

Revised WCA Handbook

MED-ESAAR2011/2012HB~001

Date: 5 July 2016



Foreword

This training has been produced as part of a training programme for Healthcare Professionals approved by the Department for Work and Pensions Chief Medical Officer to carry out benefit assessment work.

All Healthcare Professionals undertaking medical assessments must be registered practitioners, who in addition, have undergone training in disability assessment medicine and specific training in the relevant benefit areas. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

This Handbook should be read with the understanding that, as experienced practitioners, the Healthcare Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques, and therefore such information is not included.

In addition, this Handbook is not a stand-alone document, and forms only a part of the training and written documentation that a Healthcare Professional receives. As disability assessment is a practical occupation, much of the guidance also involves verbal information and coaching.

Thus, although the Handbook may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to Healthcare Professionals.

Office of the Chief Medical Officer

July 2016

Document control

Superseded documents

Version history

Version	Date	Comments
9 Final	5 th July 2016	Signed off by SH&S
9d Draft	30 th June 2016	Updated with DWP comments
9c Draft	23 rd June 2016	Updated with changes to Activity 13- Social Interaction
9b draft	17 th March 2016	Updated with DWP changes
9a Draft	25 th February 2016	Review and update
8 Final	5 th March 2015	Conversion to new Template
7 Final	09 February 2015	Signed off by MAT and CMMS

Changes since last version

General:

Updates to terminology, removal of references to Atos, additions of references to Universal Credit, references to examining HCP removed, references to out of date IT applications removed.

Section 1:

Section 1.1 – Introduction amended to reflect Universal Credit.

Section 1.2 – minor grammatical change to avoid duplication of wording.

Removal of reference to previous versions of forms

Section 1.4.1 – Reference to Atos changed to HAAS

Section 1.6 – Reference to Assessment Partners added.

Section 1.7 - Information re Prescriptive advice added (UTS15/15)

Section 1.8 – Further updates and information relating to Universal Credit.

Section 2:

General alteration of Support Group to reflect LCWRA terminology

Section 2.1- Ref to ESA Filework Guidelines changed to Filework guidelines.

Section 2.3 – Grammatical changes

Section 2.3.1 – Clarification of wording (removal of references to entitlement as out with HCP role)

Reference to UC regulations being identical for LCWRA added

Section 2.3.1.1 – Slight amendment of wording in relation to paraplegia and wheelchair use

Reference to storage of wheelchair removed (UTS 16/15)

Section 2.3.1.3 – Grammatical change to avoid repetition of words

Section 2.3.1.12 – Grammatical changes.

Altered examples of personal action.

Section 2.3.1.14 – Changes to scope of social Engagement added (UTS 13/16)

Section 2.3.2 – Reference added to indicate UC and ESA regulations the same for LCWRA

Reference to SG changed to LCWRA

Some grammatical issues amended.

Section 2.4- Reference to Regulations in UC differing from ESA for treat as LCW amended.

Reference to SG replaced with LCWRA

Section split into 2.4.1 and 2.4.2 to reflect ESA UC regulations

Section 3:

Section 3.1.2.2 – Added section to provide information on the Disability component of UC

Section 3.1.3.6 – Update to LiMA terminology

Section 3.1.3.7 – Reference to emphasise need for particular care on enquiry where ESA 50 was completed some time ago

Section 3.1.3.10 – Reference to wheelchair storage removed

Reference to Disability component of UC

Section 3.1.3.12 – Sentence added to emphasise the need to explore more serious conditions first

Section 3.1.4 – Heading changed from Examining the claimant to Clinical Examination

Section 3.1.5 – Further emphasis and clarity on requirement to phone GP if UE1 completed

Section 3.1.9 – change in wording to sentence - “are required to” changed to “should” –as per external review comments.

Reinforcement of section 2.3 wording on considering reliably and repeatedly

Section 3.2.1.2 – UTS 16/15 – wheelchair storage incorporated

Section 3.2.1.3 – Slight amendment of wording

Section 3.2.11 – “Usually” added in reference to dizziness and consciousness

Section 3.5.2 – Clarification of Games Console use as a moderate task

Section 3.5.4 – Typo amended

Change to example of personal action

Additional information added in relation to washing and dressing

Section 3.5.7 – Personality Disorder added to list of conditions and UTS 13/16 on social engagement included

Section 3.7– Reference to previous training simplified

Section 3.8 – Reference to NFD not being in the wording of the UC regs

Typos amended

Reference to specific condition changed to substantial risk

Paragraph removed where guidance was that regulations would not be separated for risk

Section 3.8 split into 3.8.1 & 2, for clarity

Full section on revised risk guidance added

Section 3.9.1 – Additional point added on risk in PSS

Section 3.10 – Reference to UC and re-referral period

Re-referral and Disability component of UC referenced

Section 3.11.1 – Reference to RMP and clerical reports amended to suitably trained HCPs

Section 3.11.3 – Reference to RMP changed to suitably trained HCP

Section 4.1.3 – Slight amendments to audio recording advice for clarity

Section 4.1.5 – Pregnancy in UC and ESA highlighted

Section 4.2.2.1 – References to Atos changed to HCP

Section 4.2.3 – Slight revision to wording on consent

Section 4.4.1 – Guidance on implicit consent for booking appointments inserted (UTS 21/13)

Appendix 6 – added- DWP revised Risk Guidance 2015 added.

Appendix 7 – added- DWP information on Work Related Activity

Outstanding issues and omissions

Updates to Standards incorporated

21/13, 16/15, 15/15, 13/16

Issue control

Author: Medical Learning and Development

Owner and approver: DWP

Signature: **Date:**

Distribution:

Contents

1.	Introduction	11
1.1	Introduction	11
1.2	Background to Employment and Support Allowance	12
1.3	The Work Capability Assessment Structure	16
1.4	The Financial Structure of ESA	16
1.4.1	Overview of the ESA claim process	17
1.5	The role of the Health Advisory Assessment Service HCP	19
1.6	The Decision Maker's Perspective	20
1.7	Universal Credit	21
1.7.1	Background to Universal Credit	21
1.7.2	Universal Credit and the WCA	22
2.	Filework	24
2.1	The Special Rules Check/Terminal Illness Check (SR or TI check)	24
2.2	Pre-board Check	25
2.3	Limited Capability for Work Related Activity (The Support Group)	25
2.3.1	Limited Capability for Work Related Activity (LCWRA) – Severe Functional Limitation	26
2.3.2	Limited Capability for Work Related Activity (LCWRA) Criteria – Special Circumstances	37
2.4	Certain claimants treated as having limited capability for work/ work-related activity	40
2.5	Re-referral Scrutiny	45
2.6	IB Re-assessment Filework	46
2.7	Request and Provision of Advice to the WCA Decision Maker when the Claimant submits further evidence	47
2.7.1	Advice provided by HAAS Healthcare professionals	47
2.7.2	The Role of the HAAS Professional	47
3.	The Functional Assessment	49
3.1	The Functional Assessment (The Limited Capability for Work and Limited Capability for Work-related Activity functional assessment)	49
3.1.1	Introduction	49
3.1.2	Reading the Documents	49

3.1.3	Interviewing the Claimant	52
3.1.4	Clinical Examination of the Claimant	60
3.1.5	Dealing with Unexpected findings at the assessment	63
3.1.6	Completing the LCW/LCWRA Medical Assessment Report Form: An Overview	65
3.1.7	Choosing and Justifying Descriptors: the Overall Approach	67
3.1.8	Completion of Functional Activity Area Pages	70
3.1.9	Variable and fluctuating conditions	70
3.1.10	Activities of Daily Living	72
3.1.11	Behaviour observed during the assessment	72
3.1.12	Clinical findings	73
3.2	Functional Categories (Physical)	74
3.2.1	Introduction	74
3.2.2	Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used – Activity 1	82
3.2.3	Standing and sitting - Activity 2	85
3.2.4	Reaching - Activity 3	89
3.2.5	Picking up and moving or transferring by use of the upper body and arms - Activity 4	90
3.2.6	Manual Dexterity - Activity 5	92
3.2.7	Navigation and maintaining safety, using a guide dog or other aid if either is or both are normally, or could reasonably be, used – Activity 8	94
3.2.8	Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person – Activity 6	98
3.2.9	Understanding Communication by	100
3.2.10	Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bedwetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used – Activity 9	107
3.2.11	Consciousness during waking moments - Activity 10	109
3.3	Examination of the Musculoskeletal System	112
3.4	Guidance on Specific Conditions (physical)	119
3.5	The Mental Function Assessment – Mental Functional Activity Categories	119

3.5.1	Introduction	119
3.5.2	Learning tasks – (Understanding and focus) - Activity 11	122
3.5.3	Awareness of everyday hazards (such as boiling water or sharp objects) – (Understanding and focus) - Activity 12	124
3.5.4	Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks) - (Understanding and Focus) – Activity 13	125
3.5.5	Coping with change - (Adapting to change) – Activity 14	127
3.5.6	Getting About - (Adapting to change) – Activity 15	129
3.5.7	Coping with social engagement due to cognitive impairment or mental disorder - (Social Interaction) – Activity 16	130
3.5.8	Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder - (Social Interaction) - Activity 17	134
3.6	Guidance on Specific Conditions – Mental Health	135
3.7	The Mental State Examination	136
3.8	Exceptional Circumstances (Non Functional Descriptors) in the LCW/LCWRA Medical Assessment	136
3.8.1	Life Threatening, Uncontrolled Disease.	137
3.8.2	Substantial Risk.	137
3.9	Personal Summary Statement	141
3.9.1	Clarify the medical basis for your choice of descriptors	141
3.9.2	Justifying your advice on LCWRA	143
3.9.3	Efficient use of Time in the LCW/LCWRA Assessment	144
3.10	Medical Advice on Re-referral Period or Prognosis at Assessment	144
3.10.1	LCW/LCWRA - Advice on when work could be considered	145
3.11	LCWRA Assessments	147
3.11.1	Introduction	147
3.11.2	Background	147
3.11.3	LCWRA Assessment Process	148
4.	Miscellaneous	151
4.1	Exceptional Situations at Medical Assessment	151
4.1.1	Clients Unfit to be seen	151
4.1.2	Lack of an Interpreter	153
4.1.3	Audio taping of assessments	153

4.1.4	Taking of Notes during an Assessment by Claimant or Companion	154
4.1.5	Functional assessment of pregnant women	155
4.1.6	Retention of Notes containing Claimant Details	155
4.2	Sensitive Information	156
4.2.1	Harmful Information	156
4.2.2	Embarrassing Information	156
4.2.3	Unauthorised vs. authorised information	158
4.2.4	Confidential Information	158
4.2.5	Information brought by the claimant to the assessment	159
4.3	Identification of Claimants	159
4.4	Domiciliary visits	161
4.4.1	Establishing the identity of the Claimant	161
4.4.2	Informing the Claimant of the reason for the telephone call	163
4.4.3	Claimant has an Appointee	163
4.4.4	Claimant requires an interpreter	163
4.4.5	Claimant has a medical condition which prevents him/her speaking on the telephone	163
4.4.6	Policy on Passive Smoking	164
Appendix 1 - The LCWRA Descriptors		165
Appendix 2 – ESA85 & UC85 Clerical Report		170
Appendix 3 - ESA85S and UC85S		240
Appendix 4- ESA85A and UC85A		242
Appendix 5 – Proof of Identity Form		246
Appendix 6 – DWP Revised Risk Guidance 2015		247
Appendix 7 – DWP Information on Work related Activity		252
Observation form		255

1. Introduction

1.1 Introduction

This handbook has been written to support Healthcare Professionals (HCPs) trained in the principles of Disability Analysis; in their training and in performing face to face Work Capability Assessments (WCA) for Employment and Support Allowance (ESA) and Universal Credit (UC). This handbook provides guidance on ESA and UC procedures and reflects the latest guidelines and regulations relevant to HCPs, in relation to “The Revised Work Capability Assessment” (Revised WCA).

The intended learning outcome of the handbook is that the HCP will be equipped with adequate knowledge of the background, principles, processes, and their own role, to be able to successfully deliver the policy intent and complete the Revised WCA learning path. The handbook is designed to be an essential source of information for the HCP regarding ESA and UC.

Much of the work carried out by The Health Advisory Assessment Centre (HAAS), including for ESA and Disability Living Allowance (DLA), is completed using the Logic Integrated Medical Assessment (LiMA) system. LiMA is an evidence based computer programme which allows the HCP to document evidence gathering and supports the evaluation of data and provision of advice on levels of disability using logic based on ‘evidence based medicine’ protocols.

The ESA and UC procedures form the foundation of knowledge and experience to produce Evidence Based reports utilising the LiMA application. This handbook will make considerable reference to the LiMA application throughout as most WCAs will be completed using the LiMA application except in certain specific or exceptional circumstances.

Some of the material in this handbook may be familiar to experienced HCPs but it is also intended to be used by those who are new to this work.

The handbook consists of four parts.

Section 1 sets out the background to the Revised WCA and the main aspects of ESA and UC.

Section 2 deals mainly with the process from receipt of the referral from Jobcentre Plus to the point at which the claimant is called for an assessment. This section covers both ESA and UC Regulations.

Section 3 deals with the major aspects of the medical assessment. The section includes details of the general approach to be adopted when assessing claimants, and the completion of both mental function and physical sections of the WCA report form. This section will relate mainly to the ESA Regulations but also highlights areas where the UC Regulations differ from the ESA Regulations.

Section 4 covers situations less commonly encountered at assessment, for example domiciliary visits or “unacceptable claimant behaviour” (UCB) procedures. It also provides guidance on issues such as potentially harmful and embarrassing information.

1.2 Background to Employment and Support Allowance

This section of the handbook provides an overview of the various amendments to ESA implemented by the Department for Work and Pensions (DWP) as a result of a number of reviews they commissioned. This section should serve to provide HCPs (especially those new to the company) with some background information and understanding of the evolution of ESA and the WCA.

In July 2006, the Welfare Reform Bill, outlining the concept of the Employment and Support Allowance, was introduced in Parliament. The Bill received Royal assent on 3 May 2007.

ESA was designed to be an integrated contributory and income-related allowance replacing Incapacity Benefit (IB) and Income Support paid on the grounds of limited capacity for work. Initially, it was intended to apply to new claimants only.

The working group involved in the review of ESA considered the impact of changing patterns of mental health problems and current treatment options. They also considered the physical descriptors in the Personal Capability Assessment (PCA) used in IB (the assessment previously used to decide on work capability) in relation to current patterns of disabling disease, advances in treatment and the modern working environment. The recommendations of this working group formed the basis of the ESA regulations of 2008. These regulations were implemented in October 2008, with all new claimants being assessed under this system.

The WCA is a functional assessment which looks at a range of different activities relating to physical, mental, intellectual and cognitive functions, to determine whether an individual could reasonably be expected to work or undertake work-related activity, or not, taking into account developments in modern healthcare and workplace environments.

Initially, it applied to new claimants only, however claimants on IB started being reassessed under the ESA regulations on 4th of April 2011 in Great Britain.

In December 2008, a White Paper “Raising Expectations” announced a Department-led review of the WCA, which involved medical experts in the fields of physical, mental and occupational health as well as representatives of employers and stakeholder groups.

The group reviewed several thousand cases using descriptor analysis and expert case study to consider the effectiveness of the WCA (ESA Regulations 2008) to accurately establish an individual’s capability for work. The cases comprised a wide range of mental health and/or physical problems covering a broad spectrum of levels of disability. The analysis of the data established that the WCA (ESA Regulations 2008) accurately identified a person’s capability for work. However, it was felt that:

- ☐ There were areas of the assessment where the ability to adapt to a condition was not fully taken into account.
- ☐ The inclusion of the concept of “adaptation” would result in a more accurate reflection of the individual’s functional capability.

- ☐ There was scope to further simplify some of the descriptors to ensure transparency of the process for claimants and ensure that HCPs and Decision Makers (DMs) are able to clearly identify the applicable descriptor in each case.

In addition to the internal WCA review, a further technical review was undertaken with representatives of specialist disability groups and technical experts. This group considered that the impact of fluctuating conditions and the inability to complete tasks safely, reliably and repeatedly due to the effects of exhaustion needed further emphasis in the descriptors.

The recommendations of these review groups were accepted by the Secretary of State and the ESA Regulations 2008 were thus amended in 2011:

- ☐ Lower Limb Function

In this area, it was felt that the 2008 activities did not accurately reflect the level of function required for the modern workplace. As a result “walking” was changed to “mobilising” to reflect the functionality of wheelchair users. It was also felt that considering standing and sitting abilities as separate entities was not relevant in the modern workplace and thus the activity was amended to reflect the ability to remain at a workstation. In the 2008 descriptors, bending and kneeling were considered, however the ability to bend or kneel are no longer considered critical in the modern workplace, so this activity has been removed.

- ☐ Upper Limb Function

The review group felt that unilateral upper limb restriction would not significantly impact on an individual’s ability to work and therefore all descriptors now relate to bilateral restriction. As bilateral restriction is a significant issue, the manual dexterity scores were revised to reflect this issue.

- ☐ Sensory Function

In the 2008 regulations, adaptation had not been taken into account in considering impairment in these areas. The review group felt that an individual’s ability to adapt must be taken into account and therefore the activity of vision was changed to the concept of being able to safely navigate. The activities of hearing and speech were changed to the more functional concept of being able to receive communication and communicate with others.

- ☐ Continence

The 2008 regulations considered those with stomas separately. It was felt that this made the assessment overly complex and thus the descriptors were amended to reflect any loss of continence. The loss of dignity associated with incontinence was reflected in the scoring of the descriptors.

- ☐ Consciousness

In this area, it was felt that infrequent loss of consciousness would not substantially impact on a person’s ability to work and therefore only those experiencing weekly or monthly episodes of loss of consciousness are awarded scoring descriptors.

☐ Mental Function

In understanding and focus, it was felt that the 2008 descriptors were complex and difficult to interpret. These were therefore simplified.

In the area of learning tasks, how an individual learns was no longer considered to be the crucial factor – it is the ability to learn that is now considered. In awareness of hazard the review group felt the important issue in the workplace was to assess the level of risk for the person and others. The activity of personal action was amended to reflect a person's ability to prioritise and complete tasks.

In adapting to change, the highest descriptor reflects a total inability to cope with any change and was considered to meet Support Group criteria. In getting about, it was considered that the familiarity of a place was more important in functional terms rather than the frequency of ability to get to places.

In the area of social interaction, the review group felt the previous descriptors were rather negative in their wording and the 2011 amendments relate to ability to engage in social contact rather than an individual's ability to behave in an appropriate manner with others.

☐ Support Group (LCWRA)

Additional Support Group categories were added in the 2011 amendments to acknowledge the difficulties some people have with conditions such as anxiety.

In the chemotherapy Support Group, those who are expected to commence chemotherapy in the next six months were considered to be in the Support Group.

☐ 'Treat as LCW'

In the original 2008 regulations, those undergoing residential rehabilitation for drugs and alcohol were not considered to have limited capability for work unless they had input from a healthcare professional. This was changed in the 2011 amendments to reflect that those undergoing residential rehabilitation for drugs and alcohol should be considered as having limited capability for work regardless of whether the input is from a healthcare professional or not.

The DWP is committed to continuously improving the WCA process, with a statutory commitment to have an independent annual review of the WCA process for the first 5 years of operation based on the Welfare Reform Act 2007.

The first Independent Review of the WCA – the Harrington Review – was launched by the Secretary of State for Work and Pensions in June 2010. Professor Malcolm Harrington led the review, and he was given a remit to report on the fairness and effectiveness of the WCA. His review was overseen by a Scrutiny Group with representation from the medical and occupational health professions, disability groups and employers.

Professor Harrington made a number of recommendations about the WCA, one of which was that every face to face WCA should contain a personalised summary of the assessment, written in plain English. This is known as the Personalised Summary Statement (PSS) and applies to all reports completed after 6th June 2011.

In 2012, further amendments were made to the ESA Regulations 2008 and subsequent 2011 amendments. These amendments were laid before parliament in December 2012 and came into effect on 28th January 2013.

While some of these amendments took immediate effect, for some changes there was a transition period of 6 months, until 28th July 2013. Since 29th July 2013, all cases are assessed under the ESA Regulations 2008 as amended in 2012.

The 2012 amendments to the ESA Regulations 2008 affected the following areas of the WCA process:

- Chemotherapy/Radiotherapy
- Definition of Hospital Patients
- Mental / Physical Risk
- Changes to the wording of some descriptors

The changes to the descriptors in the 2012 amendments related only to changes in the wording of the descriptors – there was no change to the policy intent of these descriptors.

These wording changes affected the following activities and descriptors:

- Mobilising
- Standing/sitting
- Manual dexterity
- Making self understood
- Understanding communication
- Navigation
- Continence
- Getting about

Within the 2012 amendments, in terms of the descriptors, the legislation was also updated to make it **explicit** that:

- Reasonable use of aids and appliances, including any prosthesis which a claimant uses, must always be considered
- Physical descriptors should only apply for physical conditions and mental health descriptors should only apply for mental health conditions

The questionnaire form completed by claimants is the ESA50 or ESA 50A. These forms are reviewed and updated by the DWP on a regular basis.

The current ESA85 report, both the clerical form and the LiMA application, reflect the ESA Regulations 2008 and the subsequent amendments.

1.3 The Work Capability Assessment Structure

The Work Capability Assessment (WCA) determines entitlement to benefit and rate of benefit paid in ESA. The WCA considers an individual's ability in various "activities" relating to lower limb function, upper limb function, sensory function, continence, consciousness and mental function. The assessment is based on "descriptors" in these areas. Descriptors are defined in the legislation and "describe" a restriction in an activity – for example "Cannot single-handedly use a suitable keyboard or mouse". The descriptor representing the most severe level of disability will attract 15 points meaning the person will be considered as having limited capability for work. In many situations, this will also mean the restriction is so severe that the person would also be considered as having limited capability for work-related activity.

Within the WCA, there are a number of assessments:

- ☐ Limited Capability for Work-Related Activity (LCWRA) Assessment – This aims to identify the most severely disabled where interaction with work-related activity is not required.
- ☐ Limited Capability for Work (LCW) Assessment - This aims to identify those people who currently have a limited capability for work but who would be capable of work related activity.

Overall, the WCA is designed to reflect an individual's capability and moves away from the previous concept of "functional limitations". In ESA, the assessment process aims to identify what an individual **can** achieve in terms of function.

The main aims of the WCA are to:

- ☐ Ensure that those who currently have limited capability for work or work-related activity are identified.
- ☐ Accurately identify those who, despite their condition, are fit to continue to work.
- ☐ Provide a fairer, more accurate and more robust assessment of the level of a person's functional ability in relation to capability for work in the modern workplace.

1.4 The Financial Structure of ESA

There are 2 types of ESA – contribution-based and income-related – which may affect the amount or duration of benefit paid. There are also a number of rates of benefit within the ESA structure:

- ☐ Following submission of a claim for ESA, the claimant enters the "Assessment Phase". The assessment phase continues until the DM determines LCW.
- ☐ The "work-related activity component" is an additional payment for those claimants who satisfy the ESA LCW component of the medical assessment and who engage in work-related activity. Those who do not engage in work related activity may lose entitlement to elements of the benefit.

- The “support component” is an additional payment for the claimants considered to be the most severely disabled and who satisfy criteria for entry into the “Support Group”.
- Extra premiums are payable to some claimants receiving the income related strand of ESA. These payments include the Carer Premium, the Pensioner Premium, the Higher Pensioner Premium, the Severe Disability Premium and the Enhanced Disability Premium.

The DWP DM arrives at a decision about the level of entitlement based either on advice from evidence at the filework stage or from the face-to-face assessment. The DM will decide on the evidence available whether the claimant should be treated as having limited capability for work, meets criteria for entry into the Support Group (limited capability for work and work-related activity) or does not meet the threshold of having limited capability for work.

1.4.1 Overview of the ESA claim process

The initial claim for ESA is made to Jobcentre Plus, by telephone in the majority of cases.

All initial and re-referral claims are subject to a “filework” process to determine whether a face-to-face assessment is required. This process aims to identify claimants where a recommendation can be made without the need for a face-to-face assessment.

If at the time of the claim, the claimant indicates they are terminally ill, the case is sent straight to the Health Advisory Assessment Service (HAAS) for advice.

All other claimants will be asked to provide a Med 3 or “fit note” from their GP detailing their diagnosis.

In most cases, the claimant is sent an ESA50 form to complete. This form gives the claimant the opportunity to provide details of their condition, treatment and functional abilities and restrictions. Where a claimant has a mental function problem an assessment will be carried out even if the form is not returned. Forms are available in other formats including Braille.

In initial claims, the DWP will refer the case to the HAAS for advice on whether there is evidence that the claimant has limited capability for work/limited capability for work-related activity (LCW/LCWRA).

At filework, a HCP, who has been trained in the filework process, reviews the Med 3 details as well as any information made available by the claimant, and may decide that further medical evidence (FME) is required. The FME may be requested from any healthcare professional involved in the claimant’s care. All information is then reviewed, looking for any evidence that suggests the claimant does not require a face-to-face assessment to determine their level of disability.

In initial claims, the HCP may be able to advise there is no need for a face-to-face assessment because the claimant falls in to one of the following categories:

- ☐ There is evidence of severe functional restriction meeting the criteria for having Limited Capability for Work Related Activity (see section 2.3).
- ☐ There is evidence that the claimant has Limited Capability for Work Related Activity as a result of “special circumstances” such as terminal illness or chemotherapy/radiotherapy (see section 2.3.2).
- ☐ There is evidence that the claimant meets criteria where they may be considered as ‘Treat as LCW’ for example they are having weekly haemodialysis or are currently a patient in a hospital for 24-hours or more. In this case the HCP must also have sufficient evidence to advise whether the claimant also has limited capability for work-related activity, or not (See section 2.4).

In ESA re-referral claims and IB re-assessment claims (for claimants who currently receive IB), the HCP may also advise that the claimant is likely to meet the criteria for limited capability for work where there is strong evidence to support this. The HCP must also advise at this time on LCWRA status.

In cases where the evidence does not suggest that the claimant fulfils the criteria for Limited Capability for Work Related Activity or ‘Treat as LCW’ categories and does not appear to have ongoing limited capability for work, the HCP will advise the DM that the claimant requires a face-to-face assessment.

The claimant is contacted and an appointment made for them to attend an Assessment Centre (AC) to have a face-to-face assessment. The assessing HCP will complete an appropriate assessment on the ESA85 report form.

The completed ESA85 is submitted to the DM, who decides on all available evidence whether the claimant meets any of the criteria for having Limited Capability for Work Related Activity, fulfils the prescribed degree of functional disability for limited capability for work, or does not fulfil the criteria for eligibility to ESA on grounds of disability.

The criteria for determination of limited capability for work are set out in the Regulations:

“The claimant will be considered as having limited capability for work if he/she scores at least:

- ☐ 15 points in respect of the physical descriptors; or
- ☐ 15 points in respect of the Mental Function descriptors; or
- ☐ 15 points in respect of the descriptors in a combination of mental function and physical descriptors”.

In both the physical and mental function categories, the highest descriptors in any functional category attract 15 points. A claimant may be considered as having limited capability for work if he/she is awarded the highest descriptor in any one physical or mental function category or through a combination of lower scoring descriptors in a number of functional areas.

If the DM accepts that a claimant reaches the threshold of having limited capability for work, but **does not meet** criteria to be considered to have limited capability for work

related activity, the claimant will be required to attend a series of Work Focussed Interviews (WFIs) with the Work Coach. The first WFI will take place after the decision on entitlement. During these sessions, the claimant will draw up an agreed action plan of activity which is intended to help them with a potential return to work at a point when they are able. Their engagement in this process will result in entitlement to the “work-related activity” component of ESA in addition to the ‘basic ESA’ allowance.

The Government’s “Work Programme” is to enable people to return to the workplace. The Work Programme is a single package of support providing personalised help for everyone who finds themselves out of work regardless of the benefit they are claiming.

1.5 The role of the Health Advisory Assessment Service HCP

All HCPs who give advice relating to ESA or UC must be approved by the Secretary of State for Work and Pensions. Approval involves specific training, successful completion of various stages of the approval process, and ongoing demonstration that the work being carried out meets a satisfactory standard. The ESA/UC approved HCP is required to provide advice to the DWP DM in accordance with the current guidance issued by the Department for Work and Pensions.

Approved HCPs may be either employed or contracted to work on a sessional basis.

The role of the HCP is to help DMs reach fair and proper decisions on benefit entitlement, by providing advice which is:

- ☐ Legible and concise
- ☐ Fair and impartial
- ☐ Medically correct
- ☐ Consistent and complete
- ☐ In accordance with the relevant legislation

In carrying out this function, approved HCPs act as specialist disability analysts. The role of the disability analyst is different from the more familiar clinical role of reaching a diagnosis and arranging treatment. For the disability analyst, a precise diagnosis is of secondary importance. The primary function is to make an assessment of how a person's day to day life is affected by disability, and to relate this to the legislative requirements.

For ESA and UC, the advisory role of the approved HCP falls into four main areas:

- ☐ Advice to the DM to confirm that a claimant satisfies any one of the Limited Capability for Work Related Activity criteria or any of the criteria for treating the claimant as having limited capability for work.
- ☐ Further advice or clarification requested by the DM.
- ☐ Application of the ESA/UC LCW/LCWRA medical assessment, providing an objective and impartial assessment of the claimant's functional ability for the DM.

- ☐ In filework cases, the HCP will review the available medical evidence, in order to advise whether a further LCW/LCWRA medical assessment is required or whether the appropriate advice can be given through the filework process itself.

The HCPs have to ensure that they are fully familiar with all the conditions a claimant has indicated on an ESA50 or in the available evidence (such as Med 3, 113, previous ESA85/IB85 reports) before commencing filework activity or a face-to-face assessment. Various resources are available such as the LiMA repository, relevant and appropriate Evidence-Based Medicine (EBM) based internet sites, and the HCP may also discuss the case with an experienced HCP / CSD (Customer Service Desk) HCP / MFC (Mental Function Champion) HCP.

1.6 The Decision Maker's Perspective

DMs have a very clear idea of the standard they expect from a report. The following elements are considered essential:

- ☐ Legibility
- ☐ Absence of medical jargon
- ☐ Consistency

"Consistency is a vital element in any good report. It is essential that the comments really do bear out the choice of descriptor, especially when the opinion differs from the customer's own assessment, and the Decision Maker must decide which (if either) assessment is correct." [Decision Maker]

The DM has a legal duty to ensure that their decisions are based on facts which are clearly established by evidence:

"A definite distinction is made between fact and opinion and while an opinion on its own may have persuasive value it can never take precedence over an opinion which is based on clear and concise evidence".

- ☐ Non Prescriptive Advice

The role of the HCP is purely advisory and benefit entitlement is the sole preserve of the Decision Maker. As such, **prescriptive** advice is any content that is worded in such a way that the decision-making process will be compromised.

Examples could include a clear allusion to benefit entitlement, or a firm statement indicating what the decision outcome should be. In essence, it would be virtually impossible for a Decision Maker **not** to make a particular decision (which could be favourable or non-favourable) on that individual's claim for benefit.

Reports completed by Healthcare Professionals must **never** contain prescriptive advice.

For example, reports should not reference that a claimant should be given a certain number of points. Similarly, stating that someone 'has to be in the support group' would be deemed prescriptive.

Non-prescriptive advice is where report content is worded in such a way that whilst the advice is clear to the Decision Maker, they are free to make their decision without compromise or any undue influence.

Example 1 – This would be **non-prescriptive** advice.

“He has severe breathlessness due to emphysema, and fatigue due to heart failure.

Therefore, it seems unlikely that he would be able to mobilise 50 metres reliably and repeatedly, or that he could take advantage of appropriate aids such as a self-propelled wheelchair to improve his ability to mobilise.”

Although the justification here has drawn on some of the specific words used in the descriptors the overall wording of the advice does not compromise future decision making, so is acceptable.

Example 2 - This would also be **non-prescriptive** advice.

“Her rheumatoid arthritis mainly affects her ankles and shoulders causing pain, but it also causes daily fatigue. However, from her typical day history she regularly walks to local shops which she says takes her 3 or 4 minutes.

Observation of her walking today confirmed abnormal gait and reduced pace. Clinical examination confirmed the ankle and shoulder movements are all reduced by about half. Overall a significant restriction in the ability to mobilise is likely, with the reduced shoulder function meaning any improvement by using appropriate aids such as a self-propelled wheelchair would not be possible.”

The justification here draws on evidence from several sources, and although an opinion is expressed about her disability the wording is non-prescriptive and the decision maker would be free to make whatever decision they felt to be appropriate.

1.7 Universal Credit

1.7.1 Background to Universal Credit

Universal Credit was introduced in April 2013. It provides a new single system of means-tested support for working-age people who are in or out of work.

UC was initially introduced in the form of a ‘Pathfinder’ exercise – a DWP term for a pilot which will inform future guidance and processes – in certain areas of north-west England. This was then gradually rolled out to selected areas and by the end of spring 2016, Universal Credit will be available for certain claimant groups in all jobcentres across the country.

The full service will be launched on an area by area basis from May 2016. Where the full service is in place, people will no longer be able to make new claims to benefits under the old system.

UC replaces 6 existing benefits

- ☐ Jobseeker’s Allowance (Income based)

- ☐ Income Support
- ☐ Employment and Support Allowance (Income Related)
- ☐ Working Tax Credit
- ☐ Child Tax Credits
- ☐ Housing Benefit

1.7.2 Universal Credit and the WCA

A UC claimant who reports having a long-term health condition or disability may be referred for a WCA. This applies whether the claimant is in or out of work.

The claimant completes a written questionnaire (UC50 or UC50A) to give details of the health condition (s) and how it affects his/her everyday life.

People who claim UC and have a health condition or disability may require a WCA **even though they remain in work**. This is to provide information on the degree of functional impairment that is present to inform the decision on the degree of support they should receive.

Following the WCA, the Universal Credit DM will decide which of the following applies:

- ☐ the claimant does not have limited capability for work, i.e. is fit for work
- ☐ the claimant has limited capability for work (LCW)
- ☐ the claimant has limited capability for work and work-related activity (LCWRA)

If the claimant has LCW or LCWRA the claimant may be awarded an extra amount of Universal Credit:

- ☐ If the claimant has LCW the claimant will get the lower rate - the Limited Capability for Work element
- ☐ If the claimant has LCWRA the claimant will get the higher rate - the Limited Capability for Work and Work-Related Activity element

However, payment of the LCWRA or LCW element will depend on whether:

- the claimant is also entitled to the Carer Element. In this case he or she can only get either the Carer Element or one of the two limited capability elements – not both. The higher value award would take precedence, or
- an eligible adult within the benefit unit is also entitled to a LCWRA or LCW element. Only one limited capability element is payable to a benefit unit. Where both adults are entitled to a LCW element only one LCW element is payable. Where both adults are entitled to the LCWRA element only one LCWRA element is payable. Where one is entitled to the LCWRA element and the other is entitled the LCW element, the higher value award, LCWRA, would take precedence.

The policy and process around the filework and medical assessment is similar in UC and ESA. As in ESA, there will be TI, filework and face-to-face (WCA) elements.

UC still considers Limited Capability for Work and Limited Capability for Work Related Activity; however the terms Support Group and Work-related Activity Group are not used in UC. Prognosis in UC is in terms of functional improvement rather than work and is referred to as the re-referral period.

The Revised WCA Handbook will focus mainly on the WCA for the purposes of ESA but will also highlight the differences between the ESA and UC Regulations relevant to the HCP in providing WCA advice.

2. Filework

This section provides a brief overview of the filework processes in ESA and UC to provide some background for those who will be performing ESA/UC face-to-face assessments. It serves to give the assessing HCP some understanding of the processes a claim has gone through before being called to face-to-face assessment and is not intended to be a comprehensive guide. HCPs undertaking filework will be trained specifically in ESA/UC filework and should refer to the Filework Guidelines.

2.1 The Special Rules Check/Terminal Illness Check (SR or TI check)

When a claimant contacts JCP indicating that they wish to apply for ESA/UC they may state that they are terminally ill. Existing benefit claimants may also inform JCP that they have become terminally ill. The definition of terminal illness in the Welfare Reform Act legislation is:

“That he is suffering from a progressive disease and his death in consequence of that disease can reasonably be expected within 6 months.”

When a claimant is considered to be potentially terminally ill, a referral will be sent to the Health Advisory Assessment Centre for advice. The HCP will access the case using the Medical Services Referral System (MSRS) and follow a process which has been agreed by the customer (DWP). The advice provided to the Decision Maker will be generated using the LiMA application.

A detailed explanation of this process may be found in the Filework Guidelines, however, in summary, a check takes place to find out whether a DS1500 has been submitted by the claimant. If the DS1500 confirms the claimant is terminally ill, this advice is submitted to the Decision Maker on form ESA85A or UC85A .

If no DS1500 has been submitted with the ESA/UC claim, a check takes place to see if there has been a recent application for DLA, AA or PIP under the special rules. If terminal illness was confirmed at that stage, the claimant can be considered as terminally ill for the purposes of ESA.

If no DS1500 is available and there is no confirmation of TI through a previous DLA/AA or PIP application, the HCP will seek further medical evidence from a practitioner involved in the medical care of the claimant.

It should be noted that a claimant who is TI will be entitled to the higher rate of benefit while still in the 13 week assessment phase and from day 1 of the health related UC claim.

The HCP will review the evidence obtained and provide advice on the body of evidence, indicating whether or not it is likely that the claimant is suffering a terminal illness as defined in the legislation.

If the claimant is considered to be TI, the HCP will submit this advice to the Decision Maker. If the advice is accepted, the claimant will be considered to meet the criteria of being considered to have Limited Capability for both Work and Work Related Activity (LCW/LCWRA).

N.B meeting criteria for having LCW and LCWRA is also known as Support Group in ESA) and there will be no requirement for them to be further assessed or participate in any form of work-related activity.

If the claimant is not considered to be suffering from a terminal illness, there may be sufficient evidence that they satisfy one of the other LCW/LCWRA (Support Group) criteria or one of the criteria for 'Treat as LCW'. If not, the claim will continue to be processed in the normal manner.

2.2 Pre-board Check

After the SR/TI check (if required) has been completed, each **initial** claim will be assessed under the Pre-Board Check system. Unless 'Treat as LCW' is identified by the Decision Maker, form ESA50/UC50 is issued to the claimant so that they can describe their functional abilities.

The pre-board check is designed to identify those claimants who may meet criteria to be considered to have LCW/LCWRA (Support Group) or those claimants who may meet certain criteria of 'Treat as LCW' without having a face-to-face assessment. The case will be accessed through the MSRS application and the outcome generated using LiMA. The HCP will review the information available and may choose to ask for further medical evidence. If the evidence suggests they meet criteria of having both limited capability for work and work related activity, or 'Treat as LCW' applies, the HCP will provide this advice to the Decision Maker highlighting the specific LCWRA criteria / 'Treat as LCW' category that is appropriate. The filework HCP will justify their advice and provide a prognosis (or re-referral period in UC) for the DM to consider. If the Decision Maker accepts this advice, the claimant will not have to attend for an assessment.

It should be noted that a claimant who has previously been assessed and considered to fulfil LCWRA criteria or 'Treat as LCW' category, either at face-to-face assessment or filework, will have a pre-board check at re-referral rather than re-referral scrutiny.

2.3 Limited Capability for Work Related Activity (The Support Group)

The Support Group, is the group of claimants affected by the most severe health conditions or disability who are considered to have **limited capability for work-related activity (LCWRA)**.

In Universal Credit, the term Support Group does not apply and the term Limited Capability for Work and Work Related Activity (LCWRA) is used. The term "Support Group" has been mentioned in this document as it was the most common term used when referring to LCWRA criteria in ESA, however; future references will refer to LCWRA rather than "Support Group"

The criteria for being considered to have LCWRA are set out in legislation. To be considered as having limited capability for work-related activity, there should be evidence of a severe level of functional limitation. However, there are also some additional categories that also fulfil the criteria for being considered to have limited capability for work related activity (LCWRA). These are where, although the claimant may not have severe functional limitation, it would be considered inappropriate for

them to be asked to engage in work-related activity (e.g. the terminally ill group). Where severe functional limitation can be justified, this should be considered first and applied ahead of any special circumstances.

Advice can be given to the DM where the HCP feels a person may meet the criteria of being considered to have LCWRA through advice on “paper” evidence (through information from a Health Care Practitioner involved in the medical care of the claimant, identified at the filework stage), **or** as a result of the LCW/LCWRA medical assessment where the claimant has been called for a face-to-face assessment.

The criteria for meeting the LCWRA threshold may be considered in 2 broad groups:

1. Those with severe functional limitation; and
2. Those who have special circumstances whereby they would be considered unsuitable for Work-Related Activity in the absence of severe functional limitation.

When a person is called to assessment, the HCP conducting the face-to-face assessment must always ensure they consider the possibility of the LCWRA criteria from the outset, especially in cases where the diagnosis may suggest a severe problem. The HCP must use their clinical judgement to tailor any assessment where LCWRA is identified and decide on the amount of history and level of clinical examination required in each case in order that they can fully justify their opinion to the DM. As those who meet LCWRA criteria are those with the most severe problems, the HCP must ensure the person is not unduly detained at the assessment and that adequate information is gathered in an efficient manner.

2.3.1 Limited Capability for Work Related Activity (LCWRA) – Severe Functional Limitation

The following criteria are used to consider whether a person may be considered to have limited capability for work related activity (LCWRA). These criteria are set out in terms of **descriptors**. Many of these descriptors equate to the highest descriptor within the relevant LCW descriptors.

In ESA and UC the same LCWRA criteria are listed within the Regulations, i.e. the criteria for being considered as having LCWRA are the same regardless of whether the claim has been made under UC or ESA.

These descriptors are set out in the UC or ESA legislation and relate to the person's ability to perform that activity.

In considering each of these activities the concept of repeatedly, reliably and safely must be taken into account.

If a person can perform a task but is unable to repeat it within a reasonable timescale the person should be considered unable to perform the task. For example, the HCP should consider what would be expected of an individual who did not have an impairment of their ability to mobilise. That is, a 'normal' individual would be able to perform this activity within a given time period and repeat that activity again after a reasonable rest period. The duration of the reasonable rest period can then serve as a basis for comparison to gauge the range of what is 'reasonable'.

The safety of the person must also be considered in each of the activities. If a person is unable to perform an activity or task safely, they must be considered incapable of the task.

A task must also be completed reasonably. If a person can complete a task but suffers significant pain or distress in doing so, they should be considered incapable of the activity.

The ESA Regulations 2008 (as amended), and the UC Regulations have also made it explicit that when considering function in these areas:

- Reasonable use of aids and appliances, including any prosthesis which a claimant uses, must always be considered
- Physical descriptors should only apply for physical conditions or physical disablement and mental health descriptors should only apply for mental health conditions or mental disablement

The LCWRA descriptors relate to various areas of function including:

- ☐ lower limb functions
- ☐ upper limb functions
- ☐ continence
- ☐ eating and drinking/chewing swallowing food
- ☐ communication
- ☐ learning or comprehension
- ☐ awareness of hazard
- ☐ personal action
- ☐ coping with change
- ☐ coping with social engagement
- ☐ appropriateness of behaviour with other people

A full list of the LCWRA descriptors may be found in Appendix 1.

