citizens advice Bournemouth Christchurch & Poole

Timms Review of Personal Independence Payment: Call for evidence

May 2026

About Our Response

This response draws on Citizens Advice Bournemouth Christchurch and Poole's frontline advice casework and practical experience supporting clients with Personal Independence Payment (PIP). It focuses on recurring issues observed across applications, assessments, reconsiderations and appeals, and reflects both claimant experience and systemic design problems in the current PIP framework.

This response is supported by internal case management data covering over 15,000 PIP-related issues recorded locally between 2019 and 2026, alongside detailed case evidence documenting claimant experiences across applications, assessments, reconsiderations and appeals.

1. The Role and Purpose of PIP

PIP does not adequately reflect the extra costs of disability

PIP is framed as a contribution to the extra costs of disability, but the assessment does not ask directly about or explicitly consider what those costs are. Subsequently, it fails to provide for them in a way that is specific and fair. Because there is no targeted data gathering on items such as food, transport, heating, personal support, equipment, childcare, adaptations, or social participation, PIP award levels do not meaningfully cover the real additional costs of disability, which are well-evidenced. We include a case study here of our client, John:

John has a stoma following bowel cancer and self-catheterises. He spends more on clothes due to leakages, and on support garments as he is concerned about developing a hernia. He has higher electricity usage due to having to wash *clothes and bedding more frequently because of stoma and catheter leakages. When he recently broke his arm, he had to pay for carers to come in and change his stoma bag and catheter. He receives the same points as someone who wears an incontinence pad.*

We recommend introducing explicit questions about extra costs, creating better data on what support people need. Gathering direct firsthand evidence would avoid inaccuracies, assumptions or biases.

Family life, caring and household impact are missing

The current assessment fails to consider the person's ability to manage family life, caring responsibilities, parenting, housework and domestic tasks. Disability impacts do not occur in isolation. The absence of consideration for family life gives an incomplete and unrealistic picture of daily living. For example, the rules for cooking look at whether someone can make a simple meal for one person. But in real life, someone may need to cook for a whole family. They might manage a meal for one but not be able to cope with cooking for their household. If PIP looked at whether people can cook for their actual household needs, it would better reflect the difficulties they face day to day.

Lack of clarity about who PIP is for

In our experience, there is widespread misunderstanding about the purpose of PIP. Many people apply believing that a diagnosis or being unwell automatically confers entitlement, when in fact current entitlement is linked to functional impact on daily living and mobility. If PIP continues to be intended to support people with severe, long-term functional impacts, that should be made more explicit.

Many claimants are unfortunately using PIP as a general cost-of-living top-up, because other benefits are insufficient to meet their needs. This can lead to people applying who are not eligible, creating distress for claimants and avoidable pressure on the system. Around 1 in 25 people we see clearly do not meet the criteria, and in these situations, we advise people not to apply. The current system fails to clearly and adequately explain the distinction between *being ill* and *needing support to live independently*. This lack of clarity is reflected in our local data. Over the past five years, issues categorised as *"making and managing a PIP claim"* represent the single largest group of PIP-related contacts to our service, with over 3,000 recorded issues. This suggests not misuse of the system, but persistent confusion about eligibility, process and expectations.

At the same time, there is a gap for people who are unwell but do not meet PIP thresholds, particularly where social care and support services are unavailable. We include here a case study of our client Kelly:

Kelly has Raynaud's which causes pain, stiffness and lack of blood flow in her hands and feet. It flares up in cold weather or when she is distressed. Although she does not meet the PIP threshold as she doesn't suffer this more than 50% of the time, when it flares up, she is unable to change her twins' nappies, to prepare food, bath them or to walk safely. She doesn't meet the criteria for PIP as she is not affected over 50% of the time, but she needs to be able to access practical support and help when she has a flare up.

