring/not referring this evidence.

On 4 September 2018 the Department sent a First Tier Decision letter advising the claimant that they were not entitled to PIP.

On 20 September a Communications record states:
'FE received. Parental statement appealing award and providing information. Letter from ADHD Nurse Specialist.'

The claimant's letter was addressed to the Appeal Service and was therefore not considered as a Mandatory Reconsideration request.

On 6 October 2018 the claimant's representative contacted the Department to check the letter had been received. The Mandatory Reconsideration was commenced. However, the further evidence provided alongside the claimant's letter (ADHD nurse) and the letter received from the Consultant Paediatrician was not referred to Capita for advice by the Mandatory Reconsideration Case Manager. There is no record to evidence the consideration of referring/not referring this evidence.

On 20 October 2018 the Department sent a Mandatory Reconsideration Notice to the claimant advising that there was no change to the award.

The claimant requested an Appeal and provided no additional new evidence.

On 27 November 2018 the Appeals Case Manager requested advice from Capita, referring to the further evidence, received from the claimant 2 months prior (on 20 September 2018). The Appeals Case Manager recorded their opinion that this evidence may affect specific descriptor choices.

On 12 Feb 2019 the Department chased up the advice report as it had not yet been received. A duplicate report was received on 17 February 2019 (signed 1 Dec 2019). Capita recommended descriptors which provided the claimant with an award of Enhanced Daily living and Mobility.

This case evidences how the lack of consistency in approach to referring evidence to Capita can impact on a claimant. In this case failure to refer evidence at the point it was received resulted in a considerable delay in the eventual referral and instatement of a PIP award. There is no record to explain the reason for the delay/original decision to not refer the further evidence.

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Findings –

The failure of the Department to apply a consistent policy in relation to the referral of further evidence (both medical and non-medical) to Capita for advice, and the lack of records of the Case Managers' evaluation of the impact of the evidence including decisions to refer/not refer further evidence has meant that I am unable to conclude that appropriate consideration of further evidence was undertaken by the Mandatory Reconsideration Case Managers.

It is of note that in many instances the Appeal Case Manager subsequently sent the further evidence to Capita. This variation in approach meant that there were missed opportunities at earlier stages to appropriately consider further evidence, which in some cases may have overturned awards at an earlier stage.

It also demonstrates a lack of consistency and understanding on the part of Case Managers as to what constitutes further evidence which has relevance to the decision making process, and when it should be sent to Capita. This evidences a failure to fulfil Principles 1, 3 and 4 of the Principles of Good Administration.

Recommendation 5.7 –

The Department should introduce a comprehensive, consistent policy on the referral of further evidence to Capita for advice. This policy should:

- outline the types of evidence to be referred;
- provide an expected referral timeframe (from receipt of the information) when referral should be undertaken by;
- emphasise the need for a Case Manager to record their reasoning as to why they considered it necessary to refer/not refer further evidence for advice; and
- ensure that claimants are informed when further evidence has been referred to Capita for advice or alternatively when a decision has been made not to refer.

iii. Considering evidence and recording decision making

Discussions with advocacy bodies at the commencement of my investigation, and subsequently my review of case files, highlighted concerns that Department Case Managers may routinely place more weight on the advice provided by the Disability Assessors than any other form of evidence in their decision making.

As discussed in the previous chapter, in a number of the cases reviewed, contradictions were evident between the Assessment report/Disability Assessor advice and the further evidence provided by the claimant and their health professionals. However, in the majority of cases the Case Managers (both First Tier and Mandatory Reconsideration) appeared to accept the Disability Assessor's advice without question. The Advice for Decision Making guide¹³⁶ advises:

'A1380 There is no rule of law that corroboration of the claimant's own evidence is necessary. But the decision maker should not accept evidence, from the claimant or anyone else, uncritically. It needs to be weighed carefully, in light of the circumstances of the case.'

A1390 If the evidence is contradictory, the decision maker should
1. try to resolve the discrepancy or
2. decide that there are sufficient grounds to decide the point on balance of probability.'

The Advice for Decision Making guide also advises:

'A1302 Proper consideration and careful recording of evidence when making and recording decisions are essential...'

Although I acknowledge that Mandatory Reconsideration Case Managers may have considered that the Disability Assessor's descriptor choices and advice were correct (on the balance of probability), there were limited records within the PIPCS to evidence this decision making.

During site visits undertaken as part of my investigation, a Mandatory Reconsideration Case Manager was viewed to use a basic paper template to record their (hand written) considerations of the claim. This included:

- what was claimed by the claimant on the application form;
- what descriptor choice was made by the Disability Assessor; and
- the Mandatory Reconsideration Case Manager's notes on each section.

¹³⁶ Department's Advice for Decision Making Guide, Chapter A1 Principles of decision making and Evidence, September 2017.

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However this template was for the use of the Case Manager only; the information was not retained or recorded on PIPCS.

It is acknowledged that the Mandatory Reconsideration Case Manager also completes a 'Decision Making Log' following completion of a decision, which is retained by the Department. However this log captures very limited information. An example extract is provided:

NINO	Surname	Forename	Referred to Capita	Reason for Recon	Changed on Recon?	FME to be provided?	New evidence Rec'd
xxx	xx	xx	No	Disallowance	No	Yes	No

Therefore the only apparent form of written analysis of a Mandatory Reconsideration Case Managers decision is recorded within the Mandatory Reconsideration Notice.

The purpose of the Mandatory Reconsideration Notice, like the First Tier decision letter, is to provide the claimant with the decision on their award, along with the reasons for that decision.

The Advice for Decision Making guide¹³⁷ states:

'A1117 Note: Personal Independent Payment notifications do not advise about a statement of reasons as the notifications contains sufficient information to be treated as such.'

My case file review identified an improvement in the level of explanation provided to claimants within the Mandatory Reconsideration Notices when compared to the First Tier decision letters. However, concerns were still identified.

As with First Tier decision letters, Mandatory Reconsideration Notices are completed within a template system which encourages the user (Case Managers) to select pre-populated statements. Unlike the First Tier decision letters reviewed within my investigation, the Mandatory Reconsideration Notices were typically more coherent, listing the claimants difficulties (pre-scripted statements), followed by assessment observations and then the Mandatory Reconsideration Case Manager's decision. However very little reference was usually made to the claimant's further evidence (personal statements which dispute observations, family statements or health care professional advice), unless it supported the advice of the Disability Assessor.

¹³⁷ Department's Advice for Decision Making Guide, September 2017.

The reviewed Mandatory Reconsideration Notices, like the First Tier decision letter also failed to appropriately list all evidence considered. In the majority of the cases, all available evidence was not listed and in several cases only the *'How your disability affects you'* form (PIP2 application form) was listed within the specific section *'How I made my decision...'*

However, it should be acknowledged that there were a limited number of exceptions to this. My case file review identified a small number of Mandatory Reconsideration Case Managers who utilised this section more efficiently. An extract example is provided below:

'How I made my decision

- *I looked at all of the information available to me, including;*
- *The 'How your disability affects you' form*
- *The information provided by the health professional consultation report*
- *The extra information you gave us*
- *The information provided in the letter from your General Practitioner, and*
- *The information provided in your claim for Disability Living Allowance.'*

Nevertheless, this approach also revealed its own issues. As previously identified¹³⁸, the lack of clear recording as to what information was provided and when, could lead to this list of evidence becoming misleading. For example, some Mandatory Reconsideration Case Managers listed that they had considered *'the information provided in the report from your General Practitioner'*. This could suggest that GPs had been contacted as part of the PIP claim. In reality the cases reviewed which used this statement were actually referring to the DLA GP Factual Report which had often been obtained years previous to the PIP claim. In a limited number of cases reference was also made to *'the information provided in the telephone advice from your General Practitioner'* where no medical information was actually provided during the call. For example in one of the cases reviewed, the referred telephone call consisted of the Disability Assessor ringing the GP, who declined to give out any medical information.

This limited, and at times misleading information, is likely to have contributed to the themes coming from review of the case files and discussions with advocacy bodies, which identified that claimants were not aware/distrusted whether evidence they provided as part of their claim was ever considered. This is further compounded by the Mandatory Reconsiderations Case Managers' failure to address contradictions/inconsistencies in evidence, between the Assessment report and further evidence, within the Mandatory Reconsideration Notice. As a result

¹³⁸ Chapter 4 Issue 2 ii.

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I cannot conclude that all available evidence, within the cases reviewed during my investigation, were appropriately considered during the Mandatory Reconsideration decision making process.

The Department advised my investigation:

'The Department does not accept that claimants are unaware or distrust whether evidence they provided as part of their claim was considered. The reference to this 'theme' coming from discussions with advocacy bodies is also not supported by any evidence. As previously advised, the Department meets regularly with Advice Groups through the Disability Consultative Forum and no such concerns have been raised by them with the Department.'

It is surprising that the Department advise that they do not accept the concerns raised in relation to claimant distrust as several reviews have highlighted this issue prior to publication of my report. Walter Rader reported within his Independent review report:

'246. Respondents who indicated that they had disputed the outcome of their claim commented that the process was not only stressful and complex but, in those cases where the original decision had been upheld, there was a belief that additional information had not been taken into consideration.'

AdviceNI, who are involved in the Disability Consultative Forum, also stated the following in their submission to the Second Independent review¹³⁹:

'DfC has told us that if evidence is forthcoming and compelling, they can change the decision at any point from application to MR to appeal. However, our experience contradicts that. There seems to be an abdication of responsibility on the part of the DfC when it comes to making decisions about PIP awards. We highlight in our paper on PIP Process and Appeals that bad decisions routinely go unnoticed at Mandatory Reconsideration (MR) and that rather than scrutinise the original award, DfC more often than not rubberstamp the Capita decision, even in the face of clear evidence for an award or higher award. Some advisers have been told that decisions, new evidence or reconsideration of decisions always have to go back to Capita. And in response to submissions to previous reviews, Advice NI has been told that decisions are based on the assessment reports. If that is the case, then it is Capita who is the decision maker and not DfC. The general feeling within the advice sector is that Capita makes the decisions and that their decision is final. It is clear therefore that the Department must take steps to provide confidence in the decision making process.'

¹³⁹ [second_pip_review_advice_ni_submission_september_2020f.pdf](#)

Marie Cavanagh's Second Independent Review also highlighted the thoughts of some of the Department Case Managers:

'Whilst NIPSA acknowledges certain advantages of amendments to the current process in respect of claims maintenance and submission via telephone correspondence, we contend that the process of PIP is fundamentally flawed. This relates to the dramatic reduction in the role of the case worker whereby their position is reduced to that of rubber stamping the decision of a Capita assessor as opposed to that of a decision maker, making a decision based on their applicable knowledge. Case workers and Mandatory Reconsideration Officers have further stated that when anomalies exist between customer evidence and the scoring provided by a private sector company, that this often goes unchallenged due to the excessive administration required in challenging the same'. NIPSA

The Department's apparent failure to recognise or acknowledge these repeated concerns, in order to reflect on what may be improved to restore confidence in the decision making process, is concerning.

Case Study 20 No evidence that claimants letter was considered at Mandatory Reconsideration.

Award History

DLA: Middle Care: Higher Mobility

First Tier Decision (12 October 2018): Standard Daily Living (8 points): No Mobility (4 points)

Mandatory Reconsideration (7 November 2018): No change

Appeal (2 March 2019): Enhanced Daily Living (12): Enhanced Mobility (14)

Claimant X, whose primary condition is listed as Osteoarthritis, applied for PIP on 19 July 2018 and was subsequently awarded Standard Daily Living and no Mobility.

On 18 October 2018 the claimant contacted the Department to request a copy of the Assessment report and requested a Mandatory Reconsideration.

On 29 October 2018 the Department received a letter from the claimant highlighting discrepancies made in the Assessment report.

On 7 November 2018 the claimant was sent a Mandatory Reconsideration Notice advising that the decision remained unchanged. No reference was made to the claimant's letter or the points raised within the same.

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On the 13 November 2018 the claimant contacted the Department to query whether the letter they sent was actually received by the 'Panel' [the claimant appeared to be confused between a Mandatory Reconsideration and an Appeal Panel]. An extract of the telephone call is provided below:

Telephony Advisor: *I can check if we have it or not.*

Claimant: *No, I know you have it but I want to know did the 'Panel' actually receive it.*

Telephony Advisor: *If it came in before they looked at it they would have seen everything that's on the system.*

Claimant: *So would it not be on the system stating whether they have or haven't looked at it?*

Telephony Advisor: *No they don't make those kind of notes on the system.*

Claimant: *So you can't guarantee they have seen it.*

Telephony Advisor: *That's just not how the place works.*

Claimant: *you are playing with people's lives here. You either know 100% they seen it or 100% they didn't see it.*

Telephony Advisor: *Well if it was on the system before they looked at the claim then they would have looked at it.*

Claimant: *Is there any proof on the system they looked at it.*

Telephony Advisor: *No that's what I'm saying they wouldn't make a note of every single thing they do...if it's on the system before the recon[sideration] was done they would've looked at it...*

Claimant: *100%?*

Telephony Advisor: *Yes.*

Claimant: *Can you prove it?*

Telephony Advisor: *No I can't prove it obviously.*

Claimant: *What do you mean obviously?*

Telephony Advisor: *I am as sure as I can be.*

Claimant requests to speak to Team leader who advises 'Any evidence that comes in on the system before they make a decision they look at everything. Then whenever they send out a letter it will say I have looked at, names all the evidence that he's looked at and how he's made his decision...'

Claimant: *There is nothing on mine says 'I have looked at', it just says I have looked at again...*

Team leader: *Looked at the decision again?*

Claimant: *Yeah, just 'I was told by the person who done the medical'. I would like them to write that they actually received the letter. It's alright you saying they definitely got it what proof do I have they got it. Everything I wrote, nothing is addressed on it...not one item..'*

On 16 November 2018 the Department wrote to the claimant advising *'I can confirm your letter was considered when we completed your last decision. However, as you did not supply medical evidence from a health professional we could not forward your letter to our assessors. If you want to forward medical evidence to support your claim we can look at your case again or you can go to the next step in the PIP process and appeal your decision...'*

On 5 Feb 2019 a complaint response to the claimant from the Department also advised:

'I can confirm that your letter, dated 28 Oct 2018, was referred to a Mandatory Reconsideration Case Manager who decided that the information you provided did not contain any new evidence that would affect the recommendations made by Capita in your PIP Assessment report. I apologise if this was not made clear to you in your telephone calls to the PIP centre and correspondence.'

It is unclear how the Department could confirm that the letter had been considered when there is no evidence on the system or within written notes that this letter was reviewed.

This case evidences how the failure to appropriately record consideration of all evidence can impact on a claimant and their subsequent distrust of the appropriateness of the award. It also highlights the typical consideration that only medical evidence should be forwarded to Capita for advice (however there are limited exceptions to this as identified within Case Study 18).

Case Study 21 Failure to address inconsistencies.

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision (22 October 2018): No award: No Daily Living (6 points): No Mobility (0 points)

Mandatory Reconsideration (3 December 2018): No change

Offer of Lapsed Appeal (1 March 2019): Standard Daily Living (11): No Mobility (0)

Claimant S, whose primary condition is listed as ADHD/Behavioural Problems, applied for PIP on 9 June 2018.

On 22 June 2018 the Claimant's DLA GPFR (2016) was uploaded. A limited amount of information is detailed on the form but the GP confirmed behavioural problems, excessive irritability and raised no other concerns.

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On 21 August 2018 the Department received a completed GPFR (Same GP who completed 2016 report) which listed *'Chronic mechanical back pain, behavioural difficulties/attention deficit. Had issues with incontinence during late childhood, poor concentration, lack of social engagement, needing supportive reassurance on a regular basis, forgetful needs prompted all the time, needs reminded to do all routine things, poor awareness of common dangers, poor ability to manage own affairs – benefits, self-care, home care, back pain poor exercise tolerance. Needs constant supervision in all aspects of daily living.'*

On 29 Sep 2018 a record on Capita CRM evidences a call made by the Disability Assessor to their support line. This service is utilised when the Disability Assessor needs guidance on a claim. It is recorded that the Disability Assessor queried the apparent confictions between their observations and the GP report:

'assessment is not consistent with GPFR, how to proceed, DA feels can only justify A descriptors. DISCUSSION because current GPFR indicates restrictions, then the IOS [Informal Observations], MSE [Mental state examination] must be detailed and clear, the gpfr must be addressed within the justifications and noted to be inconsistent with lack of prescribed medication or referral to other services if you consider you have sufficient evidence to robustly support your descriptor choice.'

On 22 October 2018 the Case Manager reviewed the Assessment report and additional documents and determined that the claimant was not entitled to PIP.

The claimant's appointee subsequently requested a Mandatory Reconsideration and advised they would be sending in further evidence.

On 5 November 2018 a letter was received from the claimant's appointee advising of issues with reading, writing, not understanding signs, learning and behavioural disabilities. This was accompanied with a GP letter which stated *'I have known [claimant] for a number of years and am in possession of [their] complete medical record. I have studied the copies of the reports and have also studied the points raised in [their] appeal. I am happy to confirm to the appeals panel that [claimant] account is an accurate one and represents [their] true level of debility...If you have any further queries please do not hesitate to contact me.'*

The Mandatory Reconsideration Case Manager made no request for contact to be made with the GP, however they referred the further evidence to Capita who provided a no change to advice report (1 December 2018) which stated *'Evidence provided after assessment are*

a hand written letter from the customer and a letter from GP. GP does not provide any medical information. There is no advised change to descriptors.'

On 3 December 2018 a Mandatory Reconsideration Notice was completed which informed the claimant there was no change to the original decision. Within the section 'How I made my decision' it lists:

'I looked at all the information available to me, including:

- *The 'How your disability affects you' form.*

This told me the type of help, and how much help you need...'

The Assessment report, the DLA GPFR (2016), the most recent GPFR (2018), the claimant's appointee's letter and the supporting letter from the GP are not listed. Within the section 'My decision' The letter states 'You did not send more supporting information'.

This is inaccurate as the claimant's representative sent a hand written letter and a further letter of support from the GP.

The 'My Decision' section also provided extracts of observations taken from the Assessment report. For example:

'You stated you have difficulties preparing food, taking nutrition, managing therapy, or monitoring a health condition, washing and bathing, dressing and undressing, communicating verbally and reading and understanding signs, symbols and words. The mental state examination showed you to have good cognition, intellect and memory. You engaged well with the Disability Assessor and made eye contact. You were observed to be calm throughout the assessment. You are currently not on medications and have no specialist input for your mental health. You reported that you attended mainstream education and evidence that you provided indicates no diagnosed learning difficulty or cognitive impairment. The musculoskeletal examination showed you to have power grip and pinch grip in both hands and you were able to carry out all upper and lower limb activities with no expression of pain and no breathlessness was observed. I decided you can manage these activities unaided.'

No reference was made within these findings to the claimant's GP report which advised 'Needs constant supervision in all aspects of daily living.'

It is also of note that the Notice states:

'You take medication to help with incontinence which you report is partially effective. Therefore I decided you need an aid or assistance to manage these activities.'

Although the claimant's application form advised that the claimant suffered from bedwetting from 1995 and has to wear incontinence

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pads, the GPFR only advised that the claimant '*had issues with urinary incontinence during late childhood*', there is no evidence to suggest this continued into adulthood. There is also no evidence within the GPFR to suggest that the claimant is on medication for the same. This was not questioned or clarified with the claimant's health professional.

Despite this confliction between the Assessment report, the medical evidence and the claimants own reported issues with the application form, the Mandatory Reconsideration Case Manager used a templated paragraph to conclude:

'This is consistent with your medical history, your description of a typical day, informal observations at your face to face consultation, how you engaged with the assessor, the information you provided about how your disability affects you, your mental state and musculoskeletal examination results.'

This case evidences the Mandatory Reconsideration Case Manager's failure to appropriately address, and record, inconsistencies between the advice of the Disability Assessor and the further evidence provided by the claimants and their health professionals. This is despite inconsistencies being identified at an early stage by the Disability Assessor themselves (Contact to DA support line) who did not subsequently address the same within the Assessment report.

Case Study 22 Mandatory Reconsideration Case Manager failure to question contradictions in health professional advice

Award History

DLA: Middle Care: Lower Mobility

First Tier Decision written on Mandatory Reconsideration Notice (3 June 2018): No Award: No Daily Living (6 points): No Mobility (4 points)

2nd Mandatory Reconsideration (25 August 2018): No change

Offer of Lapsed Appeal (28 January 2019): Standard Daily Living (10): Enhanced Mobility (12)

Claimant G, whose primary condition is listed as Learning Difficulty, applied for PIP on 8 Dec 2017.

Within the PIP2 Application form the claimant recorded in the extra information section for Activity 11:

'I don't go out on my own, my carer are (sic) family member is always with as I panic and Im (sic) unable to read signs and don't understand direction. And I would get lose (sic).'

On 31 December 2017 the claimant's DLA GPFR was uploaded on to the PIPCS. The GP advice report confirmed the claimant had learning difficulties, **no awareness of danger and has to be accompanied [my emphasis]**. The report also stated that although the claimant could perform all tasks of daily living they were not yet independent.

Following review of the information and Capita's face to face assessment, which did not refer to the GP report within the descriptor justifications, a Department Case Manager determined that the claimant was not entitled to PIP.

Following confusion between Mandatory Reconsideration and Appeal, the Department received a letter from the Appeals Service advising that an Appeal had been requested and providing a copy of a GP letter of support which reaffirmed history of learning disability and stated *'has a high level of anxiety and rarely leaves the house without mum.'*

The Department wrote to the claimant's appointee to advise they were unable to Appeal until they went through Mandatory Reconsideration (despite the claimant's First Tier decision being written on a Mandatory Reconsideration Notice)

On 25 August 2018 the Department sent the claimant a Mandatory Reconsideration Notice advising the award remained unchanged.

The **'How I made my decision'** section recorded:

'I looked at all the information available to me including:

- *The 'How your disability affects you' form,*
- *The information provided by the health professional consultation report; and*
- *The information provided in the report from your General Practitioner.'*

As no dates or further explanation was provided it is unclear whether the report from the GP refers to the DLA GPFR, or the letter recently received from the GP in support of the award.

The Mandatory Reconsideration Notice also recorded in respect of Activity 11:

'You said you have difficulty planning and following journeys. The assessor had difficulties assessing cognition, but you appeared to understand assessment. You were observed to have difficulties engaging and needed help from your representative. I decided you need prompting to be able to undertake any journey to avoid overwhelming psychological distress.'

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This does not corroborate with the claimant's application form which states they do not go out on their own, or the GP advice that the claimant has no awareness of danger and has to be accompanied. Despite this, the Mandatory Reconsideration Case Manager concluded the letter with the templated form of words:

'This is consistent with your medical history, your description of a typical day, informal observations at your face to face consultation, the information available at your face to face consultation, how you engaged with the assessor, the information provided about how your disability affects you and your GP report.'

This case evidences the failure of the Mandatory Reconsideration Case Manager to question the advice of Disability Assessor despite an evident conflict in advice.

It is of note that once the claimant's appointee requested an Appeal, an Appeal Case Manager referred the DLA GPFR back to Capita for further advice stating:

'Please see GP report advising of no insight or awareness of danger and not independent. Please give advice regarding safety activities 1 & 11 and advice regarding 4 & 6.' As a direct result, Capita provided a change of advice report and the claimant was awarded Standard DL and Enhanced Mobility, with activity 11 changed from descriptor b (needing prompting) to descriptor f (needing another person to accompany on familiar journey).

It is of note that, **prior** to the Assessment report being provided to the Department (27 May 2018), it was reviewed by Capita's internal audit (13 May 2018). At this point, directly after the face to face consultation, the Disability Assessor had recommended activity 11(f) and had recorded within the descriptor justification:

'FME supports her condition and lack of insight. SOH indicates [claimant] attended a specialist unit for schooling, had a statement of education and a classroom assistant. Her representative transported her to school. Therefore, it is likely [claimant] cannot follow the route of a familiar journey without another person.'

This was removed from the Assessment report and activity 11 was changed to descriptor b, prior to it being sent to the Department. It is unclear why this significant amendment was undertaken as the Auditor had agreed with the descriptor choice 11 f.

Case Study 23 Lack of consistent policy, in regard to recording evidence considered, leads to lack of certainty whether further evidence has or has not been received.

Award History

DLA: Higher care: Higher Mobility

First Tier Decision (7 December 2018): No award: No Daily Living (6 points): No Mobility (0 points)

Mandatory Reconsideration (17 Feb 2019): No change

Award following NIPSO intervention (9 September 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant AF, applied for PIP on 24 March 2018. Following receipt of Capita's face to face assessment the Case Manager determined that the claimant was not entitled to PIP.

On 31 December 2018 the claimant requested a Mandatory Reconsideration and advised they would be sending in further evidence.

