MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training & Development

Revised WCA Handbook
ESA (LCW/LCWRA) Amendment Regulations 2011

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Foreword

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

All Health Care Professionals undertaking medical assessments must be registered medical practitioners, nursing practitioners or physiotherapists 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 training must be read with the understanding that, as experienced practitioners and Disability Assessors, the Health Care Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques, and therefore such information is not contained in this training module.

In addition, this Handbook is not a stand-alone document, and forms only a part of the training and written documentation that a Health Care 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 Health Care Professionals.

Office of the Chief Medical Adviser

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Contents

1. Introduction

1.1 Introduction

This handbook has been written to support Health Care Professionals (HCPs) trained in the principles of Disability Analysis; in their training and in performing medical assessments in relation to the Employment and Support Allowance Limited Capability for Work / Limited Capability for Work Related Activity (LCW/LCWRA) Amendment Regulations 2011. The amendment regulations of 2011 may also be referred to as "The Revised Work Capability Assessment" (Revised WCA).

For guidance relating to the ESA LCW/LCWRA Regulations of 2008, HCPs are referred to "The ESA Handbook".

The intended learning outcome of the handbook is that the HCP will be equipped with adequate knowledge of the background, principles, processes, and the role of the HCP to be able to successfully promulgate the Ministerial intention and successfully complete the Revised Work Capability Assessment (WCA) learning path. The handbook is designed to be an essential source of information for the HCP regarding ESA (amendment regulations 2011) and should also serve as a reference guide.

The handbook provides guidance on Employment and Support Allowance procedures and also recognises that these form the foundation of experience to progress to the generation of Evidence Based reports utilising the LiMA application. This handbook will make considerable reference to the LiMA application throughout as all ESA reports will be completed using the LiMA application except in exceptional circumstances.

Much of the work carried out by Atos Healthcare, including ESA and DLA, is completed using the LIMA system. LiMA (Logic Integrated Medical Assessment) is an evidence based computer programme which allows the practitioner 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.

We will also use this system to provide advice for decision makers for Revised WCA assessments.

The Handbook is based on the "WCA Internal Review – Report of the Working Group" commissioned by the Department for work and Pensions, the "WCA Technical Review", and the ESA Amendment Regulations 2011 with clarifications from the Department of Work and Pensions Health, Work and Wellbeing Directorate. Additional information is drawn from Atos Healthcare experience in other benefit strands.

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 the company.

The handbook consists of four parts.

Section 1 sets out the background to the revised WCA highlighting the concepts, intention and the main aspects of ESA (2011 regulations).

Section 2 deals mainly with office based work. This section will highlight the process, from receipt of the referral from Job Centre Plus to the point at which the claimant is called for an examination.

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 ESA report form.

Section 4 covers situations less commonly encountered at examination, for example domiciliary visits or potentially violent claimants. It also provides guidance on issues such as potentially harmful and embarrassing information.

1.2 Background to Employment and Support Allowance

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

The Employment and Support Allowance was designed to be an integrated contributory and income-related allowance replacing Incapacity Benefit 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 considered the impact of the changing patterns of Mental Health problems and current treatment options. They also considered the physical descriptors in the Personal Capability Assessment (PCA) used in Incapacity Benefit 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 undergoing assessment under this system.

In December 2008, a White Paper “Raising Expectations” announced a departmental-led review of the WCA. The review was led by officials within the DWP and comprised 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 both Mental Function and Physical problems covering a broad spectrum of levels of disability.

The analysis of the data established that the WCA (ESA regulations 2008) was accurately identifying 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.
- that the inclusion of the concept of "adaptation" would result in a more accurate reflection of the individual's functional capability
- that 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 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 the 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 main recommendations included:

- 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" has been 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 the new activity relates to 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 have been revised to reflect this issue.

- Sensory Function

In the 2008 regulations, the activities in this area reflected impairment. Adaptation had not been taken into account 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 has changed to the concept of being able to safely navigate. The activities of hearing and speech have been 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 have been amended to reflect any loss of continence. The loss of dignity associated with incontinence has been 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 will be awarded scoring descriptors.

- Mental Function

In understanding and focus, it was felt that the 2008 descriptors were complex and difficult to interpret. These have therefore been simplified. In the area of learning tasks, how an individual learns is no longer considered to be the crucial factor – it is their ability to learn that is 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 has been 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 is now a Support Group. 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 new descriptors relate to ability to engage in social contact an individual's ability to behave in an appropriate manner with others.

- Support Groups

Additional Support Group categories have been added 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 will be considered as in the Support Group.

- "Treat as LCW"

In the previous 2008 regulations, those undergoing rehabilitation as an inpatient for drugs and alcohol were not considered to have limited capability for work unless they had input from a healthcare professional. This has now been amended to reflect that those undergoing inpatient rehabilitation for drugs and alcohol will be considered as having limited capability for work regardless of whether the input is from a healthcare professional or not.

The recommendations of these review groups were accepted by the Secretary of State and now form the ESA LCW/LCWRA amendment regulations 2011.

The revised WCA will apply to all those in receipt of Incapacity Benefit from 28th March 2011and most ESA claimants.

1.3 The Work Capability Assessment Structure

The assessment process for deciding entitlement to benefit and rate of benefit paid in ESA is the Work Capability Assessment (WCA). 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 use a suitable keyboard or mouse". The descriptors are presented in a hierarchical manner and attract various points. The descriptor representing the most severe level of disability is at the top in each activity. This highest descriptor will attract 15 points meaning the person will be considered as having limited capability for work. In many of the 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 (both 2008 and 2011 regulations), there are a number of assessments:

- Limited Capability for Work Related Activity (LCWRA) – This assessment aims to identify the most severely disabled where interaction with work related activity is not required.

- Limited Capability for Work Assessment (LCW) - This aims to identify those people who currently have a limited capability for work but who would benefit from assistance and support with work and health related activity to maximise their full potential.

- Work Focused Health related Assessment (WFHRA) – This aims to explore the claimants work and health related beliefs to assist the Personal Adviser in developing a programme of work related activities in order to help the claimant realise their full potential. In July 2010, the DWP announced a suspension of the WFHRA for a two year period.

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 ESA Work Capability Assessment are to:

- Ensure that those who currently have limited capability for work 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.

- Identify, for those who have limited capability for work, interventions that would help to support recovery such that return to work would again become an option. The government will be introducing a “Work Programme” to enable people to return to the workplace. The Work Programme will be a single package of support providing personalised help for everyone who finds themselves out of work regardless of the benefit they are claiming.

1.4 The Financial Structure of ESA

ESA provides a single integrated income replacement benefit for those people who are not working and have an illness or disability.

ESA will be available to those who:

- satisfy the National Insurance – related contribution conditions; or
- satisfy income and capital tests; or ;
- satisfy both

Further information on the above eligibility conditions is not included in this handbook. Should the reader seek further information on eligibility criteria, they can find this via the parliament website: www.publications.parliament.uk or the DWP website: www.dwp.gov.uk.

There are a number of rates of benefit within the ESA structure.

- Following submission of a claim for ESA, the claimant enters the “Assessment Phase”. At this time they receive the basic assessment phase rate of payment until the outcome of their claim is decided by the Decision Maker. The assessment phase is usually 13 weeks.

- The “basic allowance” is the rate set at the Job Seekers Allowance personal rate for claimants who have meet the threshold of LCW but decline to participate in “work related activity”. Work related activity involves interaction with Personal Advisers at the Jobcentre Plus and other private and voluntary sector contractors to discuss activities such training or other interventions that may eventually contribute to “work readiness”.

- 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 through interaction with the Personal Advisers in Job Centre Plus.

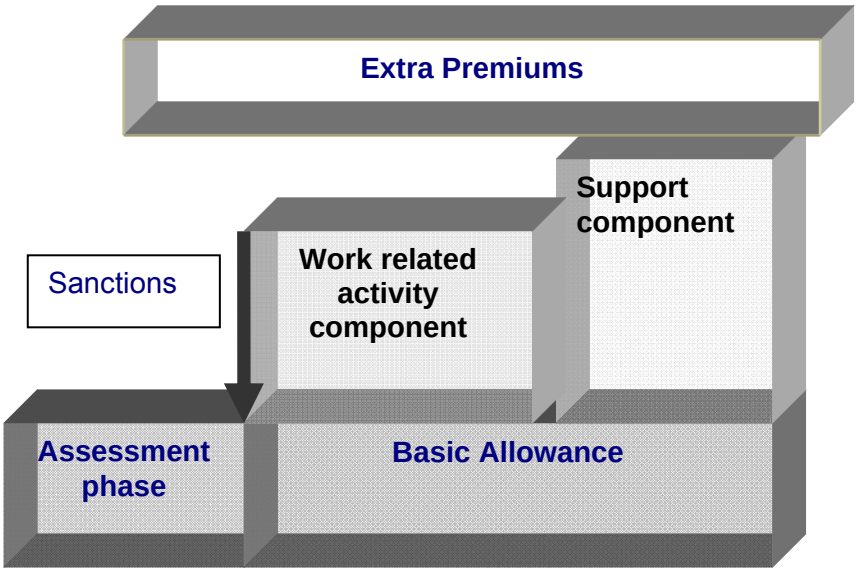
- The “support component” is an additional payment for the claimants considered to be the most severely disabled and who satisfy criteria for entry into the “Support Group”.

