Revealed: the PIP medical computer software

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Benefits and Work has obtained training materials relating to the Personal Independence Payment Assessment Tool (PIPAT) which was introduced by the DWP in October 2013 to help ATOS and Capita create standardised PIP medical reports.

Although made available in October, it is up to ATOS and Capita to decide how long they take to roll-out PIPAT, and we understand it cannot be used when assessing claimants at home, presumably due to the lack of a secure internet connection. However, if the companies use their own report creation software it is likely that it has to follow the same layout and include the same evidence as the PIPAT created form.

The first impressions we have of PIPAT, here at Benefits and Work, is that it is a budget version of LiMA, the software used by Atos to carry out employment and support allowance medicals. PIPAT contains lots of ready-made phrases that health professionals (HPs) can paste into their report, just like LiMA. But it lacks the sophistication to take items of evidence and paste them in numerous bits of the report to justify the choices of descriptor in the way that LiMA can. However, this is just the first version of PIPAT and we have no doubt that over time it will increase in complexity and in its ability to allow HPs to create reports with the minimum of thought and effort.

Below we give an outline of how PIPAT works

PIPAT overview

PIPAT is intended to allow all the details needed to carry out an assessment to be stored and worked on in one place by Atos and Capita.
So, using PIPAT, HPs can see any documents relating to a PIP claim, including the claim form and supporting medical evidence, all of which is scanned and stored in .pdf format.

HPs can also use PIPAT to record details of any requests they make for additional evidence and to justify a decision on whether to call the claimant in for a medical.

And PIPAT is also used to guide the HP through the actual medical assessment itself and to generate the report that will be used by the decision maker when deciding whether to make an award of PIP and, if so, at what rates.

PIPAT includes collections of standard phrases that HPs can choose from, as well as free text boxes they can type evidence into. They are expected to use a combination of both to create their report.

Document review

Before deciding what action to take on a new claim, a HP carries out a document review. Having looked through all the evidence available, the HP decides whether to:
send for further evidence;
invite the claimant for a ‘consultation’; or

create a report based solely on the paper evidence without assessing the claimant in person.

If the HP decides to send for further evidence they have to record their justification for doing so. PIPAT won't create the letter requesting evidence,

The options for further evidence listed in PIPAT are:

- General Practitioner
- Consultant
- Community Psychiatric Nurse
- Counsellor
- Hospital Doctor
- Occupational Therapist
- Psychiatrist
- Psychologist
- Physiotherapist
- Social Worker
- Specialist Nurse
- Teacher
- Others

When further evidence is obtained, we assume – but don't know for certain – that a further review is carried out to decide whether to create a medical report solely on the papers or to call the claimant in for assessment.

Beginning a consultation

If the claimant is summoned for a consultation – the DWP's term for a PIP medical assessment - the HP carrying out the medical should first review each item of evidence already available on PIPAT and then click on an 'Add Evidence Used' box to show that they have read that item.

If paper evidence is brought to the consultation by the claimant, the HP should make a copy and send the original to the DWP to be scanned. The HP then has to complete an Evidence Details section giving details of the content of the additional evidence.

Conditions

The HP has to list the claimant's health conditions by selecting from three consecutive drop down lists covering: the condition category; subcategory and then the specific condition. The example given in the training materials is:
Condition Category: Genitourinary disease.

Condition Subcategory: Renal failure R21 – R30.

Condition: Renal failure – acute.

History

Next the HP will take a history from the claimant covering:

- condition history;
- medication;
- treatment;
- social and occupational history; and
- functional history.

Observations

The observations section of the report is used to record both observations and formal examination findings. The HP is told that they must enter information under all of the following categories, even if just to report that the category was not examined:

- General Appearance.
- Mental State.
- Vision, Speech and Hearing.

- Cardiovascular and Respiratory.
- Musculoskeletal.
- Central Nervous System.
- Other Systems.

There are a range of ready-made phrases that the HP can select, using a list of ‘phrase names’. For example, in relation to vision, the choices include the following phrase names:

- Sight no problem
- Sight difficulty
- Sight unable
- Snellen distance vision
- Snellen near vision
- Wore glasses for test
- Forgot glasses
- Wears glasses distance only
- Glasses reading only
- Does not wear glasses
- Visual aids benefit
- Navigate

Descriptor wizard

The descriptor wizard allows the HP to choose a descriptor for each of the daily living and mobility activities. It doesn’t appear to provide any justification for the choice of descriptors, however.

At the end of each component the HP also has to answer two further questions:

How long have functional restrictions been present?

- At least 3 months

- Less than 3 months
- Not applicable

How long are functional restrictions likely to remain?

- At least 9 months
- Less than 9 months
- Not Applicable

Opinion summary

In the opinion summary section the HP provides a summary of why they have reached their conclusions. They also say:
How long before the claimant should be assessed again.

Whether the same functional restrictions are likely to be present at the date of the next assessment.

Whether the claimant is terminally ill.

Whether they will need any help with a renewal claim due to, for example, a mental health condition.

Whether anyone attended the consultation with the claimant and, if so, their relationship to the claimant.

What type of health professional carried out the assessment.

What the claimant's main disabling condition is – for statistical purposes, not as part of the assessment.

The HP also records what time the consultation started and ended and how much additional writing up time there was.