On 17 Feb 2019 a Mandatory Reconsideration Case Manager determined that the original decision remained unchanged.

On 21 Mar 2019 the claimant rang the Department to query whether their further evidence had been received as they had only now noticed that the Mandatory Reconsideration Notice did not refer to the same. The claimant's further evidence was subsequently received in the Department on 6 April 2019.

The further evidence was provided to Capita for review on 2 May 2019. In response Capita provided the Department with a change of advice report (PA6), recommending the claimant receive an award of Standard Mobility and Standard Daily Living.

The Case Manager recorded on PIPCS:

'FME received following decision and MR [Mandatory Reconsideration] and sent to AP [Assessment Provider] for consideration. No change advised. PIP2007a issued clerically to customer advising of no change. DfC [Department For Communities] letter to clmt [claimant] - advise information looked at - no change to the decision.'

On 11 May 2019 the claimant was advised that there was no change to the award outcome.

My investigation team highlighted the oversight in the process to the Department. As a result the Department wrote to the claimant on 9 September 2019 advising of an administrative error, subsequently

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awarding PIP (Standard rate Daily living and Mobility) with a backdated payment of £2,843.66.

This case evidences how the lack of consistent approach/policy to record all available evidence can lead to 'room for error' in that claimants are left unaware whether or not their further evidence was ever received and/or considered.

It also identifies a concern in relation to the consideration given to Capita advice responses by Mandatory Reconsideration Case Managers.

Findings –

The repeated failure of Mandatory Reconsideration Case Managers to record their decision making process, and appropriately advise claimants of same within the Mandatory Reconsideration Notices', evidences a failure to fulfil Principles 1 and 3 of the Principles of Good Administration. As a result I am unable to conclude from the records within the reviewed case files, that Mandatory Reconsideration Case Managers appropriately considered all available evidence.

Recommendation 5.8 –

As previously recommended within Chapter 4 (Recommendation 4.1) the Department should consider the introduction of an electronic decision template based on the informal documents currently used by some Mandatory Reconsideration Case Managers. As well as having areas to record considerations of each descriptor with accompanying evidence, this template should have specific areas to identify:

Inconsistencies in available evidence;

- Case Managers rationale for weighing any particular piece of advice over another;
- Consideration of referral for further advice; and
- Consideration of whether further evidence should be requested and why.

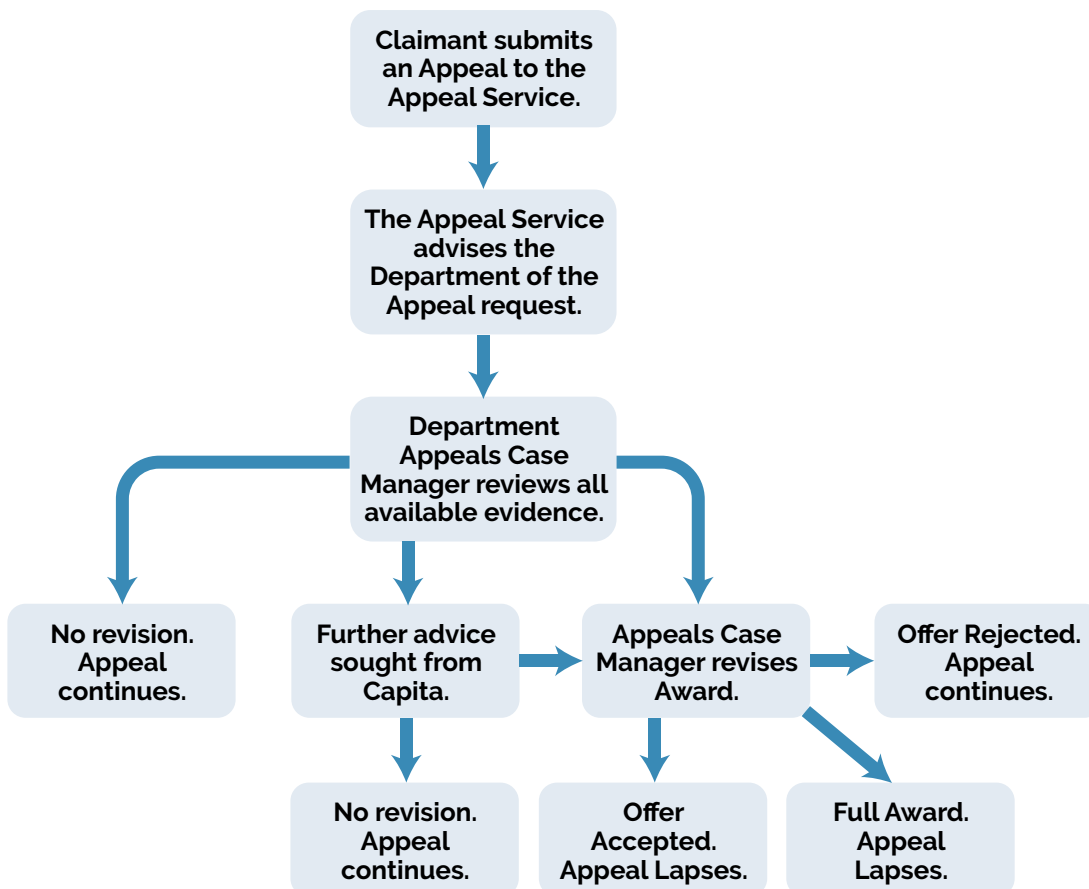
The template could be used to inform both the Mandatory Reconsideration Notice and any possible explanation calls.

Although it is acknowledged that Mandatory Reconsideration Notices are more coherent than First Tier Decision letters, significant improvements are still required. As the same template is used, recommendations made within the previous chapter should address the inefficiencies in both First Tier Decision letters and Mandatory Reconsideration Notices.

Chapter 6: Lapsed Appeals

There is an additional award review stage, following notification of a claimant's submission of an Appeal to the Appeal Service. In accordance with Department guidance¹⁴⁰, once notification of an Appeal request is provided by the Appeals Service, a Department Appeals Case Manager is required in every case to consider whether a claimant's award decision can be revised.

If an award decision is revised, the claimant will be informed of the new award via letter. If the award is the highest available (enhanced rate for both Daily Living and Mobility), the claimant's Appeal will lapse (not continue). If the award is below the highest available rate the claimant will be sent an offer of award letter. If they accept, their Appeal will lapse. If a claimant rejects the offer the Appeal will continue to the Tribunal.



¹⁴⁰Section A3036 'Advice for Decision Making Guide – Chapter 3 – Revision decisions and handling appeals' September 2017, and A5006 'Advice for Decision Making Guide – Chapter 5 – introduction' September 2017.

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Issue 1: Awareness

My case file review identified limited circumstances in which information, regarding the Department's ability to review a claim after a Mandatory Reconsideration decision, was provided to claimants. No written information regarding this additional review was provided within correspondence to the claimant. The Mandatory Reconsideration Notice solely provided information on submitting an Appeal to the Appeals Service.

My telephony review identified that, if a claimant queried their ability to send in further evidence following a Mandatory Reconsideration decision, Telephony Advisors typically communicated that the Department may/would still look at it. However, in the majority of cases these communications were dependent on a query being raised by the claimant; were at times inconsistent in their message; and rarely provided a direct communication that an Appeals Case Manager would review the claim following an Appeal submission.

It is therefore unsurprising that my case file and telephony review, identified a lack of awareness and confusion on the part of claimants in relation to this additional recourse for review by the Department, with some claimants only first becoming aware of the same when they received a letter offering them a revised award.

The Department advised my investigation that there are two reasons why it does not inform claimants of this additional review stage:

'Firstly, to do so could be perceived as the Department trying to dissuade a claimant from lodging an appeal and there's no guarantee any such review may give the claimant the award of PIP they feel they are entitled to and may be a less favourable outcome than a tribunal may award them. Claimants are only obliged by the law to have a Mandatory Reconsideration decision before they are able to lodge an appeal.

Secondly, to advise claimants that they could have a further review post their Mandatory Reconsideration would impact on the legislative timeframes involved in lodging an appeal. If the Department were to encourage claimants in any way to try and obtain more evidence after a Mandatory Reconsideration decision has been made with the advice that this may result in a change of decision and negate the need for an appeal, this could result in the claimant's appeal subsequently being made outside the time limit of 1 month from the date of decision as no new decision may result from them providing further evidence. The Appeals Service letter also advises the claimant about any evidence provided to them being shared with all parties to the appeal hence it would be shared with the Department and considered.

The reasons provided by the Department for this lack of openness and transparency are concerning. The Principles of Good Administration highlight that public bodies should be open and accountable. This includes being clear about policies and procedures. It is unclear why the Department feel they would be unable to provide appropriate advice to claimants without dissuading them from undertaking an Appeal. An appropriate communication could fully explain the claimant's Appeal rights and that a further Department review of all evidence will take place when a request for Appeal is submitted. The communication could emphasise that the Department review may or may not impact on the award – highlighting the importance of continuing to submit an Appeal in parallel to any consideration undertaken by the Department.

Since the commencement of PIP to September 2020, 750 Appeal cases have been lapsed following the Department's revision of the award. It is therefore essential that claimants are aware of the additional review, what it entails, and their ability to have further evidence reviewed at this stage.

Case Study 1 Lack of awareness of Department review following submission of an Appeal

Award History

DLA Award: Middle Care: Higher Mobility

First Tier Decision (19 July 2018): No award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (1 September 2018): No change

Offer of Lapsed Appeal (25 November 2018): Standard Daily Living (9): Standard Mobility (10)

Following conclusion of a Mandatory Reconsideration decision (no change), and submission of a complaint, claimant AB submitted an Appeal request to the Appeals Service on 4 October 2018. The Appeals Service subsequently requested an Appeals Submission from the Department, providing a copy of the claimant's Appeal request form.

At no point was the claimant advised that their case would be reviewed again by a Department Appeals Case Manager prior to the Appeal Tribunal.

On 11 October 2018 an Appeals Case Manager requested that Capita review the GP letter, which was received prior to the claimant's Mandatory Reconsideration decision. In response Capita completed a change of advice report (PA6). Although this provided the claimant with additional points, it did not provide them with a PIP award.

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The claimant was not informed of the review or the change in points.

On 17 November 2018 the Appeals Case Manager returned to Capita for a second time and again referred to the GP letter provided during the Mandatory Reconsideration. Capita provided a further change of advice report, with descriptors which provided a PIP rate of Standard Daily living and Standard Mobility.

On 25 Nov 2018 the Department wrote to the claimant with an offer of award. The letter stated:

'Having reviewed the further evidence we have received, the Department is satisfied that we could award 9 points for the daily living part of PIP and 10 points for the mobility part of PIP.'

No further information on the decision, or why it was changed, was provided.

On 30 November 2018 the claimant contacted the Department. The claimant was confused by the letter and the lapsed Appeal process. The Telephony Advisor queried if the claimant wanted to accept the offer and the claimant queried whether this was something they had to do. Both the claimant and the Telephony Advisor appeared to be unclear of the process.

On 8 Dec 2018 the claimant contacted the Department to check if their acceptance of the offer was received. Within the telephone call the claimant stated *'My money was stopped and I made a complaint and they offered me standard.'*

This case evidences the lack of communication provided to claimants prior to, and during, the lapsed Appeal process. In this case the claimant's evidence (which had already been provided at Mandatory Reconsideration) was twice referred for advice without the knowledge of the claimant. The claimant only became aware that the case was being reviewed by the Department when they received the offer of award letter - which provided significantly limited information. As a result the claimant assumed their award was overturned following their 'complaint'.

Case Study 2 Lack of awareness of Department review following submission of Appeal

Award History

DLA Award: Middle Care: Lower Mobility

First Tier Decision (11 March 2019): No award: No Daily Living (4 points): No Mobility (0 points)

Mandatory Reconsideration (2 April 2019): No change

Lapsed Appeal [2nd Mandatory Reconsideration] (25 June 2019): Standard Daily Living (10): No Mobility (0)

On 2 April 2019 claimant AD was provided with a Mandatory Reconsideration Notice (no change). On 7 April 2019 a letter from the claimant's family member, outlining areas of dispute was received by the Department. A further cover letter was issued to the claimant by the Department on 12 April which advised:

'We recently sent you a decision about your claim for disallowance. After this decision was sent to you we received the following information: A letter from [claimant's family member].

What we have decided

We have looked at this information and have decided that there is no change to the decision. The letter we sent to you dated 2 April 2019 that told you about the decision tells you what to do if you think the decision is wrong...'

On 9 May 2019 the claimant requested an Appeal to the Appeals Service, who subsequently informed the Department via a request for an Appeal submission.

On 18 May the Department's Appeals Case Manager reviewed the case and raised an advice request with Capita. On 19 May 2019 Capita completed a change of advice request (PA6) date stamped by the Department Mail Opening Unit as 26 May 2019.

On 31 May 2019 the claimant's appointee contacted the Department as they required a copy of the letter dated 12 April to inform the Appeals Service why the Appeal was late. An extract of the telephone call is provided:

'Claimant's Appointee: I've gone to Appeal but they are saying it's late. [Explained speaking to TAS today and what they would do, looking at reasons for lateness].

Telephony Advisor: So we have sent off to Capita [on] 18 May for advice so we haven't finished the reconsideration – we are still waiting on advice sought from them.

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Claimant Appointee: *I got a letter saying they had already looked at the further evidence and the decision had remained the same.*

Telephony Advisor: *What date?*

Claimant Appointee: *14 April. [letter dated 12 April]*

Telephony Advisor: *This latest one, where we referred to Capita, was 18 May.*

Claimant Appointee: *Wonder why?*

Telephony Advisor: *The one before we didn't receive any information – that's why they went ahead and made the decision – maybe it was triggered by mistake.*

Claimant Appointee: *No, they said they had received the letter – my daughter sent it from her email address and they said they had received the letter and considered this letter.*

Telephony Advisor: *Aye and no change.*

Claimant Appointee: *Yes.*

Telephony Advisor: *Now they have sent this off to Capita and asked for a revised decision – they would notify us of any change – any new markings – they would tell us if there is to be a change to the decision.*

Claimant Appointee: *I thought I had received two.*

Telephony Advisor: *No, the case was set up on 18 May – we have allowed them to May to get back to us.*

Claimant Appointee: *I don't understand that. Maybe it was just me phoning and asking about it?*

Telephony Advisor: *Maybe so. I'm trying to see if there is a note why, but there is definitely a work task saying it was sent to them [Capita] for advice 18 May – it said we have referred to them, the further evidence that was provided – it was only sent on 17th.*

Claimant Appointee: *I got a letter dated 14 April.*

Telephony Advisor: *Maybe it was a mistake?*

Claimant Appointee: *[Reiterates detail within the 12 April letter].*

Telephony Advisor: *No, it is still with Capita – that's the way it's sitting. I don't understand these dates you got letters... That evidence you sent across is still away for a decision – you thought the reconsideration process had finished?*

Claimant Appointee: *That's what they said and the letter I have in front of me. 'We have received a letter from [claimant's family member] and we have looked at the descriptors again and they haven't changed.'*

Telephony Advisor: *According to this it's still sitting with them to make a decision – allow time – leave it another week – the appeal has been received – this may still change and if it does, to a satisfactory outcome, then you may be notified to see if you are still wanting to proceed to the Appeal, depending on how award has changed.'*

The appointee made two further phonecalls to the Department to query the process on 4 June 2019 and 10 June 2019. The communications note record:

4 June "TCF [telephone call from] PAB [appointee] Advised appeal & CM [Case Manager] looking at FME can go ahead together at same time – confirmed SPT [supplementary payment Team] referral was made 2/5/19. DT MFT1"

10 June "Call from appointee for update. I advised that AP [Assessment Provider] report back today and note re: SP's today. Number provided for SPT and I advised CM would be reviewing AP report and taking any necessary action. SC MFT3"

On 22 June 2019 the claimant was sent a further Mandatory Reconsideration Notice advising that they were entitled to Standard Daily Living and no Mobility.

Although this case was provided to my investigation as a lapsed Appeal, and the Appeal the claimant had submitted had to be lapsed, the Department advise that this was considered a second Mandatory Reconsideration as the further evidence that led to the change was received before the appeal had been lodged – despite this evidence having been considered by the Mandatory Reconsideration Case Manager prior to the Appeal being submitted and despite a letter to this effect being sent on 12 April. At no point was the claimant advised that their claim was undergoing a second Mandatory Reconsideration. The claimant's Appeal was lapsed on 25 June 2019.

This case evidences the lack of clear communication provided to claimants prior to, and during, the lapsed Appeal process. In this case the claimant's evidence (which had previously been provided and considered by the Mandatory Reconsideration Case Manager) was referred for advice without the knowledge of the claimant. The Telephony Advisor appeared to be unaware of the Appeal process of review and assumed that the advice was requested as part of the initial Mandatory Reconsideration.

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Case Study 3 Lack of awareness of Department review following submission of Appeal

Award History

PIP Award (13 Oct 2017): Standard Daily Living (8 points): Standard Mobility (8 points)

Change of Circumstances (Unplanned Intervention)(May 2019): No award: No Daily Living (6 points): No Mobility (4 points)

Mandatory Reconsideration (18 June 2019): No change

Offer of Lapsed Appeal (31 August 2019): Standard Daily Living (10): Standard Mobility (10)

On 25 June 2019 claimant H received a Mandatory Reconsideration notice advising there was no change to their award. They contacted the Department to make a complaint as they stated they had been advised the Department would await further evidence before making a decision. The claimant was advised they could Appeal.

On 1 July 2019 the Department received further evidence from the claimant.

On 11 July 2019 the claimant contacted the Department as they had heard nothing from the complaints team. During this phone call the claimant was advised that evidence had been sent to Capita for review.

On 13 July 2019 the claimant contacted the Department. An extract summary of the telephone call is provided:

'Claimant: My Mandatory Reconsideration was turned down. [The Telephony Advisor] said it's gone to another Decision Maker. I have more evidence that I didn't get to submit. How long will it take as I have further information? [claimant relays circumstances] – It's a mine field. I don't understand it. [Confusion around appeal].

Telephony Advisor: Further medical evidence went to Capita to see if it makes any difference.

Claimant: I have letter from neurophysio as well, I can send it.

Telephony Advisor: I can make a note that you are sending it in. I can't say for sure if they will wait.

Claimant: Only I rang I wouldn't know about the review...nobody's communicating with me. I just don't know...[claimant got upset].

[The Telephony Advisor offered the claimant the Make the call advice line and advised the claimant to put their name and National Insurance Number on top of further evidence].'

On 14 July 2019 Capita completed a change of advice report (PA6). The recommended descriptors provided the claimant with an award of Standard Daily Living and Standard Mobility.

On 21 July 2019 the Department received a letter from the claimant along with a recent physiotherapy examination findings letter stating:

'I ask that before you make your re-consideration that this further evidence is looked at. I don't think you can deny me this as not one person had the manners to inform me that my case was being reassessed – only I rang on Monday 11th July 2019 I found this out. I will gather every bit of evidence to prove your inconsistencies and misreporting.'

On the same date (21 July 2019) the Department sent the claimant a standard progress letter (PIP0502) advising that it now had enough information to make a decision. There is no record to confirm consideration of this additional evidence which was not referred to Capita for advice.

On 31 August 2019 the Department wrote to the claimant offering the Standard Daily Living; Standard Mobility award which the claimant accepted, and their Appeal lapsed.

This case evidences the lack of communication and confused picture provided to claimants prior to and during the Lapsed Appeal process.

Case Study 4 Conflicting communication regarding Department Award review following submission of Appeal

Award History

First Tier Decision (6 Jan 2019): Standard Mobility (10 points); No Daily Living (6 points)

Mandatory Reconsideration (19 Feb 2019): No change

Appeal Decision (18 July 2019): Standard Daily Living (8); Standard Mobility (10)

On 19 February 2019 claimant L was provided with a Mandatory Reconsideration Notice which advised that there was no change to the award (Standard Mobility, No Daily Living).

On 5 March the claimant's carer contacted the Department and queried *'If I disagree with the Mandatory Reconsideration and I have evidence to prove Capita disregarded Government guidelines, do I have to wait for an Appeal?'* In response the Telephony Advisor stated that they would request a call back from the Decision maker (Case Manager) as they did not make the decision.

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On 13 April a Department Manager spoke with the claimant's carer. A PIPCS 'Notes record' records *'I confirmed that if the [Department's] Appeals team get information that was not considered at MR [Mandatory Reconsideration], they can review it and make a decision to get new evidence/ clarification/ offer an award etc.'*

On 5 July 2019 the claimant's carer contacted the Department to query the progress on the review of the award. An extract summary is provided:

'Claimant carer: *I spoke to someone who said if I sent FME which can justify changes that would be sufficient*

Telephony Advisor: *There's nothing on the system. But that would be a decision for the Appeals Service. There is a letter from [Health professional]. Problem is it is dated 2012, I can't guarantee that Capita Assessors would take that into account*

Claimant carer: *What do you mean Capita*

Telephony Advisor: *Capita are medical professionals*

Claimant carer: *With all due respect Capita did not have this information*
Telephony Advisor: *This benefit is based on observations. Because this case is with Appeals, the Appeals Service would consider that there.*

Claimant carer: *I spoke to someone in PIP and asked if we provide you with new medical evidence would we not have to go to Appeal. And they said well if you supply medical evidence, which is accepted, then not necessarily. That's why we sent it, to avoid going to Appeal.*

Telephony Advisor: *I will have to speak to supervisor as I don't know what you have been told by the Telephony Agent.*

Claimant carer: *Clearly bad stuff, inappropriate- not inappropriate – clearly unprofessional misleading, the kind of stuff I've had problems with Capita. Basically Capita and DfC [the Department] are continuing to mislead me and continuing to cause stress.*

Telephony Advisor: *What I can do is apologise for the Advisor. They should have been well aware of the process that once it goes to Appeals, the Appeals make the decision. Yes it will be looked at but...*

Claimant carer: *What you are saying to me now is if I send you new medical evidence which proved that you gave me the wrong points, you don't change the points but it still goes to Appeal, then why did I send you the evidence.*

Telephony Advisor: *Because the more evidence you send in the better. The Appeals can overturn...'*

The Telephony Supervisor was then called to the phone. They advised that evidence would be looked at by the Department's Appeals section. The claimant's carer then queried whether the original Telephony Advisor was correct in his advice to send in medical evidence. A clear answer was not provided.

This case evidences the lack of awareness amongst Telephony Advisors of how the review undertaken by the Department's Appeals section differs to that undertaken by the Appeals Service and the arrangements for sharing the information between them. This results in mixed communications being provided to claimants.

Findings –

The repeated failure of the Department to provide all claimants with clear, complete, information and advice on the Department's ability to review the award again, following a Mandatory Reconsideration decision and the submission of an Appeal, evidences a failure to fulfil Principles 1 and 3 of the Principles of Good Administration. As a result many claimants were unaware of the impact further evidence provided at this stage may have, including the possibility that they may not have to go to the Appeal Tribunal. The lack of information also resulted in the confusion, and at times frustration, of claimants.

It is of note that had the claimants (reviewed during my investigation) not Appealed, then their original award would stand. Despite, in some cases, the award being overturned based on evidence available to the Department prior to the Appeal.

Recommendation 6.1 -

The Department should include advice/information on this additional stage of review within its Mandatory Reconsideration Notice and PIP advice documents. The advice should include:

- Communication that the Department will undertake a review of the award, including the claimant's further evidence (both previously available and newly received) following submission of an Appeal request, and/or receipt of additional further evidence;
- Explanation that claimants will not be contacted if a revision is not made to their award and their appeal will continue to the Appeal Tribunal; and
- Explanation of what to expect, for example, the possibility they will be sent an offer of award letter; detail of the consequences of accepting/not accepting the revised award, etc.

The Department should also introduce a form of contact at this stage (either via telephone or letter) to inform claimants when further evidence has been sent to Capita for review.

Department guidance should be updated to reflect the changes and staff should be retrained accordingly.

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Issue 2: Advice Requests

A Department Case Manager can request advice from a Capita Disability Assessor at any stage of the PIP claim process. In the majority of cases reviewed within my investigation, an advice request was raised as a result of further evidence. This evidence may have been newly received, or may have been evidence that was available at earlier decision stages, but was not previously referred for consideration by Capita.

My case file review identified that advice requests were sent both at Mandatory Reconsideration (38%¹⁴¹ of the 99 cases reviewed that went to MR) and, more typically, following a claimant's submission of an Appeal (71%¹⁴² of the 91 cases reviewed in which an Appeal was submitted). A Case Manager initially raises an advice request electronically, this is recorded in the PIPCS¹⁴³. The request is then picked up by a Capita Disability Assessor who completes an advice report¹⁴⁴. Prior to 30 March 2021, the report was then printed in a separate facility, posted via courier, and scanned on to PIPCS by the Department's Mail Opening Unit. Only then did it become available to view by the Case Manager. The Department advise that the PIP computer system automatically placed a 7 day timer on the case for receipt of the report.