- Extra premiums are payable to some claimants on 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 Decision Maker arrives at a decision about the level of entitlement based either on advice based on evidence at the Filework stage or from the face to face ESA LCW/LCWRA medical assessment. The Decision Maker 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 or does not meet the threshold of having limited capability for work.

The financial structure of ESA may be illustrated in the following diagram.

(Diagram adapted from Welfare Reform Bill – draft regulations and supporting material – January 2007).



1.5 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 examination is required. The Filework process aims to identify claimants where a certain level of disability can be confirmed without the need for examination.

If at the time of the claim, the claimant indicates they are terminally ill, the case is sent straight to Atos Healthcare for advice.

All other claimants will be asked to provide a Med 3 from their GP detailing their diagnosis. This form is also referred to as a “Fit note”.

In most cases, the claimant is sent a form ESA 50 that they are expected to complete. This form gives the claimant the opportunity to provide details of their illnesses, treatment and functional abilities and restrictions. If a claimant has a Mental Function problem there is no compulsion for them to complete this form.

In initial claims, the Decision Maker will refer the case to Atos Healthcare 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, an Atos Healthcare HCP reviews the Med 3 details as well as any information made available by the claimant, and may decide that further medical evidence is required (FME). The FME may be requested from any HCP 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 examination to determine their level of disability.

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

- There is evidence of severe functional restriction meeting the criteria for Support Group inclusion (see section 2.3)

- There is evidence that the claimant meets Support Group criteria through “special circumstances” such as terminal illness or chemotherapy (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 radiotherapy or are currently a hospital inpatient. In this case the HCP must also have sufficient evidence to advise whether the claimant also has limited capability for work related activity. (see section 2.4)

In ESA re-referral claims and IB re-assessment claims (for claimants who currently receive Incapacity Benefit) the HCP in addition to the above may advise that the claimant is likely to meet the criteria for LCW where the claimant has previously had a face to face examination and there is strong evidence to support LCW. The HCP must also advise at this time on LCWRA status.

In cases where the evidence does not suggest the claimant fulfils any special circumstance criteria, Support Group or has LCW, the HCP will advise the Decision Maker that the claimant requires a face to face examination.

The claimant is contacted and an appointment made for them to attend a Medical Examination Centre to have a face to face assessment. The examining HCP will complete a full functional assessment on the report form – the ESA 85.

The completed ESA 85 is submitted to the Decision Maker, who decides on all available evidence whether the claimant meets any one of the criteria for the Support Group, 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.

If the claimant fails to reach the prescribed degree of disability where they would be considered to have limited capability for work, they will no longer be eligible for ESA.

The criteria for determination of limited capability for work are set out in the Welfare Reform Act 2007:

The claimant will be considered as having limited capability for work if he:

- scores 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 reach the prescribed degree of disability to be considered as having limited capability for work if he 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 Decision Maker accepts that a claimant does reach the threshold of having Limited Capability for Work, they are placed in the Work Related Activity Group (WRAG). The claimant will be required to attend a series of Work Focussed Interviews (WFIs) with the Personal Adviser. The first WFI will take place after the decision on inclusion into the WRAG. The interviews will be conducted at intervals to suit the customers labour market likelihood of employment and needs.. 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. This may include interventions such as retraining, education or condition management programmes. Their engagement in this process will result in entitlement to the “Work related Activity” component of ESA in addition to the basic ESA allowance.

It should be noted that for a period of time in 2011, some claimants will continue to be assessed under the 2008 ESA Regulations.

The 2011 regulations will apply to:

- All new claimants who apply for benefit on the grounds of ill health and are assessed after the 28th March 2011 (the date the Statutory Instrument comes into effect)..
- All existing ESA claimants who have their capability for work determined afresh after the 28th March 2011.

- All claimants in receipt of Incapacity Benefit who have their entitlement to benefit reviewed after the 28th March 2011

1.6 Sanctioning

The process of sanctioning lies outwith the AH process. To receive the higher rates of benefit, the claimant must be considered to be carrying out "reasonable steps" to manage their condition and help move them towards the workplace.

If the DM considers that the claimant has failed to participate in work related activity, then the claimant may be sanctioned and their rate of benefit reduced.

Those in the Support Group will not be required to participate in work related activity and will therefore not be subject to sanctioning procedures. However a claimant in the Support Group may opt to participate voluntarily in work related activity and engage with a PA.

The decision to apply a sanction is a complex procedure and is subject to a number of safeguarding procedures to ensure no claimant is unfairly treated.

Atos Healthcare personnel will have no role in sanctioning decisions, however advice provided to the department regarding non-attendance or non engagement at the LCW/LCWRA or WFHRA may be used as evidence in the sanctioning process.

1.7 The role of the Atos Healthcare HCP

All Health Care Professionals who give advice relating to Employment and Support Allowance 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 approved HCP is required to provide advice to the DWP Decision Maker 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 Decision Makers 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, ESA 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, the advisory role of the approved HCP falls into four main areas:

- Advice to the Department for Work and Pensions Decision Maker to confirm that a claimant satisfies any one of the Support Group criteria or any of the criteria for treating the claimant as having limited capability for work.

- Further advice or clarification requested by the Decision Maker.

- Application of the ESA LCW/LCWRA medical assessment, providing an objective and impartial assessment of the claimant's functional ability for the Decision Maker.

- In reassessment cases, where the claimant has previously been subject to the ESA LCW/LCWRA Medical Assessment (i.e. a full ESA 85 has been completed) the HCP will scrutinise the available medical evidence, in order to advise whether a further LCW/LCWRA medical assessment is required.

1.8 The Decision Maker's Perspective

Decision Makers 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 Decision Maker 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".

2. Filework

This section provides a brief overview of ESA Filework to provide some background for those who will be performing ESA examinations. It serves to give the examining HCP some understanding of the processes a claim has gone through before being called to examination and is not intended to be a comprehensive guide. HCPs undertaking Filework will be trained specifically in ESA Filework and should refer to the ESA 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 they may state that they are 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 Atos Healthcare 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. 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 ESA Filework Guidelines, however, in summary, a check takes place to find out whether a DS1500 has been submitted by the claimant. Form DS1500 is used in Disability Living Allowance and Attendance Allowance to consider applicants under the Special Rules for the terminally ill. If the DS1500 confirms the claimant is terminally ill, this advice is submitted to the Decision maker on form ESA 85A.

If no DS1500 submitted with the ESA claim, a check takes place to see if there has been a recent application for DLA/AA 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 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.

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 placed in the Support Group and there will be no requirement for them to be examined or participate in 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 Support Group criteria or one of the criteria for treating them as having LCW. If not, the claim will continue to be processed in the normal manner.

2.2 Pre-board Check

After the SR 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 ESA 50 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 be eligible for entry into the "Support Group" or those claimants who may meet certain criteria to be treated as having limited capability for work without having an examination. 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 Support Group applies or "Treat as LCW" applies, the HCP will provide this advice to the Decision Maker highlighting the specific Support Group criteria/ treat as LCW category that is appropriate. The Filework HCP will justify their advice and provide a prognosis for the DM to consider. If the Decision Maker accepts this advice, the claimant will not have to attend for assessment.

It should be noted that a claimant who has previously been assessed and entered into the Support Group, either at examination or Filework, will undergo a pre-board check at re-referral rather than re-referral scrutiny.

2.3 The Support Group

The Support Group is the group of claimants with the most severe levels of disability who are considered to have **limited capability for work related activity**.

The criteria for the Support Group are set out in Schedule 2 of the Social Security Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) Amendment Regulations 2011.

To be considered as having limited capability for work related activity, there should be evidence of a severe level of functional limitation. There are some categories for Support Group inclusion 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).

Advice may be given to the DM about a claimant's entitlement to be in the Support Group based either 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 examination.

The criteria for inclusion in the Support Group 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.

2.3.1 Support Group Criteria – Severe Functional Limitation

The following criteria are used to consider whether a person may be eligible for entry into the Support Group. These are set out in terms of **descriptors.** Many of these descriptors equate to the highest descriptor within the relevant LCW descriptors.