When justifying the HCP advice, where the HCP opinion is that the claimant has limited capability for work-related activity, because of severe functional limitation the HCP must also indicate in every case that the claimant would also satisfy criteria for having limited capability for work.

It should be noted that as a result of an Upper Tribunal decision, when providing advice on **any physical descriptors**, the use of aids and adaptations must be considered in accordance with the ruling of the Tribunals Judge. Therefore the following guidance should be followed.

A - Where a claimant normally uses an aid or appliance, they must be assessed as if they were using it

B - If an aid or appliance has been prescribed or recommended by a person with appropriate expertise, the claimant must be assessed as using it, unless it would be unreasonable for them to use it

C - If a claimant does not use an aid or appliance, *and* it has not been prescribed or recommended, the claimant must be assessed as if using it if

(i) it is normally used by people in the same circumstances acting reasonably **and**

(ii) It would be reasonable for the claimant to use it.

The Judge also held that where paragraph C applies, the DM must explain how an aid or appliance would help the claimant. For further guidance on the application of this guidance and aids and appliances – see section 3.2.1 – 3.2.2.

Each of the functional LCWRA categories will now be considered.

Note: The wording of all the functional LCWRA categories is identical in both the ESA and UC Regulations.

2.3.1.1 Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used

Cannot either

(i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion

or

(ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion

This illustrates a severe level of disability relating to the lower limbs and often upper limbs or those with very severe cardiorespiratory problems or conditions which result in poor exercise tolerance. (Where use of aids is applicable – see above and section 3.2.1 and 3.2.2). The upper limb restriction may relate to severe loss of power in the upper limbs or severe restriction of movement of joints such as the elbows, shoulders and wrists resulting in the person being unable to perform the movements required to propel a wheelchair or use other aids normally used to assist in walking where these aids are normally or may be reasonably used. This restriction may be as a result of joint deformity or pain. Consideration of the diagnosis, medical treatment and functional effects must be obtained. At filework, this may involve requesting further medical evidence (FME) from a practitioner involved in the claimant's care.

The descriptor relates to the ability to independently move useful distances by any of the means listed above where the guidance on aids and appliances is followed. If they are unable to walk or move on level ground to the degree stated, it would not be considered reasonable to expect the claimant to participate in work-related activity, because of their severe mobility restriction.

This LCWRA category could, for example, apply to a claimant with quadriplegia, who has upper and lower limb weakness, and therefore cannot walk or manually propel a wheelchair. A claimant who was paraplegic, and had normal upper limb function should be able to propel a manual wheelchair and therefore may not meet criteria for this LCWRA category unless the Decision Maker considers it reasonable for them not be using a wheelchair as a reasonable aid.

A manual wheelchair may be considered any form of wheelchair that is not electrically driven. When considering the use of a manual wheelchair, issues such as affordability must be taken into account by the Decision Maker (see section 3.2.1).

In this activity, the HCP should consider whether a person could potentially use a wheelchair regardless of whether or not they have ever used a wheelchair. In considering this issue, as above, upper limb function and cardiorespiratory status / exercise tolerance must be taken into account along with the guidance from the Tribunals Judge on the use of aids and appliances (see section 3.2.1 and 3.2.2) for further information.

When considering mobilising, the concepts of repeatedly, reliably and safely must be taken into account as detailed previously.

If the claimant is called for a LCW/LCWRA medical assessment, information about their abilities may be obtained from the clinical history, typical day history, observation and clinical examination.

(See section 3.2 for further information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.2 Transferring from one seated position to another

Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person

Again, this descriptor reflects a severe restriction of lower and upper limb function. The upper limb restriction may relate to severe loss of power in the arms or severe restriction of shoulder or elbow movements preventing the person using the upper limbs to “push up” from a chair to aid transferring. Again, the claimant who has quadriplegia may fulfil these requirements. A claimant with paraplegia who has reasonable upper limb function may not meet criteria for LCWRA in this area as they may have good ability to independently transfer from one seat to another.

When considering the ability to transfer, the use of simple aids such as sticks/ transfer boards can be taken into consideration where these are normally or could reasonably be used. A situation specific item such as a hoist would not be considered a reasonable aid.

Information must be obtained during the filework process / face-to-face assessment to confirm details of their disability and likelihood of restriction of the transferring activities.

(See section 3.2 for further information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.3 Reaching

Cannot raise either arm as if to put something in the top pocket of a coat or jacket

This activity is consistent with a severe bilateral restriction of upper limb function. It suggests severe restriction of movement of a number of joints such as significant reduction of shoulder and elbow movement resulting in an inability to reach to the upper chest. It could reflect severe problems such as muscular dystrophies where there is such gross upper limb weakness that the arms cannot be raised.

Medical evidence must be consistent with a severe bilateral upper limb functional restriction.

(See section 3.2 for further information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.4 Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this Schedule)

Cannot pick up and move a 0.5 litre carton full of liquid

This activity relates to the ability to pick up and move a very limited weight using either hand or both hands together. As indicated in the descriptor, it does not reflect ability to bend etc. It reflects purely upper limb function. To fulfil criteria for this descriptor, evidence would need to be present of a severe upper limb problem that is bilateral such as significant pain, loss of power or joint destruction in the hands and/or wrists. This may be impairment of power or grip but the evidence must be clear that it is of a severe level. This may be consistent with more severe neurological conditions or severe bilateral trauma to upper limbs. Use of reasonable aids and appliances must be taken into account as with all physical activity areas.

(See section 3.2 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.5 Manual dexterity

Cannot either:

(i) press a button, such as a telephone keypad or;

(ii) turn the pages of a book

with either hand

This activity reflects a severe limitation of fine motor and sensory function of the hands. Manual dexterity restriction to this degree would only be consistent with very significant pathology of the hands. Conditions resulting in severe weakness, for example severe Multiple Sclerosis or Quadriplegia may be consistent with this level of disability.

Severe co-ordination problems resulting from conditions such as Huntington's Chorea or severe cerebellar dysfunction may also have to be considered. Bilateral amputations of the upper limbs should be considered.

Remember that in considering function any aids or appliances should be considered, taking into account whether they are normally or could reasonably be used – see section 3.2.1 for further guidance.

(See section 3.2 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.6 Making Self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person

Cannot convey a simple message, such as the presence of a hazard

This activity represents a severe restriction on a person's ability to express themselves through any of the means listed above. Those who have no speech, for example those with severe profound pre-lingual deafness, would have to also have severe restriction of either hand function such that they could not write or text a simple message. A dense stroke with aphasia may have to be considered, however their ability to type/text would have to be taken into account before application of this descriptor. Those with no speech and a severe visual restriction may be considered in this area, however; their abilities to adapt by use of a keyboard may have to be taken into account. The limitations to expression must be primarily related to sensory deficits but other factors such as cognitive abilities must be taken into account.

Again, the guidance on consideration of use of aids and appliances from the Tribunals Judge must be taken into account.

(See section 3.2 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.7 Understanding Communication by

i) verbal means (such as hearing or lip reading) alone, or

ii) non-verbal means (such as reading 16 point print or Braille) alone, or

iii) any combination of (i) and (ii),

using any aid that is normally, or could reasonably be, used, unaided by another person

Cannot understand a simple message due to sensory impairment, such as the location of a fire escape

This descriptor relates to an individual's ability to understand communication at a very basic level. The descriptor reflects only basic comprehension of writing and is not intended to reflect any higher level of literacy. Restriction **in either vision or hearing** must be considered as an individual must have capacity to understand a simple message through **both the written and spoken word**. Ability to lip read, read 16 point print or Braille must be considered. For example, a person who has **normal hearing**, but severe sight restriction to the extent that they are unable to read a simple message in 16 point print, nor read Braille would be likely to be awarded this descriptor.

(See section 3.2 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

The guidance on the use of aids and adaptations must be followed.

2.3.1.8 Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used

At least once a week experiences

(i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or

(ii) substantial leakage of the contents of a collecting device;

sufficient to require the individual to clean themselves and change clothing

It should be noted that, unlike other LCWRA categories, the disability described is at a higher level than the highest LCW continence descriptor. Someone who had such frequent and significant loss of bowel or bladder control would mean that work-related activity would no longer be considered reasonable for the person.

“Extensive evacuation” describes the situation where leakage could not be contained by the use of pads therefore minor degrees of soiling would not be considered where pads could reasonably be used.

The descriptor relates to extensive evacuation or substantial leakage from a stoma such that a change of clothing and cleaning would be required. It does not reflect lesser degrees of dribbling or leakage.

Medical confirmation is likely to be required to confirm the extent of the problem. Consideration should also be given to the medical diagnosis, medication and treatment received. Considerable advances in the management of incontinence have been made in recent times and this should be considered.

The NICE guidelines on management of urinary and faecal incontinence provide information. These can be found on the NICE website: www.nice.org.uk

(See section 3.2 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.9 Eating and drinking

(a) Conveying food or drink to the mouth.

(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else;

(b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort;

(c) Cannot convey food or drink to the claimant's own his mouth without receiving regular prompting given by someone else in the claimant's physical presence; or

(d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimants own mouth without receiving—

(i) physical assistance from someone else, or

(ii) regular prompting given by someone else in the claimant's presence

(b) Chewing or swallowing food or drink

(a) Cannot chew or swallow food or drink;

(b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort;

(c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the claimant's presence; or

(d) Owing to a severe disorder of mood or behaviour, fails to—

(i) chew or swallow food or drink; or

(ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence.

The LCWRA criteria relating to ability to eat and drink again reflect a severe level of disability.

They may reflect severe upper limb impairment such as in severe neurological conditions, disorders of the head and neck perhaps as a result of extensive surgery for head and neck cancer resulting in significant disruption of normal anatomy, or disorders of the GI tract resulting in motility problems. This may be the case in disorders such as motor neurone disease, or previous cerebrovascular accident (CVA).

The LCWRA descriptor(s) can include those with severe disorders of mood who will not manage to effectively maintain nutrition for example in severe anorexia nervosa requiring hospitalisation.

When considering this LCWRA descriptor, evidence should normally be sought from the GP or other Health Care Professional about the claimant's diagnosis and previous treatment. Information such as PEG tube feeding or nasogastric feeding should be sought.

If someone has swallowing problems sufficiently severe, or the risk of aspiration is such that a PEG is considered to be necessary, then LCWRA should be held to apply.

When considering mental function, you should look for evidence to confirm a severe disorder of mood, for example requirement for hospital admission for a claimant with anorexia who refuses to eat at all. Someone with a lesser degree of depression associated with reduced appetite, who requires occasional encouragement to maintain nutrition, would not meet the criteria of the LCWRA category.

If the claimant is seen at an assessment, it may be necessary to document overall appearance such as thin build, pallor, cachexia; any facial disfigurement such as surgical scarring, neurological signs; or to look for associated features of severe motility problems of swallowing such as poor speech etc.

It should be noted that within the regulations, LCW is deemed to apply where this LCWRA criteria applies.

2.3.1.10 Learning tasks

Cannot learn how to complete a simple task, such as setting an alarm clock

This LCWRA descriptor reflects ability to learn very basic tasks. How the person learns is not critical. It is the ability to actually learn how to do a task that is important. This activity is intended to be relevant to learning disability of whatever cause, including the result of acquired brain injury. It may also reflect difficulties in understanding language, for example following brain injury or stroke, such that the person is unable to learn how to complete a very basic task.

The length of time taken for the individual to learn a task must be considered, for example if it has taken a person 2 years to learn a basic task, this would not be considered reasonable. Consideration must also be given to the person's ability to retain the skills to perform the task. For example, if the person was unable to perform the task the next day, they would be considered as not having learned the task.

It indicates a severe level of disability and evidence must be present to confirm this level of severity.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.11 Awareness of hazards

Reduced awareness of everyday hazards leads to a significant risk of:

(i) injury to self or others; or

(ii) damage to property or possessions,

such that they require supervision for the majority of the time to maintain safety

This LCWRA descriptor reflects a severe level of reduced awareness about common dangers such as heat, traffic, electricity etc. The descriptor represents more than forgetfulness – it is about having the insight to know that something poses a risk.

This may result from learning difficulties, severe cognitive problems or people with psychosis lacking insight. Those with simple concentration problems would not be considered in this area as they should normally have the insight to realise they have poor memory/concentration and therefore should avoid hazardous situations. Someone who requires supervision for the majority of time has a severe deficit to the extent that it would be unsafe for the person to be left alone for any significant length of time because they would be likely to come to harm.

Evidence should be sought to confirm that there is a severe learning difficulty or cognitive deficit.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.12 Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks).

Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions

This LCWRA descriptor describes a severe restriction of an individual's ability to understand how to co-ordinate actions in the correct sequence such that they successfully complete any personal actions in a logical order.

Consideration should be given as to whether a person can co-ordinate actions in the correct sequence such that they successfully complete any personal actions in a logical order for example when preparing a meal or snack. This may be as a result of severe concentration or memory problems or very severe depressive illness. Those with active psychotic features may also have problems in this area. Those with severe compulsive behaviour may have problems in this area because of repetitive rituals - they repeat a task so often, they cannot effectively complete it. Consider whether a task can be considered to be complete. Remember to consider the concepts of repeatedly and reliably.

An example of two sequential personal actions might be opening a tin of soup, and heating it up before putting it into a bowl to eat. There must be evidence of "effective" personal action that would allow a person to complete the activities of normal day to day living.

The level of disability in this category is severe. Confirmation of this should be sought, and information about diagnosis, medication and level of Healthcare Practitioner input should be consistent with a severe disability. Personal action may include self care, dressing, using the phone or other basic tasks such as making meals or going shopping.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.13 Coping with change

Cannot cope with any change to the extent that day to day life cannot be managed

This LCWRA descriptor represents a severe restriction in the ability to cope with any form of change. It does not represent change related to a specific area in life nor just a simple dislike of change. Their inability to cope with any change would result in such distress that they could not continue with their day to day life – even the most basic activities could not be managed. Those with extremely severe anxiety, severe autism or a learning disability/cognitive impairment may be affected in this area.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.14 Coping with social engagement, due to cognitive impairment or mental disorder

Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual

This LCWRA descriptor reflects severe restriction of the ability to engage in almost any form of face-to-face social contact.

In 2015, a Court of Session Judgement advised on the meaning of “always” within this descriptor. (See also section 3.5.7 – LCW Social Engagement Descriptors).

The meaning of “always precluded” has been clarified by this judgement and the following guidance from the court of session judges should be considered when choosing and justifying the social interaction descriptors.

- ☐ “Always” does not mean “at all times”; claimants need not show that they fall within the descriptor all the time, every minute, twenty four hours of every day
- ☐ ESA Regs Sch 3 Activity 13 (and Sch 2 Activity 16a, as it is coapplied) could therefore apply to a claimant whose condition is constant and continuing in its disabling effects, for the purposes of social engagement, albeit with short intermittent breaks in that being the case
- ☐ Advice should have regard to the need for steady and reliable engagement in social contact for the purposes of work and WRA, and be mindful that evidence of some kind of social engagement by the claimant, would not necessarily prevent the descriptor being met.
- ☐ Social contact where the claimant requires to be accompanied should be disregarded. Due consideration should be made as to whether being accompanied is a requirement or a choice / preference.

This descriptor may apply where there is extreme anxiety or other disorders of mental function where communication with others is impacted such as those with autistic spectrum disorder, psychosis, cognitive impairment, behavioural or personality disorders.

This descriptor may apply to a person who rarely interacts with familiar people but may do so on exceptional / rare occasions. For example a person who is socially isolated, is unable to interact with unfamiliar people but might open the bedroom door to allow family member to deliver tea on a daily basis or a person who is socially isolated, is unable to engage with unfamiliar people, and only engages with their regular CPN maybe once a week.

Evidence should confirm severe anxiety or a severe communication disorder. Medication/level of input should be consistent with a severe problem.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.15 Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace

This LCWRA descriptor represents those with extreme uncontrollable behaviour. The level of behaviour that this descriptor represents would be considered completely inappropriate in a general workplace. This may be violent, aggressive or disinhibited behaviour. The behaviour must be as a result of a mental disorder/cognitive impairment and should not include behaviour that some people feel uncomfortable with personally. People with head injury/CVA etc who have developed disinhibited behaviour may have problems in this area, as may people with psychotic conditions and personality disorders.

Evidence should be sought to confirm the extent and nature of the behaviour.

(See section 3.5 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.2 Limited Capability for Work Related Activity (LCWRA) Criteria – Special Circumstances

The LCWRA Special Circumstances Criteria are the same in both the UC and ESA Regulations). Note: the Term “Special Circumstances” is not used within the Regulations in ESA and is not used at all in UC. However, it has come into common usage as an easier way for HCPs to differentiate these regulations from the LCWRA criteria for severe functional impairment.

The following is a list of the other circumstances in ESA that may result in a claimant being treated as having limited capability for work-related activity:

1. “The claimant is terminally ill”
2. “Where the claimant is a woman, she is pregnant and there is a serious risk of damage to her health or to the health of her unborn child if she does not refrain from work-related activity”.
3. “A claimant who does not have limited activity for work-related activity as determined in accordance with regulation 34 (1)” (LCWRA Descriptors) “is to be treated as having limited capability for work-related activity if -
 - (a) The claimant “suffers from some specific disease or bodily or mental disablement and;
 - (b) by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found not to have limited capability for work-related activity”;
4. “The claimant is-
 - (i) receiving treatment for cancer by way of chemotherapy or radiotherapy;
 - (ii) likely to receive such treatment within six months after the date of the determination of capability for work-related activity; or

- (iii) recovering from such treatment,

and the Secretary of State is satisfied that the claimant should be treated as having limited capability for work-related activity.”

In UC, the treated as having LCWRA provisions use different wording - but with the same policy intent - and also include an additional provision for claimants who are disabled and over State Pension Credit age. However, the ‘risk to self or others’ provision can only be applied, as in ESA, after the WCA has taken place.

☐ Terminal Illness

Those meeting the “terminal illness” LCWRA special circumstances criteria should be identified at the SR/TI check. However, some individuals may not be identified at that stage due to lack of information, or because their condition has changed, or new information may become available in the time between the SR/TI check and the pre-board check phase. Therefore, all information from the GP (or other practitioner involved in the care of the claimant) and the ESA/UC information must be considered to assess whether the claimant now fulfils the criterion for this LCWRA Criteria.

☐ Pregnancy Risk

The LCWRA criteria relating to pregnancy should not be confused with the ‘Treat as LCW’ criteria regarding the confinement period in ESA (see section 2.4). This LCWRA criterion describes significant problems of pregnancy where there would be a serious risk to the mother or foetus if she were to engage in work-related activity. Conditions relating to pregnancy such as pre-eclampsia or placenta praevia may have to be considered. Co-existing disease such as significant mental function problems (e.g. psychosis or severe depression) should be considered. Physical problems such as severe valvular heart disease or renal disease may have to be considered.

☐ Mental /Physical Risk

The LCWRA criteria relating to “risk” if the person is found to have **limited capability for work-related activity** should be considered carefully. It will only be applicable in claimants with severe problems. HCPs should refer to section 3.8 for further guidance on the application of the “Substantial Risk” Non Functional Descriptor when considering the issue of limited capability for work. Appendix 6 also provides information to assist HCPs in the consideration of substantial risk.

☐ Chemotherapy/Radiotherapy for cancer treatment

Prior to the 2012 amendments of the ESA Regulations, only those receiving or expected to receive chemotherapy treatment by way of Intravenous, Intraperitoneal or Intrathecal routes for treatment of cancer were normally considered to meet the criteria for having LCWRA under the special circumstances. As part of the review process commissioned by the DWP, Professor Malcolm Harrington asked Macmillan Cancer Support to look into how the WCA assesses people being treated for cancer and to provide him with any recommendations for further improvements.

Macmillan presented evidence that the effects of oral chemotherapy can be as debilitating as other types of chemotherapy. The evidence also shows that certain types of radiotherapy and in particular of combined chemo-irradiation can be equally debilitating.

As a result of the evidence supplied by Macmillan, the DWP developed detailed proposals for changing the way that individuals may be assessed during their treatment for cancer.

At the time that Professor Harrington's Year 2 Review was published (24 November 2011) Ministers decided to also conduct an informal consultation to seek wider ranging views on the proposed changes. The intention of this process was to gather the views of interested stakeholders, including individuals affected by cancer, their families and carers, healthcare practitioners and cancer specialists, as well as representative groups and other lobby groups.

The revised criteria in this area within the ESA Regulations (as amended 2012), have been included in the UC Regulations and are intended to apply **only to cancer**, whether the condition being treated is benign or malignant, and conditions related to cancer. For example, myeloproliferative disorders such as myelofibrosis may be considered eligible. Similarly, benign brain tumours being treated by radiotherapy may be eligible.

This LCWRA criterion should be applied where claimants are:

- likely to receive treatment for cancer within the next 6 months
- receiving treatment for cancer
- recovering from treatment for cancer

Treatment in this specific situation is defined as chemotherapy (irrespective of route) and / or radiotherapy. It does not include surgical treatment in isolation i.e. without chemotherapy and / or radiotherapy.

It is DWP policy intent that it is the **debilitating effects** of such treatment that will determine entitlement, but the presumption would be that an individual undergoing the above treatments for cancer should be treated as having LCW/LCWRA. Consideration should include the overall effects arising from the interactions of the cancer, cancer treatment and any co-morbid conditions. It is likely for the vast majority of individuals undergoing the above treatments for cancer, it would not be reasonable that they should undertake work or work-related activity.

The term chemotherapy traditionally has been used to describe cytotoxic drugs. However, with modern developments in treatment it can also be used to describe biological therapies (such as monoclonal antibodies and cancer growth inhibitors) and hormonal therapies. For radiotherapy, both external and internal types are eligible treatments. The test for inclusion is whether the treatment is likely to have debilitating effects. Entitlement for LCW/LCWRA then depends on both the likely debilitating effects and treatment conditions being met.

Some conditions such as Rheumatoid Arthritis, Crohn's disease and vasculitis are treated with regimes that may include chemotherapeutic agents. Likewise, radioiodine can be used for thyrotoxicosis. However, these conditions would not be eligible for LCW/LCWRA under the Chemotherapy/Radiotherapy descriptors as they are not cancer related diagnoses.

Each individual will be assessed initially at the filework stage and it is likely the majority of claimants where there is evidence they are receiving treatment for cancer would be advised as meeting this LCWRA criteria at this stage. In those cases where the evidence at the filework stage does not support any debilitating effects of treatment, the claimant may need to attend a face-to-face assessment.

For further information on the definition of chemotherapy/radiotherapy/effects of cancer, treatment and co-morbidity, side effects of chemotherapy/radiotherapy and other cancer treatments, all HCPs performing Work Capability Assessments must read the CHDA Learning and Development self directed learning documents 'Common cancers and their management (MED-CMEP~139a)' and 'Review of cancer treatments and their functional effects (MED-CMEP~139)'.

2.4 Certain claimants treated as having limited capability for work/ work-related activity

In some cases, while the claimant may not have significant functional impairment, they may be treated as having limited capability for work because they fulfil certain criteria set out in the ESA/UC legislation. Those claimants identified by the DM as having LCW will be referred to the Health Advisory Assessment Centre for advice about whether the claimant also has LCWRA. At the time of the referral, these claimants will be sent an ESA50A or UC 50A form. This form is a type of questionnaire that asks the claimant for information about their abilities in various activities. The areas they are asked about relate to the activities in the WCA with particular focus on the LCWRA criteria and descriptors. The form also allows them to provide details of their medical conditions, their medication and any health care professionals they see. The evidence will be reviewed by a HCP who will determine what, if any, further evidence is required, such as a report from the GP or other healthcare professional. Once sufficient evidence is gathered, the HCP may advise either that LCWRA criteria are satisfied, or, alternatively, that they are not satisfied (i.e. that the claimant does not have LCWRA). In rare cases where no definitive advice can be given on LCWRA on the evidence held, the claimant may be referred for an assessment to establish whether LCWRA applies (see section 3.11).

The 'Treat as LCW' categories allow the claimant to be considered as having limited capability for work in certain specific situations. These may be identified during the filework process or during the face-to-face assessment. If identified at filework, then the appropriate advice should be given, including the advice on LCWRA. During a face-to-face assessment, the HCP will consider whether the claimant would fulfil any of the LCWRA criteria. If not, the full ESA/UC85, together with the ESA/UC85S should be completed as usual and in addition, in clerical cases, an ESA/UC85A should also be completed as there is no specific area on the clerical ESA/UC85 to make it clear that 'Treat as LCW' applies.

Those meeting the LCWRA criteria of ("TI," "pregnancy risk", "chemotherapy/radiotherapy" and "substantial risk") are also considered to have limited capability for work in the legislation. This means that if for example chemotherapy or radiotherapy for treatment of cancer is identified, LCW is established as well.

Those who are considered to have LCWRA by meeting the criteria for the “eating and drinking” LCWRA descriptors (section 2.3.1.9) will also be considered to be treated as LCW.

There are some differences in the ESA and UC Regulations in relation to the Treat as LCW criteria.

2.4.1 Treat as LCW criteria in ESA

In ESA, the treat as LCW criteria are as follows:

- Infectious disease exclusion by Public Health Order. (Note the wording of this criterion is slightly different in UC, however; the policy intent remains the same)

“The claimant is excluded or abstains from work, or from work of such a kind, pursuant to a request or notice in writing lawfully made under an enactment; or otherwise prevented from working pursuant to an enactment, by reason of his being a carrier, or having been in contact with a case, of a relevant disease”.

This category involves those who have been excluded from work through a Public Health Order. There are a number of Public Health Acts and a number of conditions covered in legislation. Infectious Diseases such as typhoid, salmonella and hepatitis may be covered.

However this does not mean that anyone carrying these diseases is considered to have limited capability for work. The condition of treating them as having limited capability for work only applies if there is evidence of a Public Health Order having been placed on the individual.

- Pregnancy around dates of confinement (Note this treat as LCW criterion **does not exist in Universal Credit** – it is only present in the ESA Regulations)

“that in the case of a pregnant woman whose expected or actual date of confinement has been certified in accordance with the Social Security (Medical Evidence) Regulations 1976, on any day in the period -

beginning with the first date of the 6th week before the expected week of her confinement or the actual date of her confinement, whichever is earlier; and ending on the 14th day after the actual date of her confinement if she would have no entitlement to a maternity allowance or statutory maternity pay were she to make a claim in respect of that period”.

This LCW period will vary between claimants entitled to Statutory Maternity Allowance and those who are not. Where the claimant is not entitled to Maternity Allowance, the period to be considered is from 6 weeks before the expected week of confinement until 2 weeks after the actual date of confinement.

However, where Maternity Allowance (MA) is payable, the MA period extends for the whole period of entitlement to a maximum of 39 weeks. The earliest date from which this may be payable is 11 weeks before the expected week of confinement, the latest date from which it can start is the day after the actual date of confinement. MA is awarded for the full 39 weeks irrespective of the award start date.

JCP should make it clear whether the maternity allowance applies and should indicate these dates on the file. Further guidance for filework procedures is contained in the ESA Filework Guidelines.

Should there be no note regarding maternity pay when a claimant is seen at an assessment, the examining HCP should advise based on 6 weeks before and 2 weeks after the date of confinement.

Documentary evidence of confinement dates should be obtained.

☐ Hospital patients

- (i) A claimant is to be treated as having limited capability for work on any day on which that claimant is undergoing medical or other treatment as a patient in a hospital or similar institution, or which is a day of recovery from that treatment
- (ii) The circumstances in which a claimant is to be regarded as undergoing treatment falling within paragraph (i) include where the claimant is attending a residential programme of rehabilitation for the treatment of drug or alcohol addiction
- (iii) For the purposes of this regulation, a claimant will be regarded as 'undergoing treatment as a patient in a hospital or similar institution' only if that claimant has been advised by a health care professional to stay in a hospital or similar institution for a period of 24 hours or longer
- (iv) For the purposes of this regulation, 'day of recovery' means a day on which a claimant is recovering from treatment as a patient in a hospital or similar institution as referred to in paragraph (i) and the Secretary of State is satisfied that the claimant should be treated as having limited capability for work on that day

The DWP policy intent has always been that a person should be treated as having limited capability for work if their condition is so serious that the person needs to stay in hospital or a similar institution for a prolonged time and not just for a few hours, for observation or treatment.

This category should not be used where the hospital stay has been for a limited period of time, such as observation for a few hours or hospitalisation for a procedure performed as day case surgery.

The wording of the 'Treat as LCW' category for Hospital Patients has therefore been amended to clarify that this applies only if a claimant has been advised by a health care professional to **stay in a hospital or similar institution for a period of twenty-four hours or longer**.

For Example:

- A person is admitted to hospital as a day case for carpal tunnel decompression with discharge on the same day – this would not fulfil the 'Treat as LCW' hospital patient criteria
- A person is admitted for investigation and monitoring of chest pain, with a total hospital admission for investigation and monitoring of their condition of 3 days – the 'Treat as LCW' hospital patient criteria would be fulfilled in this case

It should be noted that where the claimant is attending residential rehabilitation for the treatment of drug or alcohol addiction, the input does not have to be from a health care professional. The person would still be considered as having limited capability for work if they were in residential rehabilitation in a charitable or religious organisation providing support for their addiction issues.

If a claimant is due to go into hospital (i.e. pending hospital admission) the Decision Maker (DM) can defer a decision and treat the claimant as having limited capability for work (LCW) from the date of admission.

With reference to the above, it has been agreed with the DWP that Healthcare Professionals (HCPs) may recommend to the DM that a claimant might be treated as having LCW in cases where there is firm evidence that a claimant is due to undergo a major procedure (such as laparotomy or hip replacement surgery) within the next 21 days.

When considering advising that 'Treat as LCW' may apply in this context, the HCP should have firm evidence that the procedure is to be undertaken. The HCP should clearly state the nature of the anticipated procedure and be sure that the information is consistent with the claimant's medical condition.

☐ Regular Treatment

1. Subject to paragraph (2), A claimant receiving:

- (a) Regular weekly treatment by way of haemodialysis for chronic renal failure
- (b) Treatment by way of plasmapheresis, or
- (c) Regular weekly treatment by way of total parenteral nutrition for gross impairment of enteric function

Is to be treated as having limited capability for work during any week in which that claimant is engaged in that treatment or has a day of recovery from that treatment. Note that under the 2012 amendments to the ESA Regulations 2008, those receiving radiotherapy are no longer considered as having regular treatment. Instead, they are assessed under the cancer treatment provisions.

2. A claimant who receives the treatment referred to in paragraph (1) is only to be treated as having limited capability for work from the first week of treatment in which the claimant undergoes no fewer than:

- (a) 2 days of treatment
- (b) 2 days of recovery from any forms of treatment listed in paragraph (1) (a) to (c), or
- (c) 1 day of treatment and 1 day of recovery from that treatment,

But the days of treatment or recovery from that treatment or both need not be consecutive

- 3 For the purpose of this regulation ‘day of recovery’ , means a day on which a claimant is recovering from any forms of treatment listed in paragraph (1) (a) to (c) and the Secretary of State is satisfied that the claimant should be treated as having limited capability for work on that day

For claimants fulfilling criteria for ‘Treat as LCW’ due to infectious disease, pregnancy dates of confinement, hospital patients and regular treatment, there will be a requirement to advise whether or not LCWRA may also be applicable.

- ☐ A person who has claimed income related ESA, who is also in education, and is entitled to a DLA award of any level (Note, this relates to ESA only and does not apply in Universal Credit)

Claimants who are considered as ‘Treat as LCW’ in this category will be referred to the HAAS for advice on LCWRA.

You should treat the referral, at filework or face-to-face assessment, in the same way as any other LCWRA-only referral.

All evidence should be considered carefully and FME sought where necessary; you should justify your LCWRA advice fully.

However, you will not be expected to **identify** that a claimant fulfils this category in any other type of referral, either at filework or at face-to-face assessment. This is because it is unlikely that you will know in any individual case if the claimant is being assessed for Income Related ESA, is in receipt of DLA and is in education.

Rarely, you may become aware that the claimant is no longer in education or receiving DLA. In these circumstances, you should pass the referral back to the administration team with a note explaining why the claimant is no longer likely to be in the ‘Treat as LCW’ category. They will then arrange for the referral to be sent back to the DWP.

2.4.2 Treat as LCW criteria in Universal Credit

2.4.2.1 Treat as LCW criteria consistent between ESA and UC

As mentioned above, the wording for the “Treat as LCW” criteria is different within the UC and ESA Regulations for the following areas:

- ☐ **Infectious Disease**
- ☐ **Hospital Inpatient**
- ☐ **Regular Treatment**

However; the policy intent **remains the same in both UC and ESA**

2.4.2.2 Treat as LCW criteria present in ESA that are not applicable in UC

- ☐ **Pregnancy:**

There is no 'Treat as LCW' option for pregnant women close to the dates of their confinement in UC. Those entitled to and within the maternity allowance period, or those within the period of 11 weeks before the Estimated Date of Confinement (EDC), and 15 weeks after the Actual Date of Confinement (ADC), who are not entitled to Maternity Allowance or Statutory Maternity Pay, will have different work related requirements for UC **but will not be** "Treat as LCW".

□ Those in Education and Entitled to DLA

Regulations for disabled students are different in UC than in ESA – **disabled students cannot be referred as an LCWRA-only referral in UC**. Disabled students should be referred for a WCA in accordance to the standard referral process in UC.

2.4.2.3 Treat as LCW criteria present in UC that are not applicable in ESA

Although UC is a working age benefit, there are situations where there are claims from couples where one is under, and one is over, State Pension Credit age. This means that a claimant, as one of a couple, who is over State Pension Credit age is in receipt of UC.

The regulations allow that where that older claimant is in receipt of DLA or PIP (Personal Independence Payment) or AA (Attendance Allowance), he or she can be determined as having LCW or LCWRA (depending on their level of entitlement to one of those benefits) without the need to be referred for a WCA. To be specific, where the claimant has reached the qualifying age for State Pension Credit and is entitled to AA, the care component of DLA at the highest rate or the daily living component of PIP at the enhanced rate, then the claimant can be treated as having LCWRA. Where they are entitled to other rates of DLA or PIP, they can be treated as having LCW.

There may be cases where, depending on the level of entitlement to DLA or PIP, the claimant can be determined as having LCW without a WCA, but the Decision Maker considers that LCWRA may be more appropriate to the claimant's health condition. In these cases, the claimant would be referred for a WCA for advice on the LCWRA position.

There may also be cases where that older claimant has a health condition or disability but is not in receipt of DLA or PIP or AA, in which case the claimant may be referred for a WCA.

2.5 Re-referral Scrutiny

When a claimant has previously had a full "face-to-face" LCW/LCWRA assessment and the Decision Maker has accepted that the claimant has reached the threshold of functional limitation where they may be considered to have limited capability for work, after an appropriate period, the case will be referred to the HAAS for further advice. The re-referral date will normally be determined by the prognosis (or re-referral period) advised by the assessing HCP at the time of the assessment.

The case will be re-referred back to the HAAS and accessed by an appropriately trained HCP.

At this stage, the HCP will review, through the MSRS application, the ESA85 or UC85 from the previous referral and the current ESA50/UC50, if completed by the claimant. The HCP then decides whether there is adequate evidence to support ongoing disability to meet the threshold of LCW and suggest the criteria are “satisfied” for a further period. The claimant is “accepted” as having ongoing limited capability for work with the appropriate justification indicating which descriptors apply and why none of the LCWRA categories apply.

The HCP may request further medical evidence from a relevant Health Care Practitioner involved in the care of the claimant.

If there is evidence of likely functional improvement since the previous face-to-face LCW/LCWRA medical assessment, the HCP may advise that the claimant is referred for a further face-to-face medical assessment.

If there is evidence that the claimant has deteriorated/developed any new condition that would meet criteria for having LCWRA, this can also be advised at this time.

Cases may only be “satisfied/accepted” at re-referral scrutiny if a full face-to-face LCW/LCWRA medical assessment was completed. The full ESA85/UC85 report may not always be visible on MSRS, for example if it was completed clerically. However, the referral details on MSRS should make it clear that the person has previously been subject to a face-to-face assessment and was found to have limited capability for work.

Cases cannot be satisfied/accepted if they were found to have LCWRA at previous assessment or pre board check. If a claimant was previously found to have LCWRA the HCP must review the case as a re-referral pre-board check. The HCP must then decide if there is adequate evidence to advise that Limited Capability for Work Related Activity Criteria continue to be met. If there is evidence of improvement in their functional abilities since the last assessment such that they no longer fulfil the LCWRA criteria nor meet any criteria for ‘Treat as LCW’ the claimant should be called for an assessment.

2.6 IB Re-assessment Filework

In 2010 the Government announced plans to re-assess all current recipients of Incapacity Benefit (IB) and those in receipt of Income Support on grounds of incapacity in order to establish their readiness to work.

At this time, there were 2.5 million people in receipt of IB who under the present system do not have support to work.

The intention is that the majority of those in receipt of IB will have a WCA to assess future benefit entitlement.

Those claimants being assessed in IB re-assessment will be subject to a “Scrutiny” process by a HCP. This means at the filework stage it will be possible to accept LCW and advise which descriptors apply, ‘Treat as LCW’, advise LCWRA applies, or advise that a face-to-face assessment is required to establish LCW/LCWRA status based on the evidence held.

The WCA process will be the same for these claimants as those claiming ESA or UC.

Those with limited capability for work will be placed in the work-related activity group; this will allow them to access the “Work Programme”.

Those who are capable of work will be able to apply for JSA/Income Support.

Those who meet criteria of having limited Capability for Work Related Activity will have no requirement to participate in work related activity.

2.7 Request and Provision of Advice to the WCA Decision Maker when the Claimant submits further evidence

At times, the Decision Maker will ask for advice when further evidence has been made available in the course of an initial referral, a reconsideration or an appeal.

A collaborative approach has been developed by JCP and the HAAS to provide guidance to both Healthcare Professionals and WCA DMs to help in dealing with these referrals. Certain HAAS HCPs will be involved in providing this advice. Full detail of this guidance is provided in the Filework Guidelines. This section of the Handbook serves to provide assessing HCPs with background awareness of this role.

2.7.1 Advice provided by HAAS Healthcare professionals

Decision Makers can request advice from the HAAS in 2 Areas.

1. Before the initial decision is made.

The Decision Maker may require clarification on an existing medical report on occasions when the claimant submits additional evidence to the Decision Maker after the assessment has been completed but before the DM has provided an outcome decision.

2. After the decision is made;

These cases are reconsiderations, either with or without an appeal. In most cases there will be additional evidence to be considered.

This is usually provided by the claimant or the claimant’s representative.

2.7.2 The Role of the HAAS Professional

The appropriately trained HCPs will provide advice to the DM using all their skills as a Disability Analyst. They will review all the evidence on file and provide advice on likely functional implications of any medical evidence provided. The HCP must take into account that the primary role of the GP or hospital doctor is to diagnose and treat any medical conditions that the patient/claimant presents to them. Any information or medical report that the doctor provides to the Department for Work and Pensions in relation to disability benefits is a purely secondary activity to his/her therapeutic role. A clinician does not routinely consider the functional restrictions or disabling effects of the medical conditions that they treat. The HCPs must take into consideration that the clinician may have no specific training in assessing disabilities in their medical education, and may have considerable difficulty in giving an accurate assessment or forming an opinion in relation to the functional restrictions experienced by their

patient. In addition clinicians usually have, at best, very limited knowledge of entitlement criteria to ESA/UC through the WCA process.

HAAS professionals are specifically trained in the assessment of disability. By evaluating the clinical history, the physical examination and informal observations in the light of the claimant's daily activities, the medical disability analyst is able to provide an accurate and consistent assessment of the functional restrictions. This assessment is based on the HCP's medical training and expertise, and a body of established medical knowledge and opinion. The HCP is able to advise the DM on restrictions arising from the disabling condition(s).

HCPs can advise DMs in a number of ways that includes:

- ☐ Interpreting and explaining medical terminology in claim packs, certificates and medical reports. This can include the nature of diagnoses, the use of medication, the interpretation of clinical examination findings, the significance of special investigations and the nature of surgical or other treatments.
- ☐ Giving advice of a general nature to the Decision Maker on the likely restrictions and sequelae arising from specific physical or mental health conditions.
- ☐ Identifying and explaining limitations, inconsistencies or contradictions in the evidence, and in advising whether further evidence is likely to be useful.
- ☐ Advising on response to treatment and prognosis of the disabling condition(s).
- ☐ Advising on prognosis in relation to descriptor choices.

HCPs provide impartial expert advice on disability that is objective and based on functional assessment. If the HCP is asked to provide advice on a rare condition or a condition which they may not be familiar with, they should review the condition on the LiMA repository, on relevant medical textbooks, or on appropriate medical websites, prior to giving the advice. HCPs also have access to the online British National Formulary (BNF) which provides useful and current information on the various medications. Review of appropriate medical literature will ensure that the advice given is appropriate, consistent, fully justified and evidence based.

3. The Functional Assessment

3.1 The Functional Assessment (The Limited Capability for Work and Limited Capability for Work-related Activity functional assessment)

3.1.1 Introduction

The face-to-face Limited Capability for Work/Limited Capability for Work-related Activity functional assessment (LCW/LCWRA functional assessment) will be completed using LiMA computer program in most cases on the ESA85 or UC85 form. A clerical ESA85/UC85 form is available when LiMA cannot be used, such as for assessments completed as domiciliary visits or for Special customer record cases (previously known as Sensitive access cases). Currently only suitably trained Practitioners may complete clerical reports and the process is explained in more detail in section 4. The part of the assessment known as the Personalised Summary Statement will be completed on form ESA85S or UC85S. This is generated automatically on LiMA, however must be completed on the separate form for clerical cases. There are copies of these forms at Appendix 2 and 3. (N.B. If a clerical form is completed, this must be done using **BLACK INK**).

The functional assessment process as a whole differs in many respects from traditional history taking and clinical examination as carried out in the general practice and hospital setting. It entails bringing together information gained from questionnaires, history, observation, medical evidence and clinical examination in order to reach an accurate assessment of the disability of a claimant and so to provide the information and the opinion which the Decision Maker requires. It is a complex procedure, involving careful consideration of history, observed behaviour, clinical examination, logical reasoning and justification of advice.

It is important to allow sufficient time for the assessment to be carried out so that the report is completed to the required standards.

There are four stages in the LCW/LCWRA Assessment. These are:-

1. Reading the documents;
2. Interviewing the claimant;
3. Examining the claimant and
4. Completing the medical report form(s).

3.1.2 Reading the Documents

In preparation for the interview, you should read carefully the documents in the file /on MSRS. All the medical evidence should be considered, including any medical certification, Factual Reports, previous papers and other documents, including Tribunal documents (if available). Particular attention must be paid to the current claimant questionnaire [ESA50 or UC50] and all areas where the claimant indicates that there may be a problem must be fully explored. At times the claimant may also bring additional evidence to the assessment. **Any evidence brought by the claimant must be read** and the report should make reference to the evidence that

has been considered and justification provided if there is a conflict between the opinion of the HCP and the other medical evidence.