2. Eligibility, Fairness and equity in the award of PIP

Fundamental issues with how eligibility is assessed

Eligibility for PIP is determined through a set of descriptors that are intended to measure the impact of disability on daily living and mobility. However, our experience is that the legal framework around PIP descriptors is often misapplied and misinterpreted by assessors, leading to inconsistent outcomes, avoidable appeals, and widespread misunderstanding about who qualifies for support.

Our local data over the past five years shows persistent problems with eligibility decisions. We recorded over 2,200 issues relating to daily living eligibility and nearly 1,800 concerning mobility eligibility, alongside almost 700 challenges to decisions and more than 1,300 formal appeals.

The scale and persistence of these figures strongly suggest structural problems with how eligibility is determined, rather than isolated claimant misunderstanding.

Descriptor framework does not reflect real-world impact

Across both Daily Living and Mobility activities, the descriptors:

- Over-prioritise narrow physical tasks
- Under-represent cognitive, psychological, sensory and motivational barriers
- Fail to account for time taken, cumulative fatigue, recovery time, or variability

- Assume that coping mechanisms mean lack of need

As a result, many people with severe and ongoing functional limitations do not score points that reflect their lived experience.

The high rate of challenges and appeals reflects not claimants “testing the system”, but descriptors that fail to capture real-world impact. Case evidence repeatedly shows clients initially awarded low or no points later receiving standard or enhanced awards at tribunal, often without new medical evidence. This indicates significant inconsistency and unfairness in decision-making at earlier stages.

Daily Living descriptors:

Difficulties with daily living descriptors are reflected in our eligibility data, where issues relating to daily living eligibility account for the largest single eligibility category over five years. Many recorded cases describe people scoring no points at application despite needing prompting, supervision or support once descriptors are properly explored.

- **Preparing food / Taking nutrition**

In our experience, assessments often assume that if a person can convey food to their mouth, they are able to take nutrition adequately. This overlooks a wide range of barriers that affect whether someone can maintain a safe, appropriate, and consistent diet. Factors such as lack of motivation to eat (for example, in cases of severe depression), sensory aversions, and an inability to eat in a conventional or socially typical way are frequently given insufficient weight.

Currently, lack of motivation is only considered where there is clear medical evidence or significant weight loss. However, this does not account for individuals who are eating to a poor or inadequate standard, where a limited or unbalanced diet negatively impacts their health condition. Equally, overeating linked to physical health conditions or psychological distress - even where it leads to substantial weight gain and associated health risks - is not adequately considered within the descriptor.

The assessment framework also awards the same scoring to vastly different interventions (for example, large-handled cutlery, stomas, or PEG feeding), which does not reflect the relative level of need or impact on daily living.

While the descriptor focuses primarily on the physical preparation and cooking of food, it fails to capture wider and often more significant barriers, including:

- Managing diet in relation to medical conditions
- Neurodiversity affecting food choices, tolerance, and routine
- Eating disorders, which may make it difficult to be in the kitchen or handle food at all
- Cognitive or sensory barriers that affect decision-making about what can or cannot be eaten
- Executive functioning difficulties, such as procrastination, meaning it can take significantly longer to decide what to prepare and how to cook

In practice, we see many individuals who may technically be able to prepare food but are unable to manage a safe, appropriate, or consistent diet. For example, some clients rely on cereal or snacks rather than preparing meals or depend on friends or family to cook for them. These situations are often treated as a 'choice' rather than recognised as evidence of underlying difficulty in preparing and managing meals.

There is currently no mechanism within the descriptor to reflect these complexities, meaning that eligibility is not being assessed fairly or consistently for those with non-physical, fluctuating, or less visible barriers to nutrition.

➢ Managing therapy or monitoring a health condition

Eligibility under this descriptor is unfairly affected by NHS service limitations:

- Many people we advise are discharged despite ongoing need
- Lack of current treatment is interpreted as lack of need
- Medication non-adherence due to side effects is often penalised

The descriptor fails to recognise that people often self-manage because services are unavailable, not because support is unnecessary. This systematically disadvantages claimants.