These descriptors are set out in the legislation and relate to the persons ability to perform that activity.

In considering <u>each</u> 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 at risk when performing a task, 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 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 support group descriptors may be found in Appendix 1.

When justifying your advice, where entitlement to be in the Support Group (Severe Functional Limitation) seems appropriate, you must also, indicate in every case that the claimant would also satisfy criteria for having limited capability for work.

Each of these will now be considered.

2.3.1.1 Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be 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 upper limbs or those with very severe cardiorespiratory problems. 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. This restriction may be as a result of joint deformity or pain. Consideration of the diagnosis, medical treatment and functional effects must be obtained, usually by requesting FME from a practitioner involved in the claimant's care. The descriptors relate to the ability to independently move useful distances by any of the means listed above. 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 Support Group 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 would not fall into this Support Group category.

A manual wheelchair may be considered any form of wheelchair that is not electrically driven.

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 must be taken into account.

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 3.3 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 fall into this Support Group 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. A situation specific item such as a hoist would not be considered a reasonable aid.

Information must be obtained at the pre-board check to confirm details of their disability and likelihood of restriction of the transferring activities. (See section 3.3 for further details of assessment at the LCW/LCWRA i of this type of activity).

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 restriction 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 upper limb functional restriction.

(See section 3.3 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. (See section 3.3 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.

N.B in considering function any aids or appliances should be considered.

(See section 3.3 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 normally used.

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 a simple message. A dense CVA with aphasia may have to be considered, however their ability to type 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.

(See section 3.3 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.1.7 Understanding communication by hearing, lip reading, reading 16 point print or using any aid if reasonably used.

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. Those with severe hearing restriction can often lip read but if they are unable to this descriptor must be considered. Vision would have to be considered in this area. The descriptor reflects only basic comprehension of writing and is not intended to reflect any higher level of literacy.

2.3.1.8 Continence - Absence or loss of control over extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the presence of any aids or adaptations normally 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 Support Group categories, the disability this describes is at a higher level than the highest continence descriptor. Someone who had such frequent and significant loss of bowel of bladder control would mean WRA 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.

The descriptor relates to substantial evacuation or 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 3.3 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 Support Group 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 CVA.

The Support Group descriptor 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 Support Group 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 this Support Group 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 drink as well as eat. Someone with a lesser degree of depression associated with reduced appetite, who requires occasional encouragement to maintain nutrition, would not fall into the Support Group in this category.

If the claimant is seen at examination, it may be necessary to document any facial disfigurement or 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 Support Group applies.

2.3.1.10 Learning

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

This Support Group 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 3.3 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 Support Group 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 3.3 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 Support Group 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 for example washing before dressing. This may be as a result of severe concentration or memory problems or very severe depressive illness. Those with active psychotic features may come into this group. Those with severe compulsive behaviour who 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 2 sequential personal actions would be washing and dressing. 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.

(See section 3.3 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 Support Group 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 3.3 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 Support Group descriptor reflects severe restriction of the ability to engage in any form of face to face social contact. This may be due to extreme anxiety or disorders of mental function where communication with others is impacted such as those with autistic spectrum disorder. Problems in this area may also be encounter by those with a psychotic illness.

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

(See section 3.3 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 Support Group 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 3.3 for further details of information that may be obtained at the LCW/LCWRA medical assessment).

2.3.2 Support Group Criteria – Special Circumstances

The following is a list of the other circumstances 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)” (Support Group 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 receiving treatment by way of intravenous, intraperitoneal, or intrathecal, chemotherapy or recovering from that treatment or is likely to receive such treatment within 6 months of the date of the determination of capability for work will be treated as having limited capability for work related activity

- Those in the "terminal illness" Support Group should be identified at the SR 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 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 information must be considered to assess whether the claimant now fulfils the criterion for this Support Group.

- The Support Group criteria relating to pregnancy should not be confused with the LCW criteria regarding the confinement period (see later). This Support Group 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.

- The Support Group 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. The wording of this Support Group criterion should be particularly noted. The risk to others or the person must be substantial. It refers to **work related activity** e.g. supported placements and training etc, not just actual work. Circumstances where this may apply may be for example in those with severe personality disorder where there is a substantial risk of violence; or where the claimant has severe mental function problems such as florid psychosis, or has severely compromised immune function. When justifying inclusion in this Support Group, reference must be made to the fact that the LCW is also satisfied.

- The fundamental basis of the “chemotherapy” Support Group criterion is that this represents only a very small number of people with such severe levels of disability that it would be quite unreasonable to require them to engage in work related activity. Those undergoing chemotherapy for malignancy will often have considerable fatigue, be at risk of infection and suffer other severely debilitating effects. Each individual case should be considered carefully with respect to the impact of the treatment and side effects. When providing advice on prognosis for Support Group inclusion the nature of the condition and duration of chemotherapy should be considered. In addition, those who are expected to undergo chemotherapy within a 6 month period of the assessment will also fulfil criteria for entry into the Support Group. (This allows us to make a ”balance of probability” decision on someone who is still waiting to be told plans)

Please note that these Special Circumstances Support Group categories will automatically fulfil criteria for LCW as well as LCWRA.

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 legislation. Those claimants identified by the DM as having LCW will be referred to Atos Healthcare for advice about whether the claimant also has LCWRA. At the time of the referral, these claimants will be sent an ESA 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. 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 an 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 SG 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.

These criteria are as follows:

- Those in the various categories for the Support Group (non functional categories (“TI,”, “pregnancy risk”, “chemotherapy” and “specific risk”) are also considered to have limited capability for work in the legislation. This means that if for example chemotherapy is identified, LCW is automatically established as well.

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

- Infectious disease exclusion by Public Health Order.

"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

"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 is payable, the MAP 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 examination, 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 **INPATIENT** Treatment

"A claimant is to be treated as having limited capability for work on any day on which he is undergoing medical or other treatment as an in-patient in a hospital or similar institution or which is a day of recovery from that treatment to include where the claimant is attending residential rehabilitation for the treatment of drug or alcohol addiction".

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 an inpatient in a charitable or religious organisation providing support for their addiction issues.

- Regular Treatment

A claimant receiving:

- regular weekly treatment by way of haemodialysis for chronic renal failure;
- treatment by way of plasmapheresis or by way of radiotherapy; or
- 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.

In these claimants, if information is available that they are receiving regular treatment as defined in the legislation, the LiMA output should be "treat as having LCW" for an advised period and this information submitted to the DM for further consideration.

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

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 Atos Healthcare for further advice. The re-referral date will normally be determined by the prognosis advised by the examining HCP at the time of the assessment.

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

At this stage, the practitioner will review, through the MSRS application, the ESA85 from the previous referral and the current ESA50, 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 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 Support Group inclusion, this can also be advised at this time.

Cases may only be "satisfied" at re-referral scrutiny if a full face to face LCW/LCWRA medical assessment was completed. Their case cannot be satisfied if they were found to be in the Support Group at assessment or at pre board check. If a claimant was previously found to be in the Support Group, the HCP must review the case at re-referral and decide if there is adequate evidence to advise that continued inclusion in the Support Group is appropriate. If there is evidence of improvement in their functional abilities since the last assessment such that they no longer fulfil the Support Group criteria, the claimant should be called for an examination.

2.6 IB Re-assessment Filework

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

At present there are 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 undergo 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, "treat as LCW", enter the claimant into the Support Group or advise that a face to face assessment is required to establish LCW/LCWRA status based on the evidence held.

They will have the same ESA LCW/LCWRA examination as "ESA Claimants" with the same possible outcomes decided by the DM i.e. inclusion in the Support Group, meets the threshold for having LCW, "treat as LCW" or does not meet the threshold of having limited capability for work.

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

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 Atos Healthcare 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 Atos Healthcare to provide guidance to both Atos Healthcare HCPs and WCA DMs to help in dealing with these referrals. Certain Atos Healthcare Practitioners will be involved in providing this advice. Full detail of this guidance is provided in the ESA Filework Guidelines. This section of the Handbook serves to provide Examining HCPs with background awareness of this role.

2.7.1 Advice provided by Atos Healthcare practitioners

Decision makers can request advice from Atos Healthcare 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 customer submits additional evidence to the decision maker after the examination 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 Atos Healthcare HCP

The Atos healthcare HCP will provide advice to the Decision Maker 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 therapeutic role. A clinician does not routinely consider the functional restrictions or disabling effects of the medical conditions that they treat. They 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 through the WCA.

Atos Healthcare practitioners 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).

Atos Healthcare HCPs provide impartial expert advice on disability that is objective and based on functional assessment. The Atos healthcare HCP must provide an opinion that is fully justified and evidence based.