My case file review identified that although Capita Disability Assessors typically completed and signed off on advice requests within 24 hours of receipt, there was often a delay of between 5-8 days before this advice was uploaded on the PIPCS system.

There were also a number of cases which identified significant delays (receipt up to 10 weeks after advice completion), where seemingly misplaced advice reports (containing sensitive personal information) were not followed up by the Case Managers for a significant period of time. As a result, in some cases, claimants were not provided with the change in award until several months after the advice had been completed.

In addition, it was not apparent from the case records if the Case Managers or the Department took any further action in these cases, other than requesting an additional copy of the report from Capita. I cannot therefore be assured that the Department took steps to identify what happened to any misplaced advice reports or whether, where necessary, the Department had reported these individual information losses to the Information Commissioner and/or potentially the claimants.

The Department advised my investigation:

141 36% of MR cases further evidence (which included letters of support from claimants/carers and/or medical evidence) was not forwarded to Capita for advice. 25% of MR cases no FE was provided.

142 27% of cases in which an appeal was submitted advice was not requested from Capita (52% of these cases had provided FE with/following their Appeal request). 9% of cases reviewed did not submit an Appeal.

143 The Department's computer system.

144 PA5 – Advice report with no change, PA6 – Advice report with change to descriptors.

'The Department accepts that on occasion, delays occur between a Disability Assessor completing a supplementary report and that report being uploaded to the PIP computer system. That does not however indicate that the report was misplaced or lost. It indicates the report was not properly generated by Capita in line with the normal process and sent to the Department's Mail Opening Unit for uploading to the PIP computer system... As part of the overall controls, the Department has a system in place whereby the Commercial Services team in the Department are alerted by the PIP Centre if large numbers of "report not received" tasks are generated on any given day. This is to allow them to investigate if any wider issues have prevented non-receipt of reports rather than isolated incidents. In order to minimise delays in receipt of reports from the assessment provider, the Department is currently progressing a change to the contract with Capita that will enable Capita to send reports to the Department electronically without the need for any printing of the documents and use of a courier service.'

I welcome the Department's advisement that from 30 March 2021 Capita now send advice reports electronically. This should mitigate any delays and/or potential loss of information in the future.

However I remain concerned that the Department have suggested that a Commercial Services alert of 'large numbers' of reports not received on any given day, addresses the possible individual information loss I have identified. I am also concerned that when asked to evidence its assurances that advice reports were not missing, but had instead never been printed, the Department advised that the issue arose as a result of anomalies following the deployment of CRM365 (Capita's computer system) in February 2019, an error which was identified in May 2019. However, the Advice requests in the majority of the case studies used in this section were requested and completed before February 2019, therefore this system issue would not apply in these cases.

The Department have not provided any evidence to assure me that, at the time the delay occurred, any confirmation was sought in the individual cases that the missing reports I have identified were a result of a 'printing error'. The records within the case files, some of which are highlighted within the case studies, would suggest that some of these missing reports were printed and sent by Capita.

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Case Study 5 Delay in upload of Advice Request

Award History

DLA Award: Middle Care: Higher Mobility

First Tier Decision (14 September 2018): No Award: No Daily Living (4 points), No Mobility (0 points)

Mandatory Reconsideration (5 November 2018): No Change

Offer at Lapsed Appeal: Standard Daily Living (8): Standard Mobility (8) (offer declined)

Appeal: Awaiting Tribunal

On 21 October 2018 (prior to a Mandatory Reconsideration Decision) advice was requested from Capita in relation to Claimant K's claim. This PA5 (no change) was completed by the Disability Assessor on 22 October. It was received and uploaded on PIPCS on 29 October 2018 (7 days following completion).

As a result of the identification that the claimants DLA GPFR (2016) had not been uploaded or considered during the claim, and following the submission of an Appeal (16 December) the Appeals Case Manager requested advice. A change of advice report (PA6) was completed by the Disability Assessor on 17 December 2018, however it was not uploaded on to PIPCS until 23 December 2018 (6 days following completion). The suggested descriptor choices would have provided the claimant with Standard Mobility and Standard Daily Living.

The claimant was not advised at this point that a PA6 had been received.

On 30 December 2018 the Appeals Case Manager requested further advice. This report, which confirmed the advice provided in the previous PA6, was completed by the Disability Assessor on the same day.

When this was not received by the Department, the Appeals Case Manager contacted Capita on 8 February 2019 (6 weeks following completion). Capita's system recorded:

'query call requesting copy of supplementary report completed on 30 Dec 2018. Advised it will be sent and wait for 4-5 working days.'

The report was subsequently received by the Department on 15 February 2019.

On 17 February 2019 (two months following completion of the original PA6 report) the claimant was offered standard Daily Living and standard Mobility which they did not accept. The offer of award letter contained no reference to the advice report or the DLA GPFR, as a result the

claimant recorded within a subsequent letter to the Appeal Service:

'One thing that troubles me is this – in the letter they claim that they have based their decision on the receipt of 'further evidence'. I am at a loss as to what further evidence they are referring to . I have not sent them any further medical evidence – any medical evidence which they hold about me has already been with them prior even to my application for PIP.'

A further advice request was completed by the Disability Assessor on 28 July 2019. When this was not received by the Department the Appeals Case Manager contacted Capita. The note on the PIPCS recorded:

'T/C to Capita – a PA5 was completed on [28/7/19] – this will be uploaded. Advised them that decision assist indicates 10 points for mobility, advised by [Capita] that any further queries to contact them once PA5 received.'

The advice report was subsequently received and uploaded by the Department on 26 August 2019 (one month following completion).

The case file held no record as to whether the advice reports had been posted by courier and misplaced, or postage had been delayed.

This case evidences two separate delays on two separate advice requests.

Case Study 6 Delay in upload of Advice request

Award History

DLA Award: Higher Care: Higher Mobility

First Tier Decision (28 August 2018): No Award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (4 November 2018): No Change

Offer of Lapsed Appeal (4 February 2019): Standard Daily Living (11): Standard Mobility (10)

On 6 December 2018 advice was requested from Capita in relation to Claimant D's claim following the claimant's submission of an Appeal. This was completed by the Disability Assessor on 7 December 2018. When this was not received by the Department, the Appeals Case Manager contacted Capita on 5 January 2019 (a month following request). The note on the PIPCS recorded:

'Chased again with Capita, who said that a PA6 had been sent some weeks ago, but still not received. Will send again as priority.'

The change of advice report was not uploaded until 1 February 2019 (8 weeks following completion and almost 4 weeks from the follow up call).

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It is of note that this advice request provided the claimant with an award of Standard Daily Living (11 points) and Standard Mobility (10 points).

Case Study 7 Delay in upload of Advice request

Award History

DLA Award: *Middle Care: Lower Mobility*

First Tier Decision (11 March 2019): *No award: No Daily Living (4 points): No Mobility (0 points)*

Mandatory Reconsideration (2 April 2019): *No change*

Lapsed Appeal [2nd Mandatory Reconsideration] (25 June 2019): *Standard Daily Living (10): No Mobility (0)*

On 18 May 2019 an advice request was made by the Department to Capita in relation to Claimant AD's claim following request for an Appeal. This was completed by the Disability Assessor on 19 May 2019. When this was not received by the Department, the Appeals Case Manager contacted Capita on 3 June 2019. The note on the PIPCS recorded:

'TC to Capita, re Supp report. Sent 19/5/19, not rec'd will resend.'

Two copies of the same advice report were subsequently uploaded by the Department on both 10 and 11 June 2019 (one month after completion). The copy of the report uploaded on the 10 June had been stamped by the Department's Mail Opening unit on 26 May 2019. The copy of the report uploaded on 11 June was date stamped 10 June 2019.

It is unclear whether the copy of the report date stamped on 25 May had been identified as being uploaded to the wrong claim and re uploaded, or whether it had been misplaced within the Mail Opening Unit.

The delayed change of advice report resulted in the claimant receiving an award of Standard Daily living.

Case Study 8 Delay in upload of Advice request

Award History

First Tier Decision (16 November 2018): *Standard Daily Living (9 points): No Mobility (4 points)*

Mandatory Reconsideration (10 December 2018): *No change*

Offer of Lapsed Appeal (5 February 2019): *Standard Daily Living (9): Enhanced Mobility (12)*

On 13 December 2018 an advice request was made by the Department to Capita in relation to Claimant AG's claim following submission of an

Appeal. This was completed by the Disability Assessor on 14 December 2018. When this was not received by the Department, the Appeals Case Manager contacted Capita on 1 February 2019 (7 weeks following request). The note on the PIPCS recorded:

'Call to Capita re PA6. This was sent on 14/12/18 but not in our attachments. This will be resent today.'

The advice request was subsequently received and uploaded by the Department on 5 February 2019. There are no further records on whether the advice note reported on the 14 Dec was located or formally reported by Capita or the Department as missing information.

This change of advice report resulted in the claimant receiving an award of Enhanced Mobility and Standard Daily Living.

Case Study 9 Delay in upload of Advice request

Award History

DLA Award: Higher Care: Lower Mobility

First Tier Decision (4 September 2018): No Award: No Daily Living (0 points): No Mobility (0 points)

Mandatory Reconsideration (20 October 2018): No change

Offer of Lapsed Appeal (18 February 2019): Enhanced Mobility (12): Enhanced Daily Living (15)

On 27 November 2018 an advice request was made by the Department to Capita in relation to Claimant AE's claim following submission of an Appeal. This was completed by the Disability Assessor on 1 December 2018. When this was not received by the Department, the Appeals Case Manager contacted Capita on 12 Feb 2019 (11 weeks from request). The note on the PIPCS recorded:

'A call was made to Capita regarding advice that was not returned. They advised that a PA6 had been completed and that a duplicate would be forwarded. Appeal task deferred for return'

The advice request was subsequently received and uploaded by the Department on 17 February 2019. There are no further records on whether the advice note reported on the 14 Dec was located or formally reported by Capita or the Department as missing information.

This change of advice report resulted in the claimant receiving an award of Enhanced Mobility and Enhanced Daily Living.

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Findings –

The repeated failure of the Department to ensure that advice reports were received, and uploaded, in a timely secure manner evidences a failure to fulfil Principles 1 and 3 of the Principles of Good Administration. As a result, some claimants experienced an avoidable delay in the overturn of their award. Furthermore concerns are raised that the misplacement of advice reports, containing sensitive personal information, were not being appropriately monitored or investigated by the Department.

Recommendation 6.2 -

As previously stated I welcome the introduction of the electronic sharing of advice reports. The Department should also:

- Introduce a follow up contact to Capita if an advice report has not been received electronically within 5 days of request. This 5 day contact should be repeated until the report has been received; and
- Introduce a flagging system when Capita advise that an advice report has been sent but has not been received electronically by the Department. This 'flag' should ensure that an appropriate section of the Department investigates the missing documentation and takes appropriate steps to remedy the issue (identifying where the document has gone, and informing the claimant and the Information Commissioner's office where necessary).

Department guidance should be updated to reflect the changes and staff should be retrained accordingly.

Issue 3: Considering evidence and recording decision making

I previously identified¹⁴⁵ that the only descriptive records of Case Managers' decision making, found within my case review, were contained within the decision letters provided to claimants. These letters rely heavily on pre-scripted statements found within the Decision makers reasoning (DMR) template¹⁴⁶. My case file review identified that these same pre-scripted statements were used by Appeals Case Managers when revising decisions.

The Appeals Case Managers also completed a Decision Making log, in line with the log used by the Mandatory Reconsideration Case Managers¹⁴⁷,

¹⁴⁵ Refer to Chapter 4 (Issue 2) and Chapter 5 (Issue 4 iii).

¹⁴⁶ Explained within Chapter 4 (Issue 2).

¹⁴⁷ Refer to Chapter 5 (Issue 4 iii).

alongside an Appeal stencil¹⁴⁸. However, both records contained limited information. No further analysis of evidence or reasoning for Lapsed Appeals decisions were recorded on the PIPCS, other than the revised award correspondence, which includes an offer of award letter and a statement of award letter entitled 'About your Appeal'.

i. Offer of award letter

My case file review identified that the offer of award letter (provided to claimants when a decision has been revised below the full enhanced award) is a basic template which requires minimal input from the Appeals Case Manager (new points and new award amount). An example extract is provided:

'Please only read this part if we have ticked the box

This letter is about The Personal Independence Appeal for [claimant]. Remember the information in this letter is about them...

Having reviewed the further evidence we have received, the Department is satisfied that we could award x points for the daily living part of PIP and x points for the mobility part of PIP. Full details of the points we can award you for each activity are shown on page 3.

Please read the boxes we have ticked

These points would entitle you to the:

Standard rate of £ a week to help with your daily living needs from [date]

What we need you to do

We need you to confirm whether or not you wish to accept this offer or if you wish your appeal to continue...'

These letters provided no explanation as to why a revision had been undertaken.

Although the letter used a standard statement '*having reviewed the further evidence we have received*' there was no advice as to what this evidence was; where it came from; how it was considered or whether it directly overturned the award decision.

Furthermore, in a small number of the cases reviewed, claimants were supplied with this phrasing when an award had been revised without the receipt of further evidence. In other cases, although further evidence may have been received, awards had been overturned on the basis of

¹⁴⁸ No longer in use.

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evidence that had previously been available. In these cases the standard 'one size fits all' statement, that further evidence had been received, could at best be described as misleading.

The letters also failed to provide any clear direction that the change in award was not as a result of a review by an independent Appeal Tribunal. Although a paragraph within the letter stated '*we need you to confirm whether or not you wish to accept the offer or if you wish your appeal to continue*', it is possible that vulnerable claimants may have confused this letter as a decision taken by the Appeal Panel as a result of their Appeal request. More so as no previous information was provided to claimants in regard to the Department's additional review stage, and the last action the majority of claimants had taken in these cases was to submit their Appeal request to the Appeals Service.

In addition, the letters provided no information on whether the claim had been considered again in full; what evidence was considered; how it was weighed; or why/if the original decisions on the claim had been considered incorrect. It is therefore, unreasonable to expect that a claimant could make an informed decision to accept an offer, lapsing their Appeal, when it remained unclear whether all available evidence had been appropriately considered.

The Department advised my investigation:

'There is no evidence to indicate that claimants who receive a lapsed appeal letter are in any way confused by the content of the letter or that they require more information from the Department to make an appropriate decision on the offer of a PIP award. The content of this [template] letter was shared and discussed with members of the Disability Consultative Forum, who welcomed its introduction, as offer of awards were previously only made by phone call. Written notification of award offers in possible lapsed appeal cases is not in place in DWP. This was an additional safeguard put in place by the Department and allows claimants to seek advice if necessary before accepting any offer of an award... This section of the report also fails to make any reference to the correspondence issued to claimants prior to receiving an offer of award letter including the detailed Department's response to their appeal. The appeal response provides a schedule of the evidence considered on the case and any subsequent evidence received is detailed in a further appeal submission, which the claimant also receives a copy of.'

I am disappointed that the Department has failed to recognise the brevity of these letters and the impact this may have on a claimant's ability to make an informed decision. I am also surprised that the Department refers to Appeal submissions as a way to suggest that claimants should be 'well

aware' of the evidence the Department have considered and how this resulted in a change/offer of award.

Firstly many of the cases reviewed within my investigation had no record of a submission report being sent prior to the offer of award being made. Secondly, the Appeal submission details the evidence in support of the **original** decision made by the Department, no explanation of a change in award is given as the document seeks to defend the original decision.

For example, in case study 12, the Department sought advice from Capita following the Appeal request. A change of advice report (PA6) report was received which advised that the claimant **should** be awarded 2 points for toileting needs. This PA6 report was recorded on the subsequent Appeals Submission, however within the '*Department's response to Grounds of Appeal*' section, it is recorded:

'[Claimant] states that [claimant] has difficulties managing [claimant] toilet needs or incontinence. (Tab 3). There is a lack of evidence to confirm a level of restriction exists with this activity. Informal Observations noted that [claimant] could sit and stand without difficulty. (Tab 4). The Case Manager decided that [claimant] can manage [claimant] toilet needs unaided and has awarded 0 points for this activity.'

No reference or recognition is given to the change of advice report stating that 2 points should be awarded for this activity. It is therefore unclear how the Department consider an Appeal submission would inform a claimant how or why an original decision has been overturned.

ii. 'About your Appeal' letter

If a claimant accepts an award offer, or if a decision is revised to the full enhanced rate for both Mobility and Daily Living, the Department provide the claimant with an award letter entitled '*About your Appeal*'.

The majority of '*About your Appeal*' letters reviewed within my investigation followed a similar format as First Tier Decision letters (overview justifications¹⁴⁹). As a result, I identified the same concerns as previously raised within Chapter 4.

As with the First Tier decision, the letters failed to list all evidence considered by the Case Manager in making their decision. Where select pieces of evidence were recorded the same unclear phrasing was used – such as:

¹⁴⁹ Explained within Chapter 4: First Tier Decisions.

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- *'the information provided by the health professional's supplementary report' or*
- *'the information provided by the health professional's review report'.*

It is extremely unlikely that the claimant would be aware that these phrases refer to the advice reports provided by Capita, with the *'review report'* referring to an advice report which suggests no change (PA5) and the *'supplementary report'* referring to an advice report which suggests changes to the descriptor choices (PA6).

In addition many of the standard statements used within the letter did not apply to the claimant. For example, many of the letters stated *'You asked us to look at your claim again as you disagree with the decision.'* In the majority of cases the claimant had not asked the Department to review their claim again, they had proceeded (following Mandatory Reconsideration) to submit an Appeal to the Appeal Service, not the Department.

Other recurring statements included *'We received the further evidence you sent us.'* In the majority of cases, where further evidence was sent, the claimant had sent this to the Appeals service, who had in turn provided it to the Department. The use of this phrasing may again serve to confuse claimants who were of the understanding that their claim was now in the hands of the **independent** [my emphasis] Appeal Tribunal Panel.

The letters also failed to provide an appropriate explanation of the award decision. Like the First Tier decision letters reviewed in Chapter 4, the Appeal Case Manager used pre-scripted statements to list the claimants advised functionality, followed by the determinations, with no corresponding analysis or evaluation to explain their decision. In the majority of cases the letters provided a limited amount of personalisation, with a few extracts from Capita's assessment observations or reference to the review of one piece of evidence at the end of the letter. No direct link was made to how this evidence resulted in the chosen descriptors.

These significantly pre-scripted templates lack personalisation and, to a degree, encourage passivity and complacency in making decisions on the part of Appeal Case Managers due to the lack of input required by them. Without a requirement to appropriately record an explanation of their decisions, or the evidence they have considered, assurances cannot be given that Appeal Case Managers have undertaken an appropriate review of all available evidence in making their decision.

I acknowledge that the Department, in response to queries about the decision letters, provided explanation that their approach to decision

letters is consistent with other benefits and that they have not received any complaints or adverse feedback regarding 'overview justifications'. However, I am not persuaded that this can be reconciled with good public administration. My investigation has repeatedly identified evidence that the Department failed to appropriately record its decision making on the PIPCS system or within its letters to claimants. The Department advises that this form of letter provides a summary of how the decision was made. Having reviewed a significant number of Department award decision correspondence within my case file review, I disagree that these provide an accurate and reasonable summary of the decision making which could be readily understood by claimants with regard to the part further evidence played in the decision.

Case Study 10 Lack of decision making recorded within Lapsed Appeal correspondence

Award History

DLA Award: Middle Care: Lower Mobility

First Tier Decision (22 October 2018): No award: No Daily Living (6 points): No Mobility (0 points)

Mandatory Reconsideration (3 December 2018): No change

Offer of Lapsed Appeal (1 March 2019): Standard Daily Living (11): No Mobility (0)

On 1 March 2019 the Department sent an offer of award letter to claimant S.

No advice was provided on why an additional review (outside of the Appeal) was undertaken; what evidence had been received and considered or how/why this evidence had changed the outcome of the first award. Or, alternatively, whether the original award was determined to be incorrect. There was also no record on PIPCS that an Appeal Submission report had been sent prior to this date.

Following acceptance of the offer, on 22 March 2019 the Department provided the claimant's appointee with an award letter entitled 'About your Appeal'. An extract of the letter is provided:

'I've considered all the evidence about your conditions and how they affect you as identified in:

- *The 'How your disability affects you' form, and*
- *The information provided by the health professional's review report, and*
- *The information provided by the health professional's supplementary advice.'*

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The claimant's GPFR (General Practitioner Factual Report) dated 17 July 2016; GPFR dated 21 August 2018; Appointee letter detailing restrictions; and two further GP letters supporting the claim dated 5 November 2018 and 10 February 2019 were not listed.

The letter also has a section headed 'Decision Maker's Reasoning'. An extract of this section of the letter is provided:

'You asked us to look at your claim again as you disagree with the decision.

I made my decision using information about your health condition or disability including details of any treatment, medication, test results and symptoms. This is the best available and enough to decide how much help you need.

You asked us to look at the whole decision.

We received your further evidence you sent us.

You said you have difficulties taking nutrition, managing toilet needs or incontinence, communicating verbally and reading and understanding signs symbols and words. I decided you can eat and drink unaided, manage your toilet needs or incontinence unaided, express and understand verbal information unaided and read and understand basic and complex information either unaided or using glasses or contact lenses.

You said you have difficulties managing therapy or monitoring a health condition. I decided you need an aid to manage your medication.

You said you have difficulties making budgeting decisions. I decided you need assistance to make complex budgeting decisions.

You said you have difficulties preparing food, washing and bathing, dressing and undressing and engaging with other people face to face. I decided you need prompting to prepare or cook a simple meal for one person, wash and bathe, get dressed or undressed, keep your clothes on, or select appropriate clothing and engage with other people.

You said you have difficulty planning and following journeys. I decided you can plan and follow the route of a journey unaided. You said you also have difficulty moving around. I decided you can stand and then move more than 200 metres.

This is consistent with the available evidence.

[Claimant] was quite withdrawn although there was no significant low mood evident. [Claimant] did not have any rapport with the assessor and [claimant] relied on [their family member] to answer the questions

for [them]. [Claimant] attends [their] own GP on a monthly basis and has thought of self harm. [Claimant] requires timetables but reported [they] can use public transport and taxis.

I have considered what your needs are on the majority of days.'

This case evidences the lack of information and reasoning recorded and provided to claimants within Lapsed Appeal documentation.

In this case the claimant was asked to decide whether or not they wished to accept an award without any information on the evidence used to change the award or why it has been changed. The award letter failed to list all available evidence and provided no reasoning/analysis to explain why the original decision was overturned. The Appeals Case Manager has used the standard pre-scripted statements and concluded with extracts of observations taken from the claimant's face to face assessment. Not only is this an inappropriate and incomplete explanation but the assessment extracts were taken from the claimant's most recent new claim assessment, not the assessment the claimant was appealing against.

The letter lacks appropriate personalisation, with statements being used such as *'you asked us to look at your claim again.'* This is not the case, the claimant had applied to The Appeals Service for an Appeal, they were unaware that the Department were undertaking a review. The letter also states *'I decided you need prompting to ... get dressed or undressed, keep your clothes on, or select appropriate clothing.'* It appears that this statement, providing multiple options, is intended to address a wide range of possible claimants rather than apply specifically to the individual claimant. The advisement that an individual needs or does not need assistance to *'keep their clothes on'* is not an appropriate 'blanket' statement to use.

Case Study 11 Lack of decision making recorded within Lapsed Appeal correspondence

Award History

DLA Award: Middle Care: Higher Mobility

First Tier Decision (8 Oct 2018): No award: No Daily Living (2 points): No Mobility (0 points)

Mandatory Reconsideration (19 Nov 2018): No change

Offer of Lapsed Appeal (13 January 2019): Standard Daily Living (8): Standard Mobility (10)

On 13 Jan 2019 the Department sent claimant J an offer of award. No advice was provided on why an additional review (outside of the Appeal) was undertaken; what evidence had been received and considered or

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how/why this evidence had changed the outcome of the first award. Or, alternatively, whether the original award was determined to be incorrect. There was also no record on PIPCS that an Appeal Submission report had been sent prior to this date.

Following acceptance of the award the Department provided the claimant with an award letter on 10 Feb 2019. An extract is provided:

'I've considered all the evidence about your conditions and how they affect you as identified in:

The 'How your disability affects you form, and

The information provided by the health professional consultation report, and

The information provided by the health professional review report, and

The information provided by the health professional supplementary advice.'

The list fails to record the claimant's DLA GPFR (2014), claimant support letters identifying functional issues, appointment letters for nerve injections and radiology, photos provided by the claimant, complaint letters, Occupational Therapy (OT) reports and assessments or GP referral for an urgent MRI and prescription list (which commenced the review).