➢ Washing and bathing

The descriptors:

- Artificially segment and prioritise body parts

- Do not consider extended and ongoing prompting over longer periods, time taken in the context of impact on daily living, or recovery time
- Ignore situations where someone can wash once but not again for several days

Aids often need to be self-purchased rather than prescribed, however, evidence from the people we work with demonstrates that self-purchased items are often not given the same consideration - yet still indicate significant impairment. Being able to wash occasionally does not mean someone can wash reliably, repeatedly or safely, but reliability is not fairly captured.

➢ Managing toilet needs or incontinence

The scoring system fails to reflect severity:

- Regular Bowel accidents may score only 2 points
- Wearing pads is equated with invasive medical interventions such as self-catheterisation or stomas

These distinctions have a profound impact on dignity, independence and daily life but are often not reflected fairly in eligibility decisions. Although there is recognition that these interventions mean that managing toilet needs take a longer time, often in our experience, the consideration does not go deep enough and can be very surface level. It would be fairer if there was a new points category, for example 'an aid or appliance is needed in order to be able to perform a bodily function' - for example catheter, stoma, PEG feeding, hearing aids.

➢ Dressing and undressing

The descriptors focus on physical action only and do not clearly and demonstrably account for:

- Lack of motivation
- Shame or embarrassment leading to underreporting
- Inability to manage fastenings such as buttons or zips
- Restricted clothing choices and resulting social exclusion

These factors significantly affect daily functioning. Although regulations demonstrate the above factors can be recognised in eligibility scoring, our experience with clients shows that people are regularly under awarded points when meeting the regulatory threshold.

➢ Communicating verbally

Although psychological difficulties communicating come under this activity, reinforced by caselaw, in reality the descriptor is often assessed almost entirely around physical speech or hearing. It does not encourage applicants or their assessors to be attentive to nuance around difficulty communicating needs, or to consider lack of available communication support. Our experience with clients shows that decisions often fail to recognise how communication barriers undermine independent living. We believe that the test is too simplified and does not consider cognitive or wider difficulties with communication.

If PIP is intended to support independence, the descriptor is regularly unfairly assessed. We include here an example of our client Joseph:

Joseph is 18 and is autistic with a PDA profile. When he feels under pressure, he has mutism and cannot speak. This is not for more than 50% of the time, but it has happened in interviews and placements and has prevented him from finding a job.

➢ Reading and understanding information

The descriptor focuses on physical reading ability. Our experience with clients shows that the legal test is too over simplified, and in practise assessors often overlook cognitive overload, inability to absorb or process information, and mental fatigue and overwhelm.

➢ Engaging with other people face to face

In our experience, eligibility is often refused due to lack of “evidence”:

- Psychological distress is hard to medically evidence, particularly in a system where obtaining ongoing help for mental health needs is difficult
- Claimant lived experience is frequently discounted

For example, young people with neurodiversity or mental health needs regularly have little input from medical services that can be documented. There is often no ongoing medical input after diagnosis, as needs are managed via the EHCP until education is completed. This creates unfair outcomes for people with anxiety, trauma or neurodivergence whose impairments are real but poorly documented.

➢ Making budgeting decisions

Memory and focus as well as practical budgeting support are supposed to be assessed for this activity. In practise, assessors look at numerical tasks rather than executive functioning. Someone may understand maths but lack memory, focus or impulse control; many people need practical budgeting support rather than financial literacy, and fluctuating conditions make consistent budgeting impossible. For example, where a condition causes impulsivity - e.g. bipolar and some presentations of ADHD - one incident of poor budgeting decisions can have long term financial consequences; someone may get heavily into debt or ignore bills during a manic phase, leading to poor credit scoring and county court judgements, which in turn impact on their ability to secure housing, financial support.

In our experience, there is regular narrowing during assessment on this descriptor, often leading to incorrect conclusions about capability and unfair denial of points.