Practitioners 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

3. The Medical Assessment

3.1 The Medical Assessment (The Limited Capability for Work and Limited Capability for Work Related Activity medical assessment)

3.1.1 Introduction

The face to face Limited Capability for Work/Limited Capability for Work Related Activity medical assessment (LCW/LCWRA medical assessment) will be completed using LiMA in all but exceptional cases on form ESA85. A clerical ESA 85 is available when LiMA is not available. There is a copy of this form at Appendix 2. (N.B. If a clerical form is completed, this must be done using **BLACK INK**).

The medical assessment process as a whole differs in many respects from traditional history taking and examination as carried out in the general practice and hospital setting. It entails bringing together information gained from observation, questionnaire, medical evidence and 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, 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 ESA LCW/LCWRA Assessment. These are:-

- Reading the documents;
- Interviewing the claimant;
- Examining the claimant and
- 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. Particular attention must be paid to the current claimant questionnaire [ESA 5O] 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 bought 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

Within ESA, permitted work regulations will apply. This may be documented within the ESA file, or noted in the ESA 50 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 JCP office responsible for benefit payment before starting work.

Permitted Work in ESA

- The permitted work higher earnings limit (PWHL) will allow ESA claimants to work up to 16 hours per week for up to 52 weeks with earnings of up to £95. This applies to both the contributory and non-contributory strands of the benefit. The permitted work lower limit allows a person to earn £20 a week without any limitation on the number of their hours or number of weeks (not limited to 52 weeks) and is intended to encourage social inclusion.

- 'Supported permitted work' rules, apply to all those in receipt of ESA . This enables customers who are "supervised by a person employed by a public or local authority or voluntary organisation engaged in the procurement of work for persons who have disabilities" to undertake permitted work indefinitely, without the 52 week time limit.

  In ESA the intention is that claimants in the Support Group should be able to undertake permitted work for an indefinite period.

A LCW/LCWRA examination 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 examination undertaken by the HCP.

If the HCP provides advice / justification in the ESA85, 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.

3.1.3 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 practitioner professional standards. In keeping with the intention of ESA, it is also essential that the practitioner 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 examination 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.

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 Examination Centre.

Companions will be able to give useful information, particularly in cases where the claimant has mental function problems, learning difficulties, 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 fluent in your language, it will be necessary for the claimant to be accompanied by an interpreter. 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 an interpreter. A note of the circumstances should be made on an advice minute. [See also section on Exceptional Situations at Medical Assessments].

3.1.3.5 Interview Skills

As an essential component of the examination 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.

3.1.3.5.1 Active Listening involves:-

- Keeping an open mind and being prepared for all responses to questions

- Summarising what has been said
- Listening "between the lines".

3.1.3.5.2 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 Medical Examiner 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.

3.1.3.5.3 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.

3.1.3.5.4 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. When reporting with LiMA, it is very important to face away from the screen at frequent intervals, to ensure eye contact is maintained and develop an essential rapport with the claimant. 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 the Interview

3.1.3.6.1 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.

The time of start of examination is when you first make contact with the claimant. LiMA will document the start time of the interview as the time when the HCP begins to enter details of the diagnoses. The time the examination ends is the time when the claimant is considered by the practitioner to meet the criteria for the Support Group, or the “exam ended” button is pressed, or when you progress past “observed behaviour” on LiMA. These details will be automatically recorded by LiMA but if for any reason you complete a clerical report, you must take care to enter this data accurately.

3.1.3.6.2 Medical content of the report

List all the current diagnoses. Ensure that **all conditions** entered in the ESA 50, or other medical reports 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.

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.

3.1.3.7 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 analgesics 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. "He takes an average of 12 paracetamol (mild painkillers) a week, usually over three days" provides a 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 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 manner as it lists a number of common medications with a non-medical explanation of the purpose of the medication.

3.1.3.8 Clinical History

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

- Concise clinical history.

This should include details of any hospital treatment or investigations within the last 12 months. It is most important to keep this information, concise and relevant to the present disabilities. Note whether the claimant continues to attend hospital, and the likely date of any proposed treatment procedure or investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks' time". It is important that details of therapy relating to a mental health problem are recorded.

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 ESA 50. For example, if at the time of completion of the ESA 50, 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.

3.1.3.9 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.

You should also record details of how the claimant travelled to the MEC.

3.1.3.10 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.

You must write this section in the third person. It is a record of the claimant's everyday life, without interpretation by the medical examiner. You should make it clear that this is the claimant's account of his 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 particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and areas likely to be so 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". See also the paragraphs in relation to completing the section on activities of daily living. When exploring the typical day, you should also ensure you cover activities relevant to Support Group inclusion 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".

At an early stage of the examination 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

3.1.3.11 Support Group/Treat as LCW

If it becomes clear to you that the claimant may be in the Support Group, interrupt the examination 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 criteria for Support Group inclusion.

Remember that many of the highest LCW functional descriptors may suggest the Support Group is appropriate.

It is essential that adequate time has been spent with the claimant to obtain sufficient information to fully justify advice that the claimant meets one of the Support Group criteria. The level of information will vary in each case. For example, if a claimant is found to meet the Support Group 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 Support Group categories, you will need to fully justify functional restriction in this area. This may involve documenting some typical day information, some examination and observed behaviour. In the ESA LiMA application, when the evidence suggests the Support Group, the history, examination findings and observed behaviour will be recorded on the final report. It should also be noted that you must also justify why in each case, LCW also applies.

As always, there is a need to balance the level of information recorded. You must obtain adequate information to justify inclusion in the Support Group, however; it is important that you do not subject the claimant to further unnecessary examination, but explain the situation and conclude the interview.

In the LiMA application, there is an area on screen to allow you to access and complete advice about entitlement to the Support Group. LiMA will then generate an electronic ESA 85A.

If the report is completed clerically, you must make an explanatory note on the ESA 85 along the following lines:

"This examination was concluded when it became apparent that I could advise that the claimant was in a Support Group category."

You must also complete the ESA 85A providing full details of eligibility for Support Group inclusion. A copy of the paper version of the ESA 85A is included at Appendix 3. In circumstances where the HCP must discuss Support Group entry with the CSD HCP, the name of the advising HCP should be recorded on the ESA85A.

Where “treat as LCW” is identified at examination, the HCP will record this on the LiMA application. In all cases, the HCP must also justify whether or not LCWRA criteria are met. In clerical cases, the HCP should indicate to the DM the appropriate “treat as LCW” category and again provide full LCWRA justification in a clerical manner.

3.1.4 Examining the Claimant

Information about appropriate clinical examination will be found in section 3.4, 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 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.

The precise extent and nature of the 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 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. 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.

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 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 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 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 practitioner 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.

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 L shoulder restricted to 90 degrees (about half the normal range) and this means that the claimant cannot reach upwards above shoulder level with the L arm."

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:

PFR 450l/min (Wright) or PFR 450(EU)

3.1.4.1 Conclusion of the examination

After the interview and 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 Employment and Support Allowance or respond to criticisms of the administrative process.

If, during examination, a condition is identified which may be unknown to the claimant or his 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 examination

Situations arise when practitioners carrying out disability assessments may come across information that they feel should be reported to the claimant’s General Practitioner. The current guidance for practitioners 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 practitioners make every effort to explain to patients 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 practitioner may, in his/her professional judgement pass on information about that individual.

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

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

All practitioners are strongly advised to read these guidance notes from the GMC. If any practitioner does not have a copy then s/he should contact the GMC at 178 Great Portland St, London W1 W5JE (tel: 0845 357 8001).

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 practitioner 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 practitioner should consult with colleagues.

The guidance also indicates that if the practitioner 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:

- 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
- 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 02073336550.

The Health Professions Council (The regulatory body responsible for a number of health care professions including physiotherapists), also provide guidance about disclosure of information. This can be found in the booklet – "Confidentiality – Information for Registrants" available on the HPC website http://www.hpc-uk.org/publications/brochures

When a practitioner 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:

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

The practitioner 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 examination.

Those findings must be communicated to the claimant's General Practitioner within 24 hours, provided that the claimant gives consent for this release.

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

If you consider it necessary, contact should initially be made by telephone, followed by written confirmation using form UE1 (Rev). If you do telephone 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 practitioner's file and one to be kept in the CSD file.

Most reports completed during a 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 practitioner 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 practitioner must make an exact copy on a separate UE1 (Rev). For this purpose, the visiting practitioner 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).

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

Telephone contact must be made in all cases, 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 examination 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 practitioner's personal file (to be retained for a minimum of 10 years).

3.1.6 Completing the LCW/LCWRA Medical Assessment Report Form (ESA 85/ESA85A): An Overview

It is important when completing the ESA 85 report (or the ESA85A if Support Group criteria apply) 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 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 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.