The letter also has a section headed 'Decision Maker's Reasoning'. An extract of this section of the letter is provided:

'Daily Living

You asked us to look at your claim again as you disagree with the decision. I made my decision using information about your health condition or disability including details of any treatment, medication, test results and symptoms. This information is the best available and enough to decide how much help you need.

You asked us to look at the activities of preparing food...

Although you did not ask us to look at the other activities, I looked at all the information we have and find the other descriptors chosen are correct.

We received your further evidence you sent us.

I looked at all the information available and the areas you disagree with and find the descriptors chosen are correct.

You said you have difficulties taking nutrition, managing therapy or monitoring a health condition, communicating verbally and engaging with other people face to face. I decided you can eat and drink unaided, either

manage medication or therapy or monitor your health condition unaided, or you do not need to, express and understand verbal information unaided and engage with other people unaided.

You said you have difficulties preparing food, washing and bathing, managing toilet needs or incontinence and dressing and undressing. Further OT [Occupational Therapy] evidence confirmed that you required aids to manage these activities. I decided you need an aid to prepare or cook a simple meal for one person, wash and bathe, manage your toilet needs or incontinence and dress and undress.

Mobility

You said you have difficulty planning and following journeys. I decided you can plan and follow the route of a journey unaided.

You said you have difficulty moving around. I decided you can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres. Further OT evidence confirmed that you need a four wheeled walker.

This is consistent with your medical history and the available evidence...'

This case evidences the use of standard pre-scripted statements which do not apply to the claimant. The statement 'You asked us to look at... We received the further evidence you sent us...' is not accurate. The claimant had applied for an Appeal, they were unaware that the Department would reconsider the claim following their Appeal submission. The further evidence was sent to The Appeal Service by the claimant, not to the Department. The Appeal Service forwarded copies to the Department.

The letter also states 'I looked at all the information available and the areas you disagree with and find the descriptors chosen are correct...' However, in contradiction to this, the letter goes on to change the original descriptors.

The only reasoning provided for this change is 'Further OT evidence confirmed that you required aids to manage these activities...' This information was available prior to the assessment within the claimant's PIP2 application form as they had advised of the use of aids in relation to functionality, these were also recorded within the assessment report. However aids such as grab rails, disabled shower and rollator were negated by the initial Disability Assessor within the assessment report as the claimant was considered to be on moderate analgesia; had taken their grandson to the beach and 'will watch tv every day'.

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It is also of note that the change of advice report from Capita (PA6) which instigated the offer of award, did not refer specifically to the OT evidence as changing the decision, instead the Disability Assessor stated *'having reviewed the overall evidence it is likely that [they] would require aids...'*

The Appeal Case Manager also states *'I decided you can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres. Further OT evidence confirmed that you need a four wheeled walker.'* Again this information was available at the face to face assessment, prior to the First Tier decision, the Disability Assessor recorded within the Assessment Report that they observed the claimant use the walker.

The letter fails to appropriately explain why, two previous decisions were made (by Disability Assessors who had an awareness that the claimant used a mobility aid) that the claimant had no issues with mobility, and this decision had now been overturned on the basis of OT advice which advised that the claimant used an aid.

Case Study 12 Lack of decision making recorded within Lapsed Appeal correspondence

Award History

DLA Award: Higher Care: Lower Mobility

First Tier Decision (2nd Claim)(1 September 2018): Standard Mobility (8 points): No Daily Living (6 Points)

Mandatory Reconsideration (19 October 2018): No change

Offer of Lapsed Appeal (13 December 2018): Standard Daily Living (8): Standard Mobility (8)

On 13 December 2018 the Department sent Claimant B an offer of award letter. No advice was provided on why an additional review (outside of the Appeal) was undertaken; what evidence had been received and considered, or how/why this had changed the outcome of the first award. Or, alternatively, whether the original award was determined to be incorrect.

Following acceptance of the offer the claimant was sent an award letter entitled *'About your Appeal'* dated 31 December 2018. Extracts of the letter are provided:

'I've considered all the evidence about your conditions and how they affect you as identified in:

- The "How your disability affects you form", and
- The extra information you gave us, and
- The information provided by the health professional consultation report, and

- *The information provided by the health professional supplementary advice.'*

The claimant's DLA GPFR 2014; Appointment letters for psychiatric outpatient clinic; copies of the claimants illness related employment meetings; claimants written submissions to both the Department and the Appeals Service; previous assessment reports and decision letters; appointment letters for physiotherapy, SHIP (Self-Harm intervention Programme); and the claimant's social worker letter are not listed.

The letter also has a section headed '*Decision Maker's reasoning*'. An extract has been provided:

'Daily Living

You asked us to look at your claim again as you disagree with the decision. I made my decision using information about your health condition or disability including details of any treatment, medication, test results and symptoms. This information is the best available and enough to decide how much help you need. You asked us to look at the whole decision. We received your further evidence you sent us and social worker report.

You said you have difficulties taking nutrition, managing therapy or monitoring a health condition, communication verbally, reading and understanding signs, symbols and words, engaging with other people face to face and making budgeting decisions. I decided you can eat and drink unaided, either manage medication or therapy or monitor your health condition unaided, or you do not need to, express and understand verbal information unaided, read and understand basic and complex information either or unaided or using glasses or contact lenses, engage with other people unaided and make complex budgeting decisions unaided. You said you have difficulties preparing food, washing and bathing, managing toilet needs or incontinence and dressing and undressing. I decided you need an aid to prepare or cook a simple meal for one person, wash and bathe, manage you toilet needs or incontinence and dress and undress.

Mobility

You said you have a difficulty planning and following journeys. I decided you can plan and follow the route of a journey unaided.

You said you have difficulty moving around. I decided you can stand and then move unaided more than 20 metres but no more than 50 metres. Your medical evidence confirms your diagnosis. You are on medication for bladder infections and urinary tract infections. You are also on medication for pain and stated it is partially effective. This is consistent with the available evidence and the information you provided about how

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your disability affects you. I have considered what your needs are on the majority of days. I awarded you PIP for a set time as your needs may change.'

This case evidences the lack of information and reasoning recorded and provided to claimants within lapsed Appeal documentation.

Although the letter identifies further evidence provided by the claimant, and includes reference to the social worker's report, it provides no analysis of what this further evidence stated or if it was a result of this evidence the award was overturned.

In this case, the change in award occurred as 2 additional points were provided due to the determination that the claimant required an aid for toileting. The social worker's report listed by the Appeals Case Manager, identified the claimant's referral to SHIP for counselling and planned discussions with the claimants Consultant Psychiatrist. It also requested that the claimants GP refer the claimant to the pain clinic. There was no reference made in the social worker's report to the claimant's toileting needs.

Although incontinence issues were reported within the claimant's correspondence, there is no medical evidence within the case file which supports that the claimant is on medication for incontinence issues/ infections. The claimant's DLA GPFR dated 2014 – under the question '*self care – washing, dressing feeding, using the toilet, continence...*' the GP had written 'able to manage'.

The claimant previously underwent two Mandatory Reconsiderations which determined that the claimant had no toileting issues, stating '*You report difficulty managing your toilet needs..there is a lack of evidence to confirm such a level of restriction exists within this activity.*' and '*You receive no long term treatment or incontinence pads or aids for your bladder issues. You can get on and off the toilet with no issues.*'

It is not appropriate for me to determine whether this suggests the claimant does or does not have additional toileting needs, however the letter fails to appropriately explain on what evidence the decision was made or whether the previous decisions were considered to be incorrect and why.

Findings –

The repeated failure of Appeals Case Managers to record their decision making process, and appropriately advise claimants of the same within lapsed Appeal correspondence, evidences a failure to fulfil Principles 1 and 3 of the Principles of Good Administration. As a result I am unable to gain assurances from the reviewed case files, that Appeal Case Managers appropriately considered all available evidence.

Recommendation 6.3 -

I acknowledge that the Department do not accept that its Appeal Case Managers do not explain their decisions properly in award letters. In recognition of this the Department may wish to consider the introduction/ inclusion of a question on the understanding of these letters and the lapsed appeal process within its customer satisfaction survey. Further consideration should also be given to engaging with Advice groups to discuss the content of these letters and how they may be improved.

As previously recommended the Department should consider the introduction of an electronic decision template, for use by all Case Managers (Recommendation 4.1 and 5.8).

The offer of award letter should be reviewed and amended. The revised letter should include:

- A full explanation of the review undertaken by the Department – including clarification that this was a review undertaken by the Department, sitting outside of the Appeal;
- A full record of what evidence has been considered; and
- An appropriate explanation of why the award was overturned including, where relevant, identification that the previous award had been made incorrectly, for example as a result of the failure to consider further evidence at an earlier opportunity.

As identified, the lapsed Appeal Award letter follows the same template as First Tier Decision letters, therefore, recommendation 4.2 should address the inefficiencies across all award decision letters.

In addition, where a decision is later overturned at Appeal, the Department's presenting officer should complete a feedback template on the reasons for overturn. Where a presenting officer has not been in attendance the Department should request a written statement of reasons from the Appeals Service. The feedback template should be provided to the Case Managers involved in the claim to ensure learning and encourage personal responsibility for decision making.

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Issue 4: Getting it Right First Time

It should be acknowledged that the Department's ability to continually review cases, through Mandatory Reconsideration, lapsed Appeal, and where further evidence is received, is valuable. 13¹⁵⁰ of the cases reviewed within my case file review were provided with additional points at Mandatory Reconsideration (9 of which resulted in a change in award), and 55¹⁵¹ of the cases had awards increased at lapsed Appeal. A further 22 of the cases were provided with additional points at the Appeal Tribunal with 16 resulting in an increased award.

However, I am concerned that there is an over reliance on repeat opportunities provided within the process to review evidence as a way of ensuring claimants are given the award they were ultimately entitled to. Particularly as my case file review identified missed opportunities to get the award decision 'right first time'. This potentially means that claimants who have neither the support nor tenacity to take their case to Mandatory Reconsideration and Appeal, lose out on a critical benefit which they could be entitled to.

I have previously identified within earlier chapters and case studies, an apparent lack of First Tier and Mandatory Reconsideration Case Managers questioning contradictions between Capita assessment reports and further evidence, alongside a failure to request or refer further evidence for review. I acknowledge, and have identified¹⁵², that Appeal Case Managers often rectified some of these issues and revised award entitlements. However, I remain concerned that these decisions were not made earlier within the process.

The President of Appeals also commented on the need for the Department to take earlier evidence intervention within his latest report¹⁵³:

'As noted earlier PIP accounted for 70% of appeals registered during the reporting year. Regrettably I must repeat the comments made in last year's report. I repeat my view that the Department need to carry out a more robust investigation prior to initial decision. Once more this reflects my comments above about DLA decision making. It will be readily apparent to the reader that in almost every one of the 19 cases mentioned above, legally qualified members have referenced the benefit of having medical notes and records available at hearing. The Department should seriously consider obtaining a detailed report from a general practitioner in all cases prior to initial decision.'

¹⁵⁰ 1 of the 100 cases reviewed did not request a MR.

¹⁵¹ 9 cases of the 100 cases reviewed did not request an Appeal.

¹⁵² Chapter 1 Case Study 4, Chapter 3 Case study 1&4, Chapter 4 Case Study 1, Chapter 5 Case Studies 15-19 & 22.

¹⁵³ 'Report by the President of Appeal Tribunals on the standards of decision making by the Department for Communities' 2017/18 Available at [President's Report \(communities-ni.gov.uk\)](https://www.communities-ni.gov.uk)

Such a report could supplement any assessment carried out by a health professional...A broadly similar recommendation was made in Walter Rader's excellent and informative report (Personal Independence Payment - An Independent Review of the Assessment Process – June 2018)... Although the Department partially accepted Mr Rader's recommendation about this issue (see their response dated November 2018) there is still no evidence that they have taken any substantive action. This is most unsatisfactory.'

Case Study 13 Missed opportunities to get it right first time

Award History

First Tier Decision (2 January 2019): No award: No Daily Living (6 points): No Mobility (0 points)

Mandatory Reconsideration (8 March 2019): No change

Offer of Lapsed Appeal (11 May 2019): Standard Daily Living (8): Standard Mobility (10)

Claimant AH whose condition is recorded as COPD (Chronic obstructive pulmonary disease), applied for PIP on 12 October 2018. On 14 October the claimant's DLA evidence was uploaded including a Consultant Neurologist Report and a statement from their GP. On 22 October 2018 a further GP letter (dated 2013) and patient details printout were received from the claimant.

Following Capita's face to face assessment a Department Case Manager reviewed the available evidence and determined that the claimant was not entitled to PIP.

At no point did the Case Manager query or request further evidence to clarify contradictions/inconsistencies between the observations/descriptor choices within the Assessment report and the claimants reported functional restrictions. For example:

The Assessment report identified that the Disability Assessor chose Descriptor 12a '*can stand and then move more than 200 metres, either aided or unaided*', despite the Disability Assessor not observing the claimant walk during the consultation. The claimant had reported they could only walk between 20 to 40 metres aided, with pain and fatigue. The DLA Consultant Neurologist report advised that the claimant has pain and sciatica, Left foot drop, numbness in left leg, causing trips – likely progressive condition, alongside a further confirmed diagnosis of osteoporosis. The GP letter confirmed diagnosis of spondylosis of the spine and stated '*[They] continue to have back pain, reduced mobility due to back pain and leg weakness and the ongoing muscle twitching in [their] shoulder.*'

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As justification for choosing Descriptor 12a the Disability Assessor recorded *'..Therefore given all the evidence, it is likely [they] can stand and then move more than 200 metres aided, safely, timely, and repeatedly to an acceptable standard.'* No reference was made to previous DLA evidence or the claimant's GP letter in deciding the descriptors.

On 12 January 2019 the claimant requested a Mandatory Reconsideration advising that they had a very severe physical health disability and the extent of their disabilities were, in their view, being under assessed.

On 7 March 2019 the claimant provided a number of appointment letters and a patient record printout.

On 8 March 2019 a Mandatory Reconsideration Notice was provided to the claimant with no change to the award. At no point did the Mandatory Reconsideration Case Manager query or request further evidence to clarify contradictions/inconsistencies between the observations/descriptor choices within the Assessment report and the claimant's reported functional restrictions.

The claimant submitted an Appeal to the Appeals Service who subsequently requested an Appeals submission from the Department.

On 28 April 2019 the Appeals Case Manager referred the claim to Capita for further advice. In response the Disability Assessor advised:

'The evidence has been reviewed (9 viewable attachments) and the following advised:

[Claimant] reported the conditions of COPD, arthritis, spondylosis and stenosis causing pain in lower back. [Claimant] is prescribed moderate pain relief which is not taken at the maximum dose and moderate medication for COPD. [Claimant] conditions are managed by the GP and [Claimant] advised medication is effective. [Claimant] reported every day is a bad day.

[Claimant] reported having aids as described and is able to drive an automatic car regularly.

The IO showed some restriction sitting and standing reporting back pain in lower back. [Claimant] used a walking stick for support, no evidence of breathlessness at assessment and no evidence of upper limb restriction. The MSK showed restriction due to back pain. [Claimant] completed lower limb movements with the support of a stick. [Claimant] was able to complete upper limb movements but reported shoulder and upper back pain. [Claimant] demonstrated bilateral power and pinch grip.

The GP printout confirms conditions and medication.

I note the FME most of which is historical. The GP letter dated 24.8.13 confirms conditions and symptoms at that time. I note there is an appointment letter for 9.1.19 at the neurology centre it is unclear what this is for as [claimant] advised [they] halve] no ongoing specialist input at assessment.

Act 1B – At assessment [claimant] reported having aids, [claimant] IO and MSK showed restriction consistent with condition history. It is likely [claimant] requires aids to prepare a meal reliably.

Act 12D – At assessment [claimant] reported restriction due to pain. This appears consistent with condition history, IO and MSK. It is likely [claimant] can stand and walk 20 metres but would be restricted to 50 metres reliably.

Advised descriptors 1b, 2a, 3a, 4b, 5b, 6b, 7a, 8a, 9a, 10a, 11a, 12d

No further changes review in 3 years advised as the FE [Further Evidence] indicates a neurology appointment there is potential for change.'

The change of advice report resulted in the claimant being offered an award of Standard Daily living and Standard Mobility, which was accepted and the Appeal lapsed.

This case evidences how the questioning of evidence already available, i.e. the GP report and the observations within the face to face assessment can change a decision. If this had been questioned by the First Tier Case Manager or the Mandatory Reconsideration Case Manager it is possible that the award would have been overturned at an earlier stage – with the possibility of the decision being right first time.

Findings –

The failure of the Department to ensure that Case Managers utilise their role and decision making powers to get decisions right first time, and the Department's failure to identify variation in approach to the Case Manager role, evidences a failure to fulfil Principles 1 and 6 of the Principles of Good Administration. As a result claimants are at times faced with the distress and frustration of continual reviews which may have been resolved at an earlier stage.

As previously recommended in Recommendation 5.6 the Department should introduce a feedback template to record why decisions are overturned at lapsed Appeal and whether actions could have been taken at an earlier stage to overturn the award.

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Chapter 7: Complaints

This Chapter outlines how the Department handles PIP complaints about Capita's service delivery as the Assessment Provider and how complaints about further evidence are investigated. The governance surrounding PIP complaints is also discussed.

Issue 1: The Department's role in investigating Capita complaints.

Prior to the introduction of PIP in Northern Ireland in 2016, a decision was made that the then Social Security Agency (SSA) (previously responsible for the administration of Disability Living Allowance) would remain part of the complaints process about the Assessment Provider's (Capita) service delivery of PIP assessments. These arrangements continued when the Department for Communities was established in May 2016.

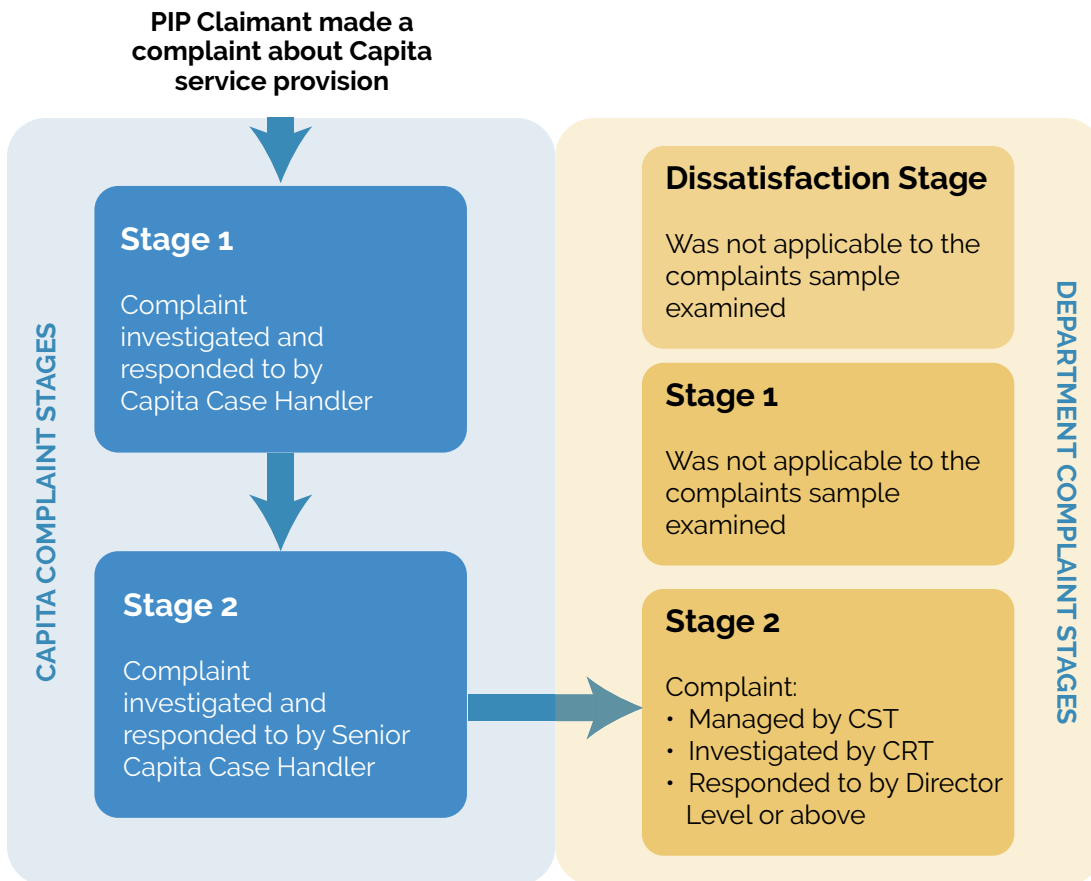
The Department told my investigation that the decision was taken to retain its involvement in the complaints process as PIP claimants were ultimately their benefit customers (regardless of the fact that the assessment is undertaken by a private contractor) and it was therefore important to review and investigate the complaint before signposting further. This approach differs from the Department for Work and Pensions which does not investigate complaints about Assessment Providers. The Department has characterised their approach as providing further governance and accountability in the delivery of PIP in Northern Ireland.

The Department advised my investigation that between June 2016 and 30 September 2020, Capita had received 3, 623 PIP complaints and the Department received 1, 616 PIP complaints. The combined total equates to 2% of the total of PIP claims processed and does not account for claimants who complained to both Capita and the Department.

As part of my investigation, 48 PIP complaint files were reviewed in which the claimants had undergone a two stage complaints process with Capita and a third complaint stage with the Department. The claimants in these cases had brought their complaints to the Department for investigation as they remained dissatisfied with Capita's responses. In making a complaint to the Department, following investigation of the issue by Capita, the claimants entered into what the Department refer to as Stage 2 of their complaints process, as illustrated by Diagram 1.

Obtaining a sample from this grouping of complaints presented my investigation with the opportunity to examine whether concerns about further evidence were appropriately dealt with at each stage. My review of the sample of complaints files, which included retrieving both the Department's and Capita's complaints material, focused on examining how concerns about further evidence are dealt with in the administration of PIP. I have however identified wider concerns about the Department's handling of PIP service complaints in relation to the Assessment Provider (Capita) which I shall address.

Diagram 1: Route by which the complaints examined in the NIPSO investigation progressed through the Capita and Department complaints process¹⁵⁴



154 Illustration produced by NIPSO.

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The Department's Customer Service Team (CST) administratively record and manage the Stage 2 complaints. It was observed that the core complaints handling duties, including preparing a draft response for the Director of Pensions and Disability, fell to the Customer Response Team (CRT) within the PIP business area.

In contrast to the outward commitments made by the Department, about the independent nature of their enquiries into complaints, there is little evidence that the Department independently or robustly investigate issues of dispute about Capita's service delivery.

Within the complaints sample reviewed, the following statement, or similar, was contained in the majority of Departmental complaint responses to the claimant:

'[name], Manager of the PIP Centre, has contacted Capita and they have provided him with an assurance that all of the issues you raised with them have been investigated and addressed in their letters to you to date.'

Although some further information is provided in a number of the Department's complaint responses, this statement essentially outlines the extent of the Department's standard of investigation in these complaints to be one of mere acceptance of what Capita concludes in respect of complaints about their service. The statement is also arguably written in an ambiguous manner so that the reader may infer a higher level of effort and scrutiny by the Department into Capita than has routinely occurred.

The Department has confirmed that in fact the Manager of the PIP Centre does not personally contact Capita within the process. A member of the Department's CRT instead contacts Capita's Complaints Team by email to ascertain if they have issued their final complaint response to the claimant and to obtain copies. It was observed that this email correspondence is not typically saved by the Department within the complaints file.

The PIP manager is then provided with Capita responses which are reviewed against the claimant's complaint to the Department. It is by this method that the Department tests the 'assurance' provided by Capita that the complaint issues raised either in writing or by telephone, have been *'investigated and addressed'*. It is important to highlight that the Department does not request copies of claimants' original complaint correspondence to Capita or the notes produced of complaints raised by telephone.

In the complaints reviewed the Department therefore did not have, unless provided by the claimant, a copy of the original complaint made to Capita. In these cases the Department seemingly relied upon Capita's summary of the complaint issues captured in their response. This included cases

where claimants had raised additional concerns with the Department about the adequacy of Capita's complaints process. There were no records of the Department conducting follow up calls with either the complainant or Capita to confirm the issues of complaint. The Department therefore cannot accurately consider whether all issues have been investigated and addressed.

The Department's CRT also prepare a 'PIP background' document, which primarily provides a timeline of the PIP application but does not present analysis around the service complaint issues raised about Capita. A draft response is prepared by the CRT which is presented to the Director of Pensions, Disability and Benefit Security, along with the background document; copies of the claimant's complaint to the Department; and Capita's responses. Following approval and sign off by the Director the Department's response is then issued to the claimant.