Any evidence brought by the claimant, should be copied for the Decision Maker (see section 4.2.5 for further guidance).

3.1.2.1 Permitted Work in ESA

The Permitted Work Rules enable people claiming sickness-related benefits to undertake certain types of work. These regulations only apply to ESA and this information may be documented within the ESA file, or noted in the ESA50 or in medical evidence. The regulations previously relating to Incapacity Benefit have been further reviewed and adapted to suit the needs of ESA.

The regulations provide the opportunity for claimants to undertake a trial of paid work, under defined conditions, without the need for prior approval from a Health Care Professional involved in their care. However, claimants are expected to tell the Job Centre Plus (JCP) office responsible for benefit payment before starting work.

A LCW/LCWRA assessment should never be aborted simply on the grounds that the claimant is undertaking permitted work. In such cases, examining HCPs should enquire about any day to day, and work-related, activities undertaken by the claimant, in order to provide the Decision Maker with comprehensive advice on the LCW/LCWRA medical assessment functional areas.

Claimants who are able to undertake permitted work may still exceed the benefit threshold under the ESA LCW/LCWRA medical assessment. Indeed, it is vital that the medical assessment process should not be biased by the knowledge that permitted work is being undertaken. In providing advice to the Decision Maker, the approved HCP has to consider all the available evidence of what the person is able to do functionally over a period of time (so that the assessment is not a snapshot on the day). Details of work-related activities currently undertaken are relevant to this consideration, as are details of other activities of daily living. An approved HCP is required to relate the functional assessment to activities undertaken in every aspect of the person's life.

Whether any work that is being done is 'permitted' or not is of little direct relevance to the LCW/LCWRA assessment undertaken by the HCP.

If the HCP provides advice / justification in the ESA85/ESA85S, which makes it clear that the person is carrying out some work of which the Decision Maker is unaware (i.e. it turns out to be non-permitted work), this would be a matter for the Decision Maker to clarify and discuss with the claimant.

In other words, as far as the HCP is concerned, it is the details of the work/activities undertaken that are important, not whether they have been permitted by the Decision Maker.

3.1.2.2 In-work Universal Credit claimants

UC is an in-work and out-of-work benefit.

In-work claimants with a health condition or disability can go through the WCA process to determine eligibility to the LCW or LCWRA element of UC.

Although being in work may suggest that a claimant is functioning well, there will be cases where the claimant chooses to remain in work despite significant or severe functional restrictions.

There is no conflict in performing a WCA on a claimant in this group simply because they are currently in work – the WCA is functionally-based and irrespective of the degree of functional loss identified at the WCA, a claimant may choose to remain in work if they are able to do so.

The advice on LCW or LCWRA will be determined by whether the specific criteria for descriptor choice, exceptional circumstances (NFD), special circumstances LCWRA or severe functional LCWRA would be fulfilled, regardless of whether the claimant is in or out of work.

However, there are some key considerations in assessing someone who is already in work.

For those individuals with a health condition or disability being assessed for UC LCW/LCWRA elements whilst in work, a key aspect of their typical day activity will be their work.

It is therefore essential that this aspect is addressed in both the occupational history and the typical day to ensure a full picture is provided.

While work has to be addressed, it has to be taken into context along with all other relevant activities.

The key to accurate, comprehensive and justifiable advice in these cases will be a full account of the individual's work situation, detailed typical day exploring other activities performed, exploration of variability, overall level of functional restrictions, together with the medical condition present and effects of any treatment, etc.

This will be important from a functional perspective as well as ensuring any advice on "risk for work" or "work and work-related activity" is soundly based on evidence.

Remember – Substantial physical / mental risk has to be considered separately in terms of work and work-related activity as per current DWP Revised Risk Guidelines 2015 (see section 3.8).

Nature of the job; hours per week worked; length of employment; precise nature of duties / responsibilities; 'typical working day'.

Travel to and from work – method, time taken, proximity of transport to workplace.

The impact of their health on their work, including any adaptations made to workplace/work pattern to accommodate their disability or time off required for treatment/appointments, use of any aids or appliances at home or at work.

The impact of their work on their health - do any work tasks adversely affect their symptoms or function, in terms of fatigue and pain as well as other physical/mental aspects? Are they struggling at work because of their disability? Any periods of sickness-related absence? Any evidence of work-related stress?

Conversely, is their work actually protective of their health? – e.g. structure/routine, social contact, self-esteem, supportive colleagues, etc.

It is not enough to advise the Decision Maker that LCW or LCWRA do not apply just because the claimant is working.

There may be cases where the claimant is working and yet the advice is that LCW or LCWRA would still apply.

Each case has to be considered on its own merit and the advice given supported by detailed justification

For example: Consider a claimant who is having treatment for cancer, with evidence of debilitating side effects from the treatment, who still works (maybe with some workplace adaptations). LCWRA for cancer treatment may still be appropriate in this case regardless of the fact that the claimant still chooses to work.

3.1.3 Interviewing the Claimant

3.1.3.1 The Nature of the Interview

The interview differs materially from the traditional consultation in clinical practice. The aim of the traditional interview is to arrive at a diagnosis and plan future medical management of a patient. In the LCW/LCWRA interview, you are gathering information which will be used to assess the claimant's abilities in all of the relevant functional areas.

A concise and relevant medical history is essential.

3.1.3.2 Interview Technique

It is important that the interview is carried out in a friendly, professional and non-confrontational way, in keeping with good customer service and in line with the approved HCP's professional standards. In keeping with the intention of ESA/UC, it is also essential that the HCP maintains a positive focus and approach identifying the claimant's capabilities rather than a more negative approach mainly identifying their restrictions.

If possible, you should meet the claimant and accompany them from the waiting room. This positive initial point of contact will help put the claimant at ease and is a natural courtesy. From your point of view, it provides an opportunity to observe the claimant outside the assessment room, and extends the time spent in contact with them. Most importantly, it initiates the rapport between HCP and claimant which is so essential to an effective interview. You should be aware of claimant care issues in those with sensory impairment, such as knowing how to guide someone with visual impairment.

Remember the claimant may be apprehensive, and that it is good practice to explain the process and purpose of the interview and examination. Allow time for the claimant to settle down before beginning the interview proper. This is time well spent as it allows the interview to proceed more smoothly and productively thereafter. It is also useful to explain that the clinical examination is not in any way a general "check up", but will be focused on the areas that affect the claimant in their everyday life. This explanation may forestall any criticism that the medical assessment was not thorough.

3.1.3.3 Claimant accompanied by relative, friend, carer

Claimants are encouraged to bring a friend or companion with them to the assessment, and feel more at ease if accompanied. Indeed the companion may be a prerequisite to enable them to come to the Assessment Centre.

Companions will be able to give useful information, particularly in cases where the claimant has mental function problems, learning difficulties, cognitive problems or communication problems, or people who stoically understate their problems.

In individuals with learning disability or cognitive impairment the role of the carer may be essential to establish their functional capabilities.

Occasionally, a companion may wish to give too forcefully their own opinion on the claimant's disability, perhaps giving a biased view.

If the companion is too intrusive, then you should point out that the claimant must be allowed to express their view.

The actual physical examination is not normally done in the presence of the companion, but strictly with the claimant's consent, and if it appears a reasonable request, then the companion should be allowed to be present.

3.1.3.4 Interpreters

Where the claimant is not sufficiently fluent in English, it will be necessary for the claimant to be accompanied by an interpreter. In some instances the HAAS may arrange for a telephone interpreting service to be available for translation. You should make a note of the name of the interpreter and the language being interpreted in the social history.

Under these circumstances the assessment may take longer than usual as adequate time will be needed for questions and responses to be interpreted. Do not appear to rush or frequently interrupt the process. Be aware of the possibility that the interpreter may be expressing their own views and conclusions rather than those of the claimant.

If the claimant attends without an interpreter and you cannot continue satisfactorily, then the interview should cease and the claimant should be requested to attend again with provision made for an interpreting service. A note of the circumstances should be made on an advice minute. [See also section 4 on Exceptional Situations at Medical Assessments].

3.1.3.5 Interview Skills

As an essential component of the assessment process, the interview requires you to possess appropriate skills. These include:-

- ☐ Active listening
- ☐ Effective questioning
- ☐ The use of clear and understandable language
- ☐ The use of positive body language.

Active Listening involves listening to, and understanding, what is being said by:

- ☐ Keeping an open mind and being prepared for all responses to questions
- ☐ Summarising what has been said
- ☐ Listening "between the lines"

Effective questioning is aimed at gaining a mental picture of the claimant in their own environment and circumstances. In this way, we obtain an overall view of the way in which their disability affects their day-to-day life:-

- ☐ Open questions invite an open response and encourage the claimant to provide a narrative answer.
- ☐ Closed questions are best confined to establishing or clarifying a fact, or restoring the direction of the interview if the claimant begins to digress.
- ☐ Extending questions enlarge upon an established topic and allow the claimant to expand on information already given.
- ☐ Linking questions pick up an earlier point and help to steer the conversation in a particular direction.
- ☐ Clarifying questions allow the HCP to check their understanding of the issues being discussed.

In general, only one question should be asked at a time. Complicated, limited response and leading questions should be avoided.

The HCP must be prepared to modify their interview technique to enable effective communication with all claimants. For example claimants with learning disability or those with Autistic Spectrum Disorder may find very open questions difficult to answer and a more closed questioning approach may have to be utilised.

The use of Clear and Understandable Language

It is essential that you use language and terms that are clear, familiar and comprehensible to the claimant. Otherwise misunderstandings are inevitable and a clear view of the claimant's disability will not be obtained.

The use of Positive Body Language

This is a skill that many HCPs already possess. However, the interview of necessity involves you in a good deal of data input, and the claimant may feel isolated and excluded as a result. Remember that a visually impaired person will miss some of the non-verbal clues which others can appreciate.

When completing a report on LiMA, it is very important to face away from the screen at frequent intervals, to ensure eye contact is maintained with the claimant and an essential rapport established. Explain to the claimant that you will have to use the computer while they are speaking to ensure that the details you record are accurate. You should explain that while you will not be able to maintain eye contact with the claimant continuously, you will be actively listening to what they have to say.

3.1.3.6 Recording Timings in the interview

Details about the claimant will have been entered on the report form by the administration staff, through the MSRS system, and you should check these to ensure they are correct.

The start time of the assessment is when you first make contact with the claimant. LiMA will document the start time of the interview when the HCP clicks on the 'exam started' icon on LiMA, or when the 'clock' icon is clicked to move on from the 'Questionnaire Information' page to the next page. The time the assessment ends is the time when the HCP clicks on the 'exam ended' icon on LiMA, or the claimant is considered by the HCP to meet the criteria for having LCWRA, or the HCP progresses past the "observed behaviour" on LiMA. These details will be automatically recorded by LiMA but when a clerical report is completed, they must be documented accurately by the examining HCP.

3.1.3.7 Medical diagnosis

List all the current diagnoses. Ensure that **all conditions** entered in the ESA50, or documented in other medical reports, such as previous benefit assessment reports, Med 3, 113, GP/Specialist/Consultant letters, are included. Previously unidentified conditions which are revealed during the assessment should also be added. These should be listed as either "Conditions Medically Identified" or "Other Conditions Reported". The HCP should explore the current symptoms experienced by the claimant and enquire into any improvement or deterioration in each condition since they completed the ESA50/UC50 or since the other medical reports were completed. It is particularly important to carefully explore any change in conditions where the ESA50/UC50 for the current claim has been completed some time ago.

In many instances the entries will be symptoms rather than exact diagnoses. Your role is to assess disability and for that reason precise diagnoses do not add to the Decision Maker's understanding of the report. Only be specific if you have good evidence of the diagnosis. If you write "Lumbar disc protrusion" rather than "Low back pain" and it transpires at a Tribunal that investigations revealed spondylolisthesis then the whole value of the evidence you have provided for the Decision Maker is undermined.

It is important to note "no other conditions claimed or identified" at the end of the diagnosis list when you have clarified with the claimant that they do not have any other problems to discuss.

3.1.3.8 Medication

Record all regular medication whether prescribed or bought over the counter. Record the dose without using shorthand or abbreviations.

It is helpful to comment on any medication being taken. For example the frequency analgesics are being taken may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. The phrase "Takes paracetamol as required" does not give enough detail and more information such as "He takes an average of 12 paracetamol (mild painkillers) a week, usually over three days" provides a better picture for the Decision Maker which will support your description of variability and pain later in the report.

It is also useful to comment on the potency of the medication. LiMA will provide a description of the level of medication etc when entered.

Note also any side-effects and likely impact on function of medication/side effects reported by the claimant and explain any additional medication used to ameliorate them; e.g. the use of Omeprazole in dyspepsia related to the use of NSAIDs.

It is also helpful to explain the purpose of the medication; for example:

- ☐ "Becotide 100 inhaler - an inhaled preparation for asthma prevention"
- ☐ "Voltarol Retard - an anti-inflammatory drug for arthritis"

The LiMA application will provide assistance in this matter as it lists a number of common medications with a non-medical explanation of the purpose of the medication. It is important to ensure that the reason for use is documented accurately especially in cases where medication may be used for different reasons, for example clarification should be sought for the reason of use of amitriptyline in a claimant with mental health problems and back pain, and the correct reason documented.

HCPs may make use of the online British National Formulary (BNF) for clarification of information on use of various medications.

3.1.3.9 Clinical History

A good history is the basis of the LCW/LCWRA medical assessment, and the following structure should be used:

The clinical history should be concise and focused on the medical conditions present; however it should still contain enough detail to allow appropriate advice to be given to the Decision Maker. A clinical history which is too brief may not provide the Decision Maker with enough information to determine entitlement to benefit and may result in rework or poor quality standards.

The clinical history should:

- List every condition identified / reported – a specific diagnosis should be given where possible, however if diagnosis is not known or is unclear from available information , then a less specific diagnosis should be recorded
- Avoid grouping together unrelated conditions
- Document symptoms – when they began, when condition was diagnosed, what the current symptoms are and how the symptoms affect function
- Document who is managing the condition
- Give details of any hospitalisation
- Give details on past/current/future treatment, including medication, various therapies, injections, surgery, etc, including any response to treatment and likely date of any proposed treatment/procedure/investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to

have a scan in 2 weeks' time"

- Explore any previously identified conditions, if no longer symptomatic, to make it clear to the Decision Maker that the condition has resolved / responded to treatment

At times the claimant may claim a medical problem for which there is no formal diagnosis, and it may be necessary to take a more detailed history of the problem. For example if the claimant indicates episodes of loss of consciousness, it is important to explore in more detail the events claimed. For example, is there an aura? When do these events happen? Do they wake up on the floor? Have they sustained any injury etc? This is necessary for the HCP to decide whether the events described may meet the criteria in the descriptors.

Include a brief outline of the claimant's problems and the functional limitations imposed by them, for example "Variable pain both elbows which the claimant states restricts his/her ability to lift and reach".

Ensure that any newly identified conditions or deterioration of symptoms are fully explored as these may impact on the claimants assessment of their functional restrictions at the time of completion of their ESA50/UC50. For example, if at the time of completion of the ESA50/UC50, a claimant identified no problem with lower limb function, but since then has fractured their ankle, you must ensure you fully address this and consider the lower limb areas carefully in the report.

It is important to fully explore psychiatric symptoms in claimants with mental health problems, including suicidal ideation if relevant, and details of therapy.

At times during the course of history taking a claimant may mention details of an alleged assault that has resulted in physical or mental function issues. Should this occur, the HCP should only record information that is likely to have functional relevance to the report and under no circumstances should they include any details of the alleged assailant.

3.1.3.10 Social and occupational history

Brief details of the claimant's domestic situation should be recorded. For example "lives in a 2-storey house with husband and two children aged 10 and 12".

You should also record a brief outline of the claimant's previous occupation including why and when they left.

Where a claimant is in work (either permitted work or in work and claiming UC), the occupational history may have to be explored in greater detail within the social and occupational history and as part of the typical day. (See sections 3.1.2.1 and 3.1.2.2)

You should also record details of how the claimant travelled to the Assessment Centre, where appropriate.

It is now mandatory to document the evidence reviewed during the assessment and this phrase is recorded within the Social History on LiMA. For Clerical reports, the HCP should document the evidence reviewed in an appropriate section of the report, such as the condition history or social history.

3.1.3.11 The Typical Day

Although not always easy to elicit, a careful and well-focused history of a typical day will greatly help you in completing the rest of the report. If you obtain and record appropriate information at this stage, it will provide you with factual evidence of the claimant's abilities, which you can then use to support your choice of descriptor. It is important to obtain sufficient detail in order to enable you to address any inconsistencies in the typical day history in your justification of descriptors/outcome in the Personalised Summary Statement.

You must write this section in the third person. It is a record of the claimant's everyday life, without interpretation by the HCP. You should make it clear that this is the claimant's account of his/her abilities and not your opinion. It is also a factual description of how the claimant's condition affects them in day to day life as elicited by careful interview, using the recommended techniques referred to in the relevant section of this handbook. Properly completed, it is of great help to the Decision Maker.

The account of the "Typical day" should be individualised to the claimant and particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and any other areas which may also be affected. For example in cases of shoulder pain, bear in mind activities which involve reaching and lifting and carrying. These activities are required in personal care tasks, and domestic and leisure activities. You should give specific examples of activities, e.g. "says she manages to self care independently and is able to wash her hair in the shower using both arms". LiMA reports should contain appropriate amounts of free text and LiMA phrases in the typical day.

See also the paragraphs in relation to completing the section on activities of daily living in sections 3.2 and 3.5. When exploring the typical day, you should also ensure you cover activities relevant to LCWRA criteria such as the person's ability to eat/drink/swallow.

Avoid making a statement such as "Can only walk 50 metres" as this may well be taken as fact by the Decision Maker or the Appeal Tribunal. Better would be; "Says he only walks 50 metres", then give an example of what the claimant actually does, as far as walking is concerned, on an average day: "Walks to the shops and back (about 200 metres in all) but says he has to stop at least twice due to back pain".

Variability needs to be explored within the history and more detail is given in section 3.1.9.

The use of aids and appliances, or reason for non-use of reasonable aids and appliances, has to be considered for all physical descriptors and should be explored in the history. (See section 3.2 for more detail)

At an early stage of the assessment you may have identified a mental function problem. Remember that many of the Mental Function Assessment descriptors can also be completed as a result of this exploration of the claimant's day-to-day life, and completing them will be very much easier if you keep in mind the seven areas involved, namely:

- ☐ Learning tasks

- ☐ Awareness of hazard
- ☐ Initiating and completing personal action
- ☐ Coping with change
- ☐ Getting about
- ☐ Coping with social engagement
- ☐ Appropriateness of behaviour with other people

3.1.3.12 LCWRA/Treat as LCW

If it becomes clear to you that the claimant may meet criteria for having LCWRA, you should interrupt the assessment and where appropriate consult with a CSD HCP. You must consider whether any person with a severe physical, mental function or sensory problem may meet one of the LCWRA criteria.

Remember that many of the highest LCW functional descriptors may suggest the LCWRA advice is appropriate.

It is essential that adequate time has been spent with the claimant to obtain sufficient information to fully justify the advice that the claimant meets one of the LCWRA criteria. **The level of information will vary in each case.** For example, if a claimant is found to meet the LCWRA criterion of terminal illness, this is likely to be indicated by the clinical history and perhaps some observations. However, if the claimant is in one of the functional LCWRA categories, you will need to fully justify functional restriction in this area, even though certain sections of the report can be curtailed. This may involve documenting some typical day information, some clinical examination findings and observed behaviour, which should be documented in the relevant sections of the report. Any documented information on history, clinical examination and observed behaviour will still be shown on the final report in the LiMA application where LCWRA is advised, however no descriptor choice outcomes will be shown in such a case.

Where a claimant is noted to have several conditions, it may be prudent to explore potentially more severe conditions first to avoid unnecessarily distressing the claimant. For example if a person mentions they have a conditions such as pancreatic cancer, this should be explored before conditions such as high cholesterol.

As always, there is a need to balance the level of information recorded. You must obtain adequate information to justify LCWRA advice, however; it is important that you do not subject the claimant to an unnecessary prolonged assessment or unnecessary clinical examination. The situation should be explained to the claimant, without direct reference to benefit entitlement or LCWRA advice, and the assessment concluded.

In the LiMA application, there is an area on screen to allow you to access and complete advice on LCWRA. LiMA will then automatically generate the ESA85A/UC85A.

If the report is completed clerically, you must make an explanatory note on the ESA85/UC85 along the following lines:

"This assessment was concluded when it became apparent that I could advise that the claimant was likely to meet LCWRA criteria."

You must also complete the ESA85A/UC85A and ESA85S/UC85S providing full details of LCWRA advice. A copy of the paper version of the ESA85A/UC85A is included at Appendix 4. In circumstances where the HCP must discuss LCWRA advice with the CSD HCP, the name of the advising CSD HCP should be recorded on the ESA85A/UC85A.

Where 'Treat as LCW' is identified at assessment, the HCP will record this on the LiMA application. This option is only available towards the end of the report, after the descriptors have been chosen, in the Non Functional Descriptor and LCWRA option section. The report cannot be curtailed and the 'Treat as LCW' option will only be available if the criteria for limited capability for work have not been met. Justification for 'Treat as LCW' will still need to be provided within the Personalised Summary Statement.

Where the report is completed clerically, an ESA85A/UC85A should also be completed in these circumstances as there is no specific area on the ESA85/UC85 to make it clear to the DM that 'Treat as LCW' may be applicable. The HCP should indicate the appropriate 'Treat as LCW' category on the ESA85A/UC85A report and, in all cases, must also justify whether or not LCWRA criteria are met. The ESA85S/UC85S must also be completed.

3.1.4 Clinical Examination of the Claimant

Information about appropriate clinical examination will be found in section 3.3, examination of the musculoskeletal system, as well as in the individual sections dealing with functional categories.

You should seek and document the claimant's express permission before proceeding to carry out any physical examination that you deem to be necessary. It is vitally important that all HCPs understand that they must not assume consent.

Explicit consent to the clinical examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report. A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

A phrase is provided in the LiMA application to support this, however the HCP will need to document such a phrase in clerical reports, when any physical examination is undertaken.

The precise extent and nature of the clinical examination will depend entirely on the circumstances of each individual case. You must use your medical professional judgement to decide what examination is indicated, and also whether the claimant should be asked to remove any clothing in order to complete this assessment effectively.

When carrying out a musculoskeletal overview examination, you should usually be able to complete this aspect of the assessment whilst the claimant is wearing loose indoor clothing, provided that you are checking to confirm normality.

This is the examination of choice in the first instance in all claimants as this will serve to demonstrate any functional loss.

If this screening process confirms a restriction then a more detailed and appropriate regional examination should be carried out.

Full general examinations are inappropriate in the Disability Analysis setting and should be avoided. When the Musculoskeletal Overview (MSO) examination proves normal, a more detailed examination is unnecessary.

If you suspect an abnormality, and thus are led towards a regional inspection and examination, it would be usual for you to ask the claimant to remove the relevant items of outer clothing in order to complete this task, if this is appropriate. Further explanations and consent to proceed are essential at this stage. Pain must be avoided during the MSO examination. The claimant should be advised to inform the HCP if any movement is uncomfortable and further attempts to move that limb/spine are then avoided. The MSO should never be slavishly followed - always be prepared to curtail the sequence of actions if a claimant indicates they are uncomfortable. The range of joint movements must be assessed through active movements and the use of passive movements to assess these movements would not be considered appropriate in a work capability assessment.

If your actions were ever queried, you should be able to justify anything that you have asked the claimant to do, with regard to undressing and their participation in the physical examination process. Similarly you should be able to justify any omissions that you have deliberately made in these areas, particularly if these might be considered to deviate from usual disability assessment practice.

As the assessment proceeds, explain any request that you make to the claimant to remove clothing, and explain every step of the physical examination process, so that there can be no misunderstanding about movements they are asked to perform or clinical tests you are carrying out.

It will **never** be necessary to ask a claimant to remove items of intimate underwear/clothing, or to carry out intimate examinations (that is examinations of the breasts, genitalia or rectum) as part of the disability functional assessment.

Please note also that use of needles is not considered appropriate in the context of disability assessment medicine, and thus the testing of pinprick sensation should **not** be undertaken. When carrying out a physical examination, you should use your medical professional judgement to decide when it is appropriate to offer an attendant, or to invite the claimant to have a relative or friend present. In this context, the duty of the attendant is to protect you from any possible complaints about unethical conduct, and the attendant's role is merely to remain in the room whilst you examine the claimant, unless you ask the attendant for assistance. This guidance assumes particular significance when the HCP and claimant are of the opposite sex.

If an attendant, relative or friend is present, you should record the fact on the report form, making a note of the person's identity. If the claimant does not want an attendant, you should record that the offer was made and declined. The physical examination should not normally be done in the presence of a relative/friend/carer, however if the claimant consents or requests them to be present, then this should be allowed. This should be documented in the ESA85/UC85 report.

Give the claimant privacy to undress and dress. Do not assist the claimant in removing clothing unless you have clarified with them that your assistance is required.

Remember when recording your clinical examination findings to interpret them for the Decision Maker by explaining in plain English the significance of the findings, e.g. "Forward flexion of Left shoulder restricted to 90 degrees (about half the normal range) and this means that the claimant cannot reach upwards above shoulder level with the Left arm." The LiMA application will give details of normal range of movement, however this should be documented in clerical reports where abnormal findings are present.

If documenting assessment of Peak Flow it is important that the reader of the report is able to determine from the report the type of meter with which the reading was taken.

Therefore, when documenting Peak Flow, please record in brackets whether a "Wright" or "EU" meter was used, like this:

Peak Flow Rate 450 l/min (Wright) or Peak Flow Rate 450 l/min (EU)

3.1.4.1 Conclusion of the assessment

After the interview and clinical examination, the claimant should be invited to ask any questions regarding the procedure. It is appropriate to advise that the Department for Work and Pensions office will be in touch with the claimant as soon as possible but a specific period of time in which this will happen should not be given. No indication should be given of the likely outcome of the claim. The claimant should be told that the decision will not be made by you, but by a Decision Maker.

During the course of the assessment, you will obtain details of the claimant's medical care. It is vital that you do not enter into discussions that are out with the role of the Disability Analyst or suggest treatment options.

If the claimant asks advice, you should suggest they speak to their own GP/other HCP involved in their care. No criticism of the claimant's previous medical management, overt or implied, should ever be made.

Do not enter into discussions about entitlement to other benefits. The claimant should be encouraged to approach the staff in their local Benefits Office for further information.

Do not enter into any debate about the details of ESA/UC or respond to criticisms of the administrative process.

If, during the assessment, a condition is identified which may be unknown to the claimant or their practitioner, the GP should be notified. This process has ethical implications and requires a fuller outline which is given below.

In all cases of difficulty you should consult with an experienced HCP.

3.1.5 Dealing with Unexpected findings at the assessment

Situations arise when HCPs carrying out disability assessments may come across information that they feel should be reported to the claimant's General Practitioner.

The current guidance for HCPs on dealing with the release of unexpected findings to a claimant's General Practitioner is as follows:

GMC Guidelines have made it clear that Registered Medical Practitioners who have contractual obligations to third parties should not pass on information to the claimant's GP without claimant consent for such action, unless there were exceptional circumstances. The GMC recommend that Registered Medical Practitioners make every effort to explain to claimants why information should be passed on to those responsible for their medical care.

There may be rare occasions when despite the claimant's inability or refusal to give informed consent, the HCP may, in his/her professional judgement pass on information about that individual.

This discretion must be exercised within the GMC guidelines, and HCPs must be prepared to justify their decision to take such action. The types of circumstances when unauthorised disclosure by HCPs would be justified include:

- (i) When the release of that information is necessary to protect others from risk of death or serious harm;
- (ii) When the claimant requires urgent medical treatment, but cannot be contacted within a suitably rapid period of time.
- (iii) When the individual is not competent to give consent.

All Registered Medical Practitioners are strongly advised to read these guidance notes from the GMC. If any HCP does not have a copy then he/she should contact the GMC via the website: <http://www.gmc-uk.org/> or at 178 Great Portland St, London W1 W5JE (tel: 0161 923 6602).

The NMC code of practice provides very similar advice.

Clause 5 states that NMC registrants have a duty to protect confidential information.

The guidance indicates that the HCP should seek patients' and clients' interests regarding the sharing of information with their family and others. When a patient or client is considered to be incapable of giving permission, the guidance states the HCP should consult with colleagues. The guidance also indicates that if the HCP is required to disclose information outside the team that will have personal consequences for patients or clients, they must obtain consent; or if consent cannot be obtained for whatever reason, disclosures can only be made where:

- (i) They can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from risk of significant harm); or
- (ii) They are required by law or by order of a court.

Further guidance on NMC code of practice can be obtained from the website www.nmc-uk.org or by contacting the Nursing and Midwifery council, 23 Portland Place, London W1B 1PZ. A telephone number for enquiries relating to NMC professional advice is 0207637718.

The Health and Care Professions Council (The regulatory body responsible for a number of health care professions including physiotherapists and Occupational Therapists), also provide guidance about disclosure of information. This can be found in the booklet – “Confidentiality – Information for Registrants” available on the HCPC website <http://www.hcpc-uk.org/publications/brochures> The HCPC can also be contacted via the website on <http://www.hcpc-uk.org/> or on 08453006184.

When an HCP identifies a need to pass information about a claimant to the GP then he/she must provide a reasonable explanation to the individual. The discussion should deal with:

- (i) The nature of the information to be passed to the GP;
- (ii) The reasons for wanting to disclose this information; and
- (iii) A request for consent to release of the information.

The HCP should record relevant details of their discussion with the claimant on form UE1 (Rev), both in respect of the information that they have given to the claimant and the claimant's response.

For example *“I advised your patient that he should report the symptom of to you and he said that he would arrange an appointment as soon as possible”*.

These details should be recorded on form UE1 (Rev) in the section *“I have examined your patient/reviewed your patient's file* in connection with their claim to benefit. I believe that you will wish to be aware....”*

Informed written consent from the claimant should be obtained on the UE1 (Rev) form and the procedural guidance must be followed in full.

The claimant should be given a photocopy (or carbon copy if photocopying facilities are not available) at the time of the assessment.

In every case, the GP must be telephoned within 24 hours to explain the unexpected findings.

The HCP must confirm details of the current GP before the claimant leaves the assessment.

If it is not possible to make telephone contact with the GP, the UE1 form must be faxed to the GP surgery following the secure faxing guidelines.

Contact by telephone: (UE1 (Rev) used as a record of the conversation)

Contact **must be made by telephone within 24 hours**, followed by written confirmation using form UE1 (Rev). When telephoning the GP, use the section *“I have examined your patient/reviewed your patient's file* in connection with their claim to benefit.*

I believe that you will wish to be aware....” on form UE1 (Rev) to record a note of the conversation.

Contact by letter: (UE1 (Rev) use and distribution)

If used as a letter, four copies must be made prior to issue to the GP. One to be handed to the claimant, one kept on the claimant’s file, one placed in the HCP’s file and one to be kept in the CSD file.

Most reports completed during a Domiciliary Visit (DV) will not be seen by a medical member of staff when they are returned to the MSC. It is therefore the responsibility of the visiting HCP to report any unexpected findings to the claimant’s GP by telephone and record details of the conversation on form UE1 (Rev).

A copy of the UE1 (Rev) form must be handed to the claimant. If neither copying facilities nor carbon paper are available, the HCP must make an exact copy on a separate UE1 (Rev). For this purpose, the visiting HCP will have been issued with three spare copies of form UE1 (Rev) along with a piece of carbon copy paper.

Each DV issued will also contain one copy of form UE1 (Rev).

HCPs should contact their respective MSC to replenish stocks of UE1 (Rev) forms.

Telephone contact must be made in all cases (whether the assessment was completed in an AC or as a DV), to ensure compliance with the 24-hour deadline. In addition, in all cases, a UE1 (Rev) form must be completed and attached in a clearly visible position to the front of the assessment report. This should include details of the information passed by telephone to the claimant’s GP. The file must then be returned to the MSC as normal, where the administration clerk will issue the completed UE1 (Rev) to the GP or Medical Carer, after taking copies for CSD (retained for 3 months), the claimant’s file and the HCP’s personal file (to be retained for a minimum of 10 years).

3.1.6 Completing the LCW/LCWRA Medical Assessment Report Form: An Overview

It is important when completing the ESA85/ESA85S/UC85/UC85S report (or the ESA85A/UC85A if LCWRA/Treat as LCW criteria advised) to bear in mind who the recipients will be.

The report will always be seen by a lay Decision Maker and may also be read by members of an Appeal Tribunal, the claimant and their representatives, and approved HCPs in future referrals.

Legibility is of paramount importance. A report which is difficult or impossible to read may be valueless to the Decision Maker and is bad customer service.

LiMA reports have the clear advantage of having no legibility problems. It is important, however, to exercise care when using LiMA to ensure you check for typing errors or other information inadvertently added into the report when using the LiMA application. LiMA provides both a spell and grammar check facility and a review facility to enable you to check the content of the report for accuracy before it is sent to the Decision Maker.

Remember that Decision Makers are not medically qualified, and your report must be clear enough for them and other non-medical readers to understand.

The Decision Makers will rely heavily on the report in coming to a decision on limited capability for work or limited capability for work-related activity, and their needs must be uppermost in your mind. The LCW/LCWRA medical assessment report must provide an objective and fair assessment of the claimant's disabilities in the physical, sensory and mental function areas, as laid out in the ESA regulations. It must make clear to the Decision Maker what descriptors you have chosen and why you have chosen them. Your choice must be supported by appropriate medical evidence.

Where your choice of descriptor differs from the claimant's stated level of disability, your supporting evidence must give the Decision Maker sufficient information to indicate why your opinion, rather than the claimant's, should be accepted.

Without a clear, consistent and well-presented report, the Decision Maker will find it difficult to accept your choice of descriptors. The requirement is for a report which:-

- ☐ Is legible
- ☐ Is consistent and with any inconsistency fully addressed
- ☐ Is clear, concise, relevant and positive
- ☐ Contains sufficient detail to justify the descriptors/outcome chosen
- ☐ Explains why the medical opinion may in some circumstances differ from the claimant's own view of their disability
- ☐ Avoids unnecessary medical terminology
- ☐ Is easily presented at an Appeal Tribunal
- ☐ Is in keeping with a consensus of medical opinion

HCPs will develop their own style in completing the LCW/LCWRA Report. However, the following general guidance is based on practical experience from previous benefit reports. The part of the report relating to diagnosis, medication, treatment and clinical history should be completed while interviewing the claimant. The remainder should be completed once the claimant has left.

3.1.6.1 Medical Terminology

The use of medical terminology should be avoided. When there is no alternative to the use of a medical expression, it should be clearly explained. For example, "Aortic stenosis (a defective heart valve)".

Some terms have passed into general use, and will be generally understood, such as angina, asthma, migraine, and schizophrenia. However, it is good practice to explain briefly the nature and effects of an unfamiliar condition.

Certain expressions should never be used, for example "functional overlay". If you think that the disability is less than claimed, you must say so explicitly, supporting your opinion by the medical evidence.

3.1.6.2 Abbreviations

Do not use technical abbreviations such as "LBP" or "IHD" in your reports. However abbreviations in common usage are acceptable, for example "etc" and "e.g." "R" and "L" may be used for right and left, so long as the meaning is clear from the context. If you need to use a medical term frequently, you can abbreviate it once it has been first explained and defined. For example, Non-insulin Dependent Diabetes Mellitus (NIDDM) can then be referred to as NIDDM in the rest of the report.

3.1.7 Choosing and Justifying Descriptors: the Overall Approach

The objective of the LCW/LCWRA medical assessment report is:

- ☐ to provide your opinion of the claimant's level of function in a number of functional categories
- ☐ to advise if a non-functional descriptor may apply
- ☐ to provide advice on prognosis where appropriate
- ☐ to advise whether or not the claimant meets criteria for having LCWRA
- ☐ to advise whether the claimant fulfils the criteria for 'Treat as LCW'
- ☐ to provide justification for your advice

For most LCWRA categories the justification of your advice will be included within the justification summary but for TI, Pregnancy Risk, Substantial Risk, Chemotherapy/Radiotherapy and Eating/Drinking, the justification must be documented in the designated section of the ESA85/UC85 report. In these cases, LiMA will automatically generate an ESA85A or UC85A form, however this must be completed separately for clerical reports. The choice of the most appropriate descriptor in the functional category areas will depend upon:

- ☐ Consideration of all the medical evidence
- ☐ The interview with the claimant
- ☐ The clinical examination / observations
- ☐ Your medical knowledge of the likely effects of the condition. For conditions that are rare or with which you are unfamiliar, you should check the EBM LiMA Repository for information. It is also very important that you gather sufficient information in the history, typical day and clinical examination to allow you to provide robust advice to the Decision Maker.

For each of the mental function, physical and sensory activity areas you must choose only one descriptor, and that should be the descriptor that reflects the claimant's level of functioning most of the time, taking into account such factors as pain, stiffness, fatigue, response to treatment and variability of symptoms.

This ensures that your opinion is not just a "snapshot" of the claimant on the day of assessment, but reflects their functional ability over a period of time.

This aspect is dealt with in more detail later.

In certain functional areas, the descriptors do not conform to a simple hierarchical progression. In these areas the descriptor chosen should be that which most accurately reflects the highest level of disability experienced by the claimant. For example, in the functional area of mobilising the claimant may have mobility restricted to 200 metres, but would also be unable to mount or descend 2 steps. In this case the latter should be selected, as it is the “higher” descriptor.

If your opinion on level of function in any area differs from that of the claimant’s you must provide full justification for your opinion. You must comprehensively justify and support your choice of descriptor by giving examples from your clinical history, activities of daily living, observation of the claimant, and clinical examination. Your evidence must provide sufficient factual information to lead the Decision Maker to understand and accept your choice. It is insufficient to simply reiterate the wording of the descriptor as justification. All the evidence provided in a functional category should give support to that particular descriptor, e.g. it would be illogical to describe how, in a typical day, the claimant sits through long films at the cinema under the category “Manual Dexterity”.

It is equally illogical to provide examination findings of a knee under “Reaching”, or neck and shoulder findings under “Standing/Sitting”.

Any conflicting evidence in the report must be fully addressed. For example you may consider that a claimant has no problem going out unaccompanied. You may use information from the typical day such as goes to the post office and bank alone, takes a bus to visit mother alone and use evidence from the mental state examination to back up your justification. However, if within the typical day a claimant has indicated they must be accompanied to go to the supermarket due to anxiety, this information cannot simply be ignored.

You must address this statement and justify why you feel that despite this statement, your opinion is that the claimant would not have substantial difficulty getting to places unaccompanied.

It is also imperative to address all the information obtained during the assessment and in the ESA50/UC50. For example if the claimant has indicated in their form that they “black out at times” but ticked no problems in the consciousness section of the ESA50/UC50, this must be fully addressed and justified by the HCP. It is inappropriate to simply “agree” with the opinion of the claimant in the consciousness section when they have provided information elsewhere that may impact on this.

If the claimant has indicated, variable or inconsistent levels of function in the ESA50/UC50, you should consider that this indicates a problem and justify your opinion appropriately.

When the claimant has indicated both that there is no problem and that there is an apparent problem in any one functional category, you should assume they are indicating that there is functional restriction and justify appropriately.

Functional activity areas on the ESA85/UC85 are linked e.g. mobilising and standing and sitting. Clinical details can be cross-referred to other relevant linked groups.

Be careful when cross-referencing your evidence from one functional activity area to another that the information is relevant to that particular group. Irrelevant cross-references are irritating, misleading, waste the readers' time and devalue the entire report.

Make sure that your evidence is consistent so that you do not contradict yourself, or appear to contradict yourself, in different sections of your report. You should explain any apparent contradictions in such a way that the Decision Maker is able to understand that two pieces of evidence which at first sight appear contradictory, are in fact compatible with one another.

There will be occasions when it is necessary to choose a "None of the above apply" descriptor even though some disability has been identified but it is not severe enough to reach the lower threshold; i.e. the penultimate descriptor.

In this circumstance you must make it clear to the Decision Maker that you have carefully considered the limitations which are present by recording all the relevant information.

For example, the claimant may have indicated that they have difficulty with walking, but you have evidence from the typical day that they only experience significant discomfort after walking at a reasonable pace for 20 minutes (i.e. well over 800m).

When completing the ESA85/UC85, you must **not**:

- ☐ Alter the wording of the descriptors: they are defined in the Regulations and cannot be modified.
- ☐ Alter the claimant's questionnaire in any way.
- ☐ In clerical reports, use correction fluid. If you make an error, it should be clearly scored out, the correct words substituted, and the alteration initialled and dated.

If in the claimant's questionnaire a functional category page is left blank, you must show on the corresponding area of your report that you have discussed the problem with the claimant, and, where appropriate, write "The claimant states that there is no problem in this area". If it emerges that the claimant is disabled in this area you should proceed to choose and justify your descriptor choice in the usual way. This phrase should not be used when the claimant has already indicated a problem in the area in the ESA50/UC50. Even where they say they have no problem at assessment, you need to provide your evidence for your choice of descriptor.

In some cases (where there is a MH diagnosis) there may be no claimant questionnaire. You should make this clear in your report, and address every functional category page as described above.

Occasionally, a significant time may have elapsed between the claimant completing the questionnaire and the assessment. Any areas which indicate a problem on the ESA50 should still be recorded; however you should ask the claimant whether their problems have changed in the intervening period, and record their reply within the condition history or typical day information.

3.1.8 Completion of Functional Activity Area Pages

For each functional activity area (except where the claimant has indicated no functional restriction and you agree with them - see above) you must record the relevant information to explain and justify your choice to the Decision Maker. Information is recorded in terms of:

- ☐ Prominent features of functional ability relevant to daily living
- ☐ Behaviour observed during the assessment
- ☐ Findings at clinical examination

3.1.9 Variable and fluctuating conditions

Much of the information recorded here will be obtained directly from the claimant, and it is important to make this clear by writing something like: "Claimant states that....., or Claimant reports that....."

Approved Health Care Professionals should provide the Decision Maker with medical advice on the most appropriate level of functional ability in each activity area. In doing so they must take into account a number of factors including:

- ☐ Any fluctuations in the medical condition i.e. how the condition changes with time – both within the course of a day and over longer periods.
- ☐ The variation of functional ability i.e. how the person's functional ability changes over time and in relation to changes in the underlying medical condition.
- ☐ Any pain which results from performing the activity.
- ☐ The ability to repeat the activity and the timescale in which they can repeat it.
- ☐ The ability to perform the activity safely.

The approved Health Care Professionals choice of descriptors should reflect what the person is capable of doing for most of the time. In other words, could the person normally carry out the stated activity when called upon to do so?

For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days. (N.B. Some of the Mental Function descriptors specify frequency of limitation and must be considered individually.)

Examining Health Care Professionals should make it clear in the report to the DM how they arrived at their opinion.