Practitioners will develop their own style in completing the ESA LCW/LCWRA Report. However, the following general guidance is based on practical experience from previous benefit reports. That part of the report relating to diagnosis, medication, treatment and clinical history can 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 ESA LCW/LCWRA medical assessment report is for you to provide your opinion of the claimant's level of function in a number of functional categories and if necessary in the mental function categories, to identify if a non-functional descriptor may apply, to provide a prognosis and to provide justification of your decision to advise whether or not the claimant fulfils criteria for the Support Group. In every case that Support Group inclusion is not advised, you must justify why in your opinion **none** of the LCWRA descriptors or Support Group Special Circumstances apply.

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 medical assessment
- 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 examination to allow you to provide robust advice to the decision maker.

For each of the mental function, physical and sensory 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 examination, 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 claimants 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 "Stand/Sit".

Any conflicting evidence in the report must be fully addressed. For example an HCP may consider that a claimant has no problem going out unaccompanied. They 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 uses evidence from the mental state examination to back up their 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. The HCP must address this statement and justify why the feel despite this statement, their 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 ESA 50. For example if the claimant has indicated in the ESA 50 that they “black out at times” but ticked no problems in the consciousness section of the ESA50, 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 ESA 50, 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 ESA 85 are linked e.g. mobilising and standing and sitting. Justification for this group of functional areas should be entered in the appropriate boxes. 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, and waste the readers' time and devalue the entire report.

A separate area of the ESA85 is dedicated to justification of your opinion that none of the LCWRA descriptors apply.

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, 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 in the usual way. This phrase should not be used when the claimant has already indicated a problem in the area in the ESA 50. Even where they at assessment say they have no problem, 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 examination. It is necessary then to ask the claimant whether their problems have changed in the intervening period, and record their reply.

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:

- Features of functional ability relevant to daily living
- Behaviour observed during the assessment
- Findings at clinical examination
- Summary of functional ability:

- Highlight and explain any inconsistencies between claimants' account and the medical evidence.
- Address variability, repeatability and fatigue.
- Clarify the medical basis for advising the chosen activity outcome descriptors.

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 are required to 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 Healthcare 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 their 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.

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 practitioner 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.

The claimant must be able to undertake all activities safely.

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 and 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 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 opinion, 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 3.3, 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 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 should be completed next. It is of limited use in some functional areas, for example in standing, as the claimant will rarely be required to stand for any significant period within the Examination 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 3.3, functional categories.

3.1.12 Clinical findings

Clinical findings are entered next. They 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 then 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.

3.1.13 Summary of functional ability

This section should be used to provide the Decision Maker with a summary of the claimant's functional ability and therefore help justify your choice of descriptors. It is important to:

- Highlight and explain **any inconsistencies** between the claimant's account of his disability and the medical evidence.
- Explain any inconsistencies in the typical day history
- Address the issues of variability, repeatability and fatigue particularly where the claimant suffers from a condition where such factors play an important part.

For example considering justification of the upper limb descriptors where “none apply” is considered appropriate by the HCP, an example of a useful summary may be:

The claimant is on mild analgesia for his frozen shoulder and has not required specialist input. His typical day history indicates he is able to shower independently, read the newspaper and make snacks for himself using the microwave, cooker and a standard kettle. Examination shows mild unilateral restriction of shoulder abduction only. All other examination findings in the upper limbs were normal. Observations indicated he removed his jacket with ease and handled papers without restriction. While the claimant indicates he is unable to chop vegetables or lift heavy pots due to his shoulder pain and struggles to dress his upper body, he has good movement in one shoulder and all other arm joints suggesting he would be able to reach above head height with at least one arm. He has good power at all levels in both arms and uses a normal kettle at home suggesting he should be capable of lifting weights in excess of 1 litre with both hands. He has normal hand power, pincer grip and movement of finger joints suggesting he should be able to manipulate small objects.

3.1.14 Clarify the medical basis for your choice of descriptors.

Ten functional categories cover disability in physical and sensory areas. The first two functional areas (walking [incorporating stairs]) and standing and sitting, 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. Some of the information obtained during interview and examination of the claimant will be relevant to more than one functional 'group' within the back/lower limb or neck/upper limb group, so it is logical to cross refer entries on the ESA85 report within these groups, provided the evidence is relevant to the function.

Details of variation/fluctuation, pain etc, and details of clinical evidence can be cross-referred, although it is usually necessary to add a sentence to render the account more specific to that function. However, details of the typical day and general observations at the examination centre are very function-related and do not lend themselves to cross referencing across any of the functional activity categories. For example, the fact that the claimant sits comfortably through a 40 minute television programme is relevant to "sitting" but not to any other category.

Box 34 of the ESA85 is devoted to the justification of why the LCWRA descriptors are not met. The groups of functional activity listed below are those groups of descriptors that must be justified:

- Mobilising
- Transferring from one seated position to another
- Reaching
- Picking up and moving
- Manual dexterity
- Reaching
- Making self understood through speaking, writing or typing or by any means normally used
- Understanding communication by hearing, lip reading, reading 16 point print or using any aid if reasonable used.
- Continence
- Eating and drinking
- Learning
- Awareness of hazards
- Initiating and completing personal action
- Coping with change
- Coping with social engagement
- Appropriateness of behaviour with other people

In addition, you must also indicate why none of the “special circumstances” Support Group criteria would apply:

- Terminal Illness
- Pregnancy “risk”
- Chemotherapy
- Specific risk

When using the LiMA application, the system will help justify areas where there is direct correlation with the LCW descriptors. For example, where the HCP has chosen “none apply” for mobilising, the LiMA application will use this information to justify that the “mobilising LCWRA” criteria is not appropriate.

When completing a clerical form, it is reasonable to refer to the justification used in the LCW areas of the report for the corresponding LCWRA descriptors. For example, if no physical disability is identified, it would be reasonable to record a form of words such as “As per activities 1,3,4,5,6,7,& 9, there is no evidence of severe restriction of function in these areas, therefore the relevant LCWRA descriptors do not apply”.

3.2 Efficient use of Time in the LCW/LCWRA Examination

Thorough preparation prior to the commencement of the LCW/LCWRA examination 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 LiMA application will invite you to fully justify the most highly scoring areas. Having provided robust evidence in one high scoring functional area, it is only necessary to give succinct and relevant details elsewhere.

Similarly, if it becomes evident during the assessment that one of the exceptional circumstance (non-functional descriptors) applies, and can be fully justified, you do not need to give lengthy details in justifying your choice of descriptors in the functional areas.

It may occasionally become apparent that a claimant falls into a Support Group category. If this is the case, follow the procedure for Support Group Conditions.

3.3 Functional Categories (Physical)

3.3.1 Introduction

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

Claimants with mental health conditions that cause physical symptoms, for example severe depressive illness and psychomotor retardation, should only be scored in the mental function activities.

The ESA regulations specify that “the person is to be assessed as if wearing any prosthesis with which [he] is fitted, or wearing or using any aid or appliance which is normally worn or used

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 they cannot walk 50 metres but could reasonably use a wheelchair to propel themselves 50 metres.

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.

This section looks 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".

PHYSICAL DESCRIPTORS

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

3.3.2 Mobilising

Activity 1: Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be used.

Descriptors

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

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 are wheelchair dependant or can use crutches or a stick to mobilise distances in excess of 200m 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 W(b) 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 this issue, the ability to use an appropriate aid, including a manual wheelchair must be considered. A manual wheelchair would be considered any chair that is not electrically propelled. If the person does not actually have a wheelchair, they should be considered in terms of whether they could use one if provided, as manual wheelchairs are widely available. In terms of considering whether or not the person could reasonable use a wheelchair, the HCP must consider their upper limb function and cardiorespiratory status.

Details of activities of daily living

Consider the claimant's ability in relation to:

- Mobility around the home
- Shopping trips, exercising pets.

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?

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 Examination Centre is relevant. You are likely, from local knowledge, to know the distance from the bus station to the examination 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 limited to mobility of less than 200 metres; a person who can mobilise around a shopping centre/supermarket is unlikely to be limited to mobility of less than 800 metres although consideration must be given to the speed of walking, stops and pauses etc. Someone who is able only to move around within their home is unlikely to manage 200m.

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 a Support Group criterion 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.

3.3.3 Standing and sitting

Activity 2: Standing and sitting

Descriptors

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 work station, either:

(i) standing unassisted by another person (even if free to move around) or;
(ii) sitting (even in an adjustable chair)
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 work station, either:

(i) standing unassisted by another person (even if free to move around) or;
(ii) sitting (even in an adjustable chair)

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.

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.

S(a) “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.

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 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.