In the majority of the complaints sample reviewed no further enquiries were made before the letter was issued to the claimant. I recognise that in many of the complaint issues raised there may be limited enquiries that the Department could in fact conduct, in particular where evidence relies solely on conflicting accounts. I am, however, concerned the Department does not routinely conduct what I consider to be basic relevant enquiries in order to '*act fairly and proportionately*'¹⁵⁵ to establish the facts of the case and to assure itself the response being provided is accurate.

In the complaint sample reviewed the Department did not routinely obtain and review Capita's complaint file material, including:

- Original complaint correspondence/telephone notes
- Relevant interview notes;
- Audit History reports; and/or
- Clinical governance reports.

The Department did not conduct its own interviews within these complaints or seek contributions from relevant Capita personnel. The Department's own Health Assessment Advisor (HAA) can be asked to provide input into complaints where the issue of dispute requires clarification from a health professional's perspective. With the exception of one case the Department did not seek input from the HAA to examine relevant issues of dispute against Capita's provision. In the case where this did take place, the HAA's input was sought only after it was requested by the claimants' advocate.

¹⁵⁵ *Principles of Good Complaint Handling, Principle 4 'Acting fairly and proportionately'*. Web document available at <https://nipso.org.uk/nipso/for-organisations/information-and-guidance/>

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During the course of my investigation I also shared some observations with the Department about a number of concerns I had about the complaint process, this included the interface of complaints with the decision making process on claims. The Department have advised that if a complaint is upheld, which leads to a change in advice from Capita, a supplementary report is provided to the Department to consider in respect of the decision making on the claim. Within the complaint sample reviewed, it was observed however that some claimants had an expectation that their complaint to Capita (whether upheld or not) was available to the Case Manager responsible for making the decision on their PIP application. It is important to highlight that this is not the case. Within my telephony review I also observed inconsistencies in advice provided to claimants about whether the Case Managers await the outcome of the complaint before making a decision.

Case Study 1 No independent investigation by the Department of complaint

Award History

DLA: Middle Care: Low Mobility

First Tier Decision (8 February 2019): No Award: Daily Living (2 points): Mobility (0 points)

Mandatory Reconsideration (4 May 2019): No change

Appeal (17 November 2019): Standard Daily Living (8): No Mobility (0)

Claimant AI, who was in receipt of Disability Living Allowance (DLA) applied for PIP on 3 November 2018. Claimant AI, accompanied by a family member, attended a face to face consultation with a Capita Disability Assessor on 31 December. The Disability Assessor completed the assessment report on 8 January and the Department issued a decision letter on 8 February 2019 notifying the claimant they were not entitled to an award of PIP. On 16 February Claimant AI contacted the Department requesting a copy of the assessment report.

On 20 March Claimant AI submitted a complaint to Capita. A Welfare Rights Officer acted on behalf of the claimant in the complaints process. The service complaint issues raised with Capita included, but were not limited to, allegations that: the Disability Assessor refused to let the claimant's family member assist the claimant during the consultation; information recorded in the assessment report from the consultation was inaccurate; and that the report was written up one week after the consultation took place. Concerns were also raised that the claimant's primary condition was recorded in the assessment report as Tinnitus but

is reported by the claimant to be Post-Traumatic Stress Disorder, Anxiety and Depression.

On 15 April Capita provided a response to the claimant which advised that the Disability Assessor had been interviewed but could not recall the assessment and therefore Capita was unable to make a conclusive decision on the issues of complaint. The Capita response advised however that having reviewed the assessment report there was no evidence that the Disability Assessor had not considered the claimant's conditions.

Claimant AI wrote again to Capita on 26 April stating that Capita's initial response was contradictory, incomplete and unsatisfactory. The claimant raised that Capita had not responded to their concern about the delay of a week, from the consultation to the completion of the assessment report, in reference to their dispute about the Disability Assessor's recall and the accuracy of the report.

Capita responded to the claimant on 4 June and acknowledged that not all issues had been fully investigated, specifically that of the report being completed one week after the consultation. Capita apologised for not addressing this issue and stated feedback had been provided to Complaints Case Handler.

Capita proceeded to inform the claimant that Disability Assessors are not expected to **complete [my emphasis]** assessment reports while with the claimant but within an agreed internal timeframe. Capita further explained quality checks may mean a slightly delayed timeline in the **submission [my emphasis]** of assessment reports to the Department, but that Claimant AI's report was submitted to the Department within the contractual Service Level Agreement (SLA).

Claimant AI's assessment report was not subject to an internal audit therefore the reference to delays resulting from quality checks is not relevant to this case. Capita's response did not advise how long the 'internal timeframe' for Disability Assessors to **complete** reports after consultation is and if it was met in this case. It merely advised that this assessment report was **submitted** within the SLA with the Department. The SLA referred to is the 'end to end' target number of days for Capita's receipt of the claim to submission of report to the Department and is not relevant to the specific complaint issue raised.

In closing the response of 4 June, Capita stated, *'I hope this letter, which is the second and final part of our internal complaint process provides you with the assurance your concerns have been investigated and addressed.'*

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Claimant AI remained dissatisfied and proceeded to submit a complaint to the Department on 18 June, attaching the earlier complaint correspondence sent to Capita at Stage 1 and Stage 2 of the Capita complaints process. Claimant AI's complaint letter to the Department also contained some further examples of concerns about the assessment and concluded:

'It is inconsistencies and contradictions such as these that have caused considerable upset to [Claimant AI] and [their family member] that the responses from Capita have only served to compound. We trust that you [the Department] will investigate all of [Claimant AI's] concerns and provide full and detailed explanations.'

The Department responded to Claimant AI's complaint on the 5 July. In respect of the original service complaint issues raised about Capita, the Department responded:

'I can advise that [name], Manager of the PIP Centre, has contacted Capita regarding this matter and they have provided him with an assurance that all of the issues you raised with them have been investigated and addressed in their letter to you dated 15 April 2019 and most recently on 5 June 2019. Having reviewed the content of the letters I am satisfied that the issues raised in your complaint have been fully investigated and addressed by Capita. While I fully accept you remain wholly dissatisfied with Capita's responses, I should explain that as there is no independent evidence available to me other than the content of your complaints to Capita and their replies, I am unable to make any further comment over and above that already provided to you.'

The Department proceeded to comment on two additional examples of concerns raised in the complaint letter sent to the Department on 18 June. A third example highlighted in the complaint letter, which related to reported inconsistencies within the assessment report about Claimant A's management of medication and which had also been raised in the original complaint to Capita, was not individually addressed in the response by the Department.

The Department had not requested any information or material from Capita, other than their complaint responses. The Department had not conducted any independent enquiries in respect of the original issues raised nor are there any records of analysis of the available evidence.

It should also be noted that the complaint correspondence between Capita and the claimant was not available to the Case Manager who conducted a Mandatory Reconsideration of the Department's decision

on 4 May 2019. The Mandatory Reconsideration resulted in no change to the decision on the PIP award.

The complaint correspondence between the claimant and the Department was not available to the Case Manager who prepared and sent the Department's schedule of evidence to the Appeals Service on 3 August 2019. The Department's PIP decision was subsequently overturned at Appeal and Claimant AI was awarded the daily living component of PIP.

Irrespective of award outcome, Claimant AI, who placed their *'trust'* in the Department to investigate their concerns suffered the injustice of not having the complaint investigated by the Department in any meaningful way.

Findings –

The Department's standard of investigation into service complaints about Capita is inadequate and does not meet Principle 4 of the Principles of Good Complaint Handling.

The Department's current approach to complaints handling, regardless of whether complaints are upheld or not, is unlikely to deliver meaningful outcomes and secure confidence in the administration of the PIP system.

Recommendations –

Given the commitment by the Department to investigate complaints about Capita's service delivery the Department should review the process by which it conducts its own investigations.

Each complaint requires an individualised approach by the Department to address the specific issues raised however there are standard actions that would be expected, to include:

- Obtaining all copies of the original complaints to Capita and for the Department to communicate with the claimant to confirm the issues of complaint that remain outstanding or which are new.
- Obtaining a copy of Capita's complaints file to include all source material gathered or created during their complaint process. This may include but is not limited to interview notes, clinical advice, audit advice, audio recordings and records of complaint analysis.
- Record within the complaints file when information is requested from Capita. This includes making notes of telephone calls and

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saving emails.

- Identify and carry out enquiries that independently test Capita's source material and findings against the complaint issues raised. This may include but is not limited to obtaining input from Departmental Advisors, interviewing witnesses [it is not part of Capita's complaint process to obtain evidence from those who accompany claimants to assessments] and seeking further contributions from Capita.
- Record the decision making in the investigation process as well as the rationale for the complaint outcome.

Both the Department and Capita should make it clear to claimants who make a complaint that Department Case Managers are not notified of complaints and do not have routine access to the complaint issues raised.

Issue 2: The Investigation of Complaints about Further Evidence

It is reported that the main themes in PIP complaints received by Capita relate to the *'conduct of the Disability Assessor'* and *'content of the assessment report'*. It is consistently recorded the main complaints received by the Department at Stage 1 of their complaint process include complaints which relate to *'benefit processing issues/ decisions/ claims disallowed'* and at Stage 2 *'unhappy with the Capita assessment/ assessment report'*.

From the complaint sample reviewed in my investigation, concerns raised by PIP claimants about further evidence were also observed in 22 out of the 48 complaints and found to be closely aligned to the primary complaint themes reported. Complaints about further evidence primarily centred on assertions that relevant further evidence was not requested, or appropriately considered, in the assessment process.

In contrast, and in response to my investigation, the Department stated it considered just 5 of the 22 cases included a complaint about further evidence not being requested or considered. The Department stated although the additional 17 complaints contained references to the claimant's concerns that the assessment report content was not supported by the evidence, it took the view that these complaints were about the content of the assessment report and how the Disability Assessor had interpreted the evidence when compiling the report.

It is recognised that often when a complaint is raised the claimant is also disputing the outcome decision on their entitlement to PIP. The claimant has a right to both challenge the decision of entitlement and make a

complaint of maladministration¹⁵⁶. In practical terms it can be difficult for all parties to navigate these processes and separate out procedural and service standards complaints from challenging the decision on the claim.

The Mandatory Reconsideration and Appeal process which the claimant may pursue to dispute the decision outcome solely looks at their entitlement to a PIP award at the time of application and will not consider whether maladministration has occurred. It is important to note that where a benefit decision is overturned, it does not follow that maladministration has occurred within the process. For instance the overturn may result from genuine additional evidence (as distinct from further evidence that simply wasn't requested) becoming available to the new decision maker (at Mandatory Reconsideration or Appeal) which was not previously available to the original decision maker.

Separate to the Mandatory Reconsideration and Appeal Process, the complaints process does not consider the benefit outcome. The complaints process can, however, and should investigate concerns that the Assessment Provider (Capita) or the Department failed in their service delivery to take into account relevant considerations in the assessment advice and decision making process. This can include allegations that relevant further evidence requests were not made or alleged failures that relevant evidence was not considered.

From the complaint sample reviewed within my investigation I found the Department's and Capita's complaints handling of concerns raised about further evidence to be inadequate and inconsistent.

In complaints where a claimant reported that relevant further evidence had not been requested from a health professional in respect of their claim, this issue was not scrutinised. Capita consistently advised claimants that the decision to request further evidence is a clinical decision for the Disability Assessor and did not investigate the issue any further. No action was taken to examine whether a request for further evidence should have in fact been sought to inform advice at initial review or on completing the assessment report. Furthermore it is incorrect to present that further evidence requests solely result from clinical driven decisions. As outlined in Chapters 2 and 3 the drive to meet service contract time targets appears to significantly influence the decision making on whether further evidence requests are made in PIP claims.

Similarly the Department's complaint process offered no further

¹⁵⁶ Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

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examination of the allegation. This is particularly concerning as the Department is not aware of what requests are made by the Disability Assessor(s) in a claim unless a request issued by Capita is responded to and held within the claim file. In addition to reinforcing the position taken by Capita, the Department failed to reflect that the substantive nature of the complaint, although often articulated as an alleged failure by the Disability Assessor, could also be extended to the Department's service provision.

Once all evidence gathering has taken place by the Capita Disability Assessor, including a face-to-face consultation where appropriate, it is the role of the Department's Case Manager to review the claim and all evidence provided to make a decision regarding the award of benefit¹⁵⁷. The assessment report contains advice but it is ultimately the responsibility of the Case Manager to ensure that all necessary evidence is brought to light to inform their decision making¹⁵⁸ and as such they may direct that further evidence is requested by the Assessment Provider (Capita). Claimants are unlikely to be aware of the role of the Case Manager in scrutinising whether the necessary evidence has been sought. I observed, from the complaints sample and telephony review conducted, that claimants were routinely informed the decision to request further evidence lies solely with the Disability Assessor.

From the complaint sample reviewed I also identified there to be an inconsistent approach by the Department and Capita in response to concerns that relevant further evidence was not adequately considered. Responses from Capita often included a statement to the effect of:

'I can also see the DA [Disability Assessor] has considered the PIP application form and FME [further medical evidence] submitted in support of your claim for PIP when selecting the descriptors for each activity...'

However, there are no records in the Capita complaints files to establish how this was determined and suggests that the extent of the scrutiny was simply a check that the evidence was listed in the assessment report. Alarming, it was noted in one case, an inaccuracy with this statement extended to no further medical evidence in fact being available to the Disability Assessor with regards to the claim. In several other cases it was identified further medical evidence was not referred to at all within the justification for the descriptor choices yet the statement was included as part of Capita's response to the complaint.

¹⁵⁷ PIP Assessment guide Part 1: the assessment process, Para 11.8. Web document available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-1-the-assessment-process>

¹⁵⁸ DfC Decision Makers Guide, Volume 1, Chapter 1-Principles of decision making and evidence, Para 1345. Web document available at <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dmg-vol1-chapter-01.pdf>

In a number of cases a clinical governance review was conducted as part of Capita's complaint investigation to further examine if the further evidence identified was appropriately considered by the Disability Assessor in formulating their advice. Whilst, this is to be welcomed it is unclear how these complaints were selected for a review and why Capita applied a different standard of investigation to complaints of a similar nature in which clinical opinion was not obtained.

I also noted a flawed understanding reflected within Capita's *'PIP Clinical Governance Statement'*¹⁵⁹. The statement stipulates in respect of complaints that:

'Investigations are carried out by trained customer relations professionals and CG [Clinical Governance] supports this team when clinical opinion is required on either report quality or general clinical queries.'

The statement however goes on:

'Capita PIP does not have the facility to action or investigate complaints specifically about report content. This is out of the scope of our services as it is covered by the 'mandatory reconsideration' process that takes place internally within the department.'

As report quality and report content are invariably linked, the attempt to distinguish is not appropriate. It is also not correct to state that report content is out of the scope of a complaint investigation on the basis that Case Managers will review the report content for the purposes of their decision making on the claim outcome. It is hard to imagine how this distinction could be easily understood or reconciled in the mind of the average claimant.

An inconsistent approach was also observed in the Department's complaints handling of these types of complaints. Typically where a claimant raised concerns that further evidence was not appropriately considered, the Department relied on the fact that the Case Manager in the claim had agreed with the Disability Assessor's advice on the descriptor choices. This was despite the fact that the Case Manager's consideration of the evidence was not reviewed in the complaint.

In one case input was obtained in the complaint investigation from a Departmental Health Assessment Advisor upon request by the claimant's advocate. Shortcomings were identified and the Department took action to feed this into the claim process and the potential impact on the claim was examined. It is unclear however why the Department applied different standards of investigation to similar complaints in which input from a Health Assessment Advisor was not requested.

¹⁵⁹ Capita *'PIP Clinical Governance Statement'*, Sections 8.2 & 8.3, P.23.

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Case Study 2 No meaningful examination of complaint that further evidence was not requested

Award History

DLA: Highest Care: Low Mobility

First Tier Decision (25 February 2019): No Award: Daily Living (2 points): Mobility (0 points)

Mandatory Reconsideration (16 April 2019): No change

Appeal Decision (15 March 2020): No Award: Decision Confirmed, Daily Living (4): Mobility (4)

Claimant AJ, whose primary condition was recorded as Diabetes Neuropathy, was in receipt of DLA when they applied by telephone for PIP on 24 December 2018. During the telephone call and in response to the question 'Who is the best person to tell us about your condition, hospital, GP [General Practitioner]?' Claimant AJ responded 'I've got quite a few different doctors for different conditions, probably my own doctor may be the best...He would have all the information from all the different hospitals I would attend.' Claimant AJ provided the contact details of their GP and it is recorded that the claimant provided consent for the Department to use their DLA evidence in support of the PIP claim.

On 13 January a Capita Disability Assessor conducted an initial review of the claim. The Disability Assessor recorded that the initial review took 10 minutes and produced advice stating:

'Items 1 to 1 of evidence have been reviewed. There is insufficient evidence to advise the DfC, therefore a face to face assessment is required.'

'Item 1' of evidence reviewed was the PIP2 application form completed by Claimant AJ in which the claimant listed eight other health conditions in addition to the primary condition recorded. Claimant AJ provided detailed answers to the fourteen questions asked in the PIP2 on how these conditions affected their day to day life. The claimant also provided the names and contact details of six health care professionals in response to the question on the form 'Tell us about the professional(s) best placed to advise us on how your health condition or disability affects you.'

The Disability Assessor who conducted the initial review made no requests to gather further evidence from any of the health professionals listed in the PIP2 application form. It is important to note that at the time of the initial review, the DLA evidence was not available to the Disability Assessor to view as a task had not created to upload the DLA evidence onto the PIPCS.

Claimant AJ subsequently attended a face to face consultation with another Disability Assessor on 8 February 2019. The Disability Assessor, who was not involved in conducting the initial review, recorded the preparation time for the consultation as taking 10 minutes and listed the available evidence at the time of the consultation as solely the claimant's questionnaire [PIP 2 application]. The DLA evidence was also not available to this Disability Assessor.

Following consultation the Disability Assessor completed an assessment report providing advice to the Department on descriptor choices based on the consultation evidence and the PIP2 application information. The consultation findings conflicted significantly with the functional impact reported by the claimant in their PIP2 application form. It is important to note that the assessment report was completed in the absence of having or requesting evidence of medical diagnosis or further evidence of functional impact.

The assessment report which contained the Disability Assessor's advice on descriptor choices was received by the Department on 16 February 2019. A Case Manager reviewed the claim and made a decision that the claimant was not entitled to PIP. The Case Manager wrote to Claimant AJ on 25 February to notify the claimant of this decision.

In making the decision, the Case Manager relied upon the consultation evidence and the advice provided in the assessment report. Despite the significant disparity between the assessment advice, which relied on the consultation findings, and the functional impact reported by the claimant in their PIP2 application form, the Case Manager did not direct for any requests for further evidence to be made in an attempt to test the contradictory evidence.

It is also important to note that at the time of making this decision, the DLA evidence had not been uploaded onto the PIPCS. This is despite Case Managers being instructed to check the notes, prior to making decisions, on whether the claimant had consented to reuse their DLA medical evidence and if the evidence had been uploaded¹⁶⁰. The DLA evidence should have been considered by the Case Manager when making the decision on entitlement. The Case Manager should also have identified from the evidence listed in the assessment report that the DLA evidence was not available to the Disability Assessor when they formulated their advice.

Within the letter to the claimant, the Case Manager states *'I made my decision using information about your health condition or disability*

¹⁶⁰ PIP Bulletin 023, Re-use of DLA Medical Evidence/Requests for copies of DLA1, Issue date: 16/05/2017

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*including details of any treatment, medication, test results and symptoms. This information is the **best available [my emphasis]** and enough to decide how much help you need.'*

Between May 2019 and August 2019 the claimant engaged in the complaints process with both Capita and the Department.

Within the complaint correspondence the claimant raises various issues, including their concern that no requests were made for further evidence:

'I requested, and have received (at a cost to me) my GP notes dating back approximately six years. I was informed by my GP that Capita did not request any notes from him, nor did they send a questionnaire for him to complete to confirm my medical condition. How can someone make a decision without this information?'

In responding to this specific complaint issue, Capita stated that:

'Upon receipt of a referral, a DA will conduct an initial review and will determine if further information is required. If deemed necessary, the DA may request further information from a customer's GP. However, this is a clinical decision and individual to a customer's situation. Please note, as per DfC guidance, this is not a mandatory part of the process. In your case, it was not deemed necessary to contact your GP for further information. The DA will review the PIP application form and any FME [further medical evidence] provided in support of a claim prior to an assessment taking place.'

Within the response, Capita also stated: *'As part of my investigation, I have looked at your case and I can see your previous DLA application was not made available by the DfC to Capita as part of your PIP application. Therefore I have found no evidence the DA who conducted your PIP assessment did not act within the DfC guidelines.'*

In the handling of this complaint issue Capita, as the Assessment Provider, did not examine in any meaningful way the quality of the decision making as to why it was deemed not necessary to request further evidence to inform the assessment advice to the Department. The PIP Assessment Guide¹⁶¹ stipulates that additional evidence from professionals supporting the claimant should be sought where the Health Professional [disability assessor] feels it would help to inform their advice. Given the absence of the DLA evidence, any evidence of diagnosis or further evidence of functionality, the Disability Assessors' decision making should have been examined with clinical governance

¹⁶¹ PIP Assessment guide Part 1: the assessment process, Para 14.1. Web document available at <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-1-the-assessment-process>

advice sought. The decision not to request further evidence should have been explained or the complaint upheld and lessons learned.

The Department's responses to the claimant on this issue offered no further accountability on this issue by stating '*I can advise [name], Manager of the PIP Centre, has contacted Capita and they have given them their assurance that all the concerns you raised with them have been fully investigated and response was issued to you...*' The Department did not examine the actions of the Case Manager in their review of the evidence used to inform their decision making. I also observed that although the error in respect of the use of DLA evidence was identified by the Department at time of the Mandatory Reconsideration, the Department did not provide an apology to the claimant in their response. Nor did the Department report any lessons learned in respect of their own role.

It is acknowledged that the Department, made significant efforts in correspondence to provide reassurance to the claimant about the policy intent of the PIP benefit system assessment process. The Department outlined the quality standards set down for Capita as the Assessment Provider and explained the auditing mechanisms in place which it relayed provide confidence that the standards are delivered. It is notable and concerning however that at an operational level the Department did not address the case specific issues of complaint over and above providing the statement that Capita confirmed that the issues were investigated.

Findings –

The Department and Capita's handling of complaints about further evidence issues is inadequate, inconsistent and demonstrates a failure to fulfil Principle 4 and Principle 6 of the Principles of Good Complaint Handling.

The availability of further evidence is a significant factor in the overturn of Department decisions at Appeals and remains a persistent confidence issue with various stakeholders. It is therefore disappointing that the Department has not taken effective ownership of how reliably the issue is addressed within the complaints system. This is a missed opportunity to identify, at both individual and system levels, whether there are shortcomings in the management of further evidence in the PIP process or alternatively to substantiate that the service delivery is robust. Investigation of these complaints could also be critical to getting PIP award decisions right first time.

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Recommendations –

Capita, as the Assessment Provider, should consistently and adequately investigate complaint issues raised about further evidence to include:

- Reviewing the Clinical Governance Statement in respect of ensuring the rights of claimants to make a complaint of maladministration are met and not incorrectly limit the issues that can be investigated;
- Routinely seeking clinical governance advice as to whether further evidence should have been requested to inform advice at initial review and in the completion of the assessment report to the Department;
- Routinely seeking clinical governance advice as to whether the further evidence was appropriately considered in the advice at initial review or in the completion of the assessment report to the Department; and
- Where these complaint issues are not substantiated, explain to the claimant the justification behind why the further evidence request was not considered necessary and/or how the further evidence was appropriately identified.

The Department, as the decision maker with statutory responsibility, should consistently and adequately investigate complaint issues raised about further evidence to include:

- Establishing what evidence was available and what requests for further evidence were made by the Assessment Provider (Capita) when they provided advice to the Department in the assessment report;
- Routinely seeking input from the Department's Health Assessment Advisor on whether the Assessment Provider should have requested further evidence to inform the advice at initial review or in the completion of the assessment report;
- Routinely seeking input from the Department's Health Assessment Advisor on whether the further evidence was appropriately considered by the Assessment Provider in the advice;
- Asking the Case Manager to account for their decision making as to why the Assessment Provider was not directed to request the further evidence identified by the claimant;
- Asking the Case Manager to account for how they appropriately considered the further evidence identified by the claimant within their decision making; and
- Where these complaint issues are not substantiated, explain to the claimant the justification behind why the further evidence request was not considered necessary and/or how the further evidence was appropriately considered.

Issue 3: Governance of Complaints Handling

Policy and Process

During the course of my investigation I provided interim observations to the Department in respect of several concerns I had about PIP complaints handling. These concerns included that the Department does not have a written policy on how Provider complaints are handled. The Department accepted my observation and agreed this would be addressed.