In such cases the Health Care Professional has to consider carefully whether the claimed level of disability on 'good' and 'bad' days is likely to be consistent with the clinical picture presented, the diagnosis(es) and the overall pattern of activity in the claimant's everyday life.

This implies that approved Health Care Professionals should provide the DM with advice on:

- ☐ The claimant's functional limitations on the majority of the days.
- ☐ The limitations found on the remaining days where the claimant's condition is worse or better, with an indication of the frequency with which these days arise.

This does not apply to some of the Mental Function Descriptors, where specific levels of frequency are indicated but will apply to all physical descriptors.

The appropriate advice can only be given if variability has been adequately explored. It is not sufficient to say "has good days and bad days". Detailed exploration of the frequency of the "good" and "bad" days, what activities can be done on "good" days and on "bad", what makes a day "good" or "bad", any specific triggers/precipitating factors for the "bad" days, etc is required in order to be able to choose the appropriate descriptors.

For conditions which vary through the day the choice of descriptor should reflect that level of activity that can be performed for a reasonable continuous period within the day. Again it should be made clear in the report to the DM how the HCP arrived at their advice.

Taking all of this into account, if a claimant cannot repeat an activity with a reasonable degree of regularity, and certainly if they can perform the activity only once, then they should be considered unable to perform that activity.

In considering each of these activities the concept of repeatedly, reliably and safely must be taken into account.

If a person can perform a task but is unable to repeat it within a reasonable timescale the person should be considered unable to perform the task. For example, the HCP should consider what would be expected of an individual who did not have an impairment of their ability to mobilise. That is, a 'normal' individual would be able to perform this activity within a given time period and repeat that activity again after a reasonable rest period. The duration of the reasonable rest period can then serve as a basis for comparison to gauge the range of what is 'reasonable'.

The safety of the person must also be considered in each of the activities. If a person is unable to perform an activity or task safely, they must be considered incapable of the task.

A task must also be completed reasonably. If a person can complete a task but suffers significant pain or distress in doing so, they should be considered incapable of the activity.

The activities do not have to be performed without any discomfort or pain. However, if the claimant cannot perform an activity effectively because of pain, they should be considered incapable of performing that activity.

When considering the effect of pain, take into account the predictability of onset, and the effectiveness of treatment. Pain which starts without warning and requires analgesia is very different from predictable angina of effort which can be forestalled, or rapidly remedied, with appropriate treatment.

Breathlessness is an important symptom to take into account, because it is not specifically reflected in many of the descriptors, but it may contribute significantly to disability in relation to mobilising and walking up and down stairs. For example, a claimant who experiences significant dyspnoea on carrying out an activity should be scored as if the activity cannot be undertaken.

You should comment on the consistency of the above factors with the diagnosis, with the stage reached by the disease, and with the claimant's lifestyle.

For example, the medical certification says the claimant has mechanical back pain, and on clinical examination you find no back abnormality.

The claimant says that on one day a week his back is so bad that he has to stay in bed. This degree of variability is very unlikely; mechanical back pain does not normally vary to this extent.

If you decide not to accept the degree of variability, etc, you should document justification, such as:

"In my view, the claimed (variability etc) is unlikely, given the following findings:" And provide one or two specific examples to support your opinion.

3.1.10 Activities of Daily Living

You will already have focused your attention on the functional areas causing difficulty to the claimant, and will have structured your typical day details along these lines. Examples of activities appropriate to each functional area are given in section 3.2, the functional categories.

The activity described must be relevant to the functional category, e.g. the ability to sit for an hour at a time watching TV is irrelevant to the category "reaching".

The activity must be described in sufficient detail to support your choice of descriptor.

For example:

"Does the shopping/cooking" does not give any useful information about picking up and moving or transferring; more detail is required:

"Says she does her own shopping and is able to load/unload her trolley without help."

"States he can do light cooking but is unable to carry a full saucepan for himself."

3.1.11 Behaviour observed during the assessment

The area relating to behaviour observed during the assessment may provide useful information for some functional areas but may be of limited use in others, for example in standing, as the claimant will rarely be required to stand for any significant period within the Assessment Centre. However, they will certainly be invited to sit, rise from sitting [often on a number of occasions during the course of the physical examination], and walk. While it is not appropriate to observe claimants undressing and dressing they may also be required to reach, and bend or kneel for example hanging up a coat or picking up a bag during the assessment.

Manual dexterity can often be assessed at the same time as buttons and zips are manipulated on coats.

Informal observations can also be made regarding vision, hearing ability and speech, and any object carried by the claimant can be documented.

It should be noted that observations refer to informal observations, not examination findings.

The report must contain sufficient detail. It is not enough to state "sat comfortably at interview"; better is to state "sat comfortably for 25 minutes in an armless chair without fidgeting, and this indicates that there would be little likelihood of any problem with sitting for longer than 30 minutes".

It is important to fully justify your opinion when you have not observed the claimant perform the actual activity you are justifying. For example, you may not see the person transfer from one seated position to another, however; you could support your opinion that they are capable of this task with justification such as:

"The claimant was observed to rise from a chair with the use of a walking stick. He was able to walk 10m with a stick with good balance to the examination room and stood for 2 minutes with the aid of a stick. These observations suggest he has adequate lower limb function, power and balance to transfer between one seat and another".

Further examples of observed behaviour relevant to specific functional activity areas are given in section 3.2, functional categories.

3.1.12 Clinical findings

Clinical findings should be expressed simply and clearly and in non-technical terms. Ideally, they should be set out in a way which reflects the recommended approach to clinical examination, that is, the Musculoskeletal Overview. If an abnormality is detected then a more detailed regional examination should be performed.

In the report set out the details of any inspection, with particular regard to muscle wasting; the results of palpation and auscultation if appropriate; PEFR where indicated; and the range of movement of joints, expressed in functional ranges of movement. Such factors as power and reflexes should be addressed when appropriate and the degree to which these findings depart from the normal should be explained.

It may also be appropriate for further neurological examination to be carried out by registered medical practitioners in some cases to assess such areas as cerebellar function or other more complex neurological conditions such as spinal injury. For example:

"Lumbar spine: forward flexion to knees; lateral flexion full on R but half normal level on L. Straight leg raise 90° (normal) on R but only 45° on L. Peak flow rate today 350 L/min, within normal limits."

It is essential to comment on and interpret the clinical findings. You should indicate whether they are in keeping with the diagnosis, the stage of the disease, and most importantly, the disability and the level of function which the claimant claims. For example:

"These signs show that the claimant has severe back problems consistent with his described level of function."

Or

"These clinical findings show that the claimant has only mild disability due to asthma, and do not confirm the severity reported by the claimant."

In claimants who are unwilling, or unable to give a clear account of their day-to-day activities, the clinical examination and your comments thereon will form an important part of the evidence for the Decision Maker, and along with observed behaviour will form the basis for your own choice of descriptor.

Where the claimant refuses to give a history or declines to be appropriately examined, this must be recorded, together with any reason given by the individual.

Only findings from the formal clinical examination should be recorded in this section, any findings noted from observation should be recorded in the relevant 'observations' section. Where the clinical examination findings differ from the behaviour noted on informal observation, then a clear explanation of this apparent inconsistency will have to be given to the Decision Maker.

3.2 Functional Categories (Physical)

3.2.1 Introduction

The ten "physical" functional categories cover disability in physical and sensory areas.

The ESA Regulations 2008, as amended and the UC Regulations 2013, have made it explicit that:

- Physical descriptors should only apply for physical conditions or physical disablement and mental health descriptors should only apply for mental health conditions or mental disablement

For example someone who has significant pain arising from a chronic back problem should only score in the physical activities and should not score in the getting about activity (which is designed to reflect the challenges experienced by people with mental, cognitive or intellectual issues).

The first two categories (mobilising and sitting and standing) are activities which predominantly involve the spine and lower limbs. Upper limb function will also have to be taken into account in cases where the person may not be able to walk but could reasonably use a wheelchair or other aids to assist their mobility.

The following three categories (reaching; picking up and moving and manual dexterity) are activities which predominantly involve the cervical spine and upper limbs.

For each functional category you must choose a descriptor, and then provide all the necessary evidence which will make clear to the Decision Maker the facts on which your choice is based.

If your choice of descriptor is different from the claimant's stated abilities, the Decision Maker needs to understand clearly why your choice is more appropriate than the claimant's.

Sections 3.2.2-3.2.11 look in detail at each functional category and the policy intent of the descriptors. It gives advice on the specific points in the typical day and observed behaviour that are relevant to the particular functional category which can be used to justify your choice of descriptor in that category.

Remember also to take into account the effects of variability, etc. Even in cases where the descriptor does not specifically mention the concept of "repeatedly and reliably" – this must always be taken into account and an appropriate entry must always be made.

Remember that in some instances it can be appropriate to cross-reference data relating to variability etc, and to clinical examination findings, but data relating to the typical day and observed behaviour are "function - specific".

The ESA Regulations 2008, as amended and the UC Regulations, have also made it clear that:

- Reasonable use of aids and appliances, including any prosthesis which a claimant uses, must always be considered

In December 2012, new guidance on the use of aids and appliances was issued based on a decision by an Upper Tribunal Judge. Detail of this decision and the guidance that HCPs must follow is detailed below. **This guidance must be applied to aids and appliances for all physical activities.**

3.2.1.1 Background to guidance on the use of aids and appliances

The background to the change in guidance on the use of aids and appliances introduced in 2012 came about based on the outcome of a single ESA claim which passed through the Appeals process.

The facts of the Upper Tribunal decision were as follows:

The case was assessed under the ESA Regulations 2008.

The claimant suffered from problems with his knee. He had not been advised to use a walking stick, and did not do so. Following application of the WCA, the DM determined that the claimant did not score any points, and ESA was terminated. On appeal, the First Tier Tribunal awarded 9 points for descriptor 3(b) (bending or kneeling). They considered that the claimant's difficulties with walking, standing and sitting could be helped by the use of a walking stick. As the score was still less than 15 points, the DM's decision was upheld.

On a further appeal, the Upper Tribunal Judge held that:

A - Where a claimant normally uses an aid or appliance, they must be assessed as if they were using it

B - If an aid or appliance has been prescribed or recommended by a person with appropriate expertise, the claimant must be assessed as using it, unless it would be unreasonable for them to use it

C - if a claimant does not use an aid or appliance, *and* it has not been prescribed or recommended, the claimant must be assessed as if using it if:

- It is normally used by people in the same circumstances acting reasonably **and**
- It would be reasonable for the claimant to use it.

The Judge also held that where paragraph C applies, the DM must explain how an aid or appliance would help the claimant.

The Judge's application of the test of 'normal use of an aid or appliance' applies to the assessment of all of the physical activities in the WCA. It is not restricted to those activities that make specific reference to aids or appliances.

In 2015, there was a further Tribunals decision providing guidance on relevant factors which should be considered by HCPs when giving advice on Activity 1 – Mobilising. This applies in particular to the use of a manual wheelchair.

This Guidance stated:

Factors such as the domestic environment are of potential relevance but need to be considered in the context of:

- ☐ The WCA's underlying purpose, and also
- ☐ The modern workplace environment

Given that it is to be expected that an employer will be willing to make reasonable adjustments in the workplace to enable someone to work, it can be assumed that these adjustments may include storage facilities for an employee's manual wheelchair.

Therefore, the HCP does not need to give consideration to using or storing a manual wheelchair in the home environment.

The updated guidance for DMs following this UT decision also highlighted the following which provides additional context when advising on mobilising:

- ☐ All medical considerations need to be taken into account
- ☐ Wheelchair use needs to be only for short distances, and for limited periods

3.2.1.2 The Decision Maker Process in terms of Aids and Appliances Guidance

The following sections describe the process that the Decision Maker will be required to follow when assessing claims, in relation to aids and appliances. It is hoped that this information will offer a useful insight into the DM's needs when considering the use of aids and appliances, and therefore will guide HCPs as to the breadth and depth of information and justification that will be required when considering their use.

☐ **Where an Aid or appliance has been prescribed or advised**

The DM assessing the claim will need to establish whether the claimant normally uses an aid or appliance, and if not, whether the use of it has been prescribed or advised.

If the claimant has been prescribed or advised to use an aid or appliance, **but** they either do not have the aid/appliance **or** do not use it, the DM will need to establish:

- Whether the aid/appliance would help the claimant
- Why they are not using it
- Whether their explanation for not using it is reasonable

Example 1

Billy has been advised by his GP to use a walking stick to help with balance problems when walking and standing. He has no upper limb problems.

He states that he doesn't like the idea of a walking stick because it makes him look old.

The DM considers that it would be reasonable to expect Billy to use a walking stick, and assesses LCW as if he is using it.

☐ **Where an Aid or appliance has not been prescribed or advised**

The DM must consider all the circumstances in order to determine whether it would be reasonable to assess the claimant as using an aid or appliance that has not been prescribed or that they have not been advised to use.

Factors include whether:

The claimant possesses the aid or appliance

The claimant was given specific medical advice about managing their condition, and it is reasonable for them to continue following that advice

The claimant would be advised to use an aid or appliance if they raised it with the appropriate authority such as a GP or occupational therapist (advice may only be given on request). Note: It is recognised that HCPs offering advice as part of the WCA process do not necessarily have specialised knowledge of aids/appliances or of their prescription. The expectation is that HCPs will make a judgement that is based on his/her medical and functional training and awareness.

It is medically reasonable for the claimant to use an aid or appliance

The health condition or disability is likely to be of short duration (Where a disability is likely to resolve in the short term, it is likely that only very simple aids that are very widely available should be considered; it is unlikely that claimants would be offered aids or appliances that require any form of specialised fitting or prescription, or structural alterations to property, would be relevant in this situation. So, if a claimant has sustained a fracture to their ankle, it would be reasonable to consider the use of crutches or a walking stick, as these would commonly be provided following an acute

injury, but anything more complex than these would not be appropriate since the disability will resolve in the short term.)

An aid or appliance is widely available (again, common sense should prevail and HCP's advice should be confined to devices that are recognised and in common use by those with similar disabilities. The HCP will, of course, have no knowledge of actual availability of aids or appliances within the claimant's local area at any given time so will be unable to consider this when offering advice.)

An aid or appliance is affordable in the claimant's circumstances (people are not routinely required to buy equipment where it can be prescribed.) Note: HCPs will not be aware of the claimant's financial situation and are not asked to explore this area. The DM has to consider this aspect of the case but the HCP is not expected to comment here.

The claimant is able to use and store the aid or appliance

The claimant is unable to use an aid or appliance due to their physical or mental health condition (for example they are unable to use a walking stick or manual wheelchair due to a cardiac, respiratory, upper body or mental health condition).

Example 2

Miranda has significantly reduced mobility due to arthritis of the right hip and is on the waiting list for a hip replacement. She uses a walking stick to help with balance, but this does not enable her to walk any further than 200 metres before she experiences pain. She has not been advised to use a wheelchair. The HCP advises that she has no other health problems, and in their opinion based on clinical experience, would be provided with a manual wheelchair if she asked her consultant about this. If she had a wheelchair, she would be able to mobilise over longer distances.

The DM decides that it would be reasonable, having considered all relevant factors, for Miranda to use a manual wheelchair, and that none of the Activity 1 descriptors apply.

Example 3

Gary has problems standing due to a condition which affects his balance. He would normally be helped by the use of a walking stick. However, the HCP advises that due to arthritis of the hands, Gary would have difficulty using a stick because he has reduced grip.

The DM determines that it would not be reasonable to assess Gary taking a walking stick into account.

3.2.1.3 HCP Guidance when considering aids and appliances within the WCA

The following section provides some background information on aids and appliances, and how these are normally prescribed/advised. It also guides HCPs as to the level of information and justification that will be required when addressing the use of aids or appliances within the WCA.

Aids and appliances form an important part of the effective rehabilitation of an individual.

Aids are devices that help performance of a function, i.e. they augment a remaining function. Examples include walking sticks and spectacles.

Appliances are devices that provide or replace a missing function. Examples include artificial limbs, stomas, and wheelchairs.

Claimants may have been advised to use aids or appliances, or indeed had these supplied, following assessment by various clinicians involved in their care. For example, Health Visitors, District Nurses and General Practitioners may provide incontinence products, commodes, and access to laundry services. Occupational Therapists can provide aids to daily living and advice on housing adaptations. The Physiotherapist can advise on appropriate walking aids and appliances. Communication aids can be supplied via a Speech Therapist.

Disability Analysts will see many people using a variety of walking aids. Walking sticks, crutches, tripods, frames and trolleys are often used. Walking aids are used by many people to provide stability because of muscle weakness or poor balance, or to reduce the load on painful or damaged joints. However, though the load to the lower limbs is reduced, the load to the upper limbs is increased. The upper limb joints are not designed for this load, and problems such as synovitis may result especially if there is an inflammatory arthritis.

The Disability Analyst will also see many people using orthoses. Orthoses are externally applied devices that are used to modify the structure or function of the neurological or musculoskeletal system. For example, prescribed footwear, knee braces, and hand/wrist supports are commonly seen in our assessments.

It is becoming increasingly common to see people in wheelchairs within the community. The commonest reasons for the need for a wheelchair are arthritis, cerebrovascular disease, chronic obstructive pulmonary disease, and heart disease. The majority of wheelchair users do not use the wheelchair all the time. Indeed special consideration needs to be given to full-time wheelchair users, with the need for lightweight, highly manoeuvrable wheelchairs. In addition, wheelchairs may need to be easily assembled and taken apart, so the person can get in and out of a car alone.

Some disabled people will need an artificial limb. Prosthetic technology has advanced such that a healthy individual with a mid-calf amputation should be able to participate in a full range of activity, walk without a limp, and engage in sports. Circulatory problems are the main reason for lower limb amputation, although 1/3 of these people have concomitant diabetes. They are usually over 50 years old, and most have additional health problems that limit walking ability.

It must be recognised that specific skills, knowledge, experience and training are required to fully assess individuals for aids and appliances which may ultimately help their function. Additionally, clinicians who assess and prescribe aids and appliances for an individual will normally have access to significantly more information about the individual's situation than HCPs offering advice as part of the WCA process. Therefore, in situations where an aid or appliance has not been recommended or prescribed, HCPs are being asked to use their skills and experience as a disability analyst to offer 'common-sense' advice to the DM in situations where they feel an aid or appliance could improve a claimant's function in terms of an individual WCA Activity.

Although the DM may be required to consider whether an individual claimant could afford to purchase a particular aid/adaptation, this question is beyond the scope of the HCP's role within the WCA process and should not be taken into account when offering advice to the DM.

In terms of a practical approach to the issue of aids and appliances, the following is advised:

1. Remember that the use of aids and appliances should be considered in all the physical activities within the WCA. It should therefore become routine to specifically ask claimants if they have any aids or appliances that they use.
2. Where the claimant states they already use an aid or appliance, find out about any problems they may have with it as well as how it assists them. Assess all the relevant physical activities within the WCA taking into account the aid/appliance and any functional improvement it brings.
3. Where the claimant states they possess an aid or appliance but do not use it, find out why this is so. What problems emerged with the aid/appliance that led them to reject it? Are there any circumstances in which they are able to use it successfully? What would have to change in order to enable them to use the aid/appliance successfully? Are they embarrassed to use it for example (as in Example 1 above where 'Billy' did not want to use the walking stick as he felt it made him look old)? Have they approached the clinician that provided the aid, or their GP perhaps, to report the problems and, if so, is anything being done about it (for example providing an alternative aid/appliance)? Assess all the relevant physical activities within the WCA, considering the claimant's stated reasons for not using the aid/appliance and offering your opinion as to whether it would be reasonable to expect they could use it successfully, based on the information available.
4. Where the claimant does not use an aid/appliance, or has not been prescribed/provided with/advised to use one, consider whether any simple aid or appliance could be used to improve the claimant's function in any of the activities. Take into account the information that has been gathered during the assessment, in terms of other medical conditions and disabilities present which may make it difficult to use an aid/appliance, as well as details about the claimant's accommodation and access to it which may affect the recommendation given.
5. Ensure that the Personalised Summary Statement addresses the issue of aids/appliances where this is relevant. Make it clear when a particular activity has been assessed with/without an aid/appliance, giving justification in terms of the relevant evidence used and the descriptor chosen. This will be particularly relevant, of course, when recommending an aid/appliance that has not previously been used by the claimant, as well as when advising that a claimant's decision not to use a particular aid/appliance seems inconsistent with the available information.
6. Remember that the role of the HCP is to offer advice only: the DM will consider the evidence that is present and will come to their own conclusions as to the use of aids/appliances in each case. Likewise the HCP is only expected to use such evidence as is reasonably available to them when

offering advice: in many cases this will be solely based on the claimant's own account.

7. Finally, remember that issues such as affordability and availability of particular aids/appliances are out with the scope of the HCP role within the WCA assessment and need not be considered when offering advice.

PHYSICAL DESCRIPTORS

Where “reasonable aids” are referred to in each physical descriptor scope – this reflects the guidance in sections 3.2.1.1-3.2.1.3 of this handbook.

(Descriptors in italics and bold reflect a level of disability meeting Support Group inclusion)

3.2.2 Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used – Activity 1

Descriptors

Wa Cannot either

(i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion

or

(ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion

Wb Cannot mount or descend two steps unaided by another person even with the support of a handrail

Wc Cannot either

(i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion

or

(ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion.

Wd Cannot either

(i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion

or

(ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion

We None of the above apply

Note that the wording of this activity has been amended to clarify the use of aids and appliances.

Scope

This activity relates primarily to lower limb function.

It is intended to reflect the level of mobility that a person would need in order to be able to move reasonably within and around an indoor environment.

It is not intended to take into account transport to or from that environment.

The modern working environment should allow for the use of a wheelchair and any other widely available aid and therefore the concept of mobilising within a workplace is considered the critical issue – rather than just the individual's ability to walk around a workplace.

The descriptors should not be confused with the traditional concept of walking (i.e. bipedal locomotion), that is, movement achieved by bearing weight first on one leg and then the other. Those who could reasonably use a wheelchair, crutches or a stick to mobilise distances in excess of 200m (in accordance with the guidelines on use of aids and appliances) would not be awarded any points for their inability to walk.

When estimating the distances over which a claimant can mobilise you should not take account of brief pauses made out of choice rather than necessity. The end point is when the claimant can reasonably proceed no further because of substantial pain, discomfort, fatigue or distress.

Descriptor Wb also reflects a severe limitation of stair climbing. This may be affected by severe lower limb pathology or breathlessness. It should be noted that the descriptor indicates inability to perform this task even if holding on to a handrail(s). Therefore the individual's abilities must be considered within the context of a handrail being present. This activity reflects a test of walking up or down 2 steps, not of whether one hand or two hands is needed for support while doing so. Therefore a person who can manage the two steps with support of two handrails would be considered as capable of performing this activity.

Within the descriptors – the concept of repeatedly and reliably is explicit. If the person could not repeat the activity within a reasonable time then they should be considered incapable of this task. The effects of fatigue must be considered.

In considering the concept of repeatedly, the activity i.e. "mobilising unaided by another person" must be kept in mind. Consider what would be expected of an individual who did not have an impairment of their ability to mobilise. That is, a 'normal' individual would be able to perform this activity within a given time period and repeat that activity again after a reasonable rest period. The duration of the reasonable rest period can then serve as a basis for comparison to gauge the range of what is 'reasonable'.

The ability to mobilise may also be restricted by limitation of exercise tolerance as a result of respiratory or cardiovascular disease. Note any restrictions due to breathlessness or angina, as well as any relevant musculoskeletal problems. The choice of descriptor must be made very carefully. If a particular descriptor activity could only be performed by inducing significant breathlessness or distress, a higher descriptor must be chosen.

Walking may occasionally also be affected by disturbances of balance due, for example, to dizziness or vertigo. The effects of any such condition should be noted and full details given in your medical report.

When considering the issue of **mobility**, the ability to use an appropriate aid, including a manual wheelchair must be **considered in line with the guidance** in sections 3.2.1.1-3.2.1.3 Note: a manual wheelchair would be considered as any wheelchair that is not electrically propelled.

Details of activities of daily living

Consider the claimant's ability in relation to:

- ☐ Mobility around the home
- ☐ Attending appointments
- ☐ Shopping trips
- ☐ Exercising pets
- ☐ Leisure activities

Include details of distances walked/mobilised and how long it takes the claimant to walk any particular distance; whether the claimant needs to stop, and if so how often, and for how long? How often is the activity performed? Does the claimant need a prolonged period of recovery following the activity?

It may be useful to consider average walking speeds in this category. Normal walking speed is 61-90m/min, a slow pace would be around 40-60m/min and a very slow pace less than 40m/min.

The method of travel to the Assessment Centre is relevant. You are likely, from local knowledge, to know the distance from the bus station to the assessment centre. Record the distance, time taken, the number of rests required, and the lengths of the rest periods.

Bear in mind that a person who can easily manage around the house and garden is unlikely to be **severely** limited in their mobility. A person who can mobilise around a shopping centre/supermarket is unlikely to be limited to mobility of less than 200 metres although consideration must be given to the size of shop, speed of walking, stops and pauses etc. Someone who is **only** able to move around within their home is unlikely to manage 50m reliably.

Observed behaviour

Observe the claimant walking from the waiting area to the examination room, and note their gait, pace and any problem with balance. Look for evidence of breathlessness precipitated by walking. If the claimant is in a wheelchair, note the manner and ease with which they propel themselves. **Claimants who are clearly breathless on mobilising within the examination centre require very careful assessment including consideration of whether LCWRA criteria applies.**

Note in general the appearance and use of the upper limbs in relation to their ability to use walking aids/propel a wheelchair.

Note the use of any aids e.g. walking stick, and whether the use was appropriate. Record any assistance needed from another person.

Clinical examination

Restricted ability to walk will commonly be due to disorders affecting the lumbar spine or lower limbs. Restrictions may also be due to disease in the respiratory or cardiovascular systems, with limitation of exercise tolerance as a result of breathlessness, angina, or claudication. The effects of fatigue must also be considered.

Where relevant, an appropriate assessment of the cardiorespiratory system must be carried out, looking for cyanosis, dyspnoea at rest or on minimal exertion, the presence of audible wheeze, signs of heart failure such as pitting dependant oedema, and the state of peripheral blood vessels. Any respiratory or cardiovascular factors affecting exercise tolerance must be taken into account when choosing a descriptor.

Peak flow may be measured, if appropriate, and the recorded measurement interpreted for the DM within the context of the other available information. Comment on technique or effort may be appropriate. A note of whether an EU or Wright Peak flow meter was used should be indicated when recording the peak flow.

Where restriction of walking is apparent, the power/ co-ordination in the upper limbs must be considered. Severe breathlessness and coronary artery disease, for example may also impact on the people's ability to both walk and propel a wheelchair.

3.2.3 Standing and sitting - Activity 2

Descriptors

Sa *Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person*

Sb Cannot, for the majority of the time, remain at a work station, either:

- (i) standing unassisted by another person (even if free to move around) or;
- (ii) sitting (even in an adjustable chair) or
- (iii) a combination of (i) and (ii)

for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion

Sc Cannot, for the majority of the time, remain at a work station, either:

- (i) standing unassisted by another person (even if free to move around) or;
- (ii) sitting (even in an adjustable chair) or
- (iii) a combination of (i) and (ii)

for more than an hour, before needing to move away in order to avoid significant discomfort or exhaustion

Sd None of the above apply

Note that the wording of this activity has been amended to make it clear that descriptors Sb (30 minutes) or Sc (1 hour) can only apply if the person cannot remain at a workstation by **sitting, standing, or a combination of both**, for a specified period, before needing to move away.

Scope

This activity relates to lower limb and back function. It is intended to reflect the need to be able to remain in one place, through either sitting or standing. When standing, a person would not be expected to need to stand absolutely still, but would have freedom to move around at the workstation or shift position whilst standing. Similarly, it is considered reasonable that a person would be able to move around when sitting. The reference to an “adjustable chair” reflects the advances in ergonomics over the years. Those with some difficulty/ discomfort on sitting can often be significantly aided by provision of an adjustable chair. This type of adaptation is likely to be considered a reasonable adjustment under the Equality Act.

Sa “Moving between adjacent seated positions” is intended to reflect a wheelchair user who is unable to transfer, without help, from the wheelchair. It reflects a substantial restriction of function important within the workplace and therefore the inability to transfer without assistance from another person implies the person has LCWRA. In considering their ability to transfer the use of “reasonable aids” such as a transfer board should be taken into account. Use of situation specific aids such as a hoist should not be considered.

In Sb and Sc, the person does not have to stand or sit for the whole 30 or 60 minutes. They can alternate between the two. For example, a person may only be able to sit for 30 minutes, but then stand for 10 or 15 and then sit for another 30 minutes. In this case they would not attract a scoring descriptor as they are able to remain at the workplace for in excess of 60 minutes. N.B. – the person must be able to stand with one hand free to make this effective standing in the workplace, so for example a person who needs 2 crutches to stand would not be considered as “effectively standing”.

Sitting

When considering sitting, the following should be taken into account.

Sitting involves the ability to maintain the position of the trunk without support from another person.

Sitting need not be entirely comfortable. The duration of sitting is limited by the need to move from the chair because the degree of discomfort makes it impossible to continue sitting and therefore any activity being undertaken in a seated position would have to cease.

Inability to remain seated in comfort is only very rarely due to disabilities other than those involving the lumbar spine, hip joints and related musculature. Reported limitations for reasons other than these require thorough exploration and strongly supported evidence. Often, a suitably adjusted chair will overcome many of these issues.

Details of activities of daily living

Consider the claimant's ability in relation to:

- ☐ Watching television (for how long at a time and type of chair)
- ☐ Other leisure or social activities, e.g. listening to the radio, using a computer, sitting in a friend's house, pub or restaurant, cinema, reading, knitting
- ☐ Sitting at meal times (which may involve sitting in an upright chair with no arms)
- ☐ Time spent travelling in cars or buses
- ☐ Holidays including travel on trains, aeroplanes, car journeys, etc

Observed behaviour

Record the claimant's ability to sit without apparent discomfort within the examination centre where this has been observed. Take great care not to give the impression in your report that the observed behaviour is the maximum that can be achieved.

Standing

When considering standing, it should be noted that descriptors Sb & Sc reflect the ability to stand **without the support of another person**. This suggests a very significant level of disability in relation to standing.

Standing can be achieved with the use of "reasonable aids or appliances". When standing, the person must be capable of some activity at the workstation, therefore someone who can only stand with the aid of 2 sticks/crutches would not be considered capable of "standing" in this context as they could not perform any useful function at the workstation. In such a case, their ability to sit must be taken into account as if they are able to remain seated for in excess of 60 minutes, they will not attract a scoring descriptor. You need to think carefully about why the person needs 2 sticks when standing. There needs to be a medical reason for this. Severely arthritic knee or hip joints might cause such a problem, but back pain should not normally do so.

Details of activities of daily living

Relevant activities are:

- ☐ Standing to do household chores such as washing up or cooking
- ☐ Standing at queues in supermarkets or waiting for public transport, standing and waiting when collecting a child from school
- ☐ Standing to watch sporting activities

You should comment on the length of time the claimant stands during any such activities.

Observed behaviour

It is usually only possible to observe the claimant standing for short periods of time but even these are of value in your report, e.g.

"I observed him standing for 3 minutes only during my examination of his spine but he exhibited no distress and this, in conjunction with my clinical examination recorded below, and would not be consistent with his stated inability to stand for less than 30 minutes. He may need to move around to ease spinal discomfort but would not need to sit down." As always, this opinion should be reinforced by typical day examples of standing ability.

Some claimants prefer to stand throughout the interview and this should be suitably recorded.

Transferring

The inability to transfer between one seated position and another suggests significant disability. It reflects those who are wheelchair dependant and unable to transfer independently. Upper limb function may be relevant in this activity. For example, a rehabilitated paraplegic who is able to transfer by use of his upper limbs would not satisfy the transferring descriptor.

Details of activities of daily living

Relevant activities may include:

- ☐ Getting out of chairs or off the bed
- ☐ Getting on and off the toilet unaided, without the assistance of another person.
- ☐ The use of public transport in the absence of a companion
- ☐ The use of an adapted car by a wheelchair dependant person
- ☐ Getting in and out of a car
- ☐ Aids used such as a board or hoist

Observed behaviour

Observe the claimant's ability to rise from sitting and note the type of chair when they are collected from the waiting area. There is a further opportunity to observe this function following the interview. This will provide some information on their likely ability to transfer.

Clinical examination

Restricted ability to sit and stand will commonly be due to disorders affecting the lumbar spine or lower limbs. The level of restriction required for sitting or standing descriptors to apply would suggest that there should be evidence of positive clinical findings in the majority of cases. Evidence of muscle wasting and testing of power in the lower limbs will be important clinical findings.

Neurological examination may be important in some cases to clarify likely level of disability.

Upper limb function may have to be reviewed when considering ability to transfer. A paraplegic who has suffered a complete spinal cord transaction but who has good upper limb power may be able to transfer, however a quadriplegic with an incomplete spinal cord injury who has limited power in both upper and lower limbs may be unable to transfer without assistance.

3.2.4 Reaching - Activity 3

Descriptors

Ra *Cannot raise either arm as if to put something in the top pocket of a coat or jacket*

Rb Cannot raise either arm to top of head as if to put on a hat

Rc Cannot raise either arm above head height as if to reach for something

Rd None of the above apply

Scope

This activity relates to shoulder function and/or elbow function. It is intended to reflect the ability to raise the upper limbs to a level above waist height.

The functional category considers the claimant's ability to reach mainly in an upward direction through movement at the shoulder joint through forward flexion or abduction. The descriptors also reflect internal rotation of the shoulder. It is an evaluation of power, co-ordination and joint mobility in the upper limbs.

It reflects a **bilateral** problem.

Consider only the ability to achieve the described reaching posture and do not measure hand function, i.e. it is not necessary for the claimant to adjust the hat if he/she can achieve the reaching movement defined in Descriptor Rb "Cannot raise either arm to top of head as if to put on a hat".

Details of activities of daily living

Consider details of self-care which involve reaching e.g.:

- ☐ Dressing and undressing (including reaching for clothes on shelves/in wardrobes)
- ☐ Hair washing and brushing
- ☐ Shaving
- ☐ Household activities such as reaching up to shelves; putting shopping away at home; household chores such as dusting; hanging laundry on a washing line
- ☐ Leisure activities such as aerobics, golf, painting and decorating

Observed behaviour

Record any spontaneous movements of the upper limbs, particularly if these are in excess of those elicited by formal examination.

Consider the speed and efficiency of dressing/undressing. Apart from the removal of outdoor clothes there will usually be no direct observation of the claimant dressing or undressing. However, you should look for evidence of protecting a painful shoulder during any observed activity.

The claimant may hang up a coat or a jacket allowing observation of shoulder and upper limb action.

Examination

Ensure that the examination clarifies whether the disability is unilateral or bilateral. If unilateral, state which side is affected and document the normality in the opposite limb. The MSO should identify any requirement for a more focussed regional examination – especially of the shoulder joint if restriction is apparent.

3.2.5 Picking up and moving or transferring by use of the upper body and arms - Activity 4

Descriptors

- Pa ***Cannot pick up and move a 0.5 litre carton full of liquid***
- Pb Cannot pick up and move a one litre carton full of liquid
- Pc Cannot transfer a light but bulky object such as an empty cardboard box
- Pd None of the above apply

Scope

This activity relates mainly to upper limb power; however joint movement and co-ordination may also have to be considered. It is intended to reflect the ability to pick up and transfer articles at waist level, i.e. at a level that requires neither bending down and lifting, nor reaching upwards. It does not include the ability to carry out any activity other than picking up and transferring, i.e. it does not include ability to pour from a carton or jug.

All the loads are light and are therefore unlikely to have much impact on spinal problems. However, due consideration should be given to neck pain and the associated problems arising from cervical disc prolapse and marked cervical spondylitis. These conditions may be aggravated by lifting weights in exceptional circumstances.

Within the descriptors, the concept of adaptation exists. There is no requirement to have two hands to achieve the tasks outlined in the descriptors.

For example in Pc, a person could reasonable manage this by using one hand and supporting the box against another part of their body.

In descriptors Pa and Pb, if the person could move the weight by using both hands together, they should be considered capable of performing the task.

The ability to carry out these functions should be considered with the use of any prosthesis, aid or appliance.

Details of activities of Daily Living

In order to get a measure of what the claimant is able to do consider domestic activities such as:

- ☐ Cooking (lifting and carrying saucepans, crockery)
- ☐ Shopping (lifting goods out of shopping trolley or from the supermarket shelves)
- ☐ Dealing with laundry/carrying the laundry
- ☐ Lifting a pillow
- ☐ Making tea and coffee
- ☐ Removing a pizza from the oven/ carrying a pizza box

Observed behaviour

Watch for hand, arm and head gestures. Note the ease (or otherwise) with which any coat or jacket is removed and replaced.

The claimant may hang up a coat or a jacket allowing observation of shoulder joint and arm action.

The claimant may lift their handbag or shopping bag several times during the interview process.

They may use a hand to open a door.

Where there is a lack of co-operation in carrying out active neck and shoulder movements then informal observations, coupled with examination of the upper limbs, may allow an estimate of the usual mobility of the shoulder girdle. This may well be confirmed by evidence from the typical day.

Examination

Consideration should be given to joint movement and power. Reduced co-ordination or other neurological problems such as tremor may have to be assessed when considering these activities. Ensure that the physical examination clarifies whether the disability is unilateral or bilateral. If unilateral, state which side is affected and document the normality in the opposite limb. The MSO should identify any requirement for a more focussed regional examination if any restriction is apparent.

3.2.6 Manual Dexterity - Activity 5

Descriptors

Ma *Cannot either:*

- (i) press a button, such as a telephone keypad or;*
- (ii) turn the pages of a book*

with either hand

Mb Cannot pick up a £1 coin or equivalent with either hand

Mc Cannot use a pen or pencil to make a meaningful mark

Md Cannot single-handedly use a suitable keyboard or mouse

Me None of the above apply

Since using a keyboard is usually a bimanual activity, the wording of descriptor Md has been amended to reflect the ability to use a keyboard or mouse singlehandedly.

Scope

This activity relates to hand and wrist function. It is intended to reflect the level of ability to manipulate objects that a person would need in order to carry out work-related tasks. Ability to use a pen or pencil is intended to reflect the ability to use a pen or pencil in order to make a purposeful mark such as a cross or a tick. It does not reflect a person's level of literacy. The same concept applies to use of a computer keyboard. When considering the use of a keyboard, ergonomic advances in equipment should be considered.

The actual familiarity with the use of a PC in technical terms is not considered in Md.

An upper tribunal decision (DG v SSWP (ESA) [2014] UKUT 100 (AAC) has clarified that activity 5/M(d) can only apply if a claimant is unable to use both a keyboard and mouse. So if a claimant can use either a keyboard or a mouse with one hand, activity 5/M(d) will not apply.

In the context of activity 5/M(d), only one hand is required to adequately operate a keyboard. The upper tribunal have dismissed claims that use of a keyboard requires the use of both hands.

The HCP must therefore consider carefully if someone who is so impaired as to be unable to use a keyboard can use a suitable mouse and vice versa. In many cases such a severe limitation for one may well mean the other is equally severely limited.

For Example:

If a person can use a mouse with one hand but not a keyboard – activity 5/M(d) does not apply

If a person can use a keyboard with one hand but not a mouse – activity 5/M(d) does not apply

If a person cannot use a mouse or a keyboard with either hand – activity 5/M(d) applies.

The descriptors reflect that those with effective function of one hand have very little restriction of function in the workplace. The descriptor scoring in these areas is weighted quite highly as bilateral restriction of hand function is disabling even in the modern workplace. The ability to turn pages in a book is considered essential in the workplace, therefore a person meeting the criteria in M(a) would be considered to have limited capability for work-related activity.

Details of Activities of daily living

Consider activities such as:

- ☐ Filling in forms (e.g. ESA50/UC50, national lottery ticket)
- ☐ Use of phones, mobile phones, setting house alarms, light switches
- ☐ Paying for things with either cards or cash
- ☐ Coping with buttons, zips, and hooks on clothing
- ☐ Cooking (opening jars and bottles; washing and peeling vegetables)
- ☐ Leisure activities such as reading books and newspapers; doing crosswords; knitting; Do-It-Yourself jobs
- ☐ Driving, including manipulating the fuel cap to refuel a car, using keys to open locks etc.

Observed behaviour

You may have the opportunity to observe how the claimant handles tablet bottles, their expenses sheet or a repeat prescription. You may also observe them lifting objects such as a pen, handling a newspaper/book, handling a mobile phone, drinking from a bottle, etc. Fine movements may be observed if the claimant adjusts their spectacles or their hair, or scratches their head.

They may also adjust their watch or unbutton a shirt cuff for examination.

Examination

In addition to the examination of the upper limbs as subsequently described, always inspect the hands carefully and document any evidence of ingrained dirt or callosities, indicating the possibility of some heavy domestic/manual work at some point in time (but be careful to consider that the callosities may not necessarily represent recent manual work).

Test grip and the ability to perform pincer movements and opposition of the thumb.

Indicate whether the problem is unilateral or bilateral.

Where the problem is unilateral, record which side has the disability and report succinctly on the normality of the "good" limb.

In view of the complexity of a hand/wrist examination provide a simply worded summary particularly if your descriptor choice is at variance with that of the claimed level of disability.

EXAMPLE

Consider the case of a man with mild, bilateral Dupuytren's contracture where the disability claimed is in excess of your descriptor choice. The following summary of your clinical findings would assist the Decision Maker:

"He has thickening of the tissues in the palms of both hands which is beginning to pull the ring and little fingers in towards the palm. However, he retains an effective range of fine finger movements and has unimpaired grip in both hands."

3.2.7 Navigation and maintaining safety, using a guide dog or other aid if either is or both are normally, or could reasonably be, used – Activity 8

Descriptors

- Va Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment
- Vb Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment
- Vc Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment
- V d None of the above apply

The wording of the activity has been amended to reflect the policy intent on the use of aids and appliances relating to all the physical activities and descriptors.

Scope

Please note that as the Navigation activity area has no LCWRA descriptor, **it is important to consider whether those with visual restriction may meet LCWRA criteria in activity 6 or 7 (Communication Activities).**

This activity not only relates to visual acuity (central vision and focus) and visual fields (peripheral vision) but takes into account the person's ability to adapt to their condition. The person's confidence and training must be taken into account.

When considering the descriptors, the HCP must always consider whether any task can be considered in a reasonable, reliable and repeatable manner.

Within the modern workplace, many adaptations can be made to accommodate those with visual impairment.

Within the workplace, the key issue is the individual's ability to navigate and maintain safety in their environment.

The environment must be taken into account. Those who are able to navigate in familiar surroundings (such as their own street) but need the support of another person in an unfamiliar environment, will have a greater level of disability than those who have adapted to navigating in any area, whether familiar or unfamiliar.

The concept of safety awareness and the person's ability to safely negotiate hazards must be considered. This is an important issue in a workplace as provision of a companion throughout the working day to ensure safety may be considered an excessive adaptation for an employer to make.