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 S(b) & S(c) reflects 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 aids. The ESA regulations specify that “the person is to be assessed as if wearing any prosthesis with which [he] is fitted, or wearing or using any aid or appliance which is normally worn or used”. 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 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 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, 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 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; and
- Getting out of chairs or off the bed
- 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.

3.3.4 Reaching

Activity 3: Reaching

Descriptors

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.

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 can achieve the reaching movement defined in Descriptor R(b) "Cannot raise either arm to top of head as if to put on a hat".

Details of activity 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 chart 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.

3.3.5 Picking up and moving

Activity 4: Picking up and moving or transferring by use of the upper body and arms

Descriptors

P(a) ***Cannot pick up and move a 0.5 litre carton full of liquid.***

P(b) Cannot pick up and move a one litre carton full of liquid.

P(c) Cannot transfer a light but bulky object such as an empty cardboard box.

.

P(d) 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 give 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 P(c), a person could reasonable manage this by using one hand and supporting the box against another part of their body.

In descriptors P(a) and P(b), 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.

3.3.6 Manual Dexterity

Activity 5: Manual Dexterity

Descriptors

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 use a suitable keyboard or mouse.

M(e) None of the above apply.

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.

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, 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; manipulating the petrol 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 or handling a newspaper. Fine movements may be observed if the claimant adjusts 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."

3.3.7 Navigation and maintaining safety

Activity 8: Navigation and maintaining safety, using a guide dog or other aid if normally used (Activity 8 is detailed at this point to reflect the structure of the ESA 85 and LiMA application)

Descriptors

V(a) Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment.

V(b) Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment.

V(c) Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment.

V (d) None of the above apply

Scope

This activity not only relates to visual acuity (central vision and focus) and visual fields (peripheral vision) but takes into account the persons ability to adapt to their condition. The person's confidence and training must be taken into account.

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 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 asses 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 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. turning the head to look for traffic/other hazards.

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 6/10 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**). If the claimant brings a CVI with them to the examination, 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. For sight impairment there is no formal definition, however those 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. Further details of sight/severe sight impairment registration can be found at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_078294.pdf

Copies of the CVI can be reviewed at:

http://www.rcophth.ac.uk/standards/cvi

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: www.dvla.gov.uk. The LiMA repository contains extensive useful information on assessment of vision and visual fields and may be referred to.

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
- 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 examination centre, and how they found their way around the centre. Note whether the claimant needed to be accompanied by another person.

Observe movement when navigating obstacles- do they rotate their neck more to adjust for reduced visual fields?

Note any observed ability to manipulate belts and buttons.

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 VA 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 of normal newsprint.

Visual field testing

Where there is a history of any visual field problem or where the practitioner at assessment feels there may be a visual field problem, visual fields must be tested.

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 one eye with the card provided
- Check there is no central defect by ensuring they can see your full face
- Stretch both arms 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 one hand and confirm the claimant can see your fingers moving and ask the claimant which hand is moving
- Move your hands 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.

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 in 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.

3.3.8 Making self understood

Activity 6: Making self understood through speaking, writing, typing, or other means normally used; unaided by another person.

Descriptors

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

SP(b) Has significant difficulty conveying a simple message to strangers

SP(c) Has some difficulty conveying a simple message to strangers.

SP(d) None of the above apply

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 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 Parkinsons Disease. In considering expressive dysphasia, the person's ability to write or type 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.

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 fall within the support group criteria.

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 ESA 50 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.

3.3.9 Understanding Communication

Activity 7: Understanding communication by both verbal means (such as hearing or lip reading) and non-verbal means (such as reading 16 point print) using any aid it is reasonable to expect them to use; unaided by another person.

Descriptors

H(a) ***Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.***

H(b) Has significant difficulty understanding a simple message from a stranger due to sensory impairment.

H(c) Has some difficulty understanding a simple message from a stranger due to sensory impairment.

H(d) None of the above apply

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 to understand a basic message.

The inability to hear a shout to communicate by hearing would only be experienced by those with significant degrees of hearing loss.

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.

For further information on associated problems such as tinnitus, and Meniere's disease, see the end of this section.

If assessing a person with significant hearing loss, their ability to understand communication through other means must be considered. For example – is their vision adequate to read large print? Do they effectively lip – read?

When considering the aspects of some difficulty and significant difficulty, the following examples may be useful:

A person who is deaf who cannot hear a shout at beyond 1 metre (80db loss) with macular degeneration to the extent that their vision is moderately impaired such that they have 6/24 vision, and can only read N16 print with a magnifying glass is likely to have “significant” problems.

A person who is deaf (80db loss) and has 6/24 distance vision but can read N16 print with their normal spectacles is likely to have “some” problems.

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 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.

The person may read/look at their tablets, repeat prescription to give you some information about visual acuity.

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 examiner. 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.

Conversational Voice Testing

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.

Near vision testing should be performed where a problem is identified with regard to hearing ability.

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.

3.3.10 Continence

Activity 9: Absence or loss of control leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting) despite the presence of any aids or adaptations normally used.

Descriptors

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) 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

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. Incontinence which occurs only while asleep is not regarded as incontinence in terms of the legislation as, with the appropriate personal hygiene, this will not affect the person's functioning whilst awake.

Similarly, incontinence occurring during a fit happens during a period when there is a period of altered consciousness, so incontinence will not of itself affect functioning. Seizures should be considered under the appropriate functional area. If a person has episodes of incontinence while under the influence of alcohol or drugs in the absence of other pathology would not be considered in this area as the descriptors refer to ability to maintain continence when fully alert/awake.

Poor mobility (i.e. continence problems are as a result of time taken to get to toilet facilities because of mobility issues) is not taken into account in this area as this is covered elsewhere.

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 dot 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, they should be considered as if using pads as these are a widely available 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. Claimants with gastro-intestinal problems such as dumping syndrome should be considered as possibly meeting the criteria for C(b) 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. 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.

Details of activities of daily living

Consider the frequency and length of any journeys or outings undertaken, e.g.

- Shopping trips
- Visits to friends or relatives
- Other social outings

and any problems encountered in undertaking these activities.

3.3.11 Consciousness

Activity 10: Consciousness during waking moments.

Descriptors

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

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) or
- 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 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, even when headache is preceded by an aura, does not result in altered consciousness or epileptiform seizures.

An aura occurs in about 25% of migraine sufferers (the remaining 75% have paroxysmal headaches without any preceding aura). The aura, when it occurs, is usually visual, experienced as flashing lights or other disturbances of vision: but there is no loss of conscious awareness.

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.

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.

3.4 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.

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.

It should be rare to have to assess passive movements, if it is essential, do so after observation of active movements as this will give an indication of the point at which discomfort is experienced.

NEVER force a passive movement beyond the point where the claimant indicates the onset of discomfort.

When examining the limbs, always examine the whole limb and not just the joint involved. 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 Atos Healthcare 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 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 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 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.

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 ≥130º
- Extension 10º
- Abduction 50º
- Adduction 25º
- External rotation ≥45º
- Internal rotation 45º.

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 ≥120º
- Extension - full

For the ankle joint, plantarflexion and dorsiflexion are assessed:

- Plantarflexion ≥50º
- Dorsiflexion ≥20º.
- For the hallux, plantarflexion and dorsiflexion are assessed:
- Plantarflexion ≥60º
- Dorsiflexion ≥40º.

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 ≥80º
- Lateral flexion (ear to shoulder) Full
- Rotation ≥80º.

Upper Limbs

Assessment of upper limb movements can be made with the claimant standing or sitting.

Shoulder Joint

Shoulder movements are flexion and extension, abduction and adduction, and internal and external rotation. The following sequence can be used to show shoulder movements: clap 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 160º
- Extension 40º
- Abduction ≥170º
- Adduction 40º
- External rotation ≥70º
- Internal rotation 95º.

Elbows

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 ≥130º
- Extension Full
- Pronation (palm downwards) 70 - 80º
- Supination (palm upwards) 60 -65º.

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, palmarflexion, radial and ulnar deviation. The normal ranges are:

- Dorsiflexion ≥30º
- Palmarflexion ≥30º
- Radial deviation 20º
- Ulnar deviation 45º.

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 20º
- Flexion at proximal interphalangeal joint 100º
- Flexion at distal interphalangeal (DIP) joint 80º
- Extension at DIP joint 10º
- Flexion at metacarpophalangeal(MCP) joint 90º
- Extension at MCP joint 45º.

For the thumb the ranges are:

- Abduction 60º
- Flexion at IP joint 80º
- Flexion at MCP joint 50º
- Flexion at carpometacarpal joint 15º.

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.

3.5 Guidance on Specific Conditions (physical)

The reader is referred to the Atos Healthcare 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.