I consider a policy is required to provide procedural clarity not only to staff who handle the complaints but also for the benefit of other staff and claimants. Within my telephony review I observed a level of misunderstanding from Department staff in the signposting of PIP complaints and some complainant confusion as to what stage the complaint was at and who the decision maker was.

I note that Capita, within their own complaints policy, documents the Department's process for managing a complaint escalated to the Department following investigation by Capita. That the Department did not document their own process for the handling of PIP complaints demonstrates a lack of ownership and a deference to Capita that I observed within the Department's PIP complaints investigations.

The failures that I identified in respect of the role of the Department in investigating Capita complaints (Issue 1) and the investigation of complaints about further evidence (Issue 2) reveal a lack of governance in the Department's handling of PIP complaints, both in policy and process.

Record Keeping

The importance of good record keeping cannot be overstated. It provides evidence of activity and decision making. It enables others to verify what has been done and provides accountability in the process.

My investigation consistently found a lack of record keeping within the Department's complaint investigations. The lack of record keeping by the Department extended to not obtaining source material from Capita and failure to create records of Department enquiries and decision making in the complaints.

I also observed shortcomings in the system used by the Department to manage complaints. The CST utilise a bespoke computer complaints handling system to support the administrative management of complaints at Stage 2 of the process. The CRT however who undertake the core complaints handling duties do not have access to this system and were

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observed to rely upon storing complaints material within individual folders the nomenclature for which was simply the month in which the letter was created. I found this to be wholly inadequate and consider the lack of provision of a universal case handling system in part contributed to poor record keeping. During the course of my investigation, my Investigating Officers had to repeatedly return to the Department to obtain full disclosure of the complaint material relating to individual cases which they had requested.

In November 2019, following a previous investigation and recommendation made by my Office, (which also found failings in the Department's handling of a complaint in a different benefit area), the Department's Guide to Effective Complaints Handling was updated to include:

'We should record information about complaints accurately so that we may learn lessons. The information recorded and method of recording, are vital in ensuring that we get the most from the complaints that are made. This will help us to resolve complaints, identify trends, prevent complaints from recurring and improve the overall service provided. In terms of good practice, it is important that business areas keep written records of what action was taken to investigate the complaint, including if it is necessary to speak to a member of staff as part of the investigation that a written note of the conversation that took place is retained.'

The Department advised my Office that all relevant Senior Managers and complaints handling teams were notified of the change in the guidance and were advised 'to ensure that they were familiar with the importance of good record keeping'. I welcome this action, however as the Department did not acknowledge the deficiencies identified by this investigation I am concerned that the Department may not yet fully accept the importance of good record keeping.

Recording and Reporting Outcomes

The Department advised my investigation that both the Department and Capita gather statistical information on complaints at a corporate level. It was relayed that the PIP centre also gather information locally from the Dissatisfaction, Stage 1 and Stage 2 complaints stages and analysis which is discussed at the monthly PIP Senior Management meeting with appropriate action taken. The Department stated the CST gather statistical information from across all business areas which is reported on a quarterly basis. In addition Capita prepare monthly complaints reports which are tabled for discussion at the monthly Performance Review Board.

I note however that until February 2020 the Department did not record whether a complaint was upheld in respect of PIP complaints. I acknowledge the Department's response that lessons were learned from individual cases which has fed into improving service, however I am concerned that in the absence of systemically recording whether complaint issues are upheld or not, wider analysis may have been limited. The Department's quarterly reports on complaints from July 2018 to June 2020 contain no information on whether complaints are substantiated or otherwise and record no information on lessons learned. I do however note and welcome that within Capita's monthly complaint summary report, data is provided on the numbers of complaints and complaint themes upheld or not upheld within the complaint process.

The Department's current '*Guide to Effective Complaints Handling*' stipulates:

Publishing information on complaints

We should publish information about the complaints we have received in ways that will reach our customers.

Publishing information on complaints:

- *is in line with the principle of answering to the public;*
- *lets customers know about our performance;*
- *shows that we take complaints seriously and that it is worth making a complaint; and*
- *allows us to show the improvements we have made as a result of complaints or comments.*

We need to regularly publish information about the complaints we have received. This information should include:

- *the numbers and types of complaints;*
- *our speed in replying compared with target times;*
- *the level of customer satisfaction with the way we handled complaints;*
- *the numbers and types of comments; and*
- *the action we have taken to improve the service as a result of complaints or comments.*

We can publish this information on posters in public areas, in local news sheets, in annual reports and on the Internet.

I have found no evidence to support that the Department publishes information on PIP complaints in line with this guidance. The Department references information about complaints in its *Annual Report and Accounts*¹⁶² however the information published does not reflect the level of detail suggested by the guidance. There is also no information published on how Provider complaints are handled by the Department.

¹⁶² DfC *Annual Report and Accounts for the year ended 31 March 2019*, P. 34. Web document available at https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-1800-annual-report-18-19-web_0.pdf

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Findings –

There are significant shortcomings in the Department's governance arrangements around the handling of PIP complaints. The lack of clear policy, recording and reporting in the Department's complaints handling evidences a failure to fulfil Principle 1 of the Principles of Good Complaint Handling.

Although Departmental staff, at all levels, expressed a deep commitment to valuing and welcoming complaints as a way of **'putting things right'** for claimants and for improving the service, the Department's governance of complaints handling does not support this commitment.

Recommendations –

It is recommended that:

- In the Department's development of a written policy for handling complaints about Providers, it is critical the Department sets out the standards of investigative action expected, as well as the administrative arrangements, for the thorough and independent investigation of these complaints;
- The Department should review and publish clear information which is accessible to PIP claimants on the Department's role in investigating complaints about Providers;
- It is essential that the Department reinforces the importance of record keeping in complaints handling;
- The Customer Relations Team who are tasked to carry out the core complaints handling duties should be provided with a complaints case management system which is adequate to support the duties of their role;
- Complaints staff should be provided with updated training on the principles of good complaints handling and importance of good record keeping;
- The Department should review the process by which it systemically records and analyses the outcome of PIP complaints; and
- In line with the Department's current *'Guide to Effective Complaints Handling'* the Department should publish information on PIP complaints in a way that reaches claimants and other interested parties.

Chapter 8: Further Evidence Statistics

I previously identified¹⁶³ concerns with Capita failing to record the number of Department requests to gather additional Further Medical Evidence (FME) until July 2019. This chapter provides further consideration of the Department and Capita's management information/statistics relating to Further Evidence.

Issue 1: The Department's Further Evidence management information

In response to my investigation proposal the Department advised¹⁶⁴ that, of the approximate 22% of claims overturned at Mandatory Reconsideration, 99% were a result of new evidence being received. The Department further advised:

'422 PIP appeals have been lapsed by PIP appeals staff having considered further evidence received in support of the appeal from the customer or their representative after they had lodged an appeal with the Appeal Service.'

In response to a recent Assembly question¹⁶⁵ the Department also stated:

'Since PIP was introduced over 20% of Mandatory Reconsideration requests have resulted in a change to the original PIP decision because additional evidence has been provided which was not available to the officer who made the initial decision...'

Yet the evidence from my investigation suggests that this blanket reasoning, that the overturn of awards is a direct result of new evidence being received, is inaccurate.

My investigation has found that the suggestion, that the evidence which overturned the decision would not have been available to the Department's Case Managers at an earlier stage of the process, cannot be substantiated for a significant number of cases which formed part of my investigation. I have uncovered no reason which would lead me to conclude that this would not therefore be the case for other claims.

The Department advised my investigation that its statement on the reason for overturn of awards was based on data taken from the Case Managers'

¹⁶³ Chapter 4, Issue 1 i.

¹⁶⁴ Department response 31 January 2019.

¹⁶⁵ Assembly Question AQO 162/17-22 – February 2020.

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decision logs. Extracts from the Mandatory Reconsideration and Appeal Case Manager decision logs (relating to 99 lapsed Appeals) were provided to my investigation. As previously identified¹⁶⁶, the detail recorded within these logs is limited.

In regard to Mandatory Reconsideration, the extracts record whether there was a change in award and if new evidence was received. No further detail was provided on whether the new evidence directly resulted in the change in award. It would therefore appear that if further evidence is received at Mandatory Reconsideration, regardless of its content or impact, this is directly equated (within management information) as being the reason for overturn.

The Department further advised my investigation that the log was enhanced in January 2019 to *'include an additional column to establish if the Further Evidence considered for any changed cases was available to the claimant (dated) prior to the 1st tier decision having been given... An analysis of this enhanced database was used to inform the response to the Assembly Question referred to in this section of the report, which showed that in 99% of cases, the further evidence was dated by the Health Professional concerned after the date the 1st tier decision was given on their claim.'*

I welcome all efforts to inform understanding on how to achieve getting the decision right first time. There is value in ascertaining if further evidence (if relevant to the change in decision) was available at an earlier stage. However I am concerned that the data gathered, i.e. the date of the last piece of evidence received, does not in itself reveal, in any meaningful way, the reason for the change in the decision. As previously stated there were no clear records in the decision logs or the change of advice reports to confirm that the 'new' evidence directly resulted in the change in award. The examples highlighted in my case studies identify that although new correspondence was sometimes received, the information contained within the correspondence, and/or the source of the information, had often been available to the Case Manager at an earlier stage of the process.

I also note that the Department's response to the Assembly Question was not based on a review of all PIP cases, despite the inference from the wording. In response to my request for clarification on how the information was gathered retrospectively for the 'enhanced database', the Department advised that the information was based on a *'statistically valid sample'*¹⁶⁷ of cases that pre-dated January 2019.

¹⁶⁶ Chapter 5, Issue 4 iii.

¹⁶⁷ The Department did not clarify how many cases it considered as part of this sample.

It is reasonable to expect that the Department, in attributing that 99% of decisions changed because *'additional evidence has been provided which was not available to the officer who made the initial decision'*, had determined with some accuracy that the overturn of award was a direct result of new evidence being received. No records have been provided to my investigation to support that this level of analysis took place. I therefore remain concerned about the information presented by the Department in answering the Assembly Question.

The extracts of the Lapsed Appeals decision log provided the same information as the Mandatory Reconsideration decision log but with an additional reason category for the overturn of an award. Repeat categories used included:

- *Appeal lapsed due to the MH¹⁶⁸/RJ¹⁶⁹ judgement rulings being introduced;*
- *FE [Further Evidence]/Additional FE was received at Appeal stage;*
- *Good reason accepted – FE received at Appeal Stage;*
- *Lapsed on existing information;*
- *Department revision as FE was received but not correctly considered;*
- *Department revision as FE was received after initial recon [reconsideration] completed;*
- *Invalid appeal as MR [Mandatory Reconsideration] had not been completed;*
- *Departmental revision as identified passport was incorrectly stamped;*
- *FE was received after Recon [Mandatory Reconsideration] decision but did not impact. Additional FE was received at appeal stage.*

The lapsed Appeal extracts identified that 18% of cases (18 of the 99 lapsed Appeal cases provided) were classified as being *'lapsed on existing information'*. A further case, although classified as *'Departmental revision as FE was rec'd but not correctly considered'*, was also lapsed on the basis of existing information.¹⁷⁰ Therefore, the Department themselves had identified that at least a fifth of Appeal cases were not lapsed as a direct result of new further evidence being received.

In addition to these cases identified by the Department, I have also highlighted within my cases studies¹⁷¹, instances where further evidence was not always 'new', or did not always directly change the award decision. In some cases the evidence and/or sources to obtain this evidence, were already available to Case Managers at an earlier stage of the PIP process, for example:

¹⁶⁸ *MH v Secretary of State for Work and Pensions (PIP)*: [2016] UKUT 531 (AAC) ; [2018] AACR 12.

¹⁶⁹ *RJ, GMcL and CS v Secretary of State for Work and Pensions v RJ (PIP)*: [2017] UKUT 105 (AAC) ; [2017] AACR 32.

¹⁷⁰ Refer to Chapter 5 Case study (16).

¹⁷¹ Chapter 1 (4-5) Chapter 2 (1) Chapter 3 (1-2) Chapter 4 (1- 3) Chapter 5 (12 – 19) Chapter 6 (13).

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- Contact details for the health professionals had been provided and both Capita and Department Case Managers had chosen not to request advice from these individuals, despite the direct request from claimants to do so;
- Evidence had been provided by the claimant at Mandatory Reconsideration stage but the Department had not provided the standard 4 weeks timeframe for receipt of evidence before making their decision. Therefore evidence which would have been available to the Mandatory Reconsideration Case Manager (had the appropriate timeframe been implemented) only became available to the Appeals Case Manager (typically recorded within decision log as '*Departmental revision as FE was received after initial recon completed*');
- Evidence had been provided by the claimant within the PIP2 application form/written statements/Mandatory Reconsideration requests/family letters of support which identified their functional issues. This information was not considered relevant until medical evidence was received at Mandatory Reconsideration which stated the same information;
- Evidence was received at an earlier stage of the claim process but was not forwarded to Capita for their consideration.

Therefore the blanket reasoning provided by the Department at the time of my investigation proposal, that the overturn of awards in all lapsed Appeals was as a result of new evidence being received was inaccurate. The Department have since accepted that the reason provided was not 'wholly accurate', but it does not agree that this represents an issue of concern. The Department emphasised the original statement was provided to my investigation and was not made in the public domain. I find this response to be reflective of the Department's failure to understand the importance of comprehensively examining why decisions are overturned and accurately reporting on this issue (both internally and externally).

The lack of any detail being recorded at Mandatory Reconsideration in relation to the reason for overturn, and the limited categorisation used by the Appeals Case Managers, mean that the Department is unable to appropriately analyse its management information on the reasons for overturn of award decisions. As a result the Department are unable to appropriately identify learning and implement improvements to the process.

Case Study 1 Lack of recorded reasoning for overturn at MR and incorrect categorisation at lapsed appeal

Award History

DLA: Middle care: Higher Mobility

First Tier Decision (9 August 2018): No Award: No Daily Living (6 points):
No Mobility (4 points)

Mandatory Reconsideration (18 September 2018): Standard Daily Living
(9): Standard Mobility (10)

Offer of Lapsed Appeal (13 November 2018): Standard Daily Living (9):
Enhanced Mobility (12)

Claimant AK whose primary condition is listed as relapsing/remitting Multiple Sclerosis (MS), applied for PIP on 5 May 2018. On 25 May 2018 the claimant's DLA General Practitioner Factual Report (GPFR) (dated April 2015) evidence was uploaded. This evidence confirmed their condition, that the claimant was under the care of neurology, with mobility slowed due to dragging feet/risk of falls – wears splints (weakness in legs) and problems with urinary urgency and fatigue. The GPFR also enclosed hospital letters from the Consultant Neurologist which confirmed functional issues and treatments (including disease modifying therapy) and identified results of MRI scans (2011).

The claimant also provided comment on their functional restrictions within their PIP2 application form, including for example – in relation to 'moving around':

'When I am leaving home or am somewhere unfamiliar or am negotiating uneven ground I need to wear splints and take my time. If I don't I will trip and have fallen badly before. I walk a lot slower than other people due to this. I cannot perform another task simultaneously due to the concentration needed to scan the ground ahead of me so I can negotiate/ find the shortest and safest path to take. When I am fatigued this takes a lot longer, I also experience spastic and jerky movements which causes further problems. These issues are compounded by symptoms of fatigue... as I have outlined in previous answers mobility is a significant problem for me as a result of multiple sclerosis...'

On 20 July 2018 the claimant underwent a face to face assessment.

The claimant's own statements on functional restrictions are recorded within the assessment report, including issues with mobility. For example the assessment report records:

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'[They] have difficulty walking and [they are] unable to walk far and only walks short distances. [They have] spasms and jerking movements all over their body which happens throughout the day and increases when they are fatigued... [They] wears ankle and foot splints when out of [their] home and holds on to furniture when at home as [they] do not wear them in his house. [They have] a blue badge to access disabled parking and walks 100 yards into [their] office without stopping. [They] could walk 100 yards before [they] would have to stop and avoids any other distances and does this 3 days a week.'

The claimant also provided the Disability Assessor with a copy of a letter from their MS nurse at the face to face consultation. The letter described the claimant's functional issues against each descriptor. The claimant was advised to post this letter to the Department and the Disability Assessor noted that it had been provided and considered on the day of assessment within the assessment report.

An extract of the Assessment Report is provided:

'MR Nurse letter dated 19/07/18 – Relapsing remitting MS, has fatigue, memory and concentration difficulties, pain and spasms, bladder and bowel urgency, decreased sensation in both hands, poor grip, drops items, prone to choking when fatigued, sets reminders on phone to manage medications, difficulty with fastenings, wears ankle/foot orthosis, difficulty processing words, has to re-read things several times, prone to trips and falls, poor balance, and has foot drop.'

[Note – The Disability Assessor's summary of letter does not include reference to the MS nurse's statement that the claimant finds getting in and out of the bath very difficult due to spasms and jerking of legs or the advice that *'[Claimant] finds mobility has become increasingly difficult. [Claimant] has to concentrate well and think about walking. [Claimant] prone to trips and falls as balance is poor, has to wear ankle foot orthoses (ankle splint) on both feet every day as has foot drop and even with these splints struggles and can only manage short distances with frequent rests after a few steps, also suffers from leg spasms and gets tired very easily'*

In relation to the descriptor for activity 12 'Moving around', the Disability Assessor (following review of both the MS Nurse letter and the GPFR) recorded within the assessment report:

'The IO [Informal Observations] shows [claimant] was able to rise to stand and walked 15 metres unaided and without difficulty or signs of pain or discomfort at normal pace which took 5 seconds. The MSK shows that although [claimant] completed the lower limb movements unaided was wobbling, took

*several attempts to raise [their] foot and was unsteady on [their] feet. [they] are prescribed orthotics to wear in both shoes. [They] reports fatigue which is also consistent with the nature of [their] condition. There is FME to support this level of restriction. **It is therefore likely they can reliably stand and then move more than 50 metres but no more than 200 metres unaided.(12 b)***

The Department's Case Manager reviewed the Assessment Report and the available evidence. The MS Nurse's letter had not been received by the Department. Although it would have been evident that the MS Nurse's letter had been available to the Disability Assessor, at no point did the Department's Case Manager query, with either Capita or the claimant, where the MS Nurse's letter was before deciding on the claim.

On 9 August the claimant was advised that they were not entitled to PIP (6 points Daily Living and 4 points Mobility). The claimant subsequently requested a Mandatory Reconsideration on 20 August 2018.

On 21 August & 1 September 2018 further evidence was received within the Department's Mail Opening Unit which included the MS Nurse's letter (previously provided and considered at assessment), a GP report and printout, MRI report dated 24 May 2018 and 9 August 2011 and several Neurology letters. The Mandatory Reconsideration Case Manager referred the further evidence for advice.

On 15 September 2018 a change of advice report (PA6) was received in the Department's Mail Opening Unit. An extract is provided:

'Available eight pieces of attachments have been reviewed. Medical evidence confirms [claimant's] diagnosis of multiple sclerosis. It confirms that [they] were diagnosed with para-pesis and ha[ve] been prescribed splints for [their] medical condition. It is stated that [claimant] has lower body restriction and has weakness. Based on available medical evidence, IO and examination, level of treatment and prescribed restriction is likely for the majority of days. Due to upper and lower body weakness as a result of his condition [claimant] is likely to require suitable aids to complete activities 1,5, and 6 reliably. Also, [claimant] is likely to require assistance from another person to get in and out of the bath reliably. Based on medical evidence, IO, examination [claimant] is likely to have difficulty walking longer distances...'

The claimant was issued with a Mandatory Reconsideration Notice on 18 September which advised that their award had been revised to Standard Daily Living and Standard Mobility. The subsequent change of descriptor for Activity 12 to (d) used the same observations from the assessment report which had originally applied descriptor (b):

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'you walked 15m unaided with normal pace and no evidence of pain. You completed all standing movements of musculoskeletal exam however appeared unsteady. There was no evidence of fatigue and no jerking movements or body spasms were observed. I decided you can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres.'(12 d)

There is no recorded reasoning that further evidence led to this change within the case file.

The Mandatory Reconsideration Case Manager decision log records: *'Changed on Recon: Y; New Evidence Rcv'd: Y'*

This case evidences how the lack of detail recorded in regard to the reason for overturn in award can impact on management statistics. Although further evidence was received at Mandatory Reconsideration stage, some had previously been considered prior to the First Tier decision (including the MS Nurse letter considered at assessment by the Disability Assessor, the GP report and the claimant's own statements).

In addition the new further evidence was not directly referred to within the change of advice. The advice listed the assessment IOs [Informal Observations] and examination findings and highlighted the claimant's diagnosis and level of treatment. This information was contained within the evidence available prior to the face to face assessment. Therefore, although the receipt of further evidence may have been the prompt which overturned the award (due to the subsequent request for further advice), it is more likely that a difference in health professional opinion directly resulted in the overturn of the award.

It is of note that the claimant subsequently requested an Appeal. No further evidence was provided with the Appeal request however the Appeals Case Manager requested additional advice from Capita in regard to descriptor 12 (moving around):

"Please see appeal uploaded 25/10/18. I have taken into account the customer's reported ability to walk 100 yards 6 [Sic] times a week, however I don't believe [they] would be able to do so repeatedly within a reasonable timeframe."

This request was based on previously considered mobility statements made by the claimant within their PIP2 and the assessment report, and by the MS nurse within their letter.

A change of advice report (PA6) was provided which advised:

*'Advice – noted all evidence, this includes evidence from MS nurse and GP. It is confirmed that his balance is affected and they have trips and falls. They have splints for their ankles which they wear daily and is confirmed to have foot drop; resulting in them being only able to walk short distances with frequent rests. Significant fatigue is also confirmed with leg spasms also. **The overall evidence would support that [claimant] is likely to be able to stand and then move for more than 1 metre, aided or unaided but no more than 20 metres, in a timely manner, repeatedly and to an acceptable standard. 12E is advised.'***

The claimant was offered an award of Standard Daily Living and Enhanced Mobility. Following acceptance by the claimant the Appeal was lapsed. Despite no new evidence being provided, the Appeal Case Manager categorised the lapsed Appeal as *'Additional FE was also received at appeal stage'*. This categorisation is inaccurate, *'Lapsed on existing information'* would have been more appropriate.

Case Study 2 Incorrect categorisation

Award History

DLA: Middle care: Higher Mobility

First Tier Decision (13 November 2018): No Daily Living (6 points):

Standard Mobility (10 points)

Mandatory Reconsideration (5 Jan 2019): No change

Appeal Lapsed (7 March 2019): Enhanced Daily Living (12): Enhanced Mobility (20)

Claimant O, whose primary condition is listed as MS, applied for PIP on 10 June 2018. A First Tier Decision provided the claimant with an award of Standard Mobility and no Daily Living.

The claimant subsequently requested a Mandatory Reconsideration, and following advice from the Telephony Advisor, provided a hand written letter and a supporting letter from their MS Specialist Nurse on 22 December 2018. This further evidence was not forwarded to Capita for review.

On 5 January 2019 the Mandatory Reconsideration Case Manager informed the claimant that the decision remained unchanged. The Mandatory Reconsideration Notice advised that further evidence had not been received.

Following an Appeal request the Appeals Case Manager referred the claimant's further evidence to Capita. It is of note that the TASK note on PIPCS records *'Please see FE scanned 23/12/2018 previously under incorrect NINO'*.

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Capita provided a change of advice report (PA6), recommending descriptors which provided the claimant with an Enhanced award for both Daily Living and Mobility.

The Department subsequently offered the claimant the new award and the Appeal lapsed. The letter made no reference to the delay in the review of the claimant's evidence as a result of it being uploaded to an incorrect claim.

Although this case was lapsed on the basis of further evidence sent in and received by the Department Mail Opening Unit prior to the Mandatory Reconsideration decision, the decision log referred to this as '*Departmental revision as FE was received after initial Recon completed*'. Despite this being an issue with the Department's handling of the claimant's evidence, rather than receipt of further evidence at Appeal, this was not appropriately recorded, nor was the claimant appropriately informed.

This case evidences a lack of clarity and appropriate detail in the reason categorisation for lapsed Appeals.

Case Study 3 Incorrect categorisation

Award History

DLA: Middle care: Higher Mobility

First Tier Decision (22 Oct 2018): No award: No Daily Living (2 points): No Mobility (0 points)

Mandatory Reconsideration (14 Dec 2018): No change

Offer of Lapsed Appeal (22 Feb 2019): Standard Daily Living (10): Standard Mobility (8)

Claimant M, whose primary condition is listed as Arthritis, applied for PIP on 11 August 2018.