The clinical history must be considered. The duration and speed of progression of visual loss is likely to impact on an individual's ability to adapt to navigation and safely negotiate hazards. For example, someone who has had sudden complete loss of vision very recently, perhaps as a result of trauma, is less likely to have adapted quickly than someone with congenital visual restriction or a slower progression of visual loss. Other medical conditions may have to be considered to assess the individuals likely ability to adapt – e.g. those with cognitive impairment may have more difficulty adapting to a visual impairment.

The person's ability must be considered in the context of using any aids such as spectacles, a white stick or guide dog they normally use. As a guide dog is not universally available/suitable for every person, the use of a guide dog must only be considered if the person already has a guide dog. The use of GPS devices would not be considered in this area.

The level of visual restriction is likely to impact on the person's ability to navigate. Visual field restriction is also important in maintaining awareness of hazard, but again, the ability to adapt should be considered – e.g. whether they have had formal mobility training to help their safety outdoors.

Any restriction identified must relate primarily to a sensory problem, and not cognitive issues as these are considered elsewhere.

Normal vision is taken as visual acuity of 6/6 at a distance of 6 metres from the Snellen chart. To hold a class 1 driving licence in the UK, acuity of 6/12 on the Snellen chart is required. To have problems in navigation, it would be expected that the person would have a severe level of sight impairment. It is likely the person will be registered as sight impaired or severely sight impaired. A person registered as sight impaired or severely sight impaired will be given a certificate of visual impairment (CVI). These forms vary slightly depending on location:

- A Certificate of Vision Impairment (CVI) is used in England
- A CVI(W) is used in Wales
- A CVI-NI 2007 is used in Northern Ireland

- A BP1 (Certificate of blindness or defective vision) is used in Scotland

If the claimant brings such a certificate with them to the assessment, the HCP must review the information on this and take it into account in their justification. A copy should be made with the claimant's permission for inclusion in the file for the DM. Registration of a person as severely sight impaired or sight impaired is the role of the consultant ophthalmologist. This can be a complex procedure but some examples are provided below.

People with acuity below 3/60 on the Snellen chart would be considered as severely sight impaired. People with acuity of 3/60 but less than 6/60 with significant visual field restriction may also be registered as severely sight impaired. People with acuity of 3/60 to 6/60 with a full visual field may be registered as sight impaired. Those who have a gross contraction of the visual field and vision of 6/18 or even better may also be registered as sight impaired.

More information can be found on:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127399/CVI-Explanatory-notes-in-DH-template.pdf.pdf

<http://www.rcophth.ac.uk>

http://www.rnib.org.uk/livingwithsightloss/registeringsightloss/Pages/register_sight_loss.aspx

It may be useful to consider DVLA driving requirements in relation to functional ability. In order to have a class 2 driving licence in the UK, a full binocular field of vision is required. For a normal class 1 driving licence in the UK, specific standards are also required and, for example, someone with a homonymous hemianopia or bitemporal defect would not be allowed to hold a licence. Further information on driving standards can be obtained on the DVLA website:

<https://www.gov.uk/government/organisations/driver-and-vehicle-licensing-agency>

The LiMA repository contains extensive useful information on assessment of vision and visual fields and may be referred to.

The effect of many blinding eye conditions depends upon lighting levels and glare. This is noted in the CVI where the consultant is asked "Does sight vary markedly in different light levels?" Most eye diseases have a degree of fluctuation in terms of daily living. For example, an individual with severe glaucoma may be tested in a clinic and found to read a few lines on a test chart, but when he/she goes outside on a sunny day, he/she may have greatly reduced vision as what little he/she has is rendered non functional by disabling glare.

Details of Activities of daily living

Consider activities such as:

- ☐ Driving – both from the visual acuity and visual field point of view
- ☐ Ability to get around indoors

- ☐ History of falls or accidents
- ☐ Ability to use public transport - get on and off buses unassisted and read the bus name and number, get on and off correct tram/train
- ☐ Mobilising independently outdoors
- ☐ Going to a supermarket
- ☐ Reading newspapers or magazines
- ☐ Maintaining safety in the kitchen, ability to cook meals
- ☐ Getting in and out of a bath
- ☐ Caring for children

Observed behaviour

Ask the claimant how they got to the assessment centre, and how they found their way around the centre. Note whether the claimant needed to be accompanied by another person.

Note any observed ability to manipulate belts and buttons – inability to do so would indicate very severe sight loss.

Observe whether the claimant manages to read their medication labels or repeat prescription sheet.

Examination

Record the aided binocular vision, and explain the significance of this to the Decision Maker.

If the claimant forgets their spectacles but there is evidence from the typical day activities and behaviour observed that there is no significant disability with vision, then this should be reflected in your descriptor choice. In these cases or in cases where the Visual Acuity is poor but you think it could improve with correction, measure it using a pinhole. Only in exceptional circumstances should a claimant be recalled to have their eyesight tested with spectacles worn.

Near vision should be recorded using a near vision chart. N8 print is the equivalent size of normal newsprint, although the high contrast of a near chart makes it easier to read than newsprint. HCPs should ensure that they use a near vision testing chart with N16 print to accurately assess ability to read 16 point print in a reasonable, reliable and repeatable manner. It should be noted that claimants registered as Severely Sight Impaired/Blind will be unlikely to be able to read 16 point print, even with a low vision aid, and therefore whether they meet criteria for LCWRA in Communication activities should be considered.

HCPs should ensure that they use a near vision testing chart with N16 print to accurately assess ability to read 16 point print. It should be noted that the HCP should assess the ability to read a short sentence on the near vision chart and not just a single word.

Visual field testing

Where there is a history of any visual field problem or where the HCP at assessment feels there may be a visual field problem, visual fields must be tested. However, this is unnecessary when it has been provided in the CVI.

Visual field testing can be a complex procedure requiring sophisticated equipment to aid diagnosis or to assess minor defects in the visual fields.

Minor defects in visual fields will rarely result in significant functional problems. Therefore for the purposes of disability analysis, the traditional method of visual field examination by the “confrontation method” detailed below is adequate to detect gross defects in the visual fields that may be of functional relevance. If the person has a CVI, details of visual field restriction may also be detailed there.

A structured approach for performing visual field testing by the “confrontation method” is outlined below:

- ☐ Ensure you have a piece of card for the claimant to cover up one eye
- ☐ Sit 60cm from the claimant and ask them to look directly into your eyes and keep looking straight at your face
- ☐ Ask the claimant to cover their Right eye with the card provided
- ☐ Check there is no central defect by ensuring they can see your full face
- ☐ Cover your left eye and stretch your right arm (i.e. the arm that is on the same side as the claimant’s uncovered eye) out in a plane equidistant between you and the claimant and at the outermost periphery of your vision
- ☐ Move the index and middle fingers on this hand and confirm the claimant can see your fingers moving and ask the claimant which hand is moving
- ☐ Move your hand to different positions to check the superior, inferior, nasal and temporal fields in order. You may wish to change the fingers being moved to ensure accuracy of response
- ☐ Repeat the process with the claimant covering their left eye, you covering your right eye and moving your left hand

For the purposes of the LCW/LCWRA, you should consider any visual field loss in the context of whether or not it is likely to impact on the person’s ability to safely navigate. This should be considered with visual acuity and the typical day and any information obtained from a CVI brought by the claimant. You must provide the DM with a detailed justification of your choice of descriptor.

3.2.8 Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person – Activity 6

Descriptors

SPa *Cannot convey a simple message, such as the presence of a hazard*

SPb Has significant difficulty conveying a simple message to strangers

SPc Has some difficulty conveying a simple message to strangers

SPd None of the above apply

The wording of this activity has been amended to reflect the DWP policy intent on the use of aids and appliances relating to all the physical activities and descriptors.

This activity relates to ability to express yourself rather than simply speech. It assumes use of the same language as the person with whom communication is being attempted. Where speech is considered, local or regional accents are not taken into consideration.

The scope of the descriptor includes impediment to communication due to physical causes, for example due to expressive dysphasia (inability to express ones thoughts) resulting from brain injury or generalised neurological conditions causing problems with speech and manual dexterity such as Motor Neurone Disease and advanced Parkinson's Disease. In considering expressive dysphasia, the person's ability to write, type or text would also have to be considered.

People who have had a CVA may have both speech and upper limb problems such that they have significant problems with communication through speech or writing.

Speech is an extremely complex activity, involving intellectual, neurological and musculoskeletal components. It may, therefore, be affected by any condition involving these areas. In rare cases, it may be that both psychological and physical factors play a part in the causation of speech difficulties. In every case, alternative methods of communication must be considered. It should be noted that the descriptors in this area infer a reduction in function due to physical limitations.

Occasionally people whose principle diagnosis is Panic Disorder claim that they have difficulty making themselves understood during an episode of acute anxiety. Similarly those with severe Chronic Fatigue Syndrome may claim that speech becomes unclear when they are tired. Consider carefully whether such claimants should be assessed under the Mental Function Assessment. You should consider their ability to make themselves understood most of the time by any means. If problems with communication are purely due to mental health problems, then this would need to be addressed within the mental function activity areas and not in the physical sensory activities.

Some claimants who suffer from breathlessness due to physical causes will describe difficulty with speech. However, in many of these cases, the problem is transitory and only occurs during extra physical effort, for example walking quickly or climbing stairs.

Therefore, for the majority of the time, they will have normal speech. If the claimant is breathless at rest, you should consider advising that they meet LCWRA criteria for mobilising.

The level of communication in the descriptors represents a very basic level of communication and this can be achieved by writing or typing if speech is not possible. The concept of communicating a message such as a hazard is hypothetical and the immediate availability of a PC/Pen and paper to write a message would not be considered. Those with significant communication problems are likely to carry items such as a pen/paper to ensure they can communicate.

Details of activities of daily living

Consider:

- ☐ The ability to socialise with family and friends
- ☐ The ability to ask for items e.g. order drinks at a bar or ask for items in a shop where self –service is not available – do they use speech or do they write a list and hand it over
- ☐ Ability to use public transport/ taxis
- ☐ Ability to use a telephone
- ☐ Ability to use text/e-mail
- ☐ Ability to deal with correspondence, complete ESA50 may give information about written communication

Observed behaviour

Describe the quality of speech at interview and any difficulty you have in understanding the claimant. Note any abnormalities of the mouth and larynx and their effects on speech. Hand function may have to be considered where speech is a significant issue. Upper limb function may have to be assessed to ascertain whether then person could communicate a simple message through the written means.

3.2.9 Understanding Communication by

i) verbal means (such as hearing or lip reading) alone,

ii) non-verbal means (such as reading 16 point print or Braille) alone, or

iii) a combination of i) and ii),

using any aid that is normally, or could reasonably be, used, unaided by another person - Activity 7

Descriptors

Ha ***Cannot understand a simple message due to sensory impairment, such as the location of a fire escape***

- Hb Has significant difficulty understanding a simple message from a stranger due to sensory impairment
- Hc Has some difficulty understanding a simple message from a stranger due to sensory impairment
- Hd None of the above apply

The wording of the activity has therefore been amended to make it clear that they could apply if a person has a hearing impairment alone, a visual impairment alone or a combination of hearing and visual impairment.

Scope

This activity relates to the ability to understand communication sufficiently clearly to be able to comprehend a simple message. It does not relate to being able to follow a complex conversation, the level of communication is basic. It is intended to take into account hearing aids if normally worn, ability to lip read and ability to read large size print or Braille to understand a basic message. It should be noted that when considering a person's ability to understand either a simple verbal or written message, the HCP must carefully consider if this can be achieved in a manner that is **reasonable** and whether the person could **repeat this on a reliable basis**. For example if a person was clearly struggling to read a single word of 16 point print using a magnifying glass, they would not be considered as understanding the written message in a reasonable, reliable or repeatable manner.

It should be noted that in this activity, a person must be able to understand communication through **both** the written and spoken word. A restriction of understanding in either of these communication modalities may result in a scoring descriptor. For example this means a person with normal hearing ability who understands the spoken word without difficulty but has visual impairment to the extent they cannot read 16 point print nor read Braille in a reasonable, reliable or repeatable manner would meet LCWRA criteria in this activity.

Considering Hearing

The methods used to assess the ability to understand communication involve considering a person's ability to hear a shout at one metre and their ability to lip read. The descriptors are intended to take into account hearing aids if normally worn. A "shout" is equivalent to 80dB of noise and therefore inability to hear a shout suggests a significant loss of hearing.

State the claimant's ability to wear a hearing aid. If the claimant has rejected the prescribed hearing aid then state the reason why. Bear in mind that a claimant who has been inconvenienced by a hearing aid and has abandoned it should be assessed without aids.

People with bilateral hearing loss with an average loss of less than 30Db do not usually gain from any form of hearing aid as the small amplification needed creates distortion of sound. Hearing aids function by amplifying sounds, but they cannot help with the processing of sound.

For this reason conductive hearing loss is more likely to be helped with an aid than sensorineural hearing loss.

For the same reason, hearing loss which is evenly distributed throughout the frequencies is more amenable to hearing aid use. Where the hearing loss varies over the frequencies, an aid can create sound distortion and discomfort.

Older claimants can have difficulties adapting to hearing aid use.

The level of lip reading required is very basic as it involves understanding only a simple message and it would be expected that the vast majority of people would meet this level of proficiency in lip reading. It is however important to be mindful that some people may not be able to lip read a simple message, for example those with severe profound pre-lingual deafness who have no experience of the spoken word. Also people with a visual impairment may be unable to lip read as they cannot adequately see the persons face to lip read.

When considering the descriptors, the HCP must comment on lip reading ability which will be apparent from the assessment in most cases and document hearing ability.

Details of activities of daily living

- ☐ Consider any restrictions reported in the typical day with communication such as difficulty socialising, shopping and engaging in hobbies
- ☐ Note the use of any accessory aids such as headphones or loop system amplification for TV, radio, or video; amplification for telephone handset; loud front door bells or door lights
- ☐ Consider their visual abilities, such as reading a newspaper, e-mails, use of the internet, watching TV, using subtitles on the television etc.
- ☐ Consider day to day tasks where contact with other people is likely such as in the supermarket, using public transport etc.

Observed behaviour

The claimant's response to a normal conversational or quiet voice during interview is a good measure of their ability to hear.

Very deaf claimants often fail to respond to their call in the waiting area; bring a companion with them to assist them with communication; or function poorly at the interview requiring you to raise your voice and repeat questions.

A person who relies on lip reading may have problems understanding questions if you are not facing the person directly when you speak to them.

It may be helpful to assess the level of restriction (some vs. significant) by considering whether they understand the main context of questions, just missing an occasional word, or whether their restriction is more significant in that they struggle to follow a conversation.

The person may read/look at their tablets, repeat prescription to give you some information about visual acuity.

Where a BSL (British Sign Language) interpreter is used, it is essential that the HCP assesses the claimant's lip reading ability.

Examination

The most relevant examination technique to assess any restriction in hearing is the **conversational voice test**. One ear is masked with the claimant's hand and the claimant looks away from the HCP. The claimant is asked to repeat numbers or words or answer simple questions which are posed in a normal conversational voice. The furthest distance away from the ear that the words can be heard is recorded.

The normal ear can detect a conversational voice at 9 metres which is impractical in most examination centres. A distance of 3 metres is acceptable proof of hearing for the purposes of reasonable functional hearing ability.

Free field speech testing, also referred to as the Conversational Voice (CV) test will give a rough guide to hearing loss. It requires the person's response to quiet voice, and conversational voice. (Testing by whisper is not recommended). The person being tested should not be able to pick up visual clues, by lip-reading.

The following is a very rough guide to the noise level of speech:

- ☐ It is normal to hear a quiet voice at 60 cms from the ear.
- ☐ Conversational voice not heard over 4 metres – loss approximates to 30dB in both ears.
- ☐ Conversational voice not heard over 3 metres - loss approximates to less than 40dB in both ears.
- ☐ Conversational voice not heard over 2 metres - loss approximates to 50 –53 dB in both ears.
- ☐ Conversational voice not heard over 1 metre - loss approximates to 61-66 dB in both ears.
- ☐ Conversational voice not heard over 30cms – loss approximates to 73-79 dB in both ears.
- ☐ Shout from not beyond 1 metre away- loss approximates to 80dB.

In unilateral hearing loss the normal ear generally compensates for the deaf one, so the overall hearing loss in such a case is unlikely to be significant.

However, checking the hearing in each ear separately and then both ears together provides the opportunity to detect unreliable responses suggestive of non-organic hearing loss.

Tinnitus

Claimants may refer to tinnitus when discussing hearing.

This is the perception of sound where there is no external stimulus. In rare instances, such sound is transmitted from vascular sources such as aortic or carotid murmurs.

Much more commonly, however, tinnitus is non-pulsatile and is linked to high frequency sensorineural deafness, which may be so slight or at such high frequency that it cannot be evaluated in a functional assessment.

The use of hearing aids can, by recruitment of background noises, help to mask tinnitus. Claimants may also have developed their own masking techniques, for example by the use of background music.

Tinnitus maskers may also be prescribed in severe cases.

Severe and/or resistant tinnitus can be very disabling and may result in sleep disturbance, anxiety and depression. The following factors will give indication of disabling tinnitus:

- ☐ Referral to a specialist unit
- ☐ The prescription of maskers/hearing aids
- ☐ The need for night sedation
- ☐ The prescription of anti-depressant medication

Tinnitus on its own is unlikely to cause functional hearing loss, however can significantly impact on concentration therefore consider applying the Mental Function test in cases of tinnitus where there is cognitive impairment or other mental disablement, such as anxiety.

Tinnitus is unlikely to impact to such a degree in itself to amount to substantial problems in understanding simple communication.

Considering Visual Restriction

The main assessment measures **are the ability to read 16 point print using reasonable aids and for those who cannot read 16 point print, an assessment of their ability to read Braille to understand a simple message** in a reasonable, reliable or repeatable manner must be considered. A severe restriction of visual fields, such as a hemianopia, or tunnel vision due to glaucoma will also cause difficulty with reading.

Again, as in hearing, the level of reading 16 point print or Braille is only to a level where a simple message can be understood. The HCP must therefore make specific enquiry into ability to read Braille where restriction of reading print is identified

It should be noted that fewer than 1% of visually impaired people are users of Braille. Of those, a small minority read fluently in Braille. Braille users are usually those who have not been able to see from an early age and have been educated in Braille.

It is worth noting that in the modern world of work, there are new technologies to help people with visual impairment to keep and find employment.

Details of activities of daily living

- ☐ Consider any restrictions reported in the typical day with communication or reading such as difficulty socialising, shopping and engaging in hobbies

- Note the use of any accessory aids such as reading glasses, large print books, magnifying glasses, talking books etc.

Consider their visual abilities, such as reading a newspaper, e-mails, use of the internet, watching TV etc, using subtitles on the television, reading numbers on buses, packaging in supermarkets etc. Consider that the person may indicate they deal with their own medication (or may even read/look at their tablets, repeat prescription at assessment) to give you some information about visual acuity. However, they may know their medication from memory so this should be backed up with formal near vision testing.

- Consider day to day tasks where contact with other people is likely or there is a need to understand the written word such as in the supermarket, using public transport etc. Ask whether they can cope with such situations unaccompanied.
- If the person uses Braille, enquiry should be made about their level of training they have had and what types of material they read in Braille – e.g. newspapers, any forms they complete that are provided in large print/Braille

Observed behaviour

Observation of ability to navigate, read newsprint etc should be recorded.

If a person has combined visual and hearing impairment where a BSL interpreter is used, the HCP should consider whether the claimant uses lip reading in addition to “sign” and how well they can see the sign language being used.

It may be useful to consider level of restriction in the context of how easily a person reads a paragraph in large print (N16) – for example if they struggle with some text but can still manage to understand the main content of the paragraph, vs. a person who struggles to such a degree that they may misunderstand the key concepts in the text.

Examination

Visual acuity both for near and distant vision should be tested, together with visual fields where appropriate, as indicated in section 3.2.7.

Summary

Thus overall, you must make an assessment of a person’s ability in both sensory modalities. Where a restriction is identified in one area, it is likely they will be awarded a scoring descriptor.

The following table may help in considering the level of restriction likely.

Hearing Impairment			Visual Impairment		
Assessment of ability to hear a shout at 1 metre	Outcome (where the person is unable to lip read)	Outcome (where the person is able to lip read)	Assessment of ability to read 16 point print	Outcome (where person is unable to read Braille)	Outcome (where the person is able to read Braille)
Cannot hear a shout at 1 metre	Cannot understand	No difficulty	Cannot read 16 point print	Cannot understand	No difficulty
Significant difficulty hearing a shout at 1m	Significant difficulty understanding	No difficulty	Significant difficulty reading 16 point print	Significant difficulty understanding	No difficulty
Some difficulty hearing a shout at 1 metre	Some difficulty understanding	No difficulty	Some difficulty reading 16 point print	Some difficulty understanding	No difficulty
No difficulty hearing shout at 1 metre	No difficulty understanding	No difficulty	No difficulty reading 16 point print	No difficulty understanding	No difficulty

For example,

A person who has no restriction of hearing but has some restriction of reading 16 point print with no ability to read Braille is likely to attract descriptor Hc.

A person who has some restriction of hearing and struggles to hear a shout at 1 metre but in addition has some reduction of vision who can still read 16 point print in a reasonable, reliable or repeatable manner but struggles with lip reading, may be awarded Hc or Hb depending on the level of their difficulty in understanding the spoken word, despite being able to read 16 point print.

A person who cannot see 16 point print but can read Braille in a reasonable, reliable or repeatable manner and hears normally, would be likely to be awarded Hd.

A person who has normal vision and can easily understand the written word, but who cannot hear at all and is unable to lip read will be likely to be awarded Ha.

A person who has normal hearing but very poor sight to the extent of being unable to read 16 point print in a reasonable, reliable or repeatable manner with no ability to read Braille will be likely to be awarded Ha.

3.2.10 Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bedwetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used – Activity 9

Descriptors

Ca At least once a month experiences

(i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or

(ii) substantial leakage of the contents of a collecting device;

sufficient to require cleaning and a change in clothing

Cb The majority of the time is at risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly

Cc None of the above apply

The wording of the continence activity has been amended to clarify that only problems with incontinence occurring whilst the person is conscious should be taken into account when considering this activity.

Scope

This functional area relates to the ability to maintain continence of bladder or bowel, or prevent leakage from a collecting device.

When considering these descriptors, the review group considered social acceptability and personal dignity to be of paramount importance. Therefore someone who has loss of continence monthly will be considered to have LCW. It should be noted that to be considered as having LCWRA, the loss of control should be weekly. It is therefore essential to ensure the history contains adequate detail to make this distinction.

These descriptors take into consideration loss of continence while the claimant is awake/conscious. Any problems with incontinence that occur during sleep or during episodes of altered consciousness such as during seizures or under influence of alcohol or drug misuse would not fulfil the criteria for these descriptors. Thus for example:

- A person has epilepsy with grand mal fits occurring 1-2 times a month, with complete loss of consciousness and bladder incontinence during the fits – none of the scoring continence descriptors would apply in this case

The descriptors relate to a substantial leakage of urine or faeces – such that there would be a requirement for the person to have to wash and change their clothing. The descriptors do not refer to minor degrees of leakage that could be managed by the use of pads and not necessitate a full change of clothing. If a person is not using pads, this issue should be explored in terms of why they choose not to use pads to allow the Decision Maker to determine whether these would be a reasonable aid.

Urgency, as typically associated with prostatism, will not usually meet the criteria for 'incontinence' or 'loss of control', as it can be controlled by regular voiding. Detrusor instability can cause significant symptoms, however the condition is likely to be controllable with the use of aids and pads in which case the scoring descriptors would not apply.

The policy intent for risk of incontinence – Cb - is that this should only apply if the likelihood of loss of control is very high **for the majority of the time**.

For Example:

- A person has Crohn's disease which is usually well controlled with medication, however he/she has flare ups which occur about once every 6 months, during the flare ups he/she has severe diarrhoea with blood and mucus and has to stay in most of the time to be close to the toilet as he/she can have episodes of bowel incontinence when the diarrhoea is very bad. These flare ups usually last about a week and then gradually settle down. In this case, none of the scoring continence descriptors would apply as the episodes of bowel incontinence are infrequent and would not result in a significant impact on function for most of the time
- Claimants with gastro-intestinal problems such as dumping syndrome should be considered as possibly meeting the criteria for Cb when their problem is unpredictable to the extent that they would become incontinent if they did not leave their work place immediately or within a very short space of time and this is a regular occurrence
- Irritable bowel syndrome can usually be controlled with medication and/or lifestyle changes and is not often associated with such urgency that a scoring descriptor is likely to apply. NICE guidelines indicate that diarrhoea prominent IBS can usually be managed with medication such as loperamide, however, all the evidence such as use of pads and restriction of lifestyle must be considered when providing advice in IBS cases

In every case, the diagnosis history/nature of the condition must be carefully considered and the true risk of loss of control considered on the balance of medical probability and evidence. Medication, specialist input and aids used must be documented.

It should be noted that in 2014, an Upper Tribunal decision determined that mobility issues must be taken into account when considering continence. This applies to both the Activity 9 LCW (Continence descriptors) and the Activity 8 LCWRA descriptor (Continence LCWRA). **Therefore in cases where a continence problem is evident, HCPs must consider the impact of impaired mobility and provide advice accordingly.**

Further guidance on this issue is detailed below.

If a claimant is incontinent because they are unable to reach the toilet quickly enough as a result of mobility issues then they should score against the relevant descriptor. So, for example if a claimant with urge incontinence has to change their clothes at least once a month despite the use of incontinence aids because they are unable to reach the toilet quickly enough as a result of a lower limb / back problem then the HCP should consider advising descriptor C(a).

This Upper Tribunal decision does not impact on how the actual “continence” problem is considered. The key issue is that the HCP must now take into account the impact of impaired mobility and how this impacts on the continence problem.

As before, the claimant must have a medical condition affecting bladder or bowel function in order for the continence activity to be considered.

When considering a claimant with a medical condition affecting bladder/bowel function who in addition has impaired mobility, consider whether their mobility issue is sufficiently severe that their ability to access toilet facilities in a normal working environment, with reasonable adjustments, would be compromised. This assumes that toilet facilities are within a reasonable distance and on the level. If the history given is of continence issues where they have been unable to reach toilet facilities upstairs or a considerable walking distance away then it is not relevant.

Within the history of daily activities you should enquire about adaptations that they might be expected to have made to ensure they are not incontinent. You would also look to demonstrate issues around their ability to rise from a chair and move within the examination centre – if there are none then it seems unlikely that they would suffer continence issues due to mobility restriction within a workplace.

As in all activity areas, careful exploration of the history is required to assess functional limitations and whether there are any reasonable adjustments or aids or appliances that should be considered.

Details of activities of daily living

Consider the frequency and length of any journeys or outings undertaken, together with any problems encountered in undertaking these activities, e.g.:

- ☐ Shopping trips
- ☐ Visits to friends or relatives
- ☐ Other social outings

Observed Behaviour

The claimant may show you pads or extra change of clothing which they carry with them when they go out. The claimant may have to leave the room during the assessment to visit the toilet. Any such information should be documented in the relevant sections of the report.

3.2.11 Consciousness during waking moments - Activity 10

Descriptors

- Fa At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration
- Fb At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration

Fc None of the above apply

Scope

This function covers any involuntary loss or alteration of consciousness resulting in significantly disrupted awareness or concentration occurring during the hours when the claimant is normally awake and which prevents the claimant from safely continuing with any activity. Such events occurring when the claimant is normally asleep should not be taken into consideration. The descriptors relate to the frequency with which such episodes of lost or altered consciousness occur. The working group reviewing the descriptors considered that seizures occurring on less than a monthly basis are unlikely to significantly impact on an individual's ability to work. It should be noted that the descriptors indicate that awareness must be significantly disrupted. This means the nature of the episodes and their effects on function must be explored to see if they fulfil the criterion of the descriptor.

In the context of disability assessments, the most likely causes of episodes of "lost consciousness" are:

- ☐ Generalised seizures (previously referred to as grand mal, tonic clonic and myoclonic seizures)
- ☐ Seizures which are secondary to impairment of cerebral circulation (e.g. as a result of cardiac dysrhythmias)
- ☐ Cardiac arrhythmia

"Altered consciousness" implies that, although the person is not fully unconscious, there is a definite clouding of mental faculties resulting in loss of control of thoughts and actions.

The causes most likely to be encountered are:

- ☐ Partial seizures which may simple or complex partial (previously known as Temporal Lobe epilepsy)
- ☐ Absence seizures which may be typical (petit mal) or atypical

Dissociative disorders, fugues and narcolepsy should be considered. Sleep apnoea is unlikely to meet the criteria for loss of consciousness as the person is in a state of sleep at the time and could be roused by noise or another person.

- ☐ Significant hypoglycaemia where the person requires the intervention of another person to manage the episode

For both lost and altered consciousness, establishing an exact diagnosis is less important than establishing whether or not any disability is present.

Any disability due to side effects of medication taken to control seizures needs to be taken into account. A mental function assessment should be performed if the side effects of medication are sufficient to interfere with cognitive ability or produce other mental disablement.

Giddiness, dizziness, and vertigo, in the absence of an epileptic or similar seizure, do not usually amount to a state of "altered consciousness". These conditions are therefore not taken into account when assessing the functional area of remaining conscious. If they affect functional ability in other categories, they should be taken into account when considering the relevant activity categories.

Migraine

Migraine is classified by the International Headache classification ICDH-2 in terms of "Migraine without aura" and "Migraine with aura". Migraine without aura is the commonest subtype.

The symptoms relating to migraine are wide ranging but do not usually result in a significant loss of consciousness **in most cases**.

One notable exception is Basilar Type Migraine. Basilar type migraine is **a rare condition** associated with aura. The symptoms relate to disruption at the brainstem and /or involvement of both hemispheres at one time without motor weakness. As a result of these headaches, a number of symptoms may occur. These include vertigo, tinnitus, hyperacusis, diplopia, ataxia, a variety of visual symptoms and decreased level of consciousness (ICDH – 2).

Thus in cases where basilar type migraine has **been formally established**, the HCP must carefully take note of symptoms to ascertain whether consciousness is disrupted to the degree described in the descriptors. The HCP must carefully enquire into frequency of episodes and the effect of treatment. (For example, verapamil has been shown to improve symptoms in some cases). Note, it is not the role of the HCP to attempt to diagnose basilar type migraine.

The effect of migraine headache on any other functional category should be assessed in the same way as the effect of any other pain, bearing in mind the frequency and severity of the attacks.

Further information on migraine classification and symptoms can be found at:

http://ihs-classification.org/en/02_klassifikation/02_teil1/01.00.00_migraine.html

Variability

It may be necessary to consider whether a claimant's claimed frequency of seizures is medically reasonable. For example, if there is no corroborative evidence from the GP and the claimant is not on any appropriate medication, this would raise doubts as to a claim of frequent episodes of lost or altered consciousness.

Details of activities of daily living

Consider:

- ☐ Whether the person drives - the DVLA will refuse to issue a licence to anyone who has had a daytime fit in the past year
- ☐ Potentially hazardous domestic activities such as cooking

- ☐ Recreational activities e.g. swimming, contact sports
- ☐ Whether the person has adapted in their lifestyle, e.g. taking a shower instead of a bath, making sure someone is home when they shower/wash, being accompanied when out, avoidance of supervising young children on their own, use of medical alert jewellery or cards, etc

Observed Behaviour

No observations are usually useful for consciousness.

Examination

No formal examination is usually required for problems with consciousness, although a neurological examination may be appropriate and useful in certain situations.

3.3 Examination of the Musculoskeletal System

Introduction

This section deals with the formal clinical examination of the cervical, thoracic and lumbar spine, and the upper and lower limbs, in the context of the medical assessment for functional disability assessment.

The back and lower limbs are relevant to the functional areas of:

- ☐ Walking and managing to negotiate steps
- ☐ Standing and sitting and transferring

The cervical spine and upper limbs are relevant to the functional areas of:

- ☐ Reaching
- ☐ Picking up and moving
- ☐ Manual dexterity
- ☐ It may be relevant in the ability to transfer from a seated position and to use a manual wheelchair/other aids

General Principles of Examination

Remember that the clinical examination is only part of a disability assessment; clinical findings together with the interview and observation of the claimant build up a picture of objective evidence to support your choice of a descriptor, especially if your choice is different from that of the claimant.

Use of an unfocussed full top-to-toe examination without observations or a functional history will create an imbalanced report with weak justification for descriptor choices and also lead to unnecessary examination of the claimant. A Musculoskeletal Overview is the examination of choice in most cases - full details at Section 3.1.4

It is essential to explain to the claimant the nature of the examination to be performed and explain that this examination is designed to look at general function of the musculoskeletal system. The Claimant will find the Musculoskeletal Overview very different from any routine examination undertaken by his GP and an explanation at the outset is valuable.

The MSO is intended to demonstrate normality. If an abnormal finding is identified then a more detailed regional examination is likely to be required. If so, it is essential to avoid undue discomfort to the claimant.

- ☐ Ask the claimant to indicate the site of the pain before palpating
- ☐ Observe active movements only, instructing the claimant not to perform or continue a movement if it becomes painful

There should be no reason to assess passive joint movements as part of the WCA as the examination being performed is based on function.

When examining the limbs, always examine the whole limb and not just the joint involved. If a unilateral problem is present, always compare the affected limb with the normal one.

Remember to record the findings in language that the Decision Maker will easily understand, i.e. do not use medical jargon and explain any medical terms used.

The examination should follow the standard clinical pattern of inspection, palpation, joint movements, muscle power, sensation and reflexes – if appropriate. The following notes should be read in conjunction with any appropriate DWP approved examination protocol.

Inspection

Observe any lack of symmetry and any evidence of trauma or disease. Look for muscle wasting; when assessing the cervical spine and upper limbs, look also for any evidence of muscle wasting of the scapular muscles. Inspect the joint contours and observe any evidence of swelling, deformity or inflammation.

Ask the claimant to point to, or otherwise identify, any painful areas, including sites of radiation of pain.

For accurate assessment of muscle wasting in the upper limbs, compare the circumference of the two limbs as follows:

Upper arm:	15cm above the lateral epicondyle
Forearm:	10cm below the lateral epicondyle

For the lower limb, the corresponding measurements are:

Thigh:	15cm above knee joint (most easily measured from medial joint space)
Calf:	15cm below knee joint

Palpation

Ask the claimant to identify any tender sites or areas of hypersensitivity, and obtain consent, before palpating. Palpate joints for any thickening, tenderness, or crepitus of the joints or tendon sheaths if appropriate.

Joint Movements

See below for details of the normal ranges of joint movement and the appropriate methods of assessing these.

Bear in mind that a claimant may purposefully or as a result of fear limit the range of active movement at a joint.

Muscle Power

Compare the muscle strength in the affected and normal limb. When assessing muscle strength in the upper limbs, a comparison can also be made with your muscle strength, bearing in mind any expected differences due to a difference in age or gender between yourself and the claimant.

Sensation

In disorders of the musculoskeletal system, remember that lost or altered sensation will almost always follow a dermatome pattern. Never use a pin or similar sharp object when testing sensation. Test for light touch using a fingertip, a wisp of cotton wool, or a paper clip.

Reflexes

Remember that the joint you are testing must be in a relaxed position. In the upper limbs, the biceps and triceps reflexes are assessed with the elbow flexed to 90 degrees. In the lower limbs, the easiest way of assessing the knee reflex is with the claimant lying on the couch, knees slightly flexed and supported on your forearm. The easiest way to assess the ankle reflex is to ask the claimant to sit on the edge of the couch with their legs hanging down.

Inappropriate Signs

Remember that psychological factors may influence the clinical picture presented by the claimant. The claimant's behaviour, whether consciously or unconsciously, may yield inappropriate physical signs and thus complicate the interpretation of physical signs. Behaviour by the claimant which is subconscious should not be construed as a deliberate attempt to deceive or be obstructive.

However, there may be instances where a claimant appears to be deliberately refusing to co-operate or may be consciously seeking to exaggerate the extent of their disability.

Signs which are inconsistent with purely organic pathology include:

- ☐ Apparent muscle weakness without wasting or disturbance of reflexes
- ☐ Regional sensory loss which does not follow any recognised dermatome when testing for nerve root compression

- ☐ Overreaction to examination
- ☐ Diffuse rather than localised tenderness
- ☐ SLR reduced on active testing, but the claimant is able to sit up on the couch with knees extended
- ☐ Jerky active movements
- ☐ Refusal to co-operate with active movements of a joint, or lack of any serious attempt to move a joint, or voluntary resistance of passive movements.

If your assessment is that the examination findings are not consistent with the stated degree of functional disability, or that the claimant was deliberately not fully co-operating with the examination, this should be clearly indicated to the Decision Maker

Negative or normal clinical findings can also be used to justify your choice of descriptor, e.g.:

"The lower spine and legs are clinically normal and this is not consistent with the reported inability to sit for more than 30 minutes."

Normal Range of Joint Movements

Note: Where movements are quoted in degrees, zero is taken as the normal anatomical position of rest.

Lumbar Spine

The movements to be considered here are:

- ☐ Forward flexion
- ☐ Extension
- ☐ Lateral flexion
- ☐ Rotation

For the purposes of functional assessment, the fingertip to floor distance gives a reasonable assessment of forward flexion; a person with no back problems should get to within 30cm (12") of the floor.

Extension can normally be accomplished to 30 degrees from the vertical.

Restriction of lateral flexion is unlikely to result in significant functional restriction and should not routinely be performed.

Rotation measures the relationship between the plane of the shoulders and that of the pelvis. Normally 40 degrees can be achieved. This mainly reflects function of the thoracic spine, with only a small amount from the lumbar spine.

Remember that it is clinically unlikely for spinal movement to be limited in all directions.

Straight leg raising (SLR) is tested with the claimant lying on the couch, and asking the claimant to raise each leg in turn from the couch as far as can be achieved without pain. Limited straight leg raising may indicate sciatic nerve root pressure, resulting in pain when the nerve is stretched. Dorsiflexion of the ankle will worsen the discomfort; plantarflexion will lessen it. This can be assessed by asking the claimant to flex their ankle while the leg is raised. An appropriate reaction to plantar/dorsiflexion will help to exclude any apparent inconsistency.

An alternative way of testing sciatic nerve stretch is to ask the claimant to slump forward in a chair with both legs extended. This manoeuvre stretches the nerve and consistency can again be checked by asking the claimant to plantar/dorsiflex the ankles.

It should be noted that straight leg raising must be assessed only from a supine position on the examination couch and not from a seated position as research suggests results from straight leg raising performed in a sitting position may be unreliable in terms of identifying sciatic nerve irritation.

Lower Limb

Hip, knee and ankle movements are tested with the claimant lying on the couch.

For the **hip**, flexion, extension, abduction, adduction, internal and external rotation are assessed. The normal ranges are:

- ☐ Flexion $\geq 130^\circ$
- ☐ Extension 10°
- ☐ Abduction 50°
- ☐ Adduction 25°
- ☐ External rotation $\geq 45^\circ$
- ☐ Internal rotation 45°

External and internal rotation are most easily measured with the hip and knee flexed to 90° , and the lower leg used as a "pointer" to determine the angle.

In the **knee joint**, flexion and extension are assessed:

- ☐ Flexion $\geq 120^\circ$
- ☐ Extension - full

For the **ankle joint**, plantarflexion and dorsiflexion are assessed:

- ☐ Plantarflexion $\geq 50^\circ$
- ☐ Dorsiflexion $\geq 20^\circ$

For the **hallux**, plantarflexion and dorsiflexion are assessed:

- ☐ Plantarflexion $\geq 60^\circ$
- ☐ Dorsiflexion $\geq 40^\circ$

Cervical Spine

Cervical pain can be referred to the shoulders and scapular regions and cause impaired function in the upper limbs. For this reason no examination of the neck is complete without a check of the shoulders and a basic neurological check of the upper limbs.

Examination of the cervical spine can be carried out with the claimant either standing or sitting. The movements to be assessed are flexion, extension, lateral flexion and rotation.

Lateral flexion is measured by asking the claimant to bend the neck to either side, rotation is measured by asking the claimant to turn the head to either side, whilst keeping the shoulders still.

The normal ranges of movement are:

- ☐ Forward flexion (Chin to chest) – no gap
- ☐ Extension $\geq 80^\circ$
- ☐ Lateral flexion (ear to shoulder) - Full
- ☐ Rotation $\geq 80^\circ$

Upper Limbs

Assessment of upper limb movements can be made with the claimant standing or sitting.

Shoulder movements are flexion and extension, abduction and adduction, and internal and external rotation. The following sequence can be used to show shoulder movements: clasp hands at full reach above the head to show abduction; touch fingers at back of neck to show abduction and external rotation; reach up the back with fingers to show adduction and internal rotation.

The normal ranges of shoulder joint movement are:

- ☐ Forward flexion 160°
- ☐ Extension 40°
- ☐ Abduction $\geq 170^\circ$
- ☐ Adduction 40°
- ☐ External rotation $\geq 70^\circ$

- ☐ Internal rotation 95°

Elbow movements include flexion and extension, pronation and supination. For the latter two movements, the neutral position is with the elbow flexed to 90 degrees, with the thumb uppermost.

The normal ranges of movement are:

- ☐ Flexion $\geq 130^\circ$
- ☐ Extension Full
- ☐ Pronation (palm downwards) 70 - 80°
- ☐ Supination (palm upwards) 60 - 65°.

Wrist: The neutral position for the wrist is with the palm down and the hand in line with the forearm. The movements to be assessed are dorsiflexion, palmar flexion, radial and ulnar deviation. The normal ranges are:

- ☐ Dorsiflexion $\geq 30^\circ$
- ☐ Palmarflexion $\geq 30^\circ$
- ☐ Radial deviation 20°
- ☐ Ulnar deviation 45°

Hands: The neutral position for the hand is with the fingers in extension and the thumb alongside the index finger. The normal ranges of movement are:

- ☐ Adduction/abduction between each finger 20°
- ☐ Flexion at proximal interphalangeal joint 100°
- ☐ Flexion at distal interphalangeal (DIP) joint 80°
- ☐ Extension at DIP joint 10°
- ☐ Flexion at metacarpophalangeal(MCP) joint 90°
- ☐ Extension at MCP joint 45°

For the **thumb** the ranges are:

- ☐ Abduction 60°
- ☐ Flexion at IP joint 80°

- ☐ Flexion at MCP joint 50°
- ☐ Flexion at carpometacarpal joint 15°

In addition, assessment of hand function should also include a test of grip strength and the ability to oppose the thumb across the palm of the hand towards the little finger, and to touch the thumb to each fingertip.

3.4 Guidance on Specific Conditions (physical)

The reader is referred to the CHDA Evidence Based Protocols. The full protocols for these and other medical conditions can be found on the CD ROM – Evidence Based Protocols for the Disability Analyst. You must obtain a copy of this CD from your local unit if you do not already have a copy.

The guidelines contain key points about the aetiology, diagnosis, treatment, prognosis, and main disabling features of a number of medical conditions that are most commonly encountered in the field of Disability Assessment Medicine and some conditions that may present challenges in the assessment of disability.

There is also extensive information on a variety of medical conditions available for reference through the LiMA application, on the LiMA repository and on SharePoint.