3.6 The Mental Function Assessment – Functional Activity Categories (Mental Function)

3.6.1 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 medication/med 3 details etc but may not always be immediately apparent. The HCP must consider in all cases whether there may be any 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.
- 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, 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 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 examination there is no evidence of functional limitation - (see section 3.8 for the mental state examination).

There are seven mental function categories to be addressed in the ESA 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 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 inclusion in the Support Group 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 persons function regardless of the actual diagnosis.

MENTAL FUNCTION ACTIVITY OUTCOME DESCRIPTORS

3.6.2 Learning tasks (Understanding and focus)

Activity 11: Learning tasks

Descriptors

LT(a) ***Cannot learn how to complete a simple task, such as setting an alarm clock***

LT(b) Cannot learn anything beyond a simple task, such as setting an alarm clock.

LT(c) 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 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 Playstation

- 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.

3.6.3 Awareness of Hazard (Understanding and focus)

Activity 12: Awareness of everyday hazards (such as boiling water or sharp objects).

Descriptors

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

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 the Support Group.

- If AH(b) 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.

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3.6.4 Initiating and completing personal action (Understanding and Focus)

Activity 13: Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks).

Descriptors

IA(a) Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions.

IA(b) Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time.

IA(c) Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions.

IA(d) None of the above apply

Scope

This activity reflects the ability to **initiate and successfully complete tasks** without need for external prompting. This Support Group 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 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 fatigue experience

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 showering, and getting dressed to go out.

- .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
  - 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
- 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.

3.6.5 Coping with change (Adapting to change)

Activity 14: Coping with change

Descriptors

CC(a) Cannot cope with any change to the extent that day to day life cannot be managed

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.

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.

CC(d) 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 MEC for assessment. It would seem unlikely that a claimant who manages to attend the MEC alone would meet the level of severity of functional restriction for anything other than CC(d) to apply.

3.6.6 Getting about (Adapting to change)

Activity 15: Getting about

Descriptors

GA(a) Cannot get to any specified place with which the claimant is familiar

GA(b) Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person

GA(c) Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person.

GA(d) None of the above apply

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 GA(c).

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.

3.6.7 Coping with social engagement (Social Interaction)

Activity 16: Coping with social engagement due to cognitive impairment or mental disorder

Descriptors

CS(a) Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.

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.

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.

CS(d) 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. Those with severe anxiety, autism, 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.

Activities of daily living
Consider any form of social contact such as:

- Use of public transport
- Shopping
- Talking to neighbours
- Use of phone
- Hobbies and interests
- Social interaction with family

Mental State Examination

The Mental State Examination findings would be expected to reflect severe 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 MEC due to the level of anxiety/communication restriction that this descriptor would normally be expected to reflect.

3.6.8 Appropriateness of Behaviour with other people (Social Interaction)

Activity 17: Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

Descriptors

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

IB(b) Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.

IB(c) Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.

IB(d) 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 no 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.

3.7 Guidance on Specific Conditions – Mental Health

The reader is referred to the Atos Healthcare Evidence Based Protocols for the Disability Analyst. These protocols have been issued to all Disability Analysts working in Atos Healthcare. 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.

3.8 The Mental State Examination

HCPs will be familiar with conducting a Mental State Examination from their previous training either in Atos Healthcare or prior to commencing employment as a Disability Analyst.

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

3.9 Exceptional Circumstance (Non Functional Descriptors) in the LCW Medical Assessment

In the development of the LCW it was acknowledged that there may be a very small minority of conditions that would not fulfil the criteria for Support Group inclusion 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 scenario:

- 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 MEC 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. If the condition has not progressed to a level where there is significant functional impairment or indeed, a non functional Support Group would be applicable, 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.

A second non-functional descriptor (relating to specific condition) is also listed in the ESA 85A.

- The claimant is suffering from some form of specific disease or bodily or mental disablement and, by reasons of such a 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.

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. However, it is extremely unlikely that someone who is at substantial risk for work would not be at substantial risk for work related activity and therefore for all practical purposes it is likely that it will apply to both.

It should also be noted that advice for entry into this Support Group can only be given after conducting **the full LCW/LCWRA medical assessment.**

Circumstances where this NFD would apply will not be commonly encountered. It may apply in circumstances where a claimant is being treated for significant mental illness, who at the time of assessment is considered to be very vulnerable to risk of relapse. In this circumstance, finding him fit for work or work related activity may carry a real possibility of harm. It may also apply to a claimant with a psychotic illness who as a result demonstrates completely unpredictable and potentially dangerous behaviour such as extreme violence.

The Decision Maker will assess the information provided and if they accept this advice, the claimant will be treated as having limited capability for work related activity.

3.10 Medical Advice on Prognosis at Examination

3.10.1 LCW/LCWRA - Advice on when a return to 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 Atos Healthcare 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 a return to work have improved. Whether the outcome of the case is inclusion in the Support Group, application of Exceptional Circumstances or advice on a functional condition, the Decision Maker will require a reasonable prognosis for a return to work. In assessing when a return to work may be possible, 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 Support Group is advised, it should be clarified on the ESA85A 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 a return to 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 return to work, taking account the effects of all conditions.

- If an early improvement is expected, a short prognosis should be given.

- If little or no functional restriction has been identified, then the shortest prognosis should be chosen.

In all cases your opinion on when a return to work 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. (3, 6, 12 or 18 months).

For example:

1. A claimant with mild mechanical, intermittent back pain scoring below the threshold of LCW where you indicate a 3 month prognosis.

Justification may be: The claimant has only intermittent back pain with minimal functional restriction most of the time. There have been no issues identified medically to preclude a return to work at this time.

2. A claimant who has had through trauma a sudden complete loss of vision with significant problems in navigating. You may have indicated a 18 month prognosis in this case.

Justification may be: The claimant has experienced a sudden onset of complete visual loss. While there is no expectation of improvement in his visual acuity, he may with time be able to adapt to his visual loss and with input and training, a return to work may be possible within about 18months.

3. A claimant who has long term complete visual loss which came on gradually during childhood. He worked previously in an office making full use of adapted equipment and mobilises freely with a white stick or his guide dog. He was made redundant and has claimed ESA. You have indicated a 3 month prognosis.

Justification may be: The claimant has long term complete visual loss. He has adapted well to his situation and was recently coping well in employment. His level of vision would not be expected to improve, however given his past occupational history, a return to work could be considered within 3 months in a suitably adapted environment.

3.10.1.1 Advice that a return to 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 a return to 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 or will inevitably deteriorate further, even with optimal treatment, you should select "in the longer term". For example it may be appropriate to apply "in the longer term" to someone with a progressive neurological condition.

Or, in the case of a young adult with a very significant degree of learning disability, who scores 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 a "in the longer term" prognosis

3.10.1.3 Exceptional Circumstances

When an Exceptional Circumstance Descriptor is applied you must **also** tick a box under the second column. 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 Examinations

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, he 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 Practitioner for completion of the ESA 85 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 Registered Medical Practitioners will be able to carry out the assessment.

3.11.2 Background

Within the ESA 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
- Hospital INPATIENT Treatment
- Regular Treatment

(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 SG 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 examination is carried out. Where this situation arises it is appropriate to proceed to face-to-face assessment.

3.11.3 LCWRA Examination Process

The following process should be followed by a Registered Medical 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 MEC.
- If the assessment is conducted as a DV, the Registered Medical Practitioner should follow the guidance in section 3.12 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 MSC with the details of the special need recorded.
- If a contracted doctor contacts a claimant and they are a hospital inpatient, 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 MSC 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, ESA85A, ESA 85A min, DVN1, SL1 and POID1. Any previous information recorded on an ESA 85A will be printed from MSRS and included in the pack. If there is no ESA 50/50A in the file due to non return, there should be an ESA 51 or ESA 53A form. (These forms confirm the request for an ESA 50 or ESA 50A).
- The Registered Medical Practitioner should check the content of the pack prior to conducting the visit.
- The Registered Medical Practitioner should conduct the assessment in accordance with Atos Healthcare Professional standards.

The following scenarios provide guidance on completion of the assessment:

Scenario 1:

If at any point during the assessment, the Examining Practitioner considers that they have adequate information to advise inclusion in the Support Group, they should complete form ESA 85A, providing sufficient information to allow the DM to consider their decision. All contracted doctors must first contact the CSD helpdesk for approval if they consider that it is appropriate to advise that the claimant is in the Support Group.

All information gathered on form ESA85 which is relevant to whether LCWRA applies must be included on the ESA 85A.

Scenario 2:

If the evidence suggests that LCWRA does not apply, the following sections of the ESA 85 should be completed:

- Box 1 (customer 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 following section should then be completed:

- Box 34

The findings of both observed behaviour and formal examination findings should be documented in this section of the report.

You must justify why each of the activities (both physical and mental function) in the Support Group would not apply. You must also indicate why SG special circumstances would not appear to be applicable.