The claimant's DLA GPFR (dated August 2015) was uploaded on 25 August 2018. The report advised that the claimant suffered from fibromyalgia, osteoarthritis (OA), palpitations, depression, splenectomy, tremble problems and fatigue. It further recorded that the claimant had '*daily pain, reduced stiffness, decreased mobility, poor response to analgesia, severe OA hands deformity - causing decreased grip. Chronic pain 1 better day, 6 worse, unable to cook due to hands, problems dressing, cannot wash hair, problems hand functioning. Cannot walk more than 30m due to increased pain legs.*'

Following a face to face assessment and review by a Department Case Manager the claimant was advised they were not entitled to PIP.

Following a Mandatory Reconsideration, where no additional evidence was provided, the claimant was advised there was no change to the award.

The Appeal Service subsequently notified the Department that the claimant had submitted an Appeal and forwarded evidence provided by the claimant's GP which again confirmed their condition and functional restrictions.

The Appeals Case Manager requested further advice from Capita stating:

'The evidence within the assessment report within MSK [Musculoskeletal examination] supports the customer had back pain and right shoulder pain. The MSK supported that [they] had slightly weaker restriction in the right hand but functional. The medical evidence supports that there is restrictions present in the customers abilities to function and this is reasonable to suggest considering the evidence within the MSK. Taking in to consideration the evidence available it seems reasonable to suggest that 1b 2b 3a...would be advised.'

Capita's Disability Assessor provided a change of advice report which recommended descriptor choices which would provide the claimant with an award of Standard rate mobility and Standard rate Daily Living. The Appeal Case Manager categorised the reason for lapsed appeal as *'FE was received at Appeal stage'*

This case evidences how the Department can determine that cases are overturned on 'new' evidence when the evidence was already available at an earlier stage of the process. The Appeals Case Manager had identified that evidence recorded within the assessment report indicated the claimant's functional restrictions. The GPFR report available prior to the face to face assessment also indicated functional restrictions. It is therefore disappointing that the categorisation of the reason of the lapsed Appeal is recorded as new evidence being received.

Case Study 4 Incorrect categorisation

Award History

DLA Award: Middle Care: Lower Mobility

First Tier Decision (18 September 2018): No Daily Living (0 points):

Standard Mobility (0 points)

Mandatory Reconsideration (6 November 2018): No change

Appeal Lapsed (23 February 2019): Enhanced Daily Living (13): Enhanced Mobility (12)

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Claimant N, whose primary condition is listed as Schizophrenia, applied for PIP on 17 May 2018. The claimant's DLA GPFR (2007) was uploaded which advised of the claimant condition and difficulty in motivation to carry out Daily Living Activities.

The claimant's GP and Community Psychiatric Nurse (CPN) also responded to advice requests from Capita. The CPN report provided additional detail on the claimant's functional restrictions, including needing encouragement and prompting and having regular reviews by a Consultant Psychiatrist.

Following a face to face assessment and Department Case Manager review, the claimant was advised that they were not entitled to PIP.

Following a request for Mandatory Reconsideration, where no further evidence was provided, the claimant was advised there was no change to the award decision.

On 21 December the Department was notified by the Appeals Service that the claimant had submitted an Appeal. On 30 December the Appeals Service forwarded on a letter from the claimant's CPN which was largely reflective of the previous information provided.

An Appeals Case Manager referred the CPN letter to Capita for advice. In response Capita's Disability Assessor provided a change of advice report which recommended descriptor choices which provided the claimant with an award of Enhanced Daily Living and Enhanced Mobility.

The Appeal Case Manager categorised the reason for lapsed appeal as '*FE received at Appeal stage*'

This case evidences how the Department can determine that cases are overturned on 'new' evidence when the evidence was already available at an earlier stage of the process. I acknowledge that the CPN letter at Appeal provided slightly more detail in certain aspects of the claimant's condition, particularly in relation to hospital stays rather than functionality. However, the CPN letter and the further evidence received prior to the face to face assessment provided duplicate information on the claimant's diagnosis, treatment and need for assistance in preparing and cooking meals, managing medication, prompting in washing and dressing and their significant symptoms. It is therefore unclear why the further evidence sent at Appeal had such a significant impact (changing from 0 points to enhanced rate) when the original CPN advice (provided prior to assessment) did not. It is disappointing that the Appeal Case Manager's categorisation of the reason for overturn of the award did not reflect that evidence, from the same health professional, reporting the same functional issues, had previously been available.

Findings –

The Department's failure to record appropriate detail on the reasons for overturn of award decisions at Mandatory Reconsideration and Lapsed Appeal evidences a failure to fulfil Principles 3 and 6 of the Principles of Good Administration. As a result, opportunities to use this information for the purposes of learning and improvement have been lost, and inaccurate reflections of the reason for overturn have been reported.

Recommendation 8.1 –

The Department should review its current method of recording the reason for the overturn of awards decisions at Mandatory Reconsideration and Lapsed Appeal. The use of reason categorisation, such as those used by Appeals Case Managers should be implemented for Mandatory Reconsideration, along with the addition of the following fields to both decision logs:

- Where further evidence is received, does it provide information previously unavailable;
- Where further evidence is received, could it have been requested by Capita/Department at an earlier stage; and
- Where further evidence is received, is it clear from the advice received/reasoning of the Case Manager that the evidence directly resulted in the overturn of the award (in this case the Case Manager may have to clarify this with the Disability Assessor if it is not clear within the change of advice report).

The Department should continuously review and analyse the reasons for overturn in awards to inform learning and improvement. These categories of data should also be reported to the public so that an accurate overview of the reasons for overturn of awards are presented.

Issue 2: Capita FME Statistics

Capita is required, as part of their contract, to routinely provide management information, including Further Medical Evidence (FME) statistics to the Department. These statistics were requested as part of my investigation.

My review of Capita's statistics highlighted concerns with how the figures were calculated and reported to the Department. The way in which the figures were labelled were not directly attributable to the published figures. For example, Capita provided monthly figures identifying the

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percentage of referrals (claims) where FME is requested. However, the percentage was calculated on the basis of the number of FME requests sent to claimant's health professionals, not the number of referrals in which FME requests were sent. So if, for example, in one referral four health professionals were sent a request, instead of this being recorded as one referral this was recorded as four referrals. The calculations therefore became inflated.

Extract of figures provided to NIPSO in December 2019:

Month	Aug 2019	Sept 2019	Oct 2019	Nov 2019
% of referrals where FME is requested	30.1%	32.7%	36.3%	45.3%

Extract of revised figures provided to NIPSO in June 2020:

Month	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	March 2020	April 2020
% of referrals where FME is requested	24.03%	24.18%	28.54%	34.47%	24.76%	25.43%	14.97%	17.96%	28.18%

This issue was raised with the Department who provided me with reassurance that the issues had previously been identified in 20 June 2019 and were corrected in January 2020. I acknowledge and welcome that the Department and Capita have made these improvements.

As management information/statistics directly relates to Capita's contract management, the issues identified during my investigation were referred to the Northern Ireland Audit Office in February 2020, for consideration within their audit.

However, I considered that the following issues remained within the terms of reference of my investigation.

i. Openness and Transparency

In response to my request for FME management information/statistics, a summarised version of figures was initially provided by Capita in October 2019. No corresponding comment was provided to highlight that these statistics were inaccurate and under review. This issue was only acknowledged by Capita following further requests for clarification on how the figures were collated.

Following identification of my concerns to the Department, I was provided with repeat reassurance that these issues in reporting had been corrected. The Department advised that this element of management information was not used for any billing purposes and had no financial consequence. The Department also provided assurance that the information was not published within the public domain, including in response to Freedom of Information (FOI) requests.

My investigation identified that this assurance was inaccurate. Between commencement of PIP and August 2020, eight FOI requests referred to further evidence. In response to these requests FME statistics were published on two occasions, as identified below:

Extracts from Department responses to FOI requests:

14 Jan 2020

Claimant FOI request:

'Given that the Department has specifically instructed people to not request access to their own medical records, which, in my case, I believe would have been material to my application, in what percentage of PIP applications does the Department request access to the applicant's medical records?'

Department response:

'...The percentage of cases in which a request is made for further medical evidence by Capita is approximately 50%...'

[At the point this request was made the Department was aware that FME figures had been reported inaccurately by Capita and amendments had been put in place. None of the statistics provided to my investigation (either pre-revision or post -revision) record an approximate 50% FME request rate. Rather, the revised percentage of FME requests figure for January 2020 was 25.43%, considerably lower than 50%]

16 April 2018

Claimant FOI request:

In the last twelve months of the total number of PIP claimants who were awarded any element of Personal Independence Payment – what percentage of these awards had further evidence requested from professionals supporting them?

Department response:

'...I regret the Department is unable to advise the number of cases where further medical evidence was requested from health professionals and an award of PIP also occurred. However, I can advise that between April 2017 and

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March 2018 further medical evidence was requested in 23,152 cases. This was out of 80,844 cases referred to Capita Health & Wellbeing, the assessment provider in Northern Ireland. This equates to 28.6% of all referrals...'

IFME statistics (now known to be inaccurate) provided by Capita to NIPSO in December 2019, recorded that between April 2017 and March 2018 FME was requested in 38,741 cases out of 86,042 referrals equating to 45% of all referrals. It would appear that statistics recorded and reported by Capita have varied throughout the process]

The FOI requests for information on FME requests, evidences the interest and significance placed on this part of the PIP process by the public. The failure of the Department to provide clear and accurate responses within the identified FOI responses is therefore concerning. Particularly as neither Departmental responses are reflective of either the previous or revised FME statistics provided by Capita.

The Department advised my investigation that it accepts that the percentage of FME disclosed was incorrect. It further advised that it *'fully recognises the impact of disclosing inaccurate data. On this occasion, the Department considers the negative impact of reporting this percentage into the public domain to be minimal, given that this has no impact on the quality of an assessment report or upon any claimant's PIP journey.'*

Although the Department provides reassurance that the inaccurate figures had no financial consequence, I am concerned that it minimises the impact of providing inaccurate and misleading statistics within the public domain. However, I welcome the Department's advisement that it will reissue the correct responses to these 2 FOI requests.

Findings –

The Department's repeated failure to provide open, clear and accurate responses to my investigation in relation to FOI requests and FME statistics evidences a failure to fulfil Principle 3 of the Principles of Good Administration.

Recommendation 8.2 –

The Department should retrain staff responsible for the provision of information to individual members of the public or external organisations requiring information. Emphasis should be placed on undertaking appropriate checks that any information provided is clear and accurate.

ii. Governance

The Department provided me with reassurance that the issues with FME management information had previously been identified within a Capita review dated 20 June 2019 and were corrected in January 2020. However, I remain concerned that these issues were not identified by the Department, themselves, at an earlier stage.

The Department's advice that *'Capita have a contractual obligation to ensure that all MI [Management Information] delivered to the Department has been validated, is accurate and fully auditable.'* does not reflect the Department's own responsibility to review and analyse the information reported. Its failure to pick up on issues, over a period of three years, which were easily identifiable within my investigation, suggest a concern that the Department is not appropriately interrogating the figures provided by Capita. The Department suggested in response to my queries that it will *'continue to closely monitor FME reporting...'* however no reference/recognition was made to its own failure to identify the issues with the FME statistics.

In addition it does not appear that, once identified, any significant weight was given to the issues as it took seven months for the statistics to be amended. This lack of urgency highlights the concerns raised throughout my investigation that further evidence is not given appropriate significance.

Although it is acknowledged that PIP is based on the functional impact a condition has on an individual this does not exclude the benefit of further evidence. This is highlighted by the Department's consistent reporting that additional further evidence is the main reason for decisions being changed at Mandatory Reconsideration, Lapsed Appeal and Appeal. It is also supported by my investigation which has highlighted the importance of further evidence and the impact of its application on PIP awards. It is therefore essential that the Department recognise the role that further evidence has in PIP claims and provides a greater focus on this in its communications to claimants, staff training, and its management information/statistics.

Findings –

The Department's failure to identify and request amendments to Capita's inaccurate reporting on FME within a timely manner evidences a failure to fulfil Principles 3 and 5 of the Good Principles of Administration. As a result I remain concerned with the Department's lack of scrutiny of the FME management information/statistics being undertaken and provided by Capita.

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Recommendation 8.3 –

I acknowledge that the Department and Capita have corrected the reporting of this information. However, given the delay in these issues being identified, the Department should review the robustness of its current methods of monitoring Capita's FME management information/statistics. In undertaking this review consideration should also be given to the Department undertaking its own collation of FME management information/statistics. These should include:

- The number of claims where further evidence is requested;
- The number of actual further evidence requests (broken down by profession/person);
- The number of further evidence requests responded to (broken down by profession/person); and
- The number of advice requests received after the First Tier decision (broken down by profession/person).

Appendix A

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions.
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

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5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix B

PRINCIPLES OF GOOD COMPLAINTS HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

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4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.

Appendix C

Terms of Reference for Investigation

BACKGROUND

The Northern Ireland Public Services Ombudsman (the Ombudsman) has launched a systemic investigation on her own initiative into the Department for Communities' (the Department) administration of the Personal Independence Payment (PIP) benefit system.

PIP is a non means tested benefit for people of working age (16 – 64 years) intended to provide help toward some of the extra costs arising from having a long term health condition or disability. PIP was introduced into Northern Ireland in June 2016, replacing Disability Living Allowance.

PURPOSE OF INVESTIGATION

The Ombudsman's investigation into the administration of PIP is being conducted in accordance with Section 8 of the Public Services Ombudsman Act (Northern Ireland) 2016 (the Act).

The purpose of the investigation is to ascertain if there is systemic maladministration¹⁷², or systemic injustice¹⁷³ sustained as a result of the exercise of the professional judgement. The Ombudsman can make recommendations should she identify systemic maladministration or systemic injustice in her investigation.

SCOPE OF INVESTIGATION

The Ombudsman will examine the actions of the Department and service provider Capita in administrating PIP with a particular focus on:

Availability and application of further evidence¹⁷⁴ in the PIP benefit decision making and internal complaints processes.

In determining whether maladministration has occurred the Ombudsman will test the actions of the Department and service provider Capita against the framework of the Principles of Good Administration¹⁷⁵.

In conducting her investigation the Ombudsman has the power to request information and the production of documents relevant to her investigation.

¹⁷² Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

¹⁷³ Injustice is also not defined in legislation but can include upset, inconvenience, or frustration.

¹⁷⁴ Evidence which is available in addition to the functional consultation, for example GP records, Occupational therapist assessments, etc.

¹⁷⁵ Parliamentary and Health Service Ombudsman (2009). Principles of Good Administration.

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For the purposes of an investigation, the Ombudsman has the same powers as the High Court in respect of the attendance and examination of witnesses and the production of documents.

REPORTING

The Ombudsman will publish interim updates on the progress of her investigation. At the conclusion of her investigation the Ombudsman will publish a report of her investigation, findings and recommendations. The Ombudsman will lay a copy of her investigation report before the Northern Ireland Assembly.

DATED

7 June 2019

Appendix D

Investigative Methodology

The investigative methodology implemented was designed to test the actions of the Department for Communities (the Department) and Capita against the Principles of Good Administration and the Principles of Good Complaints Handling with a focus on:

- The communication with the claimant, at the commencement of the claim, about the role of further evidence in the PIP process;
- The gathering and application of further evidence within PIP assessments;
- The application of further evidence within the decision making on the PIP application and how this is recorded;
- The communication with the claimant on what evidence was used and how the evidence was evaluated to reach the decision outcome on the PIP application;
- The role of evidence in mandatory reconsideration requests and lapsed appeals, and how this is communicated with the claimant; and
- The handling of complaints made by claimants about the gathering, use and application of further evidence in the PIP process.

Focusing on the availability and application of 'further evidence' in the administration of PIP, the investigation set out to methodically examine this distinct issue through a significant body of cases of PIP claims alongside policy, guidance and system data.

Research and Review

Research and review of relevant documentation included:

- The Welfare Reform (Northern Ireland) Order 2015 and associated regulations which legislate for PIP in Northern Ireland;
- Previous reports and reviews into PIP including the Inquiry by the Work and Pensions Select Committee Inquiry and the Independent Reviews conducted in Great Britain and in Northern Ireland;
- Research conducted and published by the Advice Sector;
- The Department policies, guidance and management information for the delivery of PIP and complaints;
- Capita policies, guidance and management information for PIP assessments and complaints;
- The contract and service level agreement between the Department and Capita; and
- The information published by the Department and Capita for claimants designed to explain how the PIP process works including leaflets, online content and information videos.

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Site Visits & Wider Engagement

Department Site Visits/Meetings	
PIP process walkthrough	26 June 2019
PIP Telephony team (initial phone call) and First Tier Decision	23 September 2019
Mandatory Reconsideration Team and Appeal	24 September 2019
Mail Opening Unit	25 September 2019
Complaints and Quality Assurance	27 September 2019
Health Assessment Advisor (HAA)	8 October 2019
Standards Assurance Unit	9 October 2019
Customer Service Team	11 October 2019
Continuous Improvement and Customer Insight	5 November 2019
Workflow Team	17 December 2019
Additional Appeals section visit	24 February 2020
Telephony Records review	October 2019 (18,25) November (1,8,20,29) December (6,11,18)
Capita Site Visits/Meetings	
Capita PIP process walkthrough	13 August 2019
Face to Face Assessment Observations	9 September 2019
Initial Review/ Paper Based/ Clinical Governance / Audit	20 September 2019
Statistics meeting	23 January 2020
Audit and Capita Access to PIPCS	26 February 2020
Support/Advice Sector Meetings/Submissions	
Advice NI	8 July 2019
MS Society	17 July 2019
East Belfast Independent Advice Group	24 July 2019
Law Centre NI	2 August 2019
Parkinsons UK	6 August 2019
MENCAP	6 September 2019
Participation and the Practice of Rights	Various dates
Engagement with others/Stakeholders	

PIP claimants ¹⁷⁶ and carers who contacted NIPSO to share their experiences	Various dates
Further consultation under Section 51 of the 2016 Act following commencement with the Northern Ireland Human Rights Commission, Northern Ireland Commissioner for Children and Young People, Commissioner for Older People for Northern Ireland and the Equality Commission for Northern Ireland.	21 June 2019
Northern Ireland Audit Office meeting with subsequent cooperation in respect of the Comptroller & Auditor General's work in examining the Department's management of its contract with Capita.	19 November 2019
Response from the President of the Appeal Tribunals for Northern Ireland	11 September 2020
Meeting with the Independent Reviewer for the Second Independent Review of the PIP process.	18 September 2020

Examination of a Case Sample of PIP Claims and Complaints

Sampling Selection

In considering the parameters of a case sample, consideration was given to what grouping of cases could provide the best evidence for the issue under examination – whether further evidence is appropriately gathered and/or considered at the earliest opportunity in the PIP process and if shortcomings are identified whether steps are taken by the Department to address them.

Group 1: Claims lapsed at Appeal

The Department state that the receipt of new evidence in support of a claim, **not available to the original decision maker**, is a significant factor in the overturn of decisions at Mandatory Reconsideration and at Appeal. This was also the reason provided by the Department in their response to the investigation proposal in January 2019 to explain the basis for why 422 PIP appeals had been lapsed by the Department following earlier decisions at First Tier and Mandatory Reconsideration stages.¹⁷⁷

PIP appeals which are lapsed by the Department presented the investigation with the opportunity to review the availability and application

¹⁷⁶ This included PIP claimants and their Carers who were notified that their claims formed part of the case sample and other members of the public who reached out to NIPSO following the proposal and investigation announcements.

¹⁷⁷ Response from Permanent Secretary to Ombudsman's proposal. 31 January 2019.

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of further evidence at all stages of the process - First Tier, Mandatory Reconsideration and where an Appeal was lodged. The Department had not identified failings in these cases on the part of the Department or Capita and obtaining a sample from this group of cases would provide good evidence of whether recurring service failings are present earlier in the process or alternatively demonstrate that there are no systemic problems.

Group 2: Complaints and associated claims

Another good source of evidence for the investigation was considered to be PIP complaints which had been through all three stages of the internal complaints process (Stages 1 & 2 with Capita and Stage 3¹⁷⁸ with the Department) and the associated claims. In responding to the investigation proposal the Department had reported that **all aspects of PIP claimants' complaints are fully investigated** and was reassured by the low complaint volumes since the introduction of PIP in 2016. Obtaining a sample from this grouping of claims presented the investigation the opportunity to examine whether concerns about further evidence presented in PIP complaints were appropriately dealt with as reported by Capita and the Department.

Cases Requested

Following commencement of the investigation in June 2019, the investigation requested and obtained:

1. The last 100 PIP claims (DLA assessments & new claims) registered on or after June 2018 in which the Department lapsed the Appeal; and
2. 53¹⁷⁹ complaints registered on or after June 2018 which have gone through all three stages of the complaints process and their associated claim files.

Cases Examined

NIPSO Investigators retrieved and accessed all source material pertaining to the case sample of claims and complaints. This included hard copy and electronic access to the Department and Capita's case records. NIPSO Investigators also conducted a telephony review by listening to audio recordings of Department's calls with the claimants pertaining to a number of these claims. The telephony review was considered relevant given PIP claims are for the most part initiated by telephone and many enquiries, including requests for Mandatory Reconsideration and complaints by claimants are also raised over the phone.

¹⁷⁸ The Department refer to this third stage as Stage 2 in the Department's complaint process.

¹⁷⁹ One of the 53 complaint cases was found to be a duplicate.

In total the investigation analysed claims pertaining to **100 individuals**¹⁸⁰ (**51 from Group 1 and 49**¹⁸¹ **from Group 2**) drawing out key issues relating to further evidence and across the following stages of the PIP process:

- Application
- Initial Review
- Assessment
- First Tier Decision
- Mandatory Reconsideration (where applicable)
- Lapsed Appeal (where applicable)
- Complaint Process (where applicable)

Whilst recognising there are different variables in the individual claims a data collection instrument, a semi structured checklist, was designed and utilised by the Investigation Team to draw out key information in each case. The instrument also ensured robustness and consistency in how the case records were examined and recorded within the terms of reference. The information and analysis for each case was utilised to produce aggregated data.

Data Analysis and Findings

The individual case analysis and aggregated case data were synthesised to determine if systemic maladministration¹⁸² had occurred with the actions of the Department and Capita tested against the Principles of Good Administration and the Principles of Good Complaints. While the analysis of case sample demonstrated if maladministration had occurred and the level of reoccurrence, the reliability of the findings were further enhanced by triangulation with and testing against the wider data and information obtained during the evidence gathering processes.

180 In some cases the material retrieved and examined for each individual involved more than one claim, for example if the claimant reported a change in circumstances which resulted in a new claim. Although the investigation examined all claims associated with the individual to analyse the experience of the individual and the overall decision making in the PIP process, for the purposes of the quantitative analysis the investigation considered and reported figures based on one of the claims associated with the individual. At the time of NIPSO drafting the report out of the 100 claims reported on - 1 of the claims had concluded at First Tier (initial) decision stage, 8 concluded after Mandatory Reconsideration and 91 had submitted an Appeal (of which of 56 lapsed following a revision of the decision by the Department, 26 went to Tribunal, 5 were awaiting a hearing, 3 were withdrawn and in one case an appeal was allowed but resulted in a new assessment.

181 One of the complaint cases was subsequently found not to have been subject of all three complaint stages but was retained as part of the sampling examined.

182 Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping. The Ombudsman may make a finding of systemic maladministration if it is established that maladministration has occurred repeatedly in an area or particular part of the public service. Systemic maladministration does not have to be an establishment that the same failing has occurred in the 'majority of cases', instead it is an identification that the same issue/failing has repeatedly occurred and is likely to occur again if left unremedied; or alternatively, an identification that a combination or series of failings have occurred throughout a process which are likely to occur again if left unremedied.

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The Use of Case Studies

The evidence to support the findings of systemic maladministration is laid out in the descriptive content under each issue. Case studies were included in the report by way of illustration of the issue discussed and are to help the reader to gain a better understanding by providing detail and analysis on real life examples.

Across the report 70 case studies pertaining to 40 individuals are used. The purpose of the case studies in the report is not to evidence the totality of the maladministration found and findings of maladministration were not restricted to the case studies included. Appropriate steps were taken to safeguard the anonymity of claimants in both the aggregated data and case studies.

External Adviser

Advice was sought from an External Adviser, a specialist in public law with significant experience in advising and consulting with various public bodies, government departments and parliamentary select committees, particularly on issues of administrative justice. The advice sought centred on appraising the investigative methodology used in the Own Initiative investigation.

Opportunity to Comment on Draft Report

Section 30(4) of the 2016 Act stipulates that where an investigation is conducted under Section 8, the Ombudsman must –

- a. give the listed authority an opportunity to comment on any evidence of systemic maladministration or systemic injustice, as the case may be,
- b. give any person who appears to have taken part in or authorised systemic maladministration or systemic injustice, as the case may be, an opportunity to comment on any evidence of that.

This means that where the Ombudsman identifies evidence of systemic maladministration or systemic injustice, the draft investigation report is shared prior to the conclusion of the investigation for comment on the accuracy of the evidence on which the Ombudsman bases her decision.