3.5 The Mental Function Assessment – Mental Functional Activity Categories

3.5.1 Introduction

Mental Health conditions can result in significant functional restriction for many individuals and the assessment of those with problems can be challenging. The presence of a mental health problem may be obvious from ESA50/UC50/medication/Med 3 details, etc, but may not always be immediately apparent. The HCP must consider in all cases whether there may be evidence of any mental function problem. They should be mindful that those with physical problems may also have subsequent mental health issues and careful and detailed exploration of these issues must be a part of any assessment. Some people will be reluctant to disclose mental health issues due to fear, embarrassment etc and HCPs must use all their communication skills to ensure they obtain all relevant information possible to ensure the claimant's true level of function is accurately reflected. The HCP must have a high level of suspicion about the presence of any mental function issue and must carefully explore mental health symptoms that may not be overtly "provided" by the claimant.

Therefore the mental function assessment should be applied in all cases where a specific mental disease or disability affecting mental function has been diagnosed or when there is a condition, whether mental, physical or sensory, resulting in apparent impairment of cognitive or intellectual function.

This definition would include the following circumstances:

- ☐ Where the claimant is taking any medication which impairs cognitive function to a degree that causes impairment of mental function

- ☐ Where there is evidence of an alcohol/drug dependency problem which has resulted in impairment of mental function
- ☐ Where there is evidence of a physical or sensory disability such as tinnitus or Chronic Fatigue that may impact on mental function
- ☐ Where there is evidence of learning disability or cognitive impairment
- ☐ Where there is a previously unidentified mild or moderate mental function problem identified during the LCW/LCWRA assessment

In LiMA the Mental Function descriptors must always be considered in the same way as the physical descriptors are considered.

When completing the clerical ESA85/UC85, if you choose not to apply the mental function assessment, you must justify your action to the DM. Examples of justification that may be used may include:

- ☐ There is no evidence from the assessment today of any condition diagnosed or apparent that is likely to impair mental functional ability. The claimant is not on any medication likely to impair mental function
- ☐ The claimant is on no medication for mental function problems nor is he/she receiving any support from any Health Care Practitioner for mental function problems

It is essential that a Mental State Examination is completed in each case where the mental function assessment is applied. It may be useful practice to complete a mental state examination in cases where the claimant indicates they are “depressed” but at assessment there is no evidence of functional limitation - (see section 3.7 for the mental state examination).

Self harm and suicidal tendency should be explored in the history and mental state examination. It is not enough to just indicate “no self harm tendency” in the mental state examination findings without ensuring that this would have already been addressed within the condition history or typical day. Where self harm/suicidal tendency is present, then more details to explore any plans or intent or any previous attempts/behaviour should be documented. This will allow the appropriate well justified advice on LCWRA / descriptor choice / non functional descriptor to be given.

There are seven mental function categories to be addressed in the LCW/LCWRA medical assessment.

These categories cover a number of areas relevant to those with a specific mental illness, or cognitive or intellectual impairment of mental function.

These categories cover:

- ☐ Understanding and focus (activities 11, 12, and 13)
- ☐ Adapting to change (activities 14 and 15)
- ☐ Social Interaction (activities 16 and 17)

For each functional category you must choose a descriptor, then provide all the necessary evidence in the Personalised Summary Statement which will make clear to the Decision Maker the facts on which your choice is based. If your choice of descriptor differs from the level of function indicated by the claimant, the Decision Maker needs to understand clearly why your opinion is appropriate and the claimant's is not.

This section looks in detail at each functional category and at the policy intent of the descriptors. It gives advice on the specific points in the typical day and Mental State Examination which are relevant to the particular functional category, and which can be used to justify your choice of descriptor in that category.

Remember also to take into account the effects of variability, etc. These have been fully detailed in the section on completion of the LCW/LCWRA, and are not repeated here, but an appropriate entry must always be made.

Remember that in some instances it can be appropriate to cross-reference data relating to variability etc, and to clinical examination findings, but data relating to the typical day and Mental State Examination are "function - specific".

When considering the Mental Function descriptors, some of the higher ranking descriptors reflect a very severe level of functional restriction. If choosing such descriptors you must always consider whether LCWRA advice may be appropriate.

In each of the activities, some examples of conditions where the descriptors may apply are given. These are for guidance only and the HCP must ensure that the assessment must reflect the person's function regardless of the actual diagnosis.

MENTAL FUNCTION ACTIVITY OUTCOME DESCRIPTORS

3.5.2 Learning tasks – (Understanding and focus) - Activity 11

Descriptors

LTa *Cannot learn how to complete a simple task, such as setting an alarm clock*

LTb Cannot learn anything beyond a simple task, such as setting an alarm clock

LTc Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes

LT d None of the above apply

Scope

This activity reflects the ability to learn a task. “Learning” assesses the ability to learn and retain information. The method that people learn by is not relevant - what is important is the ability to learn to do a task. It is therefore of no relevance whether a person learns a task by watching a visual demonstration, learns by reading or through verbal instruction. Within the workplace, the ability to learn tasks is vital. If the person needs to be shown how to do a task again, they have not learned it.

This activity may be relevant to conditions including learning disability and organic brain disorders including acquired brain injury or stroke. People with severe and profound learning disability are unlikely to be able to learn how to complete a simple task and people with moderate learning disability are unlikely to be able to complete a moderately complex task.

It also may reflect difficulties in understanding language, such as receptive dysphasia.

Issues to consider

- ☐ The length of time taken to learn a task and the ability to retain the information must be taken into account
- ☐ If a person learns a task on one day but is unable to repeat it the next day, they have not learned this task
- ☐ If a person takes a very long time to learn a task, for example takes 2 years to learn how to wash and dress themselves, this would not be considered reasonable and that person would not be considered to have the ability to learn this task. The inability to learn a very simple task represents a very high level of disability such that they would also be considered to have limited capability for work-related activity
- ☐ A simple task may only involve one or two steps while a moderately complex task may involve 3 or 4 steps

Details of activities of daily living

Consider basic functions of personal care and leisure activities.

Simple tasks may include:

- ☐ Brushing teeth. This would involve remembering to put toothpaste onto a brush and brushing all areas of teeth
- ☐ Washing. This would involve the ability to use soap/shower gel and wash their body
- ☐ Brushing hair
- ☐ Turning on the television/ using basic functions on the TV remote control
- ☐ Getting a glass of water

Moderately complex tasks may include:

- ☐ Using a microwave oven
- ☐ Making a cup of tea including filling kettle, putting tea bags in teapot, pouring into cup and adding milk and sugar
- ☐ Playing CDs on a stereo
- ☐ Using a games console (at a fairly basic level)
- ☐ Using a computer for basic activities such as playing a game

More complex tasks should also be considered such as driving should be detailed and any previous tasks learned in training and employment should be considered.

Careful enquiry must be made during the history to ascertain the individual's true capacity to learn tasks. For example, using a mobile phone may be considered to be a moderately complex task if the person can text, set up speed dials, change ring tones etc, however, if a person can only use the phone in a limited way to dial a number pre-set by a carer, this may be considered a simple task. Similarly use of a television/ remote control etc must be carefully considered. If the person has simply learned to use the "on" button on the TV control and digital box, this does not necessarily mean they have an ability to learn very complex tasks. Enquiry should be made into what other things they can do. If someone can set up a TV/DVD player, programme channels, rearrange leads at the back of the TV, it suggests a much greater capacity to learn more complex tasks.

Mental State Examination

Relevant findings may be general memory and concentration, general decision making ability at assessment, their ability to cope at interview, general intelligence and requirement for prompting. It may be appropriate when considering this functional area to consider and document more specific tests of memory and concentration.

3.5.3 Awareness of everyday hazards (such as boiling water or sharp objects) – (Understanding and focus) - Activity 12

Descriptors

AHa *Reduced awareness of everyday hazards leads to a significant risk of:*

- (i) injury to self or others; or*
- (ii) damage to property or possessions,*

such that they require supervision for the majority of the time to maintain safety

AHb Reduced awareness of everyday hazards leads to a significant risk of:

- (i) injury to self or others; or
- (ii) damage to property or possessions,

such that they frequently require supervision to maintain safety

AHc Reduced awareness of everyday hazards leads to a significant risk of:

- (i) injury to self or others; or
- (ii) damage to property or possessions,

such that they occasionally require supervision to maintain safety

AHd None of the above apply

Scope

This activity is intended to reflect the ability to recognise risks from common hazards that may be encountered by people with reduced awareness of danger through learning difficulties, or conditions affecting concentration, including detrimental effects of medication; or from brain injury or other neurological conditions affecting self awareness. It may also apply to people with severe depressive illness and psychotic disorders as a result of a significant reduction in attention and concentration, but is unlikely to apply to people with anxiety disorders.

Issues to consider

- ☐ The activity reflects a lack of understanding and insight that something is dangerous or that there is an impaired ability to recognise that a situation will present a potential hazard. For example a person with dementia may lack the insight to recognise why it may be dangerous for them to cook - they lack the ability to recognise that they are at risk of forgetting that the cooker is on.
- ☐ The descriptors do not reflect simple accidents that may occur through lapses in concentration/distraction such as cutting a finger when chopping vegetables when the phone goes. If a person knows that there is a risk and therefore avoids the situation, they would not score in this category. There must be evidence that they do

not realise there is a risk.

- ☐ The level of severity of the descriptors reflects the amount of supervision that would be required to ensure the safety of the person and others.
- ☐ The “majority of the time” would represent a need for “daily” supervision. “Frequently” would represent “several times a week”.
- ☐ As substantial supervision in the workplace may pose problems, the level of supervision required has been taken into consideration when determining the LCW threshold. Thus those who require supervision for the majority of the time should be considered for advice on LCWRA.
- ☐ If AHb is suggested, the HCP must consider whether the issues presented may present “risk” to the safety of the person or others and they must carefully consider whether the “substantial risk” NFD is appropriate.

Details of activities of daily living

When considering this functional category details you should ask about ability to cope with potential hazards. These may include:

- ☐ Ability to cope with road safety awareness
- ☐ How they manage if they live alone
- ☐ Driving
- ☐ Ability in the kitchen
- ☐ Awareness of electrical safety
- ☐ Responsibility for children/pets

It may be useful to consider the concept of whether the person could be safely left alone to manage basic daily life when you consider this functional category.

Mental State Examination

Cognitive issues will be important in assessing this issue.

Insight will also be an important factor. You should consider whether the claimant has adequate insight into their problems to recognise the risks present and therefore whether they are able to avoid potential hazardous situations.

3.5.4 Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks) - (Understanding and Focus) – Activity 13

Descriptors

IAa Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions

- IAb Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time
- IAc Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions
- IAd None of the above apply

Scope

This activity reflects the ability to **initiate and successfully complete tasks** without need for external prompting. This activity represents a significant restriction of an individual's ability to understand how to co-ordinate actions in the correct sequence such that they successfully complete any personal actions in a logical order for example washing before dressing.

It is intended to reflect difficulties that may be encountered by people with conditions **such as** psychosis, OCD, autism and learning disability. A very severe depressive illness that results in apathy, or abnormal levels of mental fatigue, may result in problems in this area. It may be compounded by the effects of medication.

Issues to consider

- ☐ The intention of the activity is to assess whether a person has the capability to carry out routine day to day activities or activities that may normally be associated with work. The concept of 2 sequential tasks could include opening a tin of soup, and heating it up before putting it into a bowl to eat.
- ☐ The issue of whether a person can repeatedly and reliably complete tasks must also be considered.
- ☐ There must be evidence of "effective" personal action. For example, someone with OCD may initiate many actions, but due to rituals they may not actually be able to complete them and therefore should be considered not capable of personal action. Similarly, if a person perhaps with bipolar illness manages to wash and dress but then goes out and spends all their money on non essential activities, giving no consideration to issues such as bills, rent, food etc, they would not be considered to be initiating effective personal action.

"Personal action" may include:

- ☐ ability to plan and organise a simple meal
- ☐ ability to get up, washed, dressed and ready for work in the morning (including choosing appropriate clothing)
- ☐ ability to cope with simple household tasks e.g. sorting laundry and using a washing machine
- ☐ dealing with finances
- ☐ arranging GP appointments, picking up prescriptions, taking medication

Details of activities of daily living

Areas to consider should include any behaviour that involves a decision to plan or organise a personal action to enable them to perform it.

Activities may include:

- ☐ Making travel arrangements
- ☐ Writing shopping lists
- ☐ Organising finances
- ☐ Planning a simple meal
- ☐ Getting washed and dressed (including choosing appropriate clothing)
- ☐ Ironing clothes for the next day
- ☐ Caring for children: preparing clothing, lunches etc.

Mental State Examination

General memory and concentration will be important areas to consider. Intelligence and severity of depression should be considered. It would be expected that the Mental State Examination findings should be consistent with significant impairment of mental function if choosing a descriptor in this functional category. Where depression is present, evidence of psychomotor retardation would be likely if these descriptors were applicable.

3.5.5 Coping with change - (Adapting to change) – Activity 14

Descriptors

CCa *Cannot cope with any change to the extent that day to day life cannot be managed*

CCb Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult

CCc Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult

CCd None of the above apply

Scope

This activity reflects the flexibility needed to cope with changes in normal routine. It is intended to include difficulties that may be encountered by people with moderate/severe learning disability, autistic spectrum disorder, brain injury, OCD,

severe anxiety or psychotic illness. It is not intended to reflect simple dislike of changes to routine, but rather the inability to cope with them. The permanence of the change is not relevant to the descriptors.

Issues to consider

- ☐ This activity reflects a significant level of disability where small changes result in the individual's day to day life being significantly affected i.e. day to day life is made significantly more difficult or cannot be managed.
- ☐ The highest descriptor represents a level such that a change to routine would mean that life would stop for everyone involved and basic activities could not continue.
- ☐ More specific short lived episodes such as leaving the supermarket as it is too crowded would not be considered if this was the only change to their planned day. Similarly a person who has a panic attack but manages to do most usual tasks in a day after the episode of panic would not attract a scoring descriptor in this area.
- ☐ It is important to obtain examples of when change occurred and what happened to the person when this occurred.

Activities of daily living

In this functional area you should consider the person's ability to cope in situations where some change is possible. Areas to consider may include:

- ☐ Use of public transport
- ☐ Shopping
- ☐ Dealing with appointments at hospital, GP or Jobcentre Plus
- ☐ Coping with children and their out of school activities

It may be useful to consider some of these activities in terms of the level of disability intended, for example:

- ☐ A claimant with a severe form of mental disablement who may become so distressed by the supermarket being out of stock of their usual brand of breakfast cereal that they cannot continue with other activities or complete the rest of their shopping.
- ☐ A claimant who would be unable to cope with the train being cancelled and would return home rather than wait for the next train.

Mental State Examination

It is expected that the Mental State Examination findings would be consistent with the type of conditions this descriptor is intended to reflect. They may have poor rapport and be extremely anxious at interview.

It may be that they have been completely unable to attend the AC for assessment. It would seem unlikely that a claimant who manages to attend the AC alone and coped with the assessment would meet the level of severity of functional restriction for

anything other than CCd to apply, although all the evidence should be taken into account.

3.5.6 Getting About - (Adapting to change) – Activity 15

Descriptors

- GAa Cannot get to any place outside the claimant's home with which the claimant is familiar
- GAb Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person
- GAc Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person
- GAd None of the above apply

The wording has been amended to reflect the inability to get to most places rather than a single specified place.

Scope

This activity is intended to reflect inability to travel without support from another person, as a result of disorientation; or of agoraphobia causing fear of travelling unaccompanied by another person. People with a learning disability may have significant problems in this activity. The highest descriptor represents a complete inability to leave the home.

Issues to consider

- ☐ When considering this activity, the means that the person arrives at their destination is not considered. For example, individuals who are unable to use public transport but are able to arrive at their destination by other means will not score on this activity.
- ☐ The descriptors do not reflect lesser degrees of anxiety about going out. Nor do they reflect planning and timekeeping.
- ☐ For people with anxiety, panic disorder and agoraphobia there should be supporting evidence that corroborates the severity of the condition, for example, level of medication / psychiatric input.
- ☐ Specified places with which the claimant is familiar would be locations in their local area such as the GP surgery, dentist, bank, post office, local shops etc. If a person simply avoids the large supermarket in the town but manages to go to other local shops etc, they would not score in this area.
- ☐ A person who has been unable to leave the confines of their own village for many years may attract GAc.

Activities of daily living

General level of function should be considered in this category with regard to level of anxiety and ability to leave the house. Activities to consider may be:

- ☐ Shopping
- ☐ Attending the chemist
- ☐ Attending hospital or GP appointments
- ☐ Walking the dog
- ☐ Supervising children outdoors
- ☐ General safety awareness and abilities in kitchen may support significant cognitive disruption resulting in safety issues if going out unaccompanied

Mental State Examination

Intelligence and cognitive function must be carefully considered. It would be expected that evidence of severe anxiety would be apparent to support the level of functional restriction in this area. Lesser degrees of anxiety would not fulfil the criteria.

The descriptors reflect true panic disorder or severe agoraphobia.

3.5.7 Coping with social engagement due to cognitive impairment or mental disorder - (Social Interaction) – Activity 16

Descriptors

CSa *Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual*

CSb Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual

CSc Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual

CSd None of the above apply

Scope

This activity is intended to reflect a significant lack of self-confidence in face-to-face social situations that is greater in its nature and its functional effects than mere shyness or reticence. Clarifications from the DWP confirm that the ability to interact must be in person rather than through any “virtual face to face interaction” such as Skype. Those with significant anxiety, autism, personality disorder, psychosis or learning disability may have problems in this area.

It reflects levels of anxiety that are much more severe than fleeting moments of anxiety such as any person might experience from time to time.

Issues to consider

- ☐ The level of anxiety referred to suggests a specific and overwhelming experience of fear, resulting in physical symptoms or a racing pulse, and often in feelings of impending death such as may occur in a panic attack.
- ☐ There must be evidence that the social engagement results in significant distress to the individual. CSa represents almost total social isolation.
- ☐ For people with anxiety, panic disorder and agoraphobia there should be supporting evidence that corroborates the severity of the condition, for example, level of medication / psychiatric input.

In 2015, a Court of Session Judgement advised on the meaning of “always” within this descriptor. (See also section 2.3.1.14 – LCWRA Social Engagement Descriptors).

The meaning of “always precluded” has been clarified by this judgement and the following guidance from the court of session judges should be considered when choosing and justifying the social interaction descriptors.

- ☐ “Always” does not mean “at all times”; claimants need not show that they fall within the descriptor all the time, every minute, twenty four hours of every day
- ☐ ESA Regs Sch 3 Activity 13 (and Sch 2 Activity 16a, as it is coapplied) could therefore apply to a claimant whose condition is constant and continuing in its disabling effects, for the purposes of social engagement, albeit with short intermittent breaks in that being the case
- ☐ Advice should have regard to the need for steady and reliable engagement in social contact for the purposes of work and WRA, and be mindful that evidence of some kind of social engagement by the claimant, would not necessarily prevent the descriptor being met.
- ☐ Social contact where the claimant requires to be accompanied should be disregarded. Due consideration should be made as to whether being accompanied is a requirement or a choice / preference.

Activities of daily living

Consider any form of social contact such as:

- ☐ Use of public transport
- ☐ Shopping
- ☐ Talking to neighbours
- ☐ Use of phone
- ☐ IT activities such as Skype
- ☐ Hobbies and interests

- Social interaction with family

Mental State Examination

The Mental State Examination findings would be expected to reflect significant anxiety or communication problems. Rapport is likely to be poor with lack of eye contact. The claimant may be sweating and finding the consultation difficult. They may be somewhat timid in demeanour at interview. It would seem likely the person would require a companion to attend at the AC due to the level of anxiety/communication restriction that these descriptor would normally be expected to reflect.

Examples

An example of a scenario where CS(a) may apply is as follows:

This descriptor may apply to a person who rarely interacts with familiar people but may do so on exceptional / rare occasions. For example a person who is socially isolated, is unable to interact with unfamiliar people but might open the bedroom door to allow family member to deliver tea on a daily basis or a person who is socially isolated, is unable to engage with unfamiliar people, and only engages with their regular CPN maybe once a week.

An example of a scenario where CS(b) may apply is as follows:

This may apply to a person who rarely interacts with unfamiliar people but may do so on exceptional or rare occasions. For example they struggle to interact with unfamiliar people and usually avoid them, but once every couple of weeks goes to the shops and manages to speak to the checkout assistant.

An example of a scenario where CS(c) may apply is as follows:

A person who struggles to interact with unfamiliar people, but has days when anxiety is not too bad and is able to go alone and speak to checkout assistant weekly

When considering CS(b) or CS(c). The following should be considered:

1. What is relevant is the frequency with which the person can interact when they try to do it.
2. There is a need to consider all relevant activities when social activity takes place. So for example, if a person can only interact with an unfamiliar person rarely in one situation but can interact with an unfamiliar person occasionally in another then 16c) is likely to be the most appropriate descriptor choice.
3. If the person is only able to engage with unfamiliar people rarely out of necessity, for example in order to obtain benefit e.g. attend a WCA assessment but is otherwise unable to engage, then HCPs should consider whether these occasions are so infrequent that the claimant cannot effectively engage in social contact with unfamiliar people.

“Always” should be considered in the context of work or work related activity.

If a person was only able to rarely engage in contact with familiar people with extreme difficulty and only because they had little or no choice then that is likely to meet the definition of “always” in the context of work or work related activity and CSa should be considered. An example might be someone who is effectively a recluse but can occasionally interact with their GP or a family member for lifes essentials.

If a person was only able to rarely engage in contact with unfamiliar people with extreme difficulty and only because they had little or no choice then that is likely to meet the definition of “always” in the context of work or work related activity and CSb should be considered. An example might be someone who again is severely limited but when absolutely necessary can interact with an unfamiliar person such as a shop assistant and was able to attend an assessment and provide a history albeit with some difficulty. Due consideration needs to be made as to whether this does meet the threshold to be considered meaningful interaction.

If a person was able to engage with unfamiliar people more frequently or with less difficulty then consideration must be given to whether CSc would apply. An example might be someone who can visit a shop occasionally, perhaps travelling by bus and on the way can interact with an unfamiliar neighbour or other passenger. The majority of the time should be interpreted as more than 50% of the time. Pragmatically, as no one socially interacts 100% of the time, this should be considered as majority of days of the week. If someone can interact meaningfully with someone unfamiliar to them 2 days a week without causing significant distress but has no interaction the rest of the time and is effectively a recluse, then due consideration should be given to advising CSc.

Whilst the mental state exam findings, observations and the medical history are all key areas, a focussed functional history is key to an accurate and justified descriptor choice.

The activity is only relevant where problems with social contact are due to cognitive impairment or mental disorder, and lead to a difficulty relating to others, or to significant distress.

Assessing quality of engagement in social contact

HCPs must consider not just whether social engagement occurs but the quality of such engagement.

Social contact is not limited to contact for pleasure or leisure. It includes contact for the purposes of work (or WRA). The nature and quality of the claimant's engagement with social contact needs to be considered, including elements of give and take, and initiation and response.

Social contact does not need to be friendly or genial, nor does it need to involve choice, and can be demonstrated without those elements being present, such as might be the case in professional situations or in the workplace.

The DM is required to consider how the quality of the social contact would impact on the claimant's ability to work, and whether it would be a barrier to work. Therefore the HCP must explore this during the assessment.

If someone has an absolute requirement to be accompanied to be able to engage in meaningful social contact, then they cannot be regarded to be able to engage in social contact. In order to argue that they could, due consideration would have to be given to how such an adjustment would be reasonable in the workplace.

3.5.8 Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder - (Social Interaction) - Activity 17

Descriptors

- IBa** *Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace*
- IBb** Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace
- IBc** Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace
- IBd** None of the above apply

Scope

This activity is intended to reflect difficulties in social behaviour which might for example, be encountered by people with psychotic illness or other conditions such as brain injury that result in lack of insight. The activity also includes the difficulties people with autistic spectrum disorder may have in social behaviour. It is intended to reflect the effects of episodic relapsing conditions such as some types of psychotic illness, as well as conditions resulting in consistently abnormal behaviour.

Issues to consider

- ☐ There should be evidence of a disorder of mental function for this descriptor to apply. This may be as a result of a specific mental illness or a condition, whether mental, physical, or sensory resulting in cognitive or intellectual impairment of mental function. The descriptors do not simply relate to aggressive behaviour/anger management issues where there is no underlying mental health issue.
- ☐ The descriptors relate to behaviour that would be considered in an average workplace such as a call centre as this provides a more general concept rather than applying "reasonable" to one person's standards as this may be subject to considerable variability. It is likely that the behaviour would extend beyond verbal aggression for the descriptors to apply.
- ☐ There must be evidence that the individual is unable to control their behaviour for the descriptors to apply.
- ☐ The history and nature of the events should be detailed along with the frequency in which they occur.

Where the episodes occur frequently and the episodes are major, the “risk” NFD must be carefully considered and whether or not it is applied fully justified.

Activities of daily living

Consider any activity involving interaction with others:

- ☐ Previous occupational history
- ☐ Shopping
- ☐ Childcare
- ☐ Parents nights at school
- ☐ Relationships with neighbours
- ☐ Ability to cope at appointments: GP/ Hospital etc
- ☐ Ability to cope with bills and on the phone
- ☐ Dealing with finances and bills at the post office
- ☐ Appointments with official persons such as the Bank Manager/ Social Worker/ Benefits Personnel

Mental State Examination

There is likely to be evidence of reduced insight. Cognitive function should be carefully addressed. Evidence of addiction or thought disorder should be carefully assessed. Rapport may be poor and communication difficult.

3.6 Guidance on Specific Conditions – Mental Health

The reader is referred to the CHDA Evidence Based Protocols for the Disability Analyst. If you do not have a copy, this can be accessed by contacting your local MSC.

These protocols provide advice on Mental Health conditions commonly seen during benefit assessments. They are updated regularly and based on current research.

For each documented condition they provide guidance on:

- ☐ Aetiology
- ☐ Diagnosis and clinical features
- ☐ Treatment
- ☐ Prognosis
- ☐ Main disabling effects relevant to function

There is also extensive information available for reference through the LiMA application, LiMA repository.

3.7 The Mental State Examination

HCPs will be familiar with conducting a Mental State Examination from their previous training.

A mental state examination should be applied in all relevant cases. The extent of the mental state examination conducted will be determined by the HCP; however it must in all cases be adequate to justify the chosen mental function descriptors. For example, it may not be necessary to perform a full “addictions” assessment where the history does not indicate any addiction issues whereas in cases such as head injury or learning difficulty or other conditions affecting cognitive function, more formal tests of concentration and memory may be required.

The following categories are used in LiMA for a structured Mental State Examination:

- ☐ Appearance
- ☐ Behaviour/ volition
- ☐ Conversation
- ☐ Cognition – general
- ☐ Cognitive tests – informal
- ☐ Cognitive tests – formal
- ☐ Insight
- ☐ Addictions
- ☐ Involuntary movements

3.8 Exceptional Circumstances (Non Functional Descriptors) in the LCW/LCWRA Medical Assessment

Note – the term NFD is not used in the UC Regulations, however; both the ESA and UC Regulations have similar wording in the descriptors and the same policy intent in these areas. For ease of understanding, these regulations will be referred to as NFDs in this Handbook.

In the development of the WCA it was acknowledged that there may be a very small minority of conditions that would not fulfil the criteria for having LCWRA or produce a functional score of 15 or more but may still be considered as having limited capability for work. To take account of these conditions, a non-functional descriptor (NFD) has been incorporated into the LCW medical assessment to cover the following scenarios:

3.8.1 Life Threatening, Uncontrolled Disease.

1. The claimant is suffering from a life threatening disease in relation to which
 - (a) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure, and
 - (b) in the case of a disease that is uncontrolled, there is a reasonable cause for it not to be controlled by a recognised therapeutic procedure.

This non-functional descriptor (relating to life threatening disease) is very specific in its wording and all the evidence must be carefully considered before applying this non-functional descriptor. Any advice given to the Decision Maker that application of this NFD is appropriate must be in keeping with an up to date consensus of medical opinion. It should be noted that **this NFD only applies to LCW and not LCWRA** i.e. it would still be considered reasonable for the person to engage in WRA.

For example when considering hypertension,

- ☐ A claimant who attends the AC with no previous history of hypertension and on no treatment where the blood pressure is measured and found to be high would not fulfil criteria for this NFD as there is no evidence that their disease is uncontrollable.
- ☐ However where a claimant who attends a tertiary referral centre and whose condition, despite intensive intervention, remains severe and uncontrolled and is life-threatening, would be considered as satisfying the criteria for this NFD to be applied.

Another example of where this NFD may apply is in those with Motor Neuron Disease (MND). If the condition has not progressed to a level where there is significant functional impairment, a non functional descriptor would be applicable, as the implication of having a diagnosis of MND is severe. Given there is no form of “treatment” to prevent progression it would be appropriate for this NFD to be applied.

3.8.2 Substantial Risk.

A second non-functional descriptor (relating to substantial risk) is also listed in the ESA85A/UC85A. Remember that this is generated automatically by LiMA, however must be completed separately in clerical reports.

2. The claimant suffers from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work.
 - (a) This does not apply where the risk could be reduced by a significant amount by reasonable adjustments being made in the claimant’s workplace, or
 - (b) By the claimant taking medication to manage the claimant’s condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant

It should be noted that **regulations specify that this NFD must be considered separately for LCW and LCWRA.**

Therefore HCPs must give careful consideration as to whether it applies to both LCW and LCWRA or to LCW alone.

The LCWRA equivalent Substantial Risk Descriptor is listed in section 2.3.2 of this Handbook.

3.8.2.1 Background information on Substantial Risk

The 2014 substantial risk guidelines were developed by the DWP in association with various experts. The aim of this guidance was to achieve greater consistency to the way “substantial risk” was assessed.

However, the guidance failed to place this risk in the context of the work-related activity or work that the claimant might carry out although this is a key element of this provision

The DWP has reviewed these guidelines and developed new guidance in conjunction with CHDA. The main change is that the focus on suicide has been reduced and the question of substantial risk placed in the context of work-related activity (WRA). The Department’s approach is that tailored WRA may be appropriate for most people with mental health conditions, including for people with suicidal thoughts.

The revised guidance reflects the flexibility available to work coaches when supporting claimants who are receiving ESA in the work-related activity group.

The Revised Substantial Risk Guidance was issued by the DWP in 2015 and implemented early 2016.

3.8.2.2 Guidance on advising on Substantial risk for LCW or LCW/LCWRA

Advice on Limited Capability for Work or both LCW and LCWRA as a result of substantial risk can only be given after conducting **the full LCW/LCWRA functional assessment**.

DWP policy intent is that substantial risk for work should only be applied if there are no workplace adjustments or other interventions, such as medication, which could be put in place to significantly reduce the risk. If the substantial risk could be reduced by a significant amount, the provision for substantial risk would not be satisfied. Therefore, the wording in the ESA regulations as amended 2012 and the UC Regulations clarifies that workplace adjustments or other interventions must be taken into consideration when providing advice on substantial physical / mental risk.

HCPs must take into account any information which may reduce any substantial risk in the workplace. It is therefore essential that a comprehensive history is obtained.

In addition to considering whether being found fit for work may cause a substantial risk, HCPs must also consider the concept of work related activity and whether engaging in some activities, that may assist the claimant towards an eventual goal of work when the claimant is able, would be likely to cause a substantial risk to the person.

Appendix 7 provides information from the DWP on work related activity and it is essential the HCPs reads this information and understands the concept and extent of work related activity before providing advice.

HCPs must be mindful of the wording of the legislation in that it refers to a substantial risk to the person's health when they provide advice to the Decision Maker.

It should be noted for persons claiming UC, the Substantial Risk guidance should be considered in exactly the same manner and the appropriate advice on LCW or LCWRA risk should be provided in accordance to current risk guidelines, regardless of the fact that the claimant has chosen to continue to work.

In summary, the HCP must consider:

- ☐ If a person was found to be fit for work – would there be a substantial risk to their health?
- ☐ If a person was asked to undertake work related activity, would there be a substantial risk to their health?

In order to offer the Decision Maker advice in these areas, the HCP must carefully gather and consider all the evidence available and identify key issues such as whether the person's condition means that there is significant vulnerability or whether there is potential for relapse if required to carry out work related activity or to seek work.

Key areas to consider in evidence gathering are:

- ☐ Key to provision of advice on Substantial Risk remains a well explored detailed typical day. Exploring the activities that a person manages day to day such as interaction with other people, will assist the HCP in formulating their opinion and advice on whether work related activity may be possible for the person.
- ☐ In terms of assessing whether substantial risk may apply, the HCP must evaluate aspects of self harm or deterioration. The HCP must carefully explore the history of any previous episodes of self harm or any current plans. This issue must be addressed sensitively but the HCP must obtain adequate detail to be able to consider the evidence in order to advise on substantial risk in terms of LCW or LCW/LCWRA.
- ☐ The HCP must ensure they carefully explore and obtain information on risk factors for self harm and evaluate this evidence when providing advice to the Decision Maker.
- ☐ Protective factors can also be considered by the HCP when providing their advice to the Decision Maker, however; these factors must be considered within the context of all other evidence and risk factors. Note: It would not be appropriate for the HCP to directly probe aspects of religious beliefs.
- ☐ The review and evaluation of all previous evidence, such as previous reports, FME and the ESA 50/UC50 is critical to providing advice to the Decision Maker. It is imperative that the HCP considers all the available evidence before providing advice to the DM.
- ☐ The HCP must carefully consider the level of clinical input such as past hospital admissions, variability of condition, relapses, current and past CMHT input. HCPs must carefully consider

- issues suggesting severe illness such as regular input from the home treatment team

The DWP Revised Risk Guidelines contained in Appendix 6 **must** be read in conjunction with this information.

Much of the above information relates to Substantial Risk in people with a Mental Function problem, however, it must be noted that Substantial Risk may apply in those with physical problems, although this would be expected to be an uncommon situation.

In **physical problems**, evidence gathering remains key to provision of advice.

For example:

A claimant with a latex allergy. The following information would need to be considered in order to provide a fully justified opinion:

- Medication – Do they have an Epipen and are they able to self-administer? Do they use any other medication for allergies? How often have they needed to administer?
- Condition history - details of the allergy, investigations and results; details of any anaphylactic reactions; details of any treatment e.g. desensitisations
- Occupational history - previous occupations and any adjustments to the workplace
- Typical day – Are there any precautions taken to avoid the allergen in daily life? Are there any precautions (that the person takes or not) that can reasonably apply to the workplace?

Other physical problems must be considered case by case, however considering a condition such as epilepsy, this NFD is unlikely to apply. In most cases, the condition can reasonably be controlled with medication, and even in cases where seizures are fairly regular (e.g. weekly), reasonable workplace adaptations such as avoidance of working at heights, in confined spaces or lone working can be put into place to maintain the safety of the individual.

This clearly covers everything up to “fairly regular”. The question remained about more frequent fitting perhaps with evidence of injuries.

Consider this scenario:

Claimant with no warning of fits, a history of injury whilst fitting and a fit frequency, despite medication, of more than once a week.

The policy intent has been clarified by the Medical Policy Advisers in the DWP – in this example, assuming that no other relevant factors are present, it would not be expected that risk would apply given reasonable adjustments in an adapted safe working environment.

It is important to emphasise that each case needs to be assessed individually and a ‘one size fits all approach’ is not appropriate. Consider any other factors that may make one of the functional LCWRA criteria appropriate such as:

- Evidence of significant cognitive impairment
- Sequelae of injuries sustained during fits
- Comorbidity
- Other factors that may justify application of risk such as sudden deterioration in condition, awaiting urgent MRI with suspicion of a space occupying lesion

In justifying advice to the Decision Maker, the HCP has to indicate whether any reasonable precautions / interventions / adaptations could be made within the workplace. If any such conditions could be applied to reduce the risk by a significant degree, then substantial risk for LCW would not apply. In each case, the HCP must also consider whether suitably tailored work related activity would be likely to pose a substantial risk to the health of the person if risk for work were to be identified and advised.

The Decision Maker will assess the information provided and will determine the level of benefit entitlement.

3.9 Personal Summary Statement

A key part of the report is the Personal Summary Statement. This section of the report is the area where you must fully justify your opinion on the claimant's functional ability. This summary must contain enough detail for the Decision Maker to understand your reasoning and therefore allow them to be able to make a determination on an appropriate descriptor for each activity and LCWRA criteria.

The summary is completed on form ESA85S/UC85S, which is a separate page from the ESA85/UC85 has an equivalent in LiMA. This is generated automatically by LiMA, however must be completed separately in clerical reports.

3.9.1 Clarify the medical basis for your choice of descriptors

Your summary needs to draw together the most pertinent information that you have gathered from the clinical history, typical day history, observations and clinical findings, and requires that you consider the individual's functional ability in a holistic manner. It needs to encompass the justification for all activity areas where you or the claimant have identified a problem.

It needs to be written in free text, not drawn from pre-populated fields within the LiMA platform. The summary must be personalised.

In LiMA, if you advise that having LCWRA is likely, the summary of functional ability will be automatically transferred to the ESA85A/UC85A. However, when completing the report clerically, you need to complete both the ESA85A/UC85A and the summary on form ESA85S/UC85S. It is important when completing the summary where LCWRA is being advised that you make it clear to the Decision Maker what criteria is being advised.

When completing the summary, the following key principles should be adhered to:

- ☐ Spelling and Grammar must be of a standard that the intent of the message is clear
- ☐ The summary should be easy to read. This is best achieved through use of concise spaced paragraphs. Using “bullets” is not acceptable as this does not allow the summary to read in a personalised manner
- ☐ No new information should be introduced in the PSS
- ☐ The claimant should be referenced by surname once with subsequent use of any relevant pronoun, avoid use of the term ‘claimant’ in PSS
- ☐ All listed conditions must be referenced at some point within the summary
- ☐ There is no requirement to list the stated restrictions from the ESA50/UC50 as this will be available to the Decision Maker to review, however you have to ensure that all ‘problem’ areas are adequately justified
- ☐ With conditions that are medically unlikely to cause any functional impairment a simple statement will suffice
- ☐ Where physical conditions have been referenced for mental function descriptors, or vice versa, a simple statement will suffice
- ☐ Avoid where possible the use of the exact wording of the descriptors, however if advising on LCWRA, then it should be made clear as to which criterion applies
- ☐ Relevant functional areas should be addressed in the same order as they appear on the ESA85/UC85
- ☐ Justification should contain an outline of the medical condition, main difficulties reported by the claimant, relevant observed behaviour/examination findings and key issues in the typical day
- ☐ Variability and tasks being completed reliably and repeatedly should be addressed
- ☐ Extensive repetition of the same evidence is not required
- ☐ Examination findings should be expressed as a broad overview. The full findings are available to the DM in the report
- ☐ While it is important to address conflict within the report, you do not need to reference every single piece of contradictory evidence
- ☐ An overview approach, particularly in the mental function areas may well be preferable to addressing each individual descriptor that may or may not apply
- ☐ An overall ending statement around the likely severity of disability is unlikely to add value
- ☐ Where Substantial Risk is advised, the PSS should contain clear justification of this advice and in particular there must be clarity on whether your advice relates to LCW alone or both LCW and LCWRA.

Ten functional categories cover disability in physical and sensory areas. The first two functional areas (mobilising, incorporating stairs) and standing and sitting (incorporating transferring), are activities which predominantly involve conditions of the lumbar spine and lower limbs, however; upper limb function should be considered in mobilising and transferring. The next three categories (reaching; picking up and moving; and manual dexterity) are activities which predominantly involve the upper spine and the arms/hands.

You will write a more effective justification if you group together these descriptor groups - the information about daily activities, clinical findings, variation/fluctuation, pain etc are likely to be common to all of the activities within the back/lower limb or neck/upper limb group.

For example in a case where there is an upper limb problem but you consider that the appropriate descriptor choices are “none apply”, an example of a useful summary may be:

Mr A is on mild pain killers for his frozen shoulder and has not required specialist input. His typical day history indicates good function with ability to self care independently, read the newspaper and use a cooker, microwave and standard kettle for making snacks. Examination of upper limbs (including power) was normal apart from slight restriction of abduction in one shoulder. Observations were consistent with good upper limb function. Overall, the evidence suggests that despite his left shoulder problem he has good overall function in his upper limbs.

Remember that if you are considering the use of aids and appliances in choice of descriptor, the reason you feel the claimant could use these or could not use these should be clear to the Decision Maker.

3.9.2 Justifying your advice on LCWRA

The justification of all the functional descriptors excluding eating and drinking is intrinsic to the Personalised Summary Statement and to the LCW functional descriptors.

For example, where the HCP has chosen “none apply” for mobilising, this information is used to justify that the “mobilising LCWRA” criteria is not appropriate.

However certain categories of LCWRA would not be included in the justification of the functional activities and would need to be justified separately. This section is included within the ESA85/UC85 report, on the LiMA report each category is listed, however on the clerical ESA85/UC85 report, the HCP will need to ensure all relevant areas are justified (Box 26 of the clerical ESA85/UC85). The categories which need to be addressed are:

- Terminal Illness
- Pregnancy “risk”
- Chemotherapy/Radiotherapy
- Specific substantial physical or mental risk
- Eating and drinking

3.9.3 Efficient use of Time in the LCW/LCWRA Assessment

Thorough preparation prior to the commencement of the LCW/LCWRA assessment can save a great deal of time. You should identify the affected functions, including mental health if appropriate, and concentrate on those aspects of the history, typical day, and clinical examination which provide a firm ground for your advice and your choice of activity outcome descriptors in these areas.

If it is evident early on that there is a mental health problem, the typical day enquiry should include activities and behaviours which are used in the seven functional activity areas of the Mental Function assessment. This will avoid "starting afresh" at the end of the physical component of the assessment to enquire about the mental health topics.

If the claimant has considerable disabilities and you have chosen high descriptors in a number of areas, it is sensible to keep the remainder of the LCW/LCWRA concise.

In LiMA, curtailment will often apply in these circumstances and the application will invite you to provide examples of the prominent features of daily living in only some of the activity areas. The application will record a phrase indicating that curtailment applied in the curtailed areas.

Having provided robust evidence in one high scoring functional area, it is only necessary to give succinct and relevant details elsewhere.

Curtailment does not apply to clerical reports and all relevant sections will need to be completed.

It may occasionally become apparent that a claimant meets criteria for LCWRA. If this is the case, follow the procedure for LCWRA as detailed in sections 2.3 and 3.1.3.12.

3.10 Medical Advice on Re-referral Period or Prognosis at Assessment

It should be noted that in Universal Credit, we refer to the term "re-referral period".

In ESA this was referred to as "prognosis advice".

For those claiming ESA or for those claiming UC who are not in work, the re-referral period advice for the purposes of LCW/LCWRA, whether during the filework process or during the face-to-face assessment, refers to the time frame for when the claimant could be considered fit for work or fit for work-related activity. It does not refer to the prognosis of the actual medical condition itself.

For claimants in work claiming UC, the re-referral period should be based on when you consider that there will be a substantial improvement in the claimant's functional ability, or that they may have further adapted to their condition, such that they would benefit from reassessment.