Mobility descriptors

➢ Planning and following journeys

Although the legal test is that people score the highest points if they are housebound, assessors regularly penalise people who avoid journeys due to distress:

- People who are housebound due to mental illness often score lower than those who go out with support
- There is no nuance around reassurance-based aids (e.g. Google Maps for anxiety)

Eligibility outcomes often do not fairly reflect genuine restriction of mobility.

➢ Moving around

We have found this descriptor to be particularly restricted by assessors, who inconsistently apply the legal framework. Time taken to move, pain, dizziness and fatigue are meant to be considered under this descriptor if this makes claimant stop due to severe distress. However, our evidence shows that:

- Higher awards are effectively limited to those who cannot walk more than 20 metres
- Time taken, pain, dizziness, fatigue and cumulative impact are routinely ignored in decision making
- Only flat surfaces are considered; inclines, stairs and uneven ground are excluded

This results in many people with significant mobility impairments not qualifying for appropriate support.

Mobility eligibility issues account for almost 1,800 cases within our local data over the past 5 years. These frequently involve people who can technically move short distances but cannot do so reliably, safely or repeatedly, or who avoid travel due to overwhelming psychological distress. The data reflects a consistent mismatch between assessment and lived experience.

Reassessments and long-term conditions

Eligibility decisions are repeatedly revisited even where there is no prospect of improvement:

- People with lifelong conditions (e.g. Down's syndrome, amputations) undergo repeated reassessments
- There is no exhaustive list of what constitutes lifelong conditions. For example, John's stoma (mentioned earlier) will be permanent, yet he will be reassessed as it only scores 2 points
- For people with more than one diagnosis, a lifelong condition may score low points, but decisions about regular reassessment are often based on the other conditions they have
- Awards that are effectively as short as 18 months are routine, when considering delays, appeals and then reassessment timelines. This causes distress and represents poor use of public resources

Eligibility reviews should be based on likelihood of recovery, not arbitrary timeframes.

To put this in context, our data records over 600 issues relating specifically to renewals and reviews, many of which involve people with long-term or deteriorating conditions. In numerous cases, awards were reduced or removed despite no improvement in health, leading to appeals, extended distress and avoidable administrative cost.

Variable and fluctuating conditions

The current interpretation of fluctuating conditions is unfair:

- Conditions that do not affect someone more than 50% of the time may still have devastating impact
- Single-event crashes or flare-ups are ignored
- Cumulative consequences are not recognised

This results in eligibility decisions that fail to reflect lived experience. For example, our team recently assisted a client with fibromyalgia. When we look at the claimant journey for someone with an ongoing condition such as fibromyalgia, the way the PIP process is set up is markedly disadvantageous to the client. Diagnosis can take a long time, so it can be hard to provide evidence for an initial claim outside of the claimant's self-reported experience.

The condition is not usually progressive but is ongoing. Diagnosis may be made by a rheumatologist, with current medical evidence at that point. However, there is no ongoing treatment or cure for fibromyalgia, so there is no ongoing consultant input. GPs no longer prescribe OTC pain medication, and NICE guidelines discourage prescribing opioids for chronic primary pain. Fibromyalgia patients are often left to find their own self-management solutions, which many use PIP to finance. However, decision makers in cases such as these cite 'no ongoing medical input' as a reason to downgrade or end existing awards.

Mental health and neurodiversity

Our qualitative evidence forms repeatedly record that claimants with mental health conditions and neurodivergence are found not eligible at application and reconsideration stages, only to succeed at appeal. Records consistently note that masking, learned coping strategies, and appearing articulate during assessments are misinterpreted as lack of impairment.

3. The Claimant Experience

The application form is not accessible or transparent

There are several key problems with the PIP form which are often highlighted to us by the people we work with.

The descriptors are not included in the application, so applicants do not know how their answers will be judged unless they are advised. This is made more difficult by the questions being too vague and worded in a confusing way, which leaves them open to interpretation. This leads to people needing expert help to complete the form correctly, which should not be necessary.