The draft investigation report was shared with the Department who were asked to share a copy of the draft with Capita and coordinate a response.

Following consideration of the comments provided in response to the draft report, the Ombudsman met with the Department before finalising and publishing her final report.

Appendix E

Additional Support telephony script

	<p><u>MT: Additional Support only for claimants or 3rd parties not PAB's</u></p>
	<p>Please ignore what is on PIPCS for the following questions.</p> <p>MT: We'll be sending you a PIP2 form through the post so you can tell us how your condition affects you. It is very important that you complete the form with as much information as possible and send it back to us. If you don't return the form in time then your claim to PIP may be disallowed. If you usually need help or support filling in forms, please can you tell me who will help you complete this form?</p> <p>If the claimant needs a further explanation :</p> <p>For example a family member, friend, neighbour, or local support organisation such as Citizens Advice Bureau.]</p> <p>If claimant states no move to CQ28 If claimant states yes</p> <p>YES: Note down the name, address, telephone number of the support and after submitting the claim in notes under the contact tab record the informal representative. Then move onto CQ28</p> <p>CQ28: Do you have one of the following conditions :</p> <p>Severe depression, for which you have been hospitalised, psychosis, schizophrenia, severe ADHD?</p> <p>Pause to allow claimant to answer if they have one of these conditions: If claimant answers NO If yes and claimant stated that they can complete the form themselves If claimant states YES and has given an informal representative If claimant states YES and they have no informal representative</p> <p>Or: Down's syndrome, Fragile X syndrome, severe autism, severe developmental delay, or any form of dementia*?</p> <p><i>*help text for example Alzheimer's, Lewy body dementia, or vascular dementia, severe brain injury resulting in cognitive decline.</i></p> <p>If claimant answers NO If yes and claimant stated that they can complete the form themselves If claimant states YES and has given an informal representative If claimant states YES and they have no informal representative</p> <p>If claimant answer NO: select no to both additional support questions on PIPCS and move onto declaration</p>

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If the claimant answers YES and has given an informal contact:
 CQ: You have told me that [informal rep's name] will help you to complete the PIP2 form, is this correct?

[If the claimant answers YES](#)

[If the claimant answers NO](#)

If the claimant answers YES then on PIPCS select NO to both drop down questions and move onto [declaration](#)

If claimant insists they (informal rep) will not help, or they need further or additional support, agent to record YES on PIPCS to the top drop down question and move onto [declaration](#)

If the claimant answers YES but has not given an informal representative.

CQ: Are you certain that you do not have anybody who can support you in completing the form? This can be a family member, friend, or neighbour, as well as a local support organisation.

[If the claimant states no](#)

[If the claimant states they now have an informal contact](#)

If the claimant answers no then record YES to the top drop down question on PIPCS and move onto [declaration](#)

If the claimant states they do have an informal contact:

If claimant provides an informal support, record the name, address, telephone number in Contacts tab, then notes tab, enter in subject box "Informal representative". Enter contact details in notes box, do not change priority.

CQ: Will they help you complete the PIP2 form which will be sent to you? [YES](#)

[NO](#)

If the claimant answers YES then on PIPCS select NO to both drop down questions and move onto [declaration](#)

If the claimant answers NO then record YES to the top drop down and move onto [declaration](#)

If the claimant has advised they do not need help to complete the form:

	<p>MT I know you told me before that you can fill the form in yourself, but if you do find it too difficult, do you know anybody who will be able to help you? Yes</p> <p style="text-align: center;">No</p> <p>If the claimant answers yes then record the name, address, telephone number of the support and after submitting the claim in notes under the contact tab record the informal representative. On PIPCS select no to both drop down questions and move onto declaration</p> <p>If the claimant answers no then on PIPCS select YES to the drop down box and move onto declaration</p>
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Appendix F

PIP Bulletin – Re-use of DLA Medical evidence

PIP Bulletin 023 – Re-use of DLA Medical Evidence/Requests for copies of DLA1

Go-Live Date	16/05/2017
Issue Date	16/05/2017
Issue Number	23 V5
Audience: Case Workers, Case Managers, Team Leaders	

Subject: Re-use of DLA Medical Evidence and Requests for copies of DLA1.

Timing: Immediate

Background:

When a customer is making a reassessment claim to PIP they are asked if they want the medical evidence from their DLA claim to be considered for their PIP claim. This can prove resource intensive as often the customer will ask for all previous DLA medical evidence to be used. It has been decided going forward that only medical evidence in relation to the **current DLA award** should be taken into account as part of the PIP assessment process.

A number of PIP Reassessment customers are contacting the PIP Centre when they receive the PIP2 questionnaire requesting a copy of their previous DLA claim form. The PIP Centre will not be issuing copies of DLA claim forms because PIP is a completely separate benefit from DLA, with different eligibility criteria.

Medical evidence used on DLA cases and stored on Disability and Carers Computer System (DACS) include medical evidence requested by DLA and Programme Protection Unit (PPU). Programme Protection Unit was a section within DLA whose role was to review DLA life awards; ensuring customers were receiving the right amount of DLA based on up-to-date medical evidence. This medical evidence is also stored on DACS.

NB: The following action is critical and the process must be strictly adhered to.

Action to take:

CW's

1. When following the process at the medical evidence stage the following script should be used:

Step	Action
1	<p>Script: 'Do you wish medical evidence in relation to your current DLA award taken into account as part of the PIP assessment process?</p> <p>If no go to Step 2</p> <p>If yes go to Step 3</p>
2	<p>Script: 'that's fine any necessary evidence needed will be obtained'</p> <p>Continue with the PIP claim</p>
3	<p>Confirm with the customer that the medical evidence relating to their current award of DLA, will be used as part of their PIP claim. Advise customer the medical evidence will be obtained from their DLA records and updated to their PIP claim.</p>
4	<p>CW to note the details of the medical evidence to be used.</p> <p>Continue with the claim.</p>
5	<p>Once the claim is submitted the Case Worker will create a manual task with a subject heading DLA MEDICAL EVIDENCE to the WfT to advise the medical evidence in the DLA records that is to be used.</p> <p>NB: The DLA1 is not regarded as medical evidence, and should not be treated as such. If there is a corroborative statement at the back of the DLA1, completed by a Health Professional, in this instance only should this be considered and the front page of the claim form and the corroborative statement identified for WfT as part of the manual task.</p>
6	<p>CW should access PIPCS Person Home page – Contact tab – Notes tab, annotate in the notes field that the customer has been asked if they wanted to use their DLA medical evidence and the customers reply.</p>

Workflow Team Action

2. Once the medical evidence on DACS listed under 'Documents' has been identified, the Workflow CW should now check if the case has been reviewed by PPU and medical evidence obtained.

Note: PPU process was clerical; therefore, all evidence including medical evidence will have been scanned to DACS in one bundle and present as a single Case Document item.

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Important: Only PPU medical evidence that was obtained for the current DLA award should be identified for consideration of the customer's PIP claim.

3. In Customer View on DACS the Workflow CW should:-

1	Toggle down the category 'Cases' on the left hand side (LHS) of the Customer View
2	Check for a Case Type prefixed by the number 49, followed by 6 digits For Example: 49-123456
3	Toggle down from the LHS of the Case Type 49
4	Toggle down from the LHS of Case Documents. This will return the document bundle
5	Double click on the Case Document item
6	Scroll through each page of the Case Document item to identify any PPU requested medical evidence.

CM action

4. CM should check notes to see if the customer has requested reuse of their DLA medical evidence and that it has been uploaded to PIPCS, before making their decision.

5. Where a note is not recorded, the CM will check which CW took the New Claim application, create a task to the CW Team Leader to arrange for the CW to take steps as in the agreed script.

6. Once required action has been taken by the CW, the T/L will return the task to the CM advising of current position i.e. DLA medical evidence is needed and will be uploaded in which case the CM should defer the task until DLA medical evidence is uploaded, or DLA medical evidence not needed and the CM can proceed to make their decision.

NB: It is the responsibility of the CM to check for receipt of DLA medical evidence and progress the case when the evidence is uploaded.

Action to take:

7. If a telephone call is received from the customer requesting a copy of their DLA1 claim form the following lines to take should be followed:

Script: “The PIP Centre does not issue copies of DLA claim forms because PIP is a completely separate benefit from DLA, with different eligibility criteria, therefore any information contained on the DLA claim form is not relevant to the PIP assessment process. The PIP2 Questionnaire that you have received asks you questions that are relevant to the eligibility criteria for PIP and I would encourage you to answer all the questions asked to reflect how your disability now impacts on your daily life.”

If you have any queries about this communication please contact a Business Champion.

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

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Appendix G

Extract from PIP1 DLA evidence list

About Disability Living Allowance (DLA)

a Are you getting DLA, or have you ever been awarded DLA?

Yes Go to **question b**.

No Go to **page 19**.

b Is there any medical evidence from your DLA claim that you think might help us understand how your disability affects you?

This evidence could be a report from: a GP, hospital, school or other health or social care professional. If you've had a medical examination for DLA we could use the report from the examining medical practitioner (EMP). If an Employment and Support Allowance report was used to support your DLA claim we could use this report.

No Go to **page 19**. We will not use any medical evidence from your DLA claim.

Yes Please use the following medical evidence (tick all that apply):

- GP report
- Hospital report
- School report
- Employment and Support Allowance (ESA) report
- Examining medical practitioner (EMP) report
- Consultant report or supporting letter
- Health and social care professional report
- Other medical evidence.
Please tell us what other medical evidence

I want you to use all the medical evidence from my DLA claim.

I want to see all the medical evidence from my DLA claim before I decide.

If requested, we can get your DLA file and make sure this medical evidence is used. Because of the laws about Data Protection and how long we're allowed to keep documents, old evidence may not be available. If evidence is still on your DLA file, we'll make sure that it is used.

Appendix H:

Extract from DMR Template Guidance

NEW CLAIM & REASSESSMENT

GET ACTIVITIES

The tool introduces a new way of importing descriptor choices using the 'Get Activities' button



The button works by pasting copied text from the PIPCS questionnaire, identifying descriptor choices and some crucial issues such as QP / PT considerations.

The user begins by completing their questionnaire in Decision Assist. It is important that any changes to descriptor choices and information regarding QP / PT are input **before** beginning this process. Once the questionnaire is completed the user should select 'blue link' called 'assessment questionnaire' to access its answers.

This extracts the key data from the determination and associates it with each related part of the Template including the 12 descriptors, the type of assessment, the SRTI indicator and QP/PT.



Next, the user needs to navigate to the determination, right click on the body of the text and click 'select all', then 'copy'.

The user then returns to the DMR template and clicks 'Get Activities'. This will auto-populate the descriptor choices into the template. The user will be unable to change descriptor choices without first updating the questionnaire and then following the preceding steps again.

ASSESSMENT TYPE

The user can change the type of assessment if this is necessary. The options are **SRTI, Face-to-Face, Paper based**

Standard text will be inserted into the top of your RFD for each of these options so make sure that the correct option is chosen. For Award Review decisions made under the AR1 process without a further assessment, the 'paper based' option should be selected. When working on an SRTI claim the user should always make sure that SRTI has been selected.



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The DMR template will automatically identify where either component of the benefit is to be awarded at the Enhanced level.

Daily Living	SRTE	Face to Face	Pages based	Sci.Abbrevia	Level	Disputed
Preparing food					Level All	<input type="checkbox"/>
Taking nutrition					Agree	<input type="checkbox"/>
Managing therapy or monitoring a health condition					Agree	<input type="checkbox"/>
Washing and bathing					Agree	<input type="checkbox"/>
Managing toilet needs or incontinence					Agree	<input type="checkbox"/>
Dressing and undressing					Agree	<input type="checkbox"/>
Communicating verbally					Agree	<input type="checkbox"/>
Reading and understanding signs, symbols and words					Agree	<input type="checkbox"/>
Engaging with other people face to face					Agree	<input type="checkbox"/>
Making budgeting decisions					Agree	<input type="checkbox"/>
Planning and following journeys					Agree	<input type="checkbox"/>
Moving around					Agree	<input type="checkbox"/>

In this example, the Daily Living activities are automatically greyed out as the template has detected an enhanced award for Daily Living (with standard text to be used). For the Mobility component, a standard award has been indicated, so the 'Level' option is available to the user.

LEVELS

Three options are available to the user. 'Manage, Agree, Disagree'. The selection here influences the text output in the DMR.

MANAGE

Claimant states they can manage, the user disagrees and decides help is needed. For instance claimant has said they manage their toilet needs with difficulty. User decides an aid is appropriate.

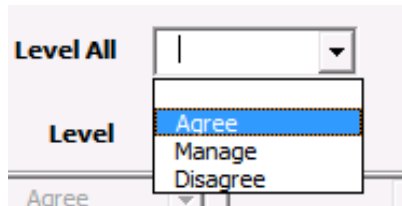
AGREE

The user agrees with the claimant about their level of restriction. For instance, the claimant has said they need prompting to take nutrition and the user agrees claimant needs prompting.

DISAGREE

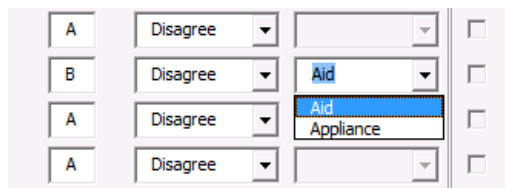
The user decides that the claimant's restriction is less or greater than they have claimed. For instance, the claimant has said they need assistance to mobilise in and out of a bath or shower and the user has decided that they would be able to manage reliably with an aid.

LEVEL ALL



This option allows the user to quickly select a level for all activities. This would be appropriate where the user feels that all activities are the same, harder, or easier than the claimant has indicated.

AIDS & APPLIANCES



Where the user is awarding a higher or lower level than the claimant has requested, the user can specify the type of help the claimant needs. This will be 'aid', 'appliance', 'supervision' or 'prompting' as appropriate (these options will vary depending on the activity' and are only active when less is selected).

OVER 65



A checkbox option exists to identify cases where the claimant is over the age of 65. Certain claimants cannot gain or increase the mobility component of PIP after the age of 65. Selecting one of these options will add an additional paragraph to the DMR output explaining why an award cannot be given or increased.

UT DECISIONS

A dropdown box is provided to add the standard text associated with Upper Tier tribunal decisions.



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DECISION MAKING REASONS

DMR Template Ver 3.0.7

Clinical information	Functional ability
how you engaged with the assessor	back movement
how you managed your finances at your face to face	balance
the available evidence information you provided	behaviour
your neurological examination results	cognitive function
your mental state examination results	concentration
your musculoskeletal examination results	dexterity
	eye contact

This is consistent with your medical history, your description of a typical day, informal observations at your face to face consultation, the evidence available at your face to face consultation, how you engaged with the assessor, the available evidence, the information you provided about how your disability affects you and your mental state and musculoskeletal examinations results.
 You have normal back movement, balance, behaviour, cognitive function and concentration.

The next page provides the opportunity for the User to add more detail to explain the reasons for their decision.

CLINICAL INFORMATION

This box allows the user to select multiple options to show what evidence has been used to make a decision. The options selected are displayed in a preview box which updates in real-time as items are added or removed.

FUNCTIONAL ABILITY

The user should normally add observations from the assessment about the claimant’s functional ability. These also populate the preview box. This is one of the most important areas to personalise your decision to the claimant’s individual circumstances and shows your decision has an objective basis.

FREE TEXT

It is possible for the user to add free text here if they have used a piece of evidence which is not listed on the dropdown menus.

OUT OF SCOPE ACTIVITIES

This box now allows the use of a generic sentence by selecting the top option. **Note:** the user will then be unable to select any further options from the rest of the list. However it is still possible to type in any further text if necessary.

If no activities are selected, the DMR Template will also prompt the user to confirm that they do not wish to list any out of scope activities.

The user can also opt to list any specific claimed activities which cannot be taken into consideration for the purposes of PIP which the claimant has identified are either the basis of their PIP claim or part of the key difficulties they have which they think we need to consider.

What cannot be taken into account

- I cannot consider any help not covered by the activities for daily living and mobility
- ability to work
- availability of public transport
- bending down to use an oven at below waist height
- physical problems with public transport
- being driven in a car
- being near to a toilet
- care of family members
- carrying shopping

REVIEW PERIOD CALCULATOR

Date of assessment Review period Years Months Review date

The review period calculator is a simple tool which enables the user to determine the review date when awarding or extending PIP. The tool is particularly helpful where the correct date is not obvious, for instance where the review is due at the end of February.

The tool does not add any text to the notification itself and is purely for the user's information.

LIMITED PERIOD AWARDS

Limited period awards Needs may change Right to stay in Great Britain is limited

Where the user needs to limit the period of the award, you can choose from two options to explain why to the claimant why.

DMR OUTPUT

The outputs from the previous screens are displayed on the next page. The user can review their work and make any final changes on this page. **At this point it is important to personalise your reasons for decision, especially in cases when you are disagreeing with the level of claimed needs or disallowing entirely.**

The [additional text] box, bottom left hand corner, has some useful standard sentences used by CMs. If a CM feels they have a useful paragraph or sentence this can be considered for use for all CMs by referring to your site DMR SPOC. A word count is provided in the bottom right hand corner.

DMR Template Ver 3.0.7

DMR Output

I made my decision using information about your health condition or disability including details of any treatment, medication, test results and symptoms. This information is the best we have available and enough to decide how much help you need.

PIP entitlement is based on your needs for the majority of days.

The information shows your health condition or disability causes you great difficulty with Daily Living activities.

You said you can manage moving around. I agree you can manage this activity.
You said you can plan and follow journeys unaided. I decided you need an orientation aid to help you follow the route of an unfamiliar journey.

This is consistent with your medical history, your description of a typical day, informal observations at your face to face consultation, the evidence available at your face to face consultation, how you engaged with the assessor and the available evidence.
You have normal back movement, balance, behaviour, cognitive function, concentration and dexterity.

I cannot consider any help you need not covered by the activities for daily living and mobility, including ability to work.]

Additional Text

Number of characters = 1131
Characters left = 3069

Auto Format ON

Previous OK Cancel

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Chapter 5 Appendix I

DFC Mandatory Request form



MR2(NI)
Mandatory Reconsideration Request

Complete this form if you want to dispute a decision, you must ask for a Mandatory Reconsideration within one calendar month from the date the decision letter was issued to you.

You should submit your written request to the office address at the top of your original decision letter.

Full Name:

Address:

.....

.....

National Insurance number:

Name of Benefit:

Date on decision letter:

Reason(s) why you disagree with the decision:

(You should specify which part(s) of the decision you disagree with and why)

.....

.....

.....

.....

Late Request:

If your Mandatory Reconsideration request is going to be late made more than one month from the date on the decision letter, you should give the reason(s) why it is late.

.....

.....

.....

Signed Dated

How DfC collects and uses information

The information the Department for Communities (DfC) collects from and about you depends mainly on the reason for your business with us.

We will use information about you for all of the Department's purposes, which include:

- The payment of social security benefits, grant loans and pensions;
- Child Maintenance;
- Employment and Training;
- Investigation of offences relating to social security;
- Social Security Research and Statistics.

DfC uses information to deal with enquiries and complaints, to provide DfC services, to protect public funds, and to conduct research and produce statistics to monitor and improve our services.

We will obtain information about you as the law allows from other organisations to check the information you give to us, protect public funds, and to improve our services.

DfC also shares information with other organisations as the law allows, for example to protect against crime, and with HM Revenue and Customs.

DfC uses external suppliers to help deliver some services. We also use technology to make decisions and improve our services. We will only ask you for information about your health when this is needed for a benefit or service you are using. We will keep your information secure, and make sure nobody has access to it who shouldn't.

Please look at the DfC Privacy Notice on <https://www.communities-ni.gov.uk/dfc-privacy-notice>

to find out more about:

- your information rights;
- how to request a copy of your information;
- DfC's data controller details and other data protection information;
- how long DfC will keep your data for; and
- more detail about how DfC uses personal information.

Chapter 5 Appendix J

DWP Mandatory Request form

If you disagree with a decision for:

- Housing Benefit please contact your local authority
- Child Benefit, Guardian's Allowance or Tax Credits please contact Her Majesty's Revenue & Customs

If you disagree with a decision made by the Department for Work and Pensions

About this form

You can use this form to ask for a Mandatory Reconsideration if you don't agree with a decision. This means a decision maker will look at your claim again and see if the decision was right or wrong.

It's important we make the right decision. To help us do that, this form will ask you to:

- tell us the reasons why you think the decision is wrong, and
- give us any new information that we haven't seen already

It is easier to call

You can ask for a Mandatory Reconsideration over the phone. Your claim will be looked at in exactly the same way. It's much quicker and you can explain why you think the decision is wrong over the phone, without needing to fill anything in. The phone number to call is at the top of your decision letter.

If you want to ask for a Mandatory Reconsideration in writing

You can use this form to ask for a Mandatory Reconsideration. There is a booklet to help you fill in this form called CRMR1A. It explains what information you need to include and has examples of the types of information we can consider. You can read it online at

www.gov.uk/mandatory-reconsideration

When you complete the form:

- Please use black ink to fill in the form and write in BLOCK CAPITALS
- You can type your information instead of writing if it is easier for you
- Everyone must complete Parts 1, 4 and 5
- Only complete Part 2 if you are filling in the form for someone else, such as a child or a person you represent

After you fill out the form

- Please print the form and sign it
- Post the form back to the address at the top of your decision letter
- Send any other relevant evidence at the same time
- We will send you a text message or letter to tell you we have received your form
- A different decision maker will look at your claim and any new information you provide. If they can change the decision, they will. It's important you understand that the amount you are awarded could go up, down or stay the same. Your benefit could also be stopped
- When we have made our decision, we will send you a letter called a Mandatory Reconsideration Notice.



Department
for Work &
Pensions

CRMR1 01/18

Part 1: About you - the person we have made the decision about

Title

Surname

First name

Date of birth

National Insurance (NI) number*

You can find this on top of the decision letter, your National Insurance (NI) numbercard, payslips or letters from the Department for Work and Pensions.

** If you are asking for a Mandatory Reconsideration on behalf of a child, please provide their Child Reference Number here.*

Letters Numbers Letter

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Child Reference Number

Which benefit are you asking for a Mandatory Reconsideration of?

Your current address

Postcode

Telephone number

Mobile phone number

We may need to call you for more information. Please tell us when it's best to contact you.

Monday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Tuesday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Wednesday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Thursday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Friday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm

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Part 2: If a representative is completing the form

You only need to fill out this section if you are a representative. Otherwise, please go to Part 3. By representative, we mean someone who isn't the person we have made a decision about. For example, this could be someone's carer, parent, relative, friend, legal Deputy etc.

Name of representative

Relationship to representative
(For example parent, carer, legal Deputy etc.)

Title

Surname

First name

Representative's address

Postcode

Representative's contact number

We may need to call you for more information. Please tell us when it's best to contact you.

Monday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Tuesday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Wednesday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Thursday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm
Friday	<input type="checkbox"/>	am	<input type="checkbox"/>	pm

Part 3: About the original decision

Are you asking us to look at your decision again within one month of the date on your decision letter?

Yes
 No If No, please tell us why below

(If necessary, use the extra space in Part 6)

Part 4: Why you disagree with the decision

Please explain in your own words why you disagree with the decision. Please be specific and provide as much detail as you can. If you disagree with more than one part of the decision, you must say why you disagree with each part.

Please read the booklet CRMR1A 'How to disagree with a decision made by the Department for Work and Pensions' for examples of information that will help.

What part(s) of your decision do you disagree with and why?

(If necessary, use the extra space in Part 6)

Do you have any new information we haven't seen or heard of?

No

Yes If Yes, please list it below

Please list all the new information you are sending with this form.

We won't be able to refund any costs if you get new evidence.

Please read the booklet CRMR1A 'How to disagree with a decision made by the Department for Work and Pensions' for examples of information that will help.

(If necessary, use the extra space in Part 6)

Have you attached all the evidence listed?

Yes

No If No, please tell us why below

Details of why you haven't attached the additional information. For example, you may have asked for a medical report but it hasn't arrived yet.

(If necessary, use the extra space in Part 6)

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Part 5: Check and sign

Check that you or your representative have:

- Explained what parts of the decision you disagree with and why
- Attached all additional evidence
- Signed this form

Please sign below

Signature

Please sign the form here after printing

Date

Name

If you are signing this form on behalf of someone else

As well as this form, please send signed authority for you to act on the claimant's behalf. You don't need to do this if you are:

- already registered as the claimant's appointee or Deputy with DWP, or
- the claimant's parents or legal guardian

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Northern Ireland

Public Services
Ombudsman

The Northern Ireland Public
Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Tel: 028 9023 3821

Fax: 028 9023 4912

Email: nipso@nipso.org.uk

www.nipso.org.uk