When considering prognosis or re-referral period, the HCP has to consider whether the condition or its functional effects are likely to improve.

This may be due to the natural resolution of the condition, or improvement with treatment, with adaptation or with the use of appropriate aids and appliances.

For claimants who are found not to have limited capability for work or work-related activity, i.e. those who are below the benefit threshold, who also do not fulfil any of the LCWRA or exceptional circumstances criteria, there is no longer a need to give advice on prognosis. The prognosis advice is automatically omitted in LiMA reports, in clerical ESA85/UC85 reports, the HCP should draw a line through the prognosis box and indicate “Not Applicable” in the prognosis justification section.

3.10.1 LCW/LCWRA - Advice on when work could be considered

Main points:

- ☐ Under the LCW/LCWRA medical procedures approved HCPs are required to give advice on prognosis without reference to the outcome of the decision making process.
- ☐ When the claimant satisfies the LCW/LCWRA medical assessment, the medical advice on prognosis provided by approved HCPs to District Offices is often used by the Decision Maker to determine when subsequent re-referral to the HAAS is appropriate.
- ☐ The DWP will wish to refer a claimant for reassessment of LCW/LCWRA at the point where there is a reasonable expectation that their prospects of engaging in work have improved or their condition may have improved such that re-assessment may be appropriate. Whether the outcome of the case is meeting LCWRA criteria, application of Exceptional Circumstances or advice on a functional condition, the Decision Maker will require a reasonable prognosis for engaging in work activity. In assessing when a claimant may be able to engage in work, the approved HCP should provide this advice based upon their assessment of the claimant, their knowledge of the natural progression of the identified medical conditions, and the time they feel a claimant may need to adapt to their condition. It should be noted that when providing a prognosis on a claimant where LCWRA is advised, it should be clarified on the ESA85A/UC85A that the prognosis applies to work-related activity.
- ☐ Where possible the HCP should advise when any disability identified would be expected to significantly improve. This may be because the key functional problems are expected to improve (with further treatment or with time); or because it would be appropriate to medically reassess the person on the basis that there is a reasonable chance that the overall medical condition will have improved significantly. In those with chronic problems where functionally no change is anticipated e.g. congenital deafness, the HCP should advise when they feel engaging in work might be possible once they have adapted to their condition and other adjustments have been put in place.
- ☐ For those deemed to be in the terminally ill group there is no requirement to include a prognosis.
- ☐ If there is more than one relevant functional condition, the HCP should aim to provide an opinion on the likely timescale for engaging in work, taking account the effects of all conditions.

- ☐ If an early improvement is expected, a short prognosis should be given.

In all cases your opinion on when engaging in work or there is likely to be an improvement in the persons condition could be considered must be fully and comprehensively justified. It is important to consider each case individually and to choose and justify the appropriate time period.

For example:

1. A claimant with mild mechanical, intermittent back pain scoring below the threshold of LCW and no LCWRA or exceptional circumstances apply – No prognosis advice is given in this case.
2. A 25 year old claimant who has a traumatic sudden complete loss of vision with severe problems understanding communication and in navigating. He is still under specialist care and undergoing treatment. You may have indicated an 18 month prognosis in this case.

Justification may be: The claimant has experienced a sudden onset of complete visual loss. He is still undergoing treatment and there may be some improvement in his condition. He may also with time be able to adapt to his visual loss and with input and training, may be able to engage in work or work-related activity within about 18 months.

3. A 58 year old claimant who was diagnosed with epilepsy several years ago. The frequency of seizures has recently increased and he has been referred back to the specialist for review. Despite medication he is still having frequent seizures, occurring on average once or twice a week, with complete loss of consciousness, at present. He has adapted his lifestyle to avoid hazardous tasks and makes sure he is accompanied if he has to go out. He has been found to have significant problems due to loss of consciousness and given a 12 month prognosis.

Justification may be: The claimant has a long history of epilepsy, with recent increase in seizure frequency. He has been referred back to the specialist and the seizure frequency may improve with appropriate medication.

3.10.1.1 Advice that engagement in work is unlikely within 2 years

If in your opinion the medical condition, level of function and the claimant's ability to adapt is unlikely to change significantly in the next 2 years but there is still a possibility of some change with time or further therapy then you should suggest a 2 year prognosis. For example, a claimant with Rheumatoid Arthritis with a significant degree of functional problems, where you would not expect any improvement of note within 2 years, BUT where surgery or other treatment in the medium term may change the clinical picture.

3.10.1.2 Advice that engagement in work is unlikely In the Longer Term

Where at assessment you find a substantial degree of functional impairment resulting from a serious medical problem which is chronic and unlikely to improve even with optimal treatment, you should select "in the longer term".

In other cases, such as in the case of a young adult with a very significant degree of learning disability, where cognitive impairment in a number of functional areas mean that he requires a high level of support, you may feel that all management and support strategies have been exhausted and further adaptation is unlikely to occur. You would then reasonably advise “in the longer term” prognosis.

3.10.1.3 Exceptional Circumstances

When an Exceptional Circumstance Descriptor is applied you must give advice on “functional prognosis” and “exceptional circumstances prognosis”. If the claimant does not have significant functional problems, the functional prognosis will usually be for 3 months. The prognosis for the exceptional circumstances should reflect when the claimant might be able to consider engaging in work activity. It would not be unusual to have two very different prognoses under the Functional and Exceptional lists, but the Decision Maker will take whatever control action is appropriate under the circumstances of that particular case. You should add a brief explanatory note of justification for your advised prognosis period.

3.11 LCWRA Assessments

3.11.1 Introduction

Occasionally you will be asked to see a case for the Revised WCA where the claimant has been identified, either by a Job Centre Plus Decision Maker (DM) or an HCP, as ‘Treat as LCW’.

That is, the claimant falls into one of the categories where LCW is accepted, but LCWRA has still to be established, and cannot be advised on the basis of documentary evidence alone.

This guidance clarifies what is required of the examining HCP for completion of the ESA85/85S/85A (and UC equivalent forms) where a face-to-face assessment is required to establish whether LCWRA may apply.

These “LCWRA only” assessments will be completed clerically, not using LiMA. Therefore only HCPs trained in the completion of clerical reports will be able to carry out the assessment.

3.11.2 Background

Within the ESA and UC legislation, certain claimants, who may not have significant functional impairment, may be treated as having Limited Capability for Work because they fulfil certain criteria set out in the legislation. These are:

- ☐ Infectious disease inclusion by Public Health Order
- ☐ Pregnancy around dates of confinement (**Only in ESA – not UC**)
- ☐ Hospital patient
- ☐ Regular treatment
- ☐ Claiming income related ESA, in education and in receipt of DLA (**ESA only – not UC**)

- ☐ Older claimants in receipt of PIP/DLA/AA in specific circumstances (**UC only**)

(See section 2.4 of this Handbook for further detail)

If a HCP has given advice that a client can be 'treated as LCW' at filework, they must also consider the LCWRA question. If there is sufficient evidence available that they can fully justify their opinion across all of the LCWRA categories, then they should offer this advice, providing full justification to the DM. However, in a small number of cases the HCP will be unable to advise on LCWRA, and should indicate this in justification. The file should then be passed to the administration section to arrange an LCWRA only assessment. This situation should only arise after the filework HCP has made every possible attempt to obtain evidence in order to provide definitive advice.

In some cases, the DM will request that an assessment is carried out. Where this situation arises it is appropriate to proceed to face-to-face assessment.

3.11.3 LCWRA Assessment Process

The following process should be followed by a suitably trained Practitioner when completing an LCWRA assessment.

- ☐ All face-to-face assessments to establish LCWRA will be conducted either as a Domiciliary Visit or in the AC
- ☐ If the assessment is conducted as a DV, the Practitioner should follow the guidance in section 4.4 with regard to notifying the claimant of appointment time and date
- ☐ If a contracted doctor contacts a claimant and establishes that they have a special need that the Doctor is unable to fulfil, the case should be returned to allocations at the ASC with the details of the special need recorded
- ☐ If a contracted doctor contacts a claimant and they are a hospital patient, they should try to establish the name of the hospital, the supervising consultant's name and the likely duration of admission. The file should then be returned to the ASC to allow further scrutiny to be conducted
- ☐ Where a DV is to be conducted, a DV pack should be obtained from administration staff. This will contain an ESA85, ESA85S, ESA85A, ESA85A min, DVN1, SL1, BF223, UE1 and POID1 (or equivalent UC forms). Any previous information recorded on an ESA85A/UC85A will be printed from MSRS and included in the pack. If there is no ESA50/50A/UC50/50A in the file due to non return, there should be an ESA51 or ESA53 form (or UC equivalent). (These forms confirm the request for a questionnaire.
- ☐ The HCP should check the content of the pack prior to conducting the visit
- ☐ The HCP should conduct the assessment in accordance with Professional standards

The following scenarios provide guidance on completion of the assessment:

Scenario 1- LCWRA applies:

If at any point during the assessment, the Assessing HCP considers that they have adequate information to advise on LCWRA, they should complete the relevant sections of the ESA85/UC85 and complete form ESA85A/UC85A, providing sufficient information to allow the DM to consider their decision. They should then **also** complete a Personalised Summary Statement on ESA85S/UC85S for the DM. This summary only needs to provide justification for the LCWRA category that is considered appropriate. All contracted doctors must first contact the CSD helpdesk for approval if they consider that it is appropriate to advise that the claimant meets LCWRA criteria.

All information gathered on form ESA8/UC85 which is relevant to whether LCWRA applies must be included on the ESA85A/ESA85S/UC85A/UC85S.

Scenario 2 – LCWRA does not apply:

If the evidence suggests that LCWRA does not apply, the following sections of the ESA85/UC85 should be completed:

- ☐ Box 1 (claimant and examination details and diagnoses list)
- ☐ Box 2 (medication)
- ☐ Box 3 (side effects of medication)
- ☐ Box 4 (history of conditions, social and occupational history and typical day history)

You would then proceed to any appropriate physical examination. The physical examination should be tailored to the conditions listed in box 1. The findings of both observed behaviour and formal examination findings should be documented in the relevant sections of the ESA85/UC85 report.

The following section should then be completed:

- ☐ Box 26

You must justify why none of the non functional LCWRA Criteria and Eat/Drink apply. (TI, Chemotherapy/Radiotherapy, Pregnancy Risk, Substantial Risk, Eat and Drink).

- ☐ When you have completed the relevant sections of the ESA85/UC85, you must then ensure you complete the final page of the ESA85/UC85. (Name of HCP, signature etc)
- ☐ You do not have to complete the descriptor pages, exceptional circumstances and prognosis pages.

You must now complete the ESA85S/UC85S. The summary must include justification of why each of the relevant functional Support Group areas does not apply. The

“relevant functional areas” will be dictated by the diagnosis, ESA50/ESA50A (or UC equivalent) details and information obtained at the assessment.

You should record pertinent aspects of the history, observations and examination findings in the summary for **each relevant** LCWRA area to robustly justify why LCWRA does not apply.

The level of detail and clinical examination should be tailored to each individual case. The extent of detail and justification will depend on the conditions described and also information that may be present in the ESA50/ESA50A/UC50/UC50A.

If you need more space, further ESA85S/UC85S forms should be included in the pack or at the AC.

For example, if a claimant has indicated significant problems only with walking and in no other areas of the ESA50/ESA50A/UC50/UC50A, you should justify your opinion in the Personalised Summary Statement with information such as:

“Mrs B has knee pain for which she takes a mild pain killer. The typical day indicates she walks for 5 minutes on a daily basis and other reasonable distances several times a week. Observed behaviour suggests a slow pace but no other substantial restriction. Examination of the lower limbs was entirely normal other than minor restriction of knee flexion. Therefore, while some restriction of mobility is possible, the evidence suggests that she should be able to safely and without distress mobilise reasonable distances most of the time”.

Scenario 3 – No longer satisfies criteria for ‘Treat as LCW’:

If the claimant no longer satisfies ‘Treat as LCW’ (for example no longer having regular treatment such as haemodialysis, or beyond their postnatal period (in ESA) or in a rework referral) the following process should be followed:

- ☐ Indicate on the ESA85/UC85 that ‘Treat as LCW’ would no longer appear to apply providing detail of the change of circumstances for the DM
- ☐ You should then proceed to complete a full LCW/LCWRA medical assessment on the clerical ESA85/ESA85S/UC85/UC85S in the usual manner taking into account any information present in an ESA50 or ESA50A or UC equivalent forms.
- ☐ The normal procedures for completion of the LCW/LCWRA forms should be followed

Non-completion of any part of assessment

Should a circumstance arise where any part of the assessment cannot be completed (LCW/ LCWRA), then a full explanation should be recorded on an ESA85A/UC85A minute form.

If an assessment cannot be completed because an interpreter is required, this should be recorded on a minute detailing the language requirement and a further appointment should be made in accordance with the guidelines.

4. Miscellaneous

4.1 Exceptional Situations at Medical Assessment

It is important to make every effort to fully assess all claimants attending for assessment. There are some situations where a full assessment may prove to be challenging. It is important when assessing claimants who exhibit more challenging behaviour that full account is taken of any medical conditions that may be influencing their behaviour before any assessment is abandoned.

4.1.1 Clients Unfit to be seen

There are several circumstances where it may be that a claimant is unfit to be seen. This may be identified before the assessment commences or during the course of the assessment.

Identified before the assessment starts

If a claimant is identified as being unfit to be seen before the assessment begins consideration must be given as to whether they can be given a second appointment.

If this is their first appointment, the claimant should be sent home unseen. Administration staff will follow their normal Claimant Sent Home Unseen (CSHU) procedures using reason "Claimant Unfit to be examined" and a second appointment scheduled.

If this is their second appointment, the referral must be withdrawn. The referring Customer Office should be contacted by administration staff to inform them that the Claimant is unfit to be assessed and that the referral is being withdrawn. Before returning the Case File to the Customer, a note should be attached explaining why it has been returned.

Identified after the assessment has begun

There are a number of scenarios where a claimant becomes unfit to be assessed once the assessment has begun.

If the claimant is unfit to be fully assessed for reasons related directly to their Medical Condition, but enough clinical detail can be obtained or observations recorded, the HCP should make all attempts to complete the assessment, providing full details of the incident and recording any appropriate descriptors or advice on LCWRA criteria.

If the assessment cannot be completed and this is their first appointment, the Claimant should be recorded as a CSHU using CSHU reason "Claimant Unfit to be Examined" and a second appointment scheduled. If the assessment cannot be completed and this is their second appointment the Claimant should be recorded as a CSHU using the process described above.

If the assessment has to be terminated due to violence or persistent uncooperative behaviour, this process is described below.

4.1.1.1 The uncooperative claimant

If a claimant arrives at an Assessment Centre (AC) exhibiting abnormal behaviour, suggestive either of mental illness, intoxication as a result of substance abuse, including alcohol or any other cause, you should if possible be accompanied by a Assessment Centre Administrator (ACA) throughout the assessment. The ACA should be prepared to leave the room to summon assistance at all times during the assessment. Every HCP should familiarise themselves with local security policies and ensure they are aware of how to summon help if required. Many assessment centres will have “panic” buttons or alarms and rooms are set up to minimise risk. Information on safety can usually be obtained from the Site Safety Adviser.

If the uncooperative behaviour of the claimant is arising from their medical condition then the report **must** be completed detailing the behaviour and applying the appropriate descriptors or advising on LCWRA. If a non-functional descriptor is appropriate it can only be applied **after** completion of the full report by selection of descriptors.

There are two circumstances in which you may terminate an assessment **without completing the assessment**:

- ☐ The behaviour of the claimant poses a threat to you or to other staff or claimants.
- ☐ Persistent uncooperative behaviour by the claimant.

Examples of situations causing either of the above may include an inappropriate and threatening attitude, or intoxication - from either alcohol or other substance abuse.

In such circumstances, particularly if the problem arises as a result of intoxication, administration staff should be informed and the CSHU procedures followed as detailed above.

If the assessment and reports cannot be completed then you should consult an experienced disability analyst for advice about how to complete a full and detailed account of the claimant's behaviour, giving the reasons for terminating the assessment. A full account of the reasons for failing to complete the assessment should be recorded on an ESA85A/UC85A min.

If an ACA is present during the interview they should countersign the statement as being an accurate record of the events.

Where an interview is terminated without completion of the assessment in the circumstances described at (4) above, the *Decision Maker* may wish to consider disallowance on the grounds of failure to submit to assessment or may wish to consider “good cause” for failing to comply with assessment.

They depend on the information being comprehensive enough to support their decision if the claimant appeals against it.

If a claimant is threatening or abusive, for whatever cause, including as a result of illness, the appropriate DWP Unacceptable Claimant Behaviour (UCB) processes should be followed and put in place immediately.

The assessing HCP should complete the relevant incident forms/accident forms as soon as practicable following the incident. Details of the incident should also be entered into the company accident book accessed electronically.

A Health and Safety Incident Report form should also be completed if any incident occurs in keeping with the Health and Safety policy.

Further detail on the UCB process can be obtained from the ASC.

4.1.2 Lack of an Interpreter

If a claimant attends for assessment and they do not speak English (or any other language which you speak), or they communicate in BSL and are not accompanied by an interpreter, you should establish the claimant's native language and take the following action:

- ☐ If possible pass the case to a HCP who speaks the claimant's language to enable the assessment to continue, or
- ☐ Find an interpreter from amongst the assessment centre staff, if any, to allow the assessment to continue, or
- ☐ If neither of the above is possible the claimant should be told that a fresh appointment will be made when an interpreter can be present.

This information should be written down clearly for the claimant to take away for a friend or relative etc. to translate, to make sure they understand.

An ESA85A/UC85A min should be annotated 'initial appointment abandoned due to lack of interpreter. Claimant speaks Further appointment to be arranged with interpreter'. You should sign and date this note.

4.1.3 Audio taping of assessments

Audio Recording

The DWP never requires that a medical assessment for advising on entitlement to state sickness or disability benefits be recorded.

A claimant may request that their assessment is audio recorded. Requests for audio recording of assessment can only be agreed if stringent safeguards are in place to ensure that the recording is complete, accurate and the facility is available for simultaneous copies to be made available to both parties present. Dual CD recording machines are available to provide audio recordings where capacity allows. For requests made by claimants for their assessment to be audio recorded, the resource team at the ASC will be responsible for arranging for the audio recording equipment to be sent to the appropriate AC for the assessment.

A claimant may also make a request to record the assessment using their own equipment and this may be agreed in advance of their appointment date if a complete and identical copy of the recording can be provided to the HCP at the end of the assessment, and the recording is in CD or audio cassette format only.

Mobile phones are not acceptable for this purpose. Videotaping of assessments or recordings that the HCP is not explicitly aware of are not allowed.

Further information can be obtained from your local ASC or CHDA website.

Unauthorised recording

The DWP reserves the right to take appropriate action where a recording is used for unlawful purposes for example if it is altered, and publicised for malicious reasons.

4.1.4 Taking of Notes during an Assessment by Claimant or Companion

From time to time you may encounter a situation where the claimant is accompanied by a companion and either the claimant or companion may wish to take notes during the assessment.

Persons who are entitled to be in attendance are always entitled to take notes. This is because it is for their own purposes and not an official record of the process.

To attempt to deny the right to do so is likely to be contrary to Human Rights legislation.

To request a copy of the notes is unlikely to be helpful – it will place you in the position where you will be obliged to review the notes and comment on their reliability.

However, you should record in the medical report, the fact that notes were being taken. The following warning should also be given and the fact documented in the report. LiMA will offer the phrases as an optional addition.

For any handwritten report, on the rare occasions when this is necessary, the report should be annotated on the front cover.

The form of words you should use has been clarified on legal advice. Please replace any copies of existing desk aids you hold with the one incorporating the following form of words:

“Where notes are taken by you, we consider it of assistance to both myself, as the examining HCP, and yourself to point out the following:

1. It is your right to take notes for your own use and benefit.
2. The notes will not be included in the Report I make save for the fact that notes were taken and further, they are not accepted by myself or the DWP as an official record of this assessment.
3. If the notes are subsequently produced at any time for any purpose, such as part of an appeal process, I the Assessing HCP, my employer and the Dept of Work and Pensions reserve all rights to challenge anything in the notes in the event we are asked to comment on the content of the notes at a future time.
4. You are free to use your notes as you choose but if you chose to publicise the notes (other than in connection with correspondence with the DWP or under any appeal procedure) I would ask that you do not publicise my name.”

4.1.5 Functional assessment of pregnant women

Pregnancy is a normal physiological process and therefore **cannot alone** satisfy the criterion of limited capability for work or limited capability for work-related activity unless 'Treat as LCW' criteria in ESA apply.

When appropriate a full LCW/LCWRA functional assessment will be carried out to assess the functional limitations due to the diagnosed cause of incapacity, regardless of whether or not it is related to the pregnancy. A pregnant claimant will need to be treated with considerable sensitivity at assessment. For example, an MSO may well be appropriate but an abdominal examination would never be appropriate.

Consideration should be given to whether or not the pregnancy-related LCWRA may apply – see sections 2.3.2 and 2.4. You should also consider whether treating the woman as having limited capability for work around the dates of confinement may be appropriate if being assessed under ESA regulations – see sections 2.3.2 and 2.4.

4.1.6 Retention of Notes containing Claimant Details

There may be rare instances where notes are taken, by the HCP, when assessing claimants. In line with DWP Security Accreditation, the following guidance has been put in place to ensure claimant's data is adequately protected.

HCPs must note the following:

- ☐ There should be no instance of notes relating to the content of the ESA85/UC85 or claimant details being retained by any HCP on any claimant. Only a NINo can be kept as a reference for payment purposes as any information needed could be provided on supply of the NINo. The recording of NINOs for information, other than what is absolutely necessary for operational and medical purposes, is strictly forbidden. This includes written information pertaining to assessments HCPs have carried out (kept as records of assessments completed, as an example). Please be aware that there is a risk that any loss of sensitive information, including large amounts of NINOs, could be referred to the Information Commissioner. All staff have a responsibility to handle DWP data in the correct manner and although at times it is unavoidable (such as out of hours work) it is CHDA policy to restrict the handling of claimant data to the workplace at all times, as the appropriate security measures are already in place to minimise the risk of loss or theft.
- ☐ Any additional notes, (for example a note of inability to access a property) made on the day of assessment must never have any claimant identifying details recorded on them and should be destroyed in a secure manner* at the end of the session or working day.
- ☐ Clerical report forms e.g. ESA85/UC85, ESA85A/UC85A or ESA85S/UC85S should be returned to the MSC in the normal manner.

*Paper records containing protected personal data must be destroyed by incineration, pulping, shredding or placed in confidential waste so that reconstruction is unlikely.

Note: Claimant data should never be recorded or stored on any unauthorised electronic device.

4.2 Sensitive Information

Certain information which may be encountered in benefit work is of a sensitive nature, and you should know how to deal with such information. It is conveniently categorised as:

- ☐ Harmful information
- ☐ Embarrassing information
- ☐ Unauthorised information
- ☐ Confidential information.

4.2.1 Harmful Information

This is information which has not been disclosed to the claimant by their medical attendant, and of which they are unaware. It is information which would be considered as seriously harmful to their health if divulged to them and is the **only type of information which under the regulations may be withheld from the claimant in the event of a review or appeal**. Examples are details of:

- ☐ Malignancy
- ☐ Progressive neurological conditions
- ☐ Major mental illness

Try to avoid writing Harmful Information in your reports, however if this is essential information for the DM to consider in relation to the claim, perhaps in advising about terminal illness, you should record the harmful information clearly identifying it as such only on the final page of the ESA85/UC85 report and, if omitting an entry from the body of the report would leave a gap, write a "harmless synonym" at the relevant place. For example:

"Bronchial trouble and persistent headache".

HARMFUL INFORMATION

"True Diagnosis: Bronchial carcinoma with cerebral metastases."

If you encounter Harmful Information in a report prepared by another HCP you should discuss it with an experienced HCP before meeting the claimant.

4.2.2 Embarrassing Information

This is information which could not be considered harmful to the claimant's health, but which may well upset or anger them and embarrass you and the Department for Work and Pensions. If recorded in a report such information may not legally be withheld from the claimant.

Examples of this type of sensitive information include:

- ☐ Criticism of treatment given elsewhere
- ☐ Suspicion of malingering which you cannot substantiate
- ☐ Reference to any conviction

Under the Rehabilitation of Offenders Act 1974, after the expiry of a rehabilitation period a conviction becomes “spent”. The rehabilitation period varies in length, depending on the sentence imposed; some sentences can never be spent.

Once a conviction becomes spent, the person is treated for a number of purposes as if they had never been convicted of the offence in question. This subject merits further explanation.

The Rehabilitation of Offenders Act makes it an offence for anyone **with access to criminal records** to disclose a spent conviction **unless authorised to do so**.

The intention of the legislation is that, once a conviction becomes spent, any question relating to criminal convictions in, e.g., job or insurance application forms, can, with certain exceptions, be answered in the negative.

Only malicious allegations of spent convictions would carry a risk of legal action for defamation of character, if it could be proved by the claimant that the allegation was made with malice.

Within a LCW/LCWRA medical assessment it is necessary to avoid reference to any conviction - spent or otherwise - unless such information has a direct bearing on the claim.

4.2.2.1 Requirement of HCPs

HCPs may receive information that relates to current or spent criminal convictions, either in factual reports from a third party, e.g. a GP, or directly from a claimant during interview. HCPs need to understand the implications of the Rehabilitation of Offenders Act in order that they can deal appropriately with such information.

4.2.2.1.1 Medical reports provided by a third party

If a report submitted to the Department for Work and Pensions or the HAAS by a third party makes reference to a criminal conviction, the author will not contravene the Act unless they have access to the person’s criminal records. In the case of a factual report from a GP or hospital, this risk would be so unlikely that it can reasonably be disregarded. The information in such a report is likely to have come from the claimant.

HCPs can therefore accept in good faith that reference to criminal convictions in third party reports, without risk of contravening Rehabilitation of Offenders legislation. Such information should, however, be treated like any other potentially embarrassing information, unless mention of the conviction is directly relevant to the benefit claim in question.

4.2.2.1.2 Medical reports provided by HCPs

Similarly, since neither the Department nor HCPs working within the HAAS will normally have access to a person’s criminal record, any information about convictions

will have come from the claimant. Hence, if there is good reason for the assessing HCP to record such information – i.e. it is materially relevant to the claim – he or she may do so, in good faith, without fear of contravening the legislation. If a claimant wishes to have mention of a conviction recorded on the medical report, the HCP should:

Confirm with the claimant that they are content for the information to be disclosed in the report; and

Record the information together with a note stating “I confirm that this information has been incorporated at the request of the claimant.”

You should not write embarrassing information in your reports.

If you encounter any information which you consider potentially embarrassing, and are unsure how it should be dealt with, you should seek advice from an experienced HCP.

If the embarrassing information is removed from the file it may be necessary to refer the claimant for assessment by a different HCP as your opinion may be influenced by evidence which would not be available to the Decision Maker.

4.2.3 Unauthorised vs. authorised information

Unauthorised information comprises letters written from one health professional to another and forwarded to a third party without the express permission of the author of the letter. When a person submits a claim for ESA or UC, the DWP is responsible for obtaining their consent for the release of any medical information necessary to process their claim. As part of the evidence gathering process for ESA/UC claims, GPs can forward hospital letters, etc. where consent is held by the DWP because they form part of the patient record. Therefore, hospital letters, specialist letters, etc. that are supplied with a claim or as a result of a request for FME where consent is held, should be considered as authorised information. They can be utilised by HCPs and subsequently by Decision Makers in the assessment process.

4.2.4 Confidential Information

Confidential Information relates to any document received in respect of a claim and marked "Confidential" or "In Confidence".

Such a document cannot be used in the consideration of a case, and if one is encountered you should take the same measures as described for Embarrassing Information.

A claimant may attempt to give you information which they do not wish to have recorded on the report; that is they wish certain facts to be treated "In Confidence". It should be explained that such information cannot be taken into account as it cannot be made available to the Decision Maker.

A claimant may present a letter or medical report for you to read. You should accept that the claimant is the "owner" of the document and that the permission of the author for its use has been obtained.

4.2.5 Information brought by the claimant to the assessment

At times the claimant may bring additional evidence with them to the assessment that **must be read** by the HCP.

To reduce any delay to the claimant when an HCP is reading and photocopying this evidence during the assessment, the following process has been implemented.

When a claimant arrives at the AC reception, the ACA must ask them if they have brought any FME.

If FME is presented, the ACA will ask for the claimant's consent to photocopy the information, making clear that DWP will also need to see it.

If the claimant does not agree to the document being photocopied, they will explain that although the HCP can use and summarise the information contained in the evidence in their report, the Decision Maker will not have a copy of the evidence and cannot give it proper consideration.

The ACA will then photocopy the evidence and return the originals to the claimant.

Prior to being given to a HCP, the copies will be:

- hole punched in the top left corner
- attached on top of the claimant's case file
- a note added marked 'new FME'
- today's date marked on the FME (stamped if possible)

If no copying facilities are available, offer to have the copying done at the Assessment Services Centre and to have the original returned by post. If this is unacceptable to the claimant, you should explain that as above, the Decision Maker cannot give the information proper consideration.

4.3 Identification of Claimants

In most situations when assessments are conducted in an assessment centre, the administration staff will confirm the identity of the claimant. In certain circumstances, the admin staff will not be able to confirm the identity of the claimant and this task will be the responsibility of the examining HCP.

It should however be noted that in all circumstances it is the responsibility of the examining HCP to ensure that they are satisfied that correct identity of the claimant has been established before they proceed with any assessment.

When an assessment is conducted as a domiciliary visit or in some assessment centres where there is no administrative support, the examining HCP will be solely responsible for establishing the identity of the claimant and therefore all HCPs must be aware of the "Checking Proof of Identity procedures". A copy of the form POID 1 can be found in Appendix 5.

The following guidance is extracted from the agreed CHDA Administration Guidance.

Checking Proof of Identity

If a case file exists the Proof of Identity form (POID1) should be included with the file.

If a case file does not exist, the POID1 form should be held at the AC for a period of 6 months after which time it should be destroyed.

The process for checking a Claimant's ID is as follows:

- Ask the claimant to sign the POID1 form
- Ask the claimant to provide Identification. The list of acceptable forms of ID is contained in Appendix 5 on the POID 1 form. It should be noted that in November 2014, in order to align with the DWP Proof of Identity requirements, claimants will now have to provide a maximum of TWO types of approved identification
- Tick the evidence provided on the form. If the claimant has an appointee, identification should be provided for both the appointee and the claimant using the usual procedure
- Compare the signature on the POID1 form against the signature used on their questionnaire

If for any reason you do not have access to the questionnaire you should carry out the action described below:

- Complete Part 2A of the POID1 form
- Place the POID1 form in the case file (if one exists)
- Carry out the following appropriate action

Signatures match

If the signature on the POID1 matches that held on the questionnaire you should complete Part 2A of the POID1 form and allow the assessment to take place.

Signatures do not match

If the signature on the POID1 form does not appear to match that held on the questionnaire you should carry out the following action:

- If the claimant produced an acceptable form of identification, but the signatures do not match, you should discreetly advise the examining HCP of the discrepancy before the assessment starts. The examining HCP should then ask more in depth questions relating to case history to establish correct identity. If the identity of the claimant is proven, the examining HCP should complete Parts 2A and 2B of the form and the assessment should be carried out as normal.
- If the claimant was unable to provide sufficient evidence of knowledge of the case history, then the assessment should be suspended. A CHDA HCP can authorise refusal of an assessment

Identification presented is insufficient

If the client is unable to provide identification or the maximum two approved items requested, note the POID1 with the forms of identification the client has provided. If the client's signature matches, the assessment should be carried out as normal.

Questionnaire not available

If the questionnaire is not available the assessing HCP should ask the claimant further in depth questions relating to the case history before deciding whether the assessment should continue.

If the assessing HCP is 100% certain that the person in front of them is NOT who they say they are, the assessment should not take place.

If the assessing HCP is in some doubt as to the identity of the person in front of them, the assessment may continue, but a note to their uncertainty should be attached to the case file.

4.4 Domiciliary visits

Not all benefit assessments are conducted at the examination centre. On occasions a claimant will indicate that they are unfit to travel to or to attend the AC and a domiciliary visit becomes necessary.

Any HCP who is undertaking a Domiciliary visit should ensure they have completed the mandatory reading of the "Dealing with Aggressive and Potentially Violent Behaviour" module and are fully familiar with the DWP Unacceptable Claimant Behaviour (UCB) Process.

If you are asked to visit a claimant in their own home it is essential that the correct approach is made when arrangements are made by telephone. The Data Protection Act requires us to adhere to the following process:

4.4.1 Establishing the identity of the Claimant

When making the telephone call it is essential that the HCP or administrative person establish the identity of the person to whom they are talking at the outset.

The following script or something very similar must be used:

"I'm Dr/Ms/Mr X (admin staff and Health Care Professionals to give full name) from the HAAS and I would like to speak to Mr/Mrs/Miss/Ms (Use Full Name of Claimant)."

No further details should be given until the claimant has been positively identified.

A positive identification of the claimant should be sought and this would normally be the DOB or NINO.

If you are uncertain that the person to whom you are speaking is the claimant, terminate the call.

HCPs should also be aware of “Implicit Consent” rules that will allow engagement with a 3rd party in certain circumstances.

Implicit consent is a process currently used by the DWP to be able to liaise with a 3rd party on behalf of a claimant without the need for an appointee. The introduction of implicit consent in the scheduling of appointments allows the service provider to arrange appointments with the 3rd party should they contact on behalf of the claimant and be able to provide certain details about the claimant.

If a 3rd party contacts the HAAS on behalf of a claimant regarding an appointment the HAAS may assume implicit consent provided the 3rd party can provide the following details regarding the claimant:

- Claimant’s Name
- National Insurance Number (NINO)
- Date of Birth
- Details from appointment letter

The 3rd party must also identify their relationship to the claimant.

If this is established the service provider may proceed to arrange the appointment with the 3rd party providing them with details of the date and time of the appointment and the location. No other aspect of the claimant’s case should be discussed with the 3rd party. The appointment letter should however be issued in writing to the claimant themselves.

Following the call, details that the appointment was scheduled with a 3rd party should be recorded on the appropriate system/manual (if DV) as well as details that implicit consent was established to arrange the appointment.

If the claimant is unavailable, or any 3rd party is unable to provide the required details, make arrangements to call back, without revealing any further details appertaining to the nature of the telephone call. If the claimant cannot be contacted via the telephone the normal procedure, using the appropriate letter, should be followed. In most cases appointments for an assessment are made by administrative staff. If a circumstance should arise where the examining HCP is responsible for arranging their own appointments, the HCP should be mindful that the regulations state that claimants must be notified of the appointment date seven days prior to the assessment unless they have agreed to an appointment at shorter notice.

HCPs should also be aware that even if the claimant agrees to an appointment at shorter notice, there must still be sufficient time for the claimant to receive an appointment letter and the claimant information sheet through the post prior to the appointment. Therefore, appointments should not be made at less than three days notice to allow receipt of this information. The HCP must also complete a manual scheduling form at the time of making the appointment. Claimant information, appointment letters and copies of forms can be obtained from administration staff at a local AC. When the HCP conducts the actual assessment at home, the “checking proof of identity procedures” should be followed and form POID 1 completed. (See section 4.3).

4.4.2 Informing the Claimant of the reason for the telephone call

Having established the identity of the claimant, there is then a need to explain why the telephone call is being made. The following form of words should be used as appropriate dependent upon whether it is the HCP or administrative staff making the call:

“I am one of the Health Care Professionals providing medical advice on your claim to benefit” OR

“I have been asked by one of the Health Care Professionals who provides medical advice on your claim to benefit to obtain further information”

Unusual Circumstances

There may be instances when the above procedure cannot be used due to the fact that:

- ☐ The claimant has an appointee;
- ☐ The claimant requires an interpreter; or
- ☐ The claimant has a medical condition that precludes a telephone conversation.

If any of these circumstances arise whilst contact is being made by telephone, greater care must be exercised to ensure that we remain within the confines of the DATA PROTECTION ACT.

4.4.3 Claimant has an Appointee

If the referral shows that the claimant has an appointee, a check should initially be made to verify that we are talking about the correct claimant by checking DOB, address and NINO. Once this is confirmed, the person who claims to be the appointee should be asked for verification of their name and address which will be shown on the referral. Further information may then be divulged.

4.4.4 Claimant requires an interpreter

If, when making a telephone call to the claimant, it becomes obvious that an interpreter is required, staff should advise the person to whom they are speaking that a letter will be sent to the claimant in due course. The telephone call should be terminated without divulging any of the claimant's details, unless the person can provide details as per implicit consent agreement.

4.4.5 Claimant has a medical condition which prevents him/her speaking on the telephone

As in the case of an interpreter, once it becomes obvious that the claimant cannot speak on the telephone, staff should advise the person to whom they are speaking that a letter will be sent to the claimant in due course, unless the implicit consent rules can be invoked.

The telephone call should be terminated without divulging any of the claimant's details.

In all cases a common sense approach must be used by staff when making contact with a claimant by telephone.

4.4.6 Policy on Passive Smoking

The assessing HCP should take note of the following guidance:

Due to potential health concerns associated when Healthcare Professional (HCPs) undertake domiciliary medical assessments within a passive smoking environment, guidance from the DWP policy on passive smoking is as follows:-

“When visiting customers:

- Employees can politely request that they don't smoke during the interview.
- Should they refuse the employee may terminate the interview.
- Should the customer still need to be interviewed attempts should be made to re schedule the visit or as a last resort they will be required to attend a DWP office.

It is good practice to advise the customer of this request prior to the visit”.

If the claimant refuses to stop smoking during the assessment, the HCP can terminate the assessment. The claimant should then be offered an appointment to attend an Assessment Centre (even if they fall under the category that would normally not be required to attend an AC). It can then be shown that you have offered them an alternative. If they refuse or can't attend because of their health, they should be offered another home visit, but warned that this will only take place if the customer agrees not to smoke during the visit. If at the next home visit, the customer again refuses to stop smoking, the HCP should terminate the visit

It should be noted that it is a personal choice of the HCP whether to proceed with the assessment if the assessment is to take place in a smoke filled environment.

Appendix 1 - The LCWRA Descriptors

	<i>Activity</i>	<i>Support Group</i>
1	Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used	Cannot either (i) Mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) Repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion
2	Transferring from one seated position to another	Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from someone else
3	Reaching	Cannot raise either arm as if to put something in the top pocket of a coat or jacket
4	Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this schedule)	Cannot pick up and move 0.5 litre carton full of liquid
5	Manual dexterity	Cannot either - (a) press a button, such as a telephone keypad or; (b) turn the pages of a book with either hand

	Activity	Support Group
6	Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person	Cannot convey a simple message, such as the presence of a hazard
7	Understanding communication by i) verbal means (such as hearing or lip reading) alone, or ii) non-verbal means (such as reading 16 point print or Braille) alone, or iii) any combination of (i) and (ii), using any aid that is normally, or could reasonably be, used, unaided by another person	Cannot understand a simple message due to sensory impairment, such as the location of a fire escape
8	Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used	At least once a week experiences (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device; sufficient to require the individual to clean themselves and change clothing
9	Learning tasks	Cannot learn how to complete a simple task, such as setting an alarm clock, due to cognitive impairment or mental disorder

	Activity	Support Group
10	Awareness of hazard	<p>Reduced awareness of everyday hazards, due to cognitive impairment or mental disorder, leads to a significant risk of:</p> <p>(i) injury to self or others; or (ii) damage to property or possessions,</p> <p>such that they require supervision for the majority of the time to maintain safety</p>
11	Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks)	<p>Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions</p>
12	Coping with change	<p>Cannot cope with any change, due to cognitive impairment or mental disorder, to the extent that day to day life cannot be managed</p>
13	Coping with social engagement, due to cognitive impairment or mental disorder	<p>Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual</p>
14	Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder	<p>Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace</p>

	Activity	Support Group
15	Conveying food or drink to the mouth	<p>(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else;</p> <p>(b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort;</p> <p>(c) Cannot convey food or drink to the claimant's own mouth without receiving regular prompting given by someone else in the claimant's physical presence; or</p> <p>(d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimant's own mouth without receiving—</p> <ul style="list-style-type: none"> (i) physical assistance from someone else; or (ii) regular prompting given by someone else in the claimant's presence
16	Chewing or swallowing food or drink	<p>(a) Cannot chew or swallow food or drink;</p> <p>(b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort;</p> <p>(c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the claimant's presence; or</p> <p>(d) Owing to a severe disorder of mood or</p>

		behaviour, fails to— (i) chew or swallow food or drink; or (ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence
--	--	---

Appendix 2 – ESA85 & UC85 Clerical Report

ESA85 15/11

Employment and Support Allowance Medical report form

Medical report form

Surname	<input type="text" value="Mr/Mrs/Miss/Ms"/>
Other names	<input type="text"/>
National Insurance Number	<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"/> <input type="text"/>
Date of birth	<input type="text" value="/"/> <input type="text" value="/"/>
<hr/>	
Time examination and interview started	<input type="text"/>
Time examination and interview ended	<input type="text"/>
Time report completed	<input type="text"/>
Date of examination	<input type="text" value="/"/> <input type="text" value="/"/>
Place of examination	<input type="text"/>
Healthcare Professional's name	<input type="text"/>

List all diagnoses, either previously diagnosed or found during the assessment and any other conditions reported by the client

Conditions medically identified
Other conditions reported

1	1
2	2
3	3
4	4

Medication (including reason for use)	2

Side effects due to medication (including comment on functional relevance)	3

(including reason for leaving work)

3

Description of functional ability

Having considered whether the condition is likely to vary during the average week and if the function can be carried out regularly and repeatedly taking into account fluctuation, pain, stiffness, breathlessness, balance problems etc, the description of functional ability is as follows:

History of Conditions (relevant clinical and functional history) including hospital treatment and tests carried out in the past 12 months, and any specific therapy for mental health problems received in the past 3 months.

4

Social and occupational history
(including reason for leaving work)

4

3

Description of functional ability - continued

Record here the client's description of a typical day including the effects of the medical condition(s) on daily living. Please highlight the impact of bad days on impairment of functional ability and level of severity and variability, taking into account fluctuation, pain, fatigue, stiffness, breathlessness, balance problems etc.

4

Medical Opinion – Physical

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used (Activity 1)

Tick the first box that applies.

W_a Cannot either

- (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion

W_b Cannot mount or descend two steps unaided by another person even with the support of a handrail ☐

W_c Cannot either

- (i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion

W_d Cannot either

- (i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion

W_e None of the above apply ☐

Medical Opinion – Physical

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used (Activity 1)

Tick the first box that applies.

W_a Cannot either

(i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐

(ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_b Cannot mount or descend two steps unaided by another person even with the support of a handrail ☐

W_c Cannot either

(i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐

(ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_d Cannot either

(i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐

(ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_e None of the above apply ☐

Standing and sitting

(Activity 2)

Tick the first box that applies.