As mentioned in the previous section, the form does not prompt people to think about variability, cumulative impact, time taken, or recovery time. As a result, people who receive advice are more likely to succeed. People living alone often downplay difficulties, having normalised significant impairment. Overall, people that we work with feel the process is about “saying the right thing” rather than accurately describing their reality.

Emotional harm and distress

Our experience with clients demonstrates clearly to us that the PIP process itself causes harm; repeatedly describing limitations pushes people into a negative mental state.

Long decision times create distress and financial instability. Waiting months (or over a year with appeals) leaves people in severe hardship. For example:

Tim was a homeless client who was living in a camper van. He received an enhanced award on both daily living and mobility which meant his van was classified as a disability vehicle and tax exempt. At review, he received 0 points on both elements, despite no change in his conditions.

As a result, his vehicle was reclassified and now liable for vehicle tax, but with the loss of income he could not afford it. This left him stranded away from his support network as he no longer had transport. He was also unable to access the counsellor who was supporting him with his mental health issues because he could not pay for sessions. We had to support him with food bank vouchers and the Household Support Fund.

Delays are a persistent theme in both our quantitative and qualitative data. Over five years, more than 1,300 cases involved appeals, often following long periods without income. Case records repeatedly describe claimants experiencing severe anxiety, worsening mental health, debt, and food insecurity while waiting for decisions.

Mandatory reconsideration and appeals

Mandatory reconsiderations often correct obvious errors, rather than offering meaningful review. Meanwhile, appeals can take up to a year, during which people can fall into destitution, and there is no assessment or maintenance rate during appeals, even where someone previously had an award.

Losing PIP has cascading consequences which have severe impacts on people's lives, for example: Loss of Carer's Allowance for someone else; Housing Benefit reductions (shared room rate, non-dependant deductions), and Increased debt and need for crisis support.

Evidence records consistently link PIP delays and refusals to acute financial hardship, including reliance on food banks, rent arrears, debt accumulation, and loss of related entitlements such as Carer's Allowance and disability premiums. These impacts frequently persist for months while appeals are ongoing.

Reliance on charitable support and food banks

Our local data shows sustained and growing reliance on charitable support and food banks among people engaging with the PIP system, indicating that statutory support is frequently insufficient or delayed.

Between 2018 and 2026, we recorded over 88,000 instances of charitable support and food bank–related issues across our service. This includes more than 31,000 applications for charitable support and 34,000 recorded instances of support being received, demonstrating widespread and ongoing financial hardship rather than short-term crisis need.

Food bank use remains consistently high, with over 9,600 recorded food bank referrals, the majority linked to Trussell Trust food banks. Demand increases notably during periods when clients are awaiting PIP decisions, undergoing reassessment, or appealing incorrect or reduced awards.

This data shows a clear link between problems within the PIP system, such as delays, inappropriate eligibility decisions and reassessment practices, and the need for emergency charitable support. Many clients require food banks and other charitable assistance despite receiving Universal Credit or other benefits, highlighting that income during these periods is insufficient to meet basic living costs.

Charitable provision is increasingly acting as a substitute safety net for delays and inadequacies within PIP, rather than as exceptional or short-term support. This reliance is neither sustainable nor appropriate and masks the true level of unmet need created by the current design and delivery of PIP.

4. The Changing Context

Rising PIP applications reflect:

- Cost of living pressures
- Covid-related mental health impacts
- Long Covid
- An ageing population
- People remaining on PIP after State Pension age (due to absence of mobility in Attendance Allowance)

This is not simply inappropriate claiming; it reflects genuine unmet need.

Key Recommendations

- Poor decision making, which does not reflect the legal test, is routine. Better training for assessors is key
- Make PIP's purpose and eligibility clearer
- Ask explicitly about extra costs
- Reform reassessments based on recovery likelihood
- Recognise variable, fluctuating and cumulative conditions
- Introduce a maintenance rate during appeals
- Redesign descriptors to reflect real-world impact, and Include descriptors on the form
- Use PIP as a gateway to access wider tailored support (OTs, therapies, services)