- S_a** Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person ☐
- S_b** Cannot, for the majority of the time, remain at a workstation, either:
- (i) standing unassisted by another person (even if free to move around) or; ☐
 - (ii) sitting (even in an adjustable chair); or
 - (iii) a combination of (i) and (ii),
- for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion
- S_c** Cannot, for the majority of the time, remain at a workstation, either:
- (i) standing unassisted by another person (even if free to move around) or; ☐
 - (ii) sitting (even in an adjustable chair); or
 - (iii) a combination of (i) and (ii),
- for more than an hour before needing to move away in order to avoid significant discomfort or exhaustion
- S_d** None of the above apply ☐

Lower Limb – Activities 1 and 2

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

5

Behaviour observed during assessment

6

Relevant features of clinical examination

7

Reaching

(Activity 3)

Tick the first box that applies.

- R_a Cannot raise either arm as if to put something in the top pocket of a coat or jacket ☐
- R_b Cannot raise either arm to top of head as if to put on a hat ☐
- R_c Cannot raise either arm above head height as if to reach for something ☐
- R_d None of the above apply ☐
-

Picking up and moving or transferring by the use of the upper body and arms

(Activity 4)

Tick the first box that applies.

- | | | |
|----------------|---|--------------------------|
| P _a | Cannot pick up and move a 0.5 litre carton full of liquid | <input type="checkbox"/> |
| P _b | Cannot pick up and move a one litre carton full of liquid | <input type="checkbox"/> |
| P _c | Cannot transfer a light but bulky object such as an empty cardboard box | <input type="checkbox"/> |
| P _d | None of the above apply | <input type="checkbox"/> |
-

Manual dexterity

(Activity 5)

*Tick the first box that applies.***M_a Cannot either:**

- (i) press a button, such as a telephone keypad or;
 - (ii) turn the pages of a book
- with either hand

☐**M_b Cannot pick up a £1 coin or equivalent with either hand**☐**M_c Cannot use a pen or pencil to make a meaningful mark**☐**M_d Cannot single-handedly use a suitable keyboard or mouse**☐**M_e None of the above apply**☐

Upper Limb – Activities 3, 4 and 5

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

8

Behaviour observed during assessment

9

Relevant features of clinical examination

10

Navigation and maintaining safety, using a guide dog or other aid if either or both are normally, or could reasonably be, used
(Activity 8)

Tick the first box that applies.

- | | | |
|----------------|---|--------------------------|
| V _a | Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _b | Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _c | Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _d | None of the above apply | <input type="checkbox"/> |
-

**Making self understood through speaking, writing, typing,
or other means which are normally, or could reasonably be,
used, unaided by another person** (Activity 6)

Tick the first box that applies.

- | | |
|--|--------------------------|
| SP _a Cannot convey a simple message, such as the presence of a hazard | <input type="checkbox"/> |
| SP _b Has significant difficulty conveying a simple message to strangers | <input type="checkbox"/> |
| SP _c Has some difficulty conveying a simple message to strangers | <input type="checkbox"/> |
| SP _d None of the above apply | <input type="checkbox"/> |
-

Understanding communication by -
(i) verbal means (such as hearing or lip reading) alone,
(ii) non-verbal means (such as reading 16 point print or
Braille) alone, or
(iii) a combination of (i) and (ii),
using any aid that is normally, or could reasonably be,
used, unaided by another person (Activity 7)

Tick the first box that applies.

- | | | |
|----------------|---|--------------------------|
| H _a | Cannot understand a simple message due to sensory impairment, such as the location of a fire escape | <input type="checkbox"/> |
| H _b | Has significant difficulty understanding a simple message from a stranger due to sensory impairment | <input type="checkbox"/> |
| H _c | Has some difficulty understanding a simple message from a stranger due to sensory impairment | <input type="checkbox"/> |
| H _d | None of the above apply | <input type="checkbox"/> |
-

Vision, Speech and Hearing – Activities 8, 6 and 7

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

11

Behaviour observed during assessment

12

Relevant features of clinical examination

13

Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used (Activity 9)

Tick the first box that applies.

- C_a At least once a month experiences ☐
- (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or
- (ii) substantial leakage of the contents of a collecting device; sufficient to require cleaning and a change in clothing
- C_b The majority of the time is at risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly ☐
- C_c None of the above apply ☐
-

Continence – Activity 9

Medical evidence used to support your choice of activity outcome

Prominent features of functional ability relevant to daily living	14
Relevant features of clinical examination	15

Consciousness during waking moments

(Activity 10)

Tick the first box that applies.

- | | | |
|----------------------|---|--------------------------|
| F_a | At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration | <input type="checkbox"/> |
| F_b | At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration | <input type="checkbox"/> |
| F_c | None of the above apply | <input type="checkbox"/> |
-

Consciousness during waking moments – Activity 10

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

16

Relevant features of clinical examination

17

Mental, cognitive and intellectual function

This part to be completed when a specific mental illness has been diagnosed, or when there is a condition, whether mental, physical, or sensory resulting in cognitive or intellectual impairment of mental function. If not applying the assessment give reasons below.

Are you applying the mental function assessment? Yes ☐
No ☐

I have considered whether this client has a specific mental disease or disability affecting mental function. I have not applied the mental function assessment (as per the Limited Capability for Work legislation) because there is no recent history of a mental disease having been diagnosed or treated, and there is no medical or other evidence before me nor any findings that mental function is affected.

Evidence to support the decision not to apply the mental function part of the test

Medical Opinion – Mental Function

Understanding and Focus

Learning tasks

(Activity 11)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| LT _a | Cannot learn how to complete a simple task, such as setting an alarm clock | <input type="checkbox"/> |
| LT _b | Cannot learn anything beyond a simple task, such as setting an alarm clock | <input type="checkbox"/> |
| LT _c | Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes | <input type="checkbox"/> |
| LT _d | None of the above apply | <input type="checkbox"/> |
-

Awareness of everyday hazards (such as boiling water or sharp objects)
(Activity 12)

Tick the first box that applies.

- AH_a Reduced awareness of everyday hazards leads to a significant risk of:
(i) injury to self or others; or
(ii) damage to property or possessions,
such that they require supervision for the majority of the time to maintain safety ☐
- AH_b Reduced awareness of everyday hazards leads to a significant risk of:
(i) injury to self or others; or
(ii) damage to property or possessions,
such that they frequently require supervision to maintain safety ☐
- AH_c Reduced awareness of everyday hazards leads to a significant risk of:
(i) injury to self or others; or
(ii) damage to property or possessions,
such that they occasionally require supervision to maintain safety ☐
- AH_d None of the above apply ☐

**Initiating and completing personal action (which means
planning, organisation, problem solving, prioritising or
switching tasks)**

(Activity 13)

Tick the first box that applies.

- | | | |
|-----------------|---|--------------------------|
| IA _a | Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions | <input type="checkbox"/> |
| IA _b | Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time | <input type="checkbox"/> |
| IA _c | Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions | <input type="checkbox"/> |
| IA _d | None of the above apply | <input type="checkbox"/> |

Understanding and Focus – Activities 11, 12, and 13

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

18

Relevant features of clinical examination

19

Adapting to Change

Coping with change

(Activity 14)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| CC _a | Cannot cope with any change to the extent that day to day life cannot be managed | <input type="checkbox"/> |
| CC _b | Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult | <input type="checkbox"/> |
| CC _c | Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult | <input type="checkbox"/> |
| CC _d | None of the above apply | <input type="checkbox"/> |

Getting about

(Activity 15)

Tick the first box that applies.

- | | | |
|-----------------|---|--------------------------|
| GA _a | Cannot get to any place outside the claimant's home with which the claimant is familiar | <input type="checkbox"/> |
| GA _b | Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person | <input type="checkbox"/> |
| GA _c | Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person | <input type="checkbox"/> |
| GA _d | None of the above apply | <input type="checkbox"/> |

Adapting to Change – Activities 14 and 15

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

20

Relevant features of clinical examination

21

Social Interaction

Coping with social engagement due to cognitive impairment or mental disorder

(Activity 16)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| CS _a | Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _b | Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _c | Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _d | None of the above apply | <input type="checkbox"/> |
-

Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

(Activity 17)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| IB _a | Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _b | Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _c | Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _d | None of the above apply | <input type="checkbox"/> |

Social Interaction – Activities 16 and 17

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

22

Relevant features of clinical examination

23

Exceptional Circumstances (Non-functional descriptors)

My advice based on the Limited Capability for Work and Limited Capability for Work 24
Related Activity medical examination I have carried out as a healthcare professional
approved by the Secretary of State, is that this person

- is suffering from a life threatening disease in relation to which-
 - (a) there is medical evidence that the disease is uncontrollable, or
uncontrolled, by a recognised therapeutic procedure, and No ☐
 - (b) in the case of a disease that is uncontrolled, there is a
reasonable cause for it not to be controlled by a recognised
therapeutic procedure Yes ☐
- is suffering from some specific disease or bodily or mental disablement
and, by reasons of such disease or disablement, there would be a
substantial risk to the mental or physical health of any person if they
were found not to have limited capability for work and that
the risk could not be significantly reduced by reasonable adjustments
made in the workplace or by taking prescribed medication No ☐
Yes ☐
 (If 'Yes,' please complete an ESA85A if you are also advising the
corresponding LCWRA category)

Please contact the CSD (Customer Service Desk) to confirm appropriate use of
the NFD.

By checking this box you are confirming that you have contacted CSD and that
they have approved the Non- Functional Descriptor (NFD) choice. ☐

I have discussed this NFD with

Please justify the answers you have given above in relation to exceptional
circumstances.

25

Limited Capability for Work-Related Activity

Please justify if, in your opinion, the person does not meet any of the descriptors for limited capability for work-related activity. 26
Please provide evidence in support of your opinion for each area of functional activity.

I advise that work could be considered within:

28

Functional problems

Exceptional circumstances
(where applicable)

3 months

☐☐

6 months

☐☐

12 months

☐☐

18 months

☐☐**I advise that work is unlikely:**

Within 2 years

☐☐

In the longer term

☐☐**Justification for the above advice**

29

This form has been completed by a healthcare professional approved by the Secretary of State for Work and Pensions.

I have completed this form in accordance with the current guidance to ESA examining healthcare professionals as issued by the Department for Work and Pensions.

I can confirm that there is no harmful information in the report other than indicated.

Signature

Name in Capital Letters

Approved Disability Analyst

Date

Registered Medical Practitioner

☐

Registered Nurse

☐

Registered Occupational Therapist

☐

Registered Physiotherapist

☐

Harmful Information – not to be copied to the client

UC85 16/01

Universal Credit

Medical report form

Medical report form

Surname	<input type="text" value="Mr/Mrs/Miss/Ms"/>
Other names	<input type="text"/>
National Insurance Number	<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"/>
Date of birth	<input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>
<hr/>	
Time examination and interview started	<input type="text"/>
Time examination and interview ended	<input type="text"/>
Time report completed	<input type="text"/>
Date of examination	<input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>
Place of examination	<input type="text"/>
Healthcare Professional's name	<input type="text"/>

List all diagnoses, either previously diagnosed or found during the assessment and any other conditions reported by the client

Conditions medically identified	Other conditions reported
1	1
2	2
3	3
4	4

Medication (including reason for use)	2
--	---

Side effects due to medication (including comment on functional relevance)	3
---	---

Description of functional ability

Having considered whether the condition is likely to vary during the average week and if the function can be carried out regularly and repeatedly taking into account fluctuation, pain, stiffness, breathlessness, balance problems etc, the description of functional ability is as follows:

History of Conditions (relevant clinical and functional history) including hospital treatment and tests carried out in the past 12 months, and any specific therapy for mental health problems received in the past 3 months.

4

Social and occupational history
(including reason for leaving work)

4

Description of functional ability - continued

Record here the client's description of a typical day including the effects of the medical condition(s) on daily living. Please highlight the impact of bad days on impairment of functional ability and level of severity and variability, taking into account fluctuation, pain, fatigue, stiffness, breathlessness, balance problems etc.

4

Description of functional ability - continued

Typical day continued

4

Medical Opinion – Physical

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used (Activity 1)

Tick the first box that applies.

W_a Cannot either

- (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_b Cannot mount or descend two steps unaided by another person even with the support of a handrail ☐

W_c Cannot either

- (i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_d Cannot either

- (i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or ☐
- (ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion ☐

W_e None of the above apply ☐

Standing and sitting

(Activity 2)

Tick the first box that applies.

- S_a Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person ☐
- S_b Cannot, for the majority of the time, remain at a workstation, either:
- (i) standing unassisted by another person (even if free to move around) or; ☐
 - (ii) sitting (even in an adjustable chair); or
 - (iii) a combination of (i) and (ii),
- for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion
- S_c Cannot, for the majority of the time, remain at a workstation, either:
- (i) standing unassisted by another person (even if free to move around) or; ☐
 - (ii) sitting (even in an adjustable chair); or
 - (iii) a combination of (i) and (ii),
- for more than an hour before needing to move away in order to avoid significant discomfort or exhaustion
- S_d None of the above apply ☐
-

Lower Limb – Activities 1 and 2

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

5

Behaviour observed during assessment

6

Relevant features of clinical examination

7

Reaching

(Activity 3)

Tick the first box that applies.

- | | | |
|----------------|--|--------------------------|
| R _a | Cannot raise either arm as if to put something in the top pocket of a coat or jacket | <input type="checkbox"/> |
| R _b | Cannot raise either arm to top of head as if to put on a hat | <input type="checkbox"/> |
| R _c | Cannot raise either arm above head height as if to reach for something | <input type="checkbox"/> |
| R _d | None of the above apply | <input type="checkbox"/> |
-

**Picking up and moving or transferring by the use of the
upper body and arms**

(Activity 4)

Tick the first box that applies.

- | | |
|--|--------------------------|
| P _a Cannot pick up and move a 0.5 litre carton full of liquid | <input type="checkbox"/> |
| P _b Cannot pick up and move a one litre carton full of liquid | <input type="checkbox"/> |
| P _c Cannot transfer a light but bulky object such as an empty cardboard box | <input type="checkbox"/> |
| P _d None of the above apply | <input type="checkbox"/> |
-

Manual dexterity

(Activity 5)

*Tick the first box that applies.***M_a Cannot either:****(i) press a button, such as a telephone keypad or;****(ii) turn the pages of a book****with either hand**☐**M_b Cannot pick up a £1 coin or equivalent with either hand**☐**M_c Cannot use a pen or pencil to make a meaningful mark**☐**M_d Cannot single-handedly use a suitable keyboard or mouse**☐**M_e None of the above apply**☐

Upper Limb – Activities 3, 4 and 5

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living	8
---	---

Behaviour observed during assessment	9
--------------------------------------	---

Relevant features of clinical examination	10
---	----

Navigation and maintaining safety, using a guide dog or other aid if either or both are normally, or could reasonably be, used
(Activity 8)

Tick the first box that applies.

- | | | |
|----------------|---|--------------------------|
| V _a | Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _b | Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _c | Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment | <input type="checkbox"/> |
| V _d | None of the above apply | <input type="checkbox"/> |
-

**Making self understood through speaking, writing, typing,
or other means which are normally, or could reasonably be,
used, unaided by another person** (Activity 6)

Tick the first box that applies.

- | | |
|--|--------------------------|
| SP _a Cannot convey a simple message, such as the presence of a hazard | <input type="checkbox"/> |
| SP _b Has significant difficulty conveying a simple message to strangers | <input type="checkbox"/> |
| SP _c Has some difficulty conveying a simple message to strangers | <input type="checkbox"/> |
| SP _d None of the above apply | <input type="checkbox"/> |
-

Understanding communication by -

- (i) verbal means (such as hearing or lip reading) alone,**
 - (ii) non-verbal means (such as reading 16 point print or Braille) alone, or**
 - (iii) a combination of (i) and (ii),**
- using any aid that is normally, or could reasonably be, used, unaided by another person**

(Activity 7)

Tick the first box that applies.

- | | | |
|----------------|---|--------------------------|
| H _a | Cannot understand a simple message due to sensory impairment, such as the location of a fire escape | <input type="checkbox"/> |
| H _b | Has significant difficulty understanding a simple message from a stranger due to sensory impairment | <input type="checkbox"/> |
| H _c | Has some difficulty understanding a simple message from a stranger due to sensory impairment | <input type="checkbox"/> |
| H _d | None of the above apply | <input type="checkbox"/> |
-

Vision, Speech and Hearing – Activities 8, 6 and 7

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

11

Behaviour observed during assessment

12

Relevant features of clinical examination

13

Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used

(Activity 9)

Tick the first box that applies.

- C_a At least once a month experiences ☐
- (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or
- (ii) substantial leakage of the contents of a collecting device; sufficient to require cleaning and a change in clothing
- C_b The majority of the time is at risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly ☐
- C_c None of the above apply ☐

Continence – Activity 9

Medical evidence used to support your choice of activity outcome

Prominent features of functional ability relevant to daily living

14

Relevant features of clinical examination

15

Consciousness during waking moments

(Activity 10)

Tick the first box that applies.

- F_a At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration ☐
- F_b At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration ☐
- F_c None of the above apply ☐
-

Consciousness during waking moments – Activity 10

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

16

Relevant features of clinical examination

17

Mental, cognitive and intellectual function

This part to be completed when a specific mental illness has been diagnosed, or when there is a condition, whether mental, physical, or sensory resulting in cognitive or intellectual impairment of mental function. If not applying the assessment give reasons below.

Are you applying the mental function assessment? Yes ☐
No ☐

I have considered whether this client has a specific mental disease or disability affecting mental function. I have not applied the mental function assessment (as per the Limited Capability for Work legislation) because there is no recent history of a mental disease having been diagnosed or treated, and there is no medical or other evidence before me nor any findings that mental function is affected.

Evidence to support the decision not to apply the mental function part of the test

Medical Opinion – Mental Function

Understanding and Focus

Learning tasks

(Activity 11)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| LT _a | Cannot learn how to complete a simple task, such as setting an alarm clock | <input type="checkbox"/> |
| LT _b | Cannot learn anything beyond a simple task, such as setting an alarm clock | <input type="checkbox"/> |
| LT _c | Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes | <input type="checkbox"/> |
| LT _d | None of the above apply | <input type="checkbox"/> |
-

Awareness of everyday hazards (such as boiling water or sharp objects)

(Activity 12)

Tick the first box that applies.

AH_a Reduced awareness of everyday hazards leads to a significant risk of:

(i) injury to self or others; or

(ii) damage to property or possessions,

such that they require supervision for the majority of the time to maintain safety

☐

AH_b Reduced awareness of everyday hazards leads to a significant risk of:

(i) injury to self or others; or

(ii) damage to property or possessions,

such that they frequently require supervision to maintain safety

☐

AH_c Reduced awareness of everyday hazards leads to a significant risk of:

(i) injury to self or others; or

(ii) damage to property or possessions,

such that they occasionally require supervision to maintain safety

☐

AH_d None of the above apply

☐

**Initiating and completing personal action (which means
planning, organisation, problem solving, prioritising or
switching tasks)**

(Activity 13)

Tick the first box that applies.

- | | | |
|-----------------|---|--------------------------|
| IA _a | Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions | <input type="checkbox"/> |
| IA _b | Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time | <input type="checkbox"/> |
| IA _c | Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions | <input type="checkbox"/> |
| IA _d | None of the above apply | <input type="checkbox"/> |

Understanding and Focus – Activities 11, 12, and 13

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

18

Relevant features of clinical examination

19

Adapting to Change

Coping with change

(Activity 14)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| CC _a | Cannot cope with any change to the extent that day to day life cannot be managed | <input type="checkbox"/> |
| CC _b | Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult | <input type="checkbox"/> |
| CC _c | Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult | <input type="checkbox"/> |
| CC _d | None of the above apply | <input type="checkbox"/> |

Getting about

(Activity 15)

Tick the first box that applies.

- | | | |
|-----------------|---|--------------------------|
| GA _a | Cannot get to any place outside the claimant's home with which the claimant is familiar | <input type="checkbox"/> |
| GA _b | Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person | <input type="checkbox"/> |
| GA _c | Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person | <input type="checkbox"/> |
| GA _d | None of the above apply | <input type="checkbox"/> |

Adapting to Change – Activities 14 and 15

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

20

Relevant features of clinical examination

21

Social Interaction

Coping with social engagement due to cognitive impairment or mental disorder

(Activity 16)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| CS _a | Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _b | Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _c | Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual | <input type="checkbox"/> |
| CS _d | None of the above apply | <input type="checkbox"/> |
-

Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

(Activity 17)

Tick the first box that applies.

- | | | |
|-----------------|--|--------------------------|
| IB _a | Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _b | Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _c | Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace | <input type="checkbox"/> |
| IB _d | None of the above apply | <input type="checkbox"/> |

Social Interaction – Activities 16 and 17

Medical evidence used to support your choice of activity outcomes

Prominent features of functional ability relevant to daily living

22

Relevant features of clinical examination

23

Exceptional Circumstances (Non-functional descriptors)

My advice based on the Limited Capability for Work and Limited Capability for Work 24 Related Activity medical examination I have carried out as a healthcare professional approved by the Secretary of State, is that this person

- is suffering from a life threatening disease in relation to which-

(a) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure, and

No ☐

(b) in the case of a disease that is uncontrolled, there is a reasonable cause for it not to be controlled by a recognised therapeutic procedure

Yes ☐

- is suffering from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if they were found not to have limited capability for work and that the risk could not be significantly reduced by reasonable adjustments made in the workplace or by taking prescribed medication
(If 'Yes,' please complete a UC85A if you are also advising the corresponding LCWRA category)

No ☐

Yes ☐

Please contact the CSD (Customer Service Desk) to confirm appropriate use of the NFD.

By checking this box you are confirming that you have contacted CSD and that they have approved the Non- Functional Descriptor (NFD) choice.

☐

I have discussed this NFD with

Please justify the answers you have given above in relation to exceptional circumstances.

25

Limited Capability for Work-Related Activity

Please justify if, in your opinion, the person does not meet any of the descriptors for limited capability for work-related activity. 26
Please provide evidence in support of your opinion for each area of functional activity.

I advise that the client should be re-referred in:			28
	Functional problems	Exceptional circumstances (where applicable)	
3 months	<input type="checkbox"/>	<input type="checkbox"/>	
6 months	<input type="checkbox"/>	<input type="checkbox"/>	
12 months	<input type="checkbox"/>	<input type="checkbox"/>	
18 months	<input type="checkbox"/>	<input type="checkbox"/>	
2 years	<input type="checkbox"/>	<input type="checkbox"/>	
No significant functional change anticipated			
	<input type="checkbox"/>	<input type="checkbox"/>	

Justification for the above advice	29

This form has been completed by a healthcare professional approved by the Secretary of State for Work and Pensions.

I have completed this form in accordance with the current guidance to UC examining healthcare professionals as issued by the Department for Work and Pensions.

I can confirm that there is no harmful information in the report other than indicated.

Signature

Name in Capital Letters

Approved Disability Analyst

Date

Registered Medical Practitioner

☐

Registered Nurse

☐

Registered Occupational Therapist

☐

Registered Physiotherapist

☐

Harmful Information – not to be copied to the client

Appendix 3 - ESA85S and UC85S

ESA85S 05/11	<i>Employment and Support Allowance</i> Personalised Summary Statement	
	Surname	Mr/Mrs/Miss/Ms
	Other names	
	National Insurance Number	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div>
	Date of birth	<div> / </div> <div> / </div>
<div></div>		
Signature		
Name in Capital Letters		
Date	<div> / </div> <div> / </div>	<i>Approved Disability Analyst</i>
Registered Medical Practitioner	<input type="checkbox"/>	Registered Nurse <input type="checkbox"/>
Registered Occupational Therapist	<input type="checkbox"/>	Registered Physiotherapist <input type="checkbox"/>
1	Restricted Medical	

UC85S 13/04

*Universal Credit****Personalised Summary Statement***

Surname	Mr/Mrs/Miss/Ms									
Other names										
National Insurance Number	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>									
Date of birth	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> / /									

--

Signature	
-----------	--

Name in Capital Letters	
-------------------------	--

Date	/ /	<i>Approved Disability Analyst</i>
------	-----	------------------------------------

Registered Medical Practitioner	<input type="checkbox"/>	Registered Nurse	<input type="checkbox"/>
---------------------------------	--------------------------	------------------	--------------------------

Registered Occupational Therapist	<input type="checkbox"/>	Registered Physiotherapist	<input type="checkbox"/>
-----------------------------------	--------------------------	----------------------------	--------------------------

Appendix 4- ESA85A and UC85A

ESA85A 15/11 *Employment and Support Allowance* **Medical report form**

Surname	Mr/Mrs/Miss/Ms
Other names	
National Insurance Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>

- ☐ I am unable to advise on the evidence held. The case will need to be referred for an assessment.
-
- ☐ I advise that the person meets the criteria for having limited capability for work.
-
- ☐ In my opinion, the client falls into the limited capability for work related activity category of
-
-
- ☐ I advise that the person meets the criteria for being treated as having limited capability for work
-
-
- ☐ From the evidence available, it does not appear that this person is suffering from a progressive disease likely to limit life expectancy to less than 6 months.
-
- ☐ From the evidence available, it does not appear that this person meets the criteria for limited capability for work related activities
-
- ☐ I advise that work could be considered within
- 3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐
- ☐ I advise that work is unlikely
- within 2 years ☐ in the longer term ☐

ESA85A
15/11**Employment and Support Allowance
Medical report form**

Surname	<input type="text" value="Mr/Mrs/Miss/Ms"/>
Other names	<input type="text"/>
National Insurance Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>

Justification of any advice given above

Advice regarding Limited Capability for Work

Advice regarding Limited Capability for Work Related Activity

This form has been completed by a healthcare professional approved by the Secretary of State for Work and Pensions.

I have completed this form in accordance with the current guidance to ESA examining healthcare professionals as issued by the Department for Work and Pensions.

Signature Name in Capital Letters Date / / *Approved Disability Analyst*Registered Medical Practitioner ☐Registered Nurse ☐Registered Occupational Therapist ☐Registered Physiotherapist ☐

UC85A 13/11

Universal Credit Medical report form

Surname	<input type="text" value="Mr/Mrs/Miss/Ms"/>
Other names	<input type="text"/>
National Insurance Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>

- ☐ I am unable to advise on the evidence held. The case will need to be referred for an assessment.
-
- ☐ I advise that the person meets the criteria for having limited capability for work.
-
- ☐ In my opinion, the client falls in to the limited capability for work related activity category of
-
-
- ☐ I advise that the person meets the criteria for being treated as having limited capability for work
-
-
- ☐ From the evidence available, it does not appear that this person is suffering from a progressive disease likely to limit life expectancy to less than 6 months.
-
- ☐ From the evidence available, it does not appear that this person meets the criteria for limited capability for work related activities
-
- ☐ I advise that the client should be re-referred in:
- 3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐ 2 years ☐
- ☐ No significant functional change anticipated
-

UC85A 13/11

**Universal Credit
Medical report form**

Surname	<input type="text" value="Mr/Mrs/Miss/Ms"/>
Other names	<input type="text"/>
National Insurance Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>

Justification of any advice given above

Advice regarding Limited Capability for Work

Advice regarding Limited Capability for Work Related Activity

This form has been completed by a healthcare professional approved by the Secretary of State for Work and Pensions.

I have completed this form in accordance with the current guidance to UC examining healthcare professionals as issued by the Department for Work and Pensions.

Signature	<input type="text"/>
Name in Capital Letters	<input type="text"/>
Date	<input type="text"/> / <input type="text"/> / <input type="text"/> Approved Disability Analyst
Registered Medical Practitioner	<input type="checkbox"/>
Registered Occupational Therapist	<input type="checkbox"/>
Registered Nurse	<input type="checkbox"/>
Registered Physiotherapist	<input type="checkbox"/>

Appendix 5 – Proof of Identity Form

MEDICAL SERVICES	
Provided on behalf of the Department of Work and Pensions	
PROOF OF IDENTITY SLIP	
<u>PART 1 - Claimant's personal details</u>	
Full Name (please print):	
Date of Birth:/...../.....	
Signature: Date:/...../.....	
<u>PART 2 - Personal Identification that we need</u> (For office use only)	
The claimant should provide either one item from List 1, or two items from List 2.	
<u>List 1: One item from:</u>	
<input type="checkbox"/> Passport	
<input type="checkbox"/> Identity Card	
<input type="checkbox"/> Standard Acknowledgement Letter (held by people seeking asylum)	
<u>List 2: If the claimant does not have any of the items from List 1, then they must provide two items from the following list. Both of the items must be currently in use.</u>	
<input type="checkbox"/> Rent book or tenancy agreement	<input type="checkbox"/> Medical card
<input type="checkbox"/> Current credit card or charge card	<input type="checkbox"/> Services Identity card
<input type="checkbox"/> Current cheque guarantee card	<input type="checkbox"/> Household bills
<input type="checkbox"/> Bank or Building Society book	<input type="checkbox"/> Ball sheets
<input type="checkbox"/> Membership card of a known association	<input type="checkbox"/> Original birth certificate
<input type="checkbox"/> Cheque Book	<input type="checkbox"/> Senior Citizen pass with photograph
<input type="checkbox"/> Letter showing home address	<input type="checkbox"/> Marriage or civil partnership certificate
<input type="checkbox"/> Full driver's licence	<input type="checkbox"/> Any other form of identification
<input type="checkbox"/> ES40 and JSA agreement	
A) Has correct Identity been established by MCA? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
(If 'No' or 'N/A', complete part 'B' below)	
B) Has examining HCP been able to establish correct Identity? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<p>Atos Healthcare is a trading name of Atos IT Services UK Limited and a trademark of the Atos Group. Atos IT Services UK Limited is registered in England and Wales. Registered Address: 4 Triton Square, Regent's Place, London NW1 3HG, UK. Registered No.: 01243534. VAT No.: GB232327983. F01D1 07/14</p>	

Appendix 6 – DWP Revised Risk Guidance 2015

Guidance for HCPs on Substantial Risk in Considering Claimants with a Mental Function Problem

This update is for guidance but your advice should be based on your clinical judgement and consideration of the evidence in each individual case.

This guidance is intended to assist Healthcare Professionals (HCPs) carrying out the Work Capability Assessment (WCA) and replaces previous guidance on the interpretation of substantial risk in the context of regulation 29(2)(b) and regulation 35(2) of the Employment and Support Allowance Regulations 2008 and the UC Regulations 2013 as amended by the UC and Miscellaneous Amendment Regulations 2014.

The guidance makes clear that this provision should only be applied in exceptional circumstances, and that in applying the guidance a two stage process should be followed:

- Stage one – assess the evidence of risk of suicide or self-harm
- Stage two – assess whether substantial risk would be triggered by a finding that the claimant is able to seek employment or is able to undertake activity to prepare them to move towards work (bearing in mind that there is good evidence that the right sort of employment is in general good for mental health).

The substantial risk criteria should only be recommended if there is evidence that substantial risk to the mental or physical health of any person, by reason of some specific disease or bodily or mental disablement, would be triggered if the claimant were found not to have limited capability for work or work-related activity.

For further information about the non-functional circumstances in which claimants might be found to have limited capability for work-related activity please read section 2.3.2 of the WCA Handbook.

Background

Following completion of a detailed functional assessment, HCPs are required to provide advice to the decision maker as to whether there would be a substantial risk to the mental or physical health of any person if the claimant is either found fit for work or able to undertake work-related activity. Legislation underpinning this is set out in regulation 29(2) (b) and regulation 35(2) of the Employment and Support Allowance Regulations 2008 and the UC Regulations 2013 as amended by the UC and Miscellaneous Amendment Regulations 2014.

Limited Capability for Work

A claimant who does not have limited capability for work as determined in accordance with the limited capability for work assessment is to be treated as having limited capability for work if the claimant suffers from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, *there would be a substantial risk to the mental or*

physical health of any person if the claimant were found not to have limited capability for work. [Emphasis added]

This does not apply where the risk could be reduced by a significant amount by:

- reasonable adjustments being made in the claimant's workplace; or
- the claimant taking medication to manage the claimant's condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant.

Limited Capability for Work-Related Activity

A claimant who does not have limited capability for work-related activity in accordance with the limited capability for work assessment is to be treated as having limited capability for work-related activity if:

- the claimant suffers from some specific disease or bodily or mental disablement; and
- by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work-related activity.

Policy intent

The WCA is a functional assessment and the majority of claimants who are not fit for work or work related activity should be identified by the functional activities. However, the assessment recognises that there will be small number of claimants who have a high level of function but for whom the decision that they must seek work or undertake work-related activity would be detrimental. This provision should only be applied in exceptional circumstances.

You should note that regulations refer to "substantial risk" to mental or physical health. Substantial risk has been defined as a risk "that cannot sensibly be ignored having regard to the nature and gravity of the feared harm in the particular case"¹. The substantial risk can apply to either the claimant or a third party, for example if there is a risk of injury to another as a result of violent behaviour by the claimant.

The impact of being found fit for work or required to carry out work-related activity

Work and work-related activity (WRA) are very different. If a claimant is found fit for work and chooses to apply for Jobseeker's Allowance, the claimant will usually be expected (subject to relaxations in certain cases) to be available for work, to search for work and to accept suitable employment, which may involve an employer making reasonable adjustments for the claimant as required by the Equality Act.

Work-related activity can involve any of a range of activities supervised by DWP, or a third party organisation, that assist the claimant to move closer towards the world of work. It is work preparation activity intended to give the claimant the best possible prospects of moving into work at a point when they are able.

When a claimant is allocated to the work-related activity group a discussion with a DWP

¹ IM v Secretary of State for Work and Pensions (ESA), paragraph 65.

adviser usually takes place within 10 days of the WCA. At the discussion (which can be over the phone if appropriate to the claimant's circumstances), the adviser will find out more about the claimant, their aims for the future, their health condition, their current circumstances, and how they can best be supported to start moving closer towards the world of work.

The activity which the claimant is required to undertake could include completing online tasks (such as a self-assessment or a diary of daily activities), telephone or face-to-face discussions with the DWP or Work Programme providers to discuss goals and agree specific activities, taking part in courses to improve skills or confidence, or in some cases continue to engage in activity already taking place (whether arranged themselves or by a third party organisation).

The requirement for work-related activity is different for each individual ESA claimant. Work-related activity must be appropriate and personal to the individual.

Claimants must not be asked by DWP to do anything that is unrealistic or could put their health at risk, or be required to undertake work-related activity that includes applying for a job or undertaking work as an employee or otherwise.

If the claimant feels that the work-related activity they have been asked to complete is inappropriate or unreasonable, they can discuss this with the DWP adviser, and if this does not resolve the issue the claimant can request a formal reconsideration.

Stage 1 – assessing risk

You should explore the claimant's mental state during the assessment, including thoughts of self-harm or suicide. Indicators of a high suicidal intent include clear plans, preparation and avoiding possible intervention. Previous suicide attempts are an additional indication. There is no reason to assume that being required to carry out work-related activity will trigger the risk provisions in all cases where claimants experience suicidal thoughts or have self-harmed.

HCPs are not required to undertake a formal psychiatric risk assessment but instead need to consider the risk that could arise as a consequence of an individual being found either fit for work or placed in the work-related activity group. You should base your advice on the balance of probability, consideration of the evidence and clinical judgement in each individual case.

If at any point you consider that the claimant is a significant suicide risk, you must advise the GP if the claimant's clinical team are not already aware (form UE1). You must give specific details of the risk and why you have reached that conclusion. See section 3.1.5 of the WCA handbook for further information.

Stage 2 – would risk of suicide or self-harm be triggered if the claimant were found not to have limited capability for work or work-related activity

There is a strong evidence base showing that the right sort of employment is generally good for physical and mental health and well-being. "When their health condition permits, sick and disabled people (particularly those with 'common health problems') should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:

- is therapeutic;

- helps to promote recovery and rehabilitation;
- leads to better health outcomes;
- minimises the harmful physical, mental and social effects of long-term sickness absence;
- reduces the risk of long-term incapacity;
- promotes full participation in society, independence and human rights;
- reduces poverty; and
- improves quality of life and well-being.”²

So you should not assume that recommending that a claimant is fit for work or for work related activity will trigger substantial risk to physical or mental health.

2a) Recommending that a claimant is fit for work

If you conclude that finding a claimant fit for work would trigger risk of suicide or self-harm then you need to consider whether there are factors that would mitigate the risk if the claimant were found fit for work.

- Is the risk that would arise to physical or mental health substantial?
- Have you considered the benefits of employment weighed against any potential risks? Remember that there is good evidence that people in work have better health outcomes and are at lower risk of suicide.
- Could the risk be significantly reduced by any reasonable workplace adjustments or prescribed medication?

It should be noted that a claimant’s normal anxiety or concern about their ability to cope with the demands of work or a return to work does not constitute a substantial risk.

If you consider that there would be a substantial risk to the mental or physical health of the claimant or another person as a result of a finding that the claimant was fit for work despite potential workplace adjustments or prescribed medication (i.e. that regulation 29(2)(b) applies) you should advise the decision maker accordingly, providing robust justification for your advice. You will then need to consider whether there would be a substantial risk if the claimant were found fit for work-related activity.

2b) Recommending that a claimant is fit for work-related activity

The HCP cannot know exactly what activities the claimant will be asked to carry out. However, the flexibility in the DWP approach, tailoring work-related activity to each claimant’s circumstances and health condition, and the requirement that claimants must not be asked to do anything that could put their health at risk, make it unlikely that many claimants will be at substantial risk if required to carry out work-related activity.

In exceptional circumstances, however, you may consider that a claimant is in such a vulnerable situation that a finding that they can undertake work-related activity might give rise to a substantial risk to their or another person’s mental or physical health. Such exceptional

² Taken from: “Is Work Good for Your Health and Wellbeing”, Waddell & Burton:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

circumstances might, though will not necessarily, include:

- current crisis or home treatment team intervention
- currently sectioned or recently discharged from a section of the Mental Health Act and the Mental Health (Care & Treatment) (Scotland) Act 2003
- psychotic illness considered vulnerable to relapse
- a history of violent behaviour as a result of a mental health condition that resulted in recent injury to a third party

The above examples are for illustrative purposes. Some claimants in the above categories might not be placed at substantial risk by a finding that they can undertake work-related activity. Likewise, there may be claimants who do not fit into the above examples who you conclude would be placed at substantial risk by a finding that they can undertake work-related activity.

As when considering the risks of a finding that a person is fit for work, you should take into account that there is good evidence that unemployed people are at greater risk of suicide and that long term unemployment carries the greatest risk. While, as outlined above, work is different from work-related activity it is important to remember that work-related activity is a vital tool in supporting disabled people and people with health conditions, including mental health conditions, to move closer to the labour market.

If you consider that there would be a substantial risk to the claimant's or another person's mental or physical health if they were placed in the work-related activity group (i.e. that regulation 35(2) applies) you should advise the decision maker accordingly, providing robust justification for your advice.

Appendix 7 – DWP Information on Work related Activity

Work Related Activity

When the DWP Decision Maker receives the HCP's advice they make a decision on whether the claimant has Limited Capability for Work (LCW), or Limited Capability for Work and Limited Capability for Work-Related Activity (LCW and LCWRA).

The obligations claimants must meet to continue to receive ESA following the outcome of the Work Capability Assessment (WCA) differ depending on whether the claimant is found to have LCW or LCW and LCWRA.

- **Support Group** (LCW and LCWRA) claimants are not required to attend work-focused interviews or undertake work-related activity. Claimants can volunteer for certain work-related support at any point during their claim. However, participation remains voluntary.
- **Work Related Activity Group** (LCW) claimants, subject to certain exceptions, will be required to attend work-focused interviews and undertake work-related activity. Broadly, the purpose is to improve the capability or readiness for work, with a view to helping their prospects of moving into work in the future.

ESA claimants **cannot** be required to search for jobs or apply for a job.

Work Focused Interviews

Work-focused interviews are carried out by work coaches at the Jobcentre or Work Programme provider. The aim is to identify the help and support claimants need to overcome barriers, and move them into a position where they would be better placed to get back to work at some point in the future.

Work coaches use this interview to assess the claimant's prospects for obtaining work in the future and to identify work-related activity (WRA) which is suitable for that claimant. There are no requirements for the number of interviews a claimant must attend.

Work Related Activity

WRA can be one or more defined activities that help move ESA claimants closer to a position where they may be ready to search for and take up work in the future. WRA will be different for each individual claimant as it must be appropriate and reasonable, taking into account their circumstances. ESA claimants cannot be required to search for or apply for jobs. Furthermore they cannot be required to receive medical treatment.

Agreeing Work-Related Activity

Work Coaches have the freedom to determine, in consultation with the claimant, what WRA is appropriate and reasonable. The claimant's circumstances must be taken into account; including physical or mental health and any learning or cognitive issues, as failure to undertake WRA can result in a sanction applied to the claimant's benefit. The claimant's circumstances are explored at their first work-focused interview, which usually takes place within ten days of the WCA decision.

WRA agreed with the claimant must be appropriate, personal to the customer and aimed at improving access to opportunities in the labour market. Claimants must not be asked to undertake anything that is unrealistic or could put their health at risk.

Examples of work related activity

The circumstances of each ESA claimant are different and WRA that is suitable for one claimant may not be suitable for others.

WRA can take place in various settings and locations, including in the claimant's own home. This will be determined by various factors, including the nature of the WRA, and the claimant's individual circumstances, including the nature and severity of their health conditions.

Examples may include:

- Meetings by telephone such as a telephone review with work coach to discuss barriers, goals, and make referrals
- Completing tasks online such as setting up an e-mail account, researching support available on the internet to help them towards their goals or completing e-learning as agreed with a work coach
- Attendance at a Jobcentre or Work Programme provider premises to take part in a skills & experience review or individual mentoring support
- Group sessions such as referral to external specialist intervention partners for confidence building and motivation workshops

For a specific claimant, WRA could look like this:

- The claimant identifies that a skills need is the main barrier preventing them moving closer to the labour market, when they are able to do so would be referred to the appropriate skills provision;
- Where a claimant has a health condition that prevents them returning to their previous line of work, the work coach and claimant may agree that a short training course and/or skills check would enable the claimant to identify a different field of work they could do, when they are able to do so.

WRA can also take a less formal shape and/or be less demanding, which might be appropriate for people with more severe mental health or developmental disorders. This could include things like:

- Preparing or updating their CV;

- Leaving the house once a week, gradually increasing until they are leaving the house every day;
- Researching local public transport routes with a view to getting used to travelling within their local area;
- Keeping a diary of their day to day activities
- Making a list of hobbies and things that they enjoy/used to enjoy doing;
- Improving their digital/IT skills by setting up an e-mail account.

If the Claimant feels the WRA is inappropriate or unreasonable

If the claimant feels that the work related activity they have been asked to complete is inappropriate or unreasonable, they can discuss their concerns with the Work Coach or Work programme Provider, and ask for it to be reconsidered.

Observation form

Please photocopy this page and use it for any comments and observations on this document, its contents, or layout, or your experience of using it. If you are aware of other standards to which this document should refer, or a better standard, you are requested to indicate this on the form. Your comments will be taken into account at the next scheduled review.

Name of sender: _____ Date: _____

Location and telephone number: _____

Please return this form to: Centre for Health and Disability Assessments
Learning and Development
Room 263 2nd Floor
Five Ways House
Islington Row Middleway
Birmingham
B15 1SL