You should record aspects of the history, observations and examination findings in this area for **each** of the Support Group areas to robustly justify why LCWRA does not apply.

The level of detail and 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 ESA 50A.

If you need more space, two blank ESA85A mins are included in the pack for this reason or if the assessment is conducted at the MEC, further ESA 85A mins can be obtained there.

For example, if on the ESA 50A, the claimant has indicated no upper limb problems; it may be adequate to record detail such as:

“The claimant has indicated no problem in upper limb function. I have discussed this with the claimant and the history, observations and examination findings would seem consistent with their statement”. Therefore, from the condition history, typical day history and observed behaviour, they would have sufficient upper limb function to raise either arm as if to put something in the top pocket of a jacket, pick up a £1 coin/turn the pages of a book, pick up and move 0.5l and eat and drink.

However, if your opinion differs significantly from the claimant’s (either from information in the ESA 50A or from the typical day), you will have to provide much greater detail. For example, if a claimant has indicated significant problems

with walking, you may have to justify your opinion with information such as:

"The claimant has indicated significant mobility problems due to knee pain, however analgesia is low and the typical day history indicates that they walk to the local shop (a five minute walk) on a daily basis and walk from the car park to the hospital 3 times weekly with the aid of a stick. Observed behaviour showed the claimant to walk without distress with a slow gait around the home. Examination of the lower limbs revealed full back, hip and ankle movement. Examination of the knees revealed no swelling or deformity and only 10 degrees loss of flexion. There was no muscle wasting and tone and power were normal. Therefore, while some restriction of mobility is possible, the evidence suggests the claimant should be able to safely and without distress mobilise in excess of 50 metres most of the time".

- When this section of the form has been completed, you should then complete the final page only.

- You do **not** have to complete the descriptor pages, exceptional circumstances and prognosis pages.

Scenario 3:

If the claimant no longer satisfies "treat as LCW" (for example no longer having regular treatment such as haemodialysis, or beyond their postnatal period or in a rework referral) the following process should be followed:

- Indicate on the ESA 85 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 in the usual manner taking into account any information present in an ESA 50 or ESA 50A

- The normal procedures for completion of the LCW/LCWRA form 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/WFHRA), then a full explanation should be recorded on an ESA 85A minute.

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.

3.12 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 MEC and a domiciliary visit becomes necessary.

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:

3.12.1 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 Atos Healthcare 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.

If the claimant is unavailable, 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 ESA 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 (AL1C or DVN1) 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 (Medical Services Scheduling Form – SL1) at the time of making the appointment. Claimant information, appointment letters and copies of form SL1 can be obtained from administration staff at a local MSC. 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).

3.12.2 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 practitioner 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.

3.12.3 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.

3.12.4 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.

3.12.5 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.

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. 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 examined before the examination 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 Client is unfit to be examined 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 examined once the examination 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 Examination, providing full details of the incident and recording any appropriate descriptors or advice on Support Group inclusion.

If the examination cannot be completed and this is their first appointment, the Client should be recorded as a CSHU using CSHU reason “Claimant Unfit to be Examined” and a second appointment scheduled. If the examination cannot be completed and this is their second appointment the Client should be recorded as a CSHU using the process described above.

If the examination 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 a Medical Services Examination Centre (MSEC) 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 Medical Examination Attendant (MEA) throughout the assessment. The MEA 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 examination 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 inclusion into the appropriate Support Group. If a non-functional descriptor is appropriate it can only be applied **after** completion of the report by selection of descriptors.

There are two circumstances in which you may terminate an assessment **without completing the test:**

- 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 ESA 85A min.

If an MEA 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 examination 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 Potentially Violent Situation procedures should be followed and put in place immediately.

The examining HCP should obtain the relevant documentation locally and pass these to the administration staff.

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 practitioner who speaks the claimant's language to enable the assessment to continue, or
- Find an interpreter from amongst the examination 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 ESA 85Amin 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 and video taping of examinations

At the present time, the DWP are considering their position on the issue of audio taping of assessments following the publication of the "Harrington Report" in 2010. In this report, one of Professor Harrington's recommendations was that there should be a pilot and evaluation involving the audio taping of assessments.

Until this evaluation has taken place and further guidance is issued, should a claimant attend the assessment requesting permission to either audio or videotape the medical assessment you should politely refuse on the following grounds:

The Department for Work and Pensions does not require that a medical assessment for the purpose of advising on entitlement to state sickness or disability benefits be recorded on audio or videotape.

Such a claimant request can only be agreed with the prior consent of the examining practitioner, and then only if stringent safeguards are in place to ensure that the recording is complete, accurate, and that the facility is available for simultaneous copies to be made available to all parties present. The recording must be made by a professional operator, on equipment of a high standard, properly calibrated by a qualified engineer immediately prior to the recording being made.

The equipment must have facility for reproduction so that a copy of the tape can be retained by all parties

The responsibility for meeting the cost of the above requirement rests with the claimant.

Any request by a claimant for an assessment to be audio or videotaped must be declined unless the above safeguards are in place. The claimant must instead be offered the opportunity of a rescheduled assessment in the presence of a companion or other witness. If the claimant refuses to avail him/her self of this opportunity and refuses to proceed with the assessment, the practitioner should return the file to the Department for Work and Pensions with an ESA 85A min explaining the situation.

Unauthorised taping

It is for Atos Healthcare, in conjunction with their legal advisers, to determine the action to be taken in the event of a claimant making an audio or video recording without the prior knowledge and consent of the examining practitioner, or without ensuring that the safeguards defined above are in place.

4.1.4 Taking of Notes during an Examination 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 practitioner, 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 examination.

3. If the notes are subsequently produced at any time for any purpose, such as part of an appeal process, I the Examining Practitioner, 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 Medical assessment of pregnant women

Pregnancy is a normal physiological process and therefore **cannot alone** satisfy the medical criterion of limited capability for work or limited capability for work related activity unless "treat as LCW" criteria apply.

When appropriate a full LCW/LCWRA medical 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 examination. 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 Support Group criterion may apply – see section 2. You should also consider whether treating the woman as having limited capability for work around the dates of confinement may be appropriate – see section 2.

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 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 practitioner you should discuss it with an experienced practitioner 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 Atos Healthcare

Atos Healthcare 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. Atos Healthcare 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 Atos Healthcare 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.

Atos Healthcare 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 Atos Healthcare HCPs

Similarly, since neither the Department nor Atos Healthcare 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 examining practitioner 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 practitioner 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 practitioner.

If the embarrassing information is removed from the file it may be necessary to refer the claimant for assessment by a different practitioner as your opinion may be influenced by evidence which would not be available to the *Decision Maker*.

4.2.3 Unauthorised information

Unauthorised information comprises letters written from one healthcare professional to another and forwarded to a third party without the express permission of the author of the letter. Hospital discharge letters for example are often sent along with factual reports from general practitioners. Unless the General Practitioner has first sought the permission of the author of the letter it should be regarded as unauthorised. If you encounter such information, and you are unsure how it should be dealt with, you should seek advice from an experienced practitioner.

If the unauthorised information is removed from the file it may be necessary to refer the claimant for assessment by a different practitioner as your opinion may be influenced by evidence which would not be available to the *Decision Maker*.

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. The HCP must read this evidence. You should ask the claimant whether they wish to have the letter included in their file in support of their claim. If so, it should be photocopied, a note made in the file of the source and date of receipt of the document, and the original returned to the claimant. If no copying facilities are available, offer to have the copying done at the Medical Services Centre and to have the original returned by post. If this is unacceptable to the claimant, you should explain that it cannot be used in support of the claim as it will not be seen and considered by the *Decision Maker*.

4.3 Identification of Claimants

In most situations when assessments are conducted in an examination 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 Atos Healthcare “Checking Proof of Identity procedures”. A copy of the form POID 1 with guidance on completion can be found in Appendix 4.

The following guidance is extracted from the agreed Atos Healthcare 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 MEC for a period of 6 months after which time it should be destroyed.

The process for checking a Client's ID is as follows:

- Ask the client to sign the POID1 form
- Ask the client to provide Identification. A list of acceptable forms of ID is contained in Appendix 4.
- Circle the evidence provided on the form. If the client has an appointee, identification should be provided for both the appointee and the client 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 examination 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 client produced an acceptable form of identification, but the signatures do not match, you should discreetly advise the examining practitioner of the discrepancy before the examination starts. The examining practitioner should then ask more in depth questions relating to case history to establish correct identity. If the identity of the client is proven, the examining practitioner should complete Parts 2A and 2B of the form and the examination should be carried out as normal.
- If the client was unable to provide sufficient evidence of knowledge of the case history, then the examination should be suspended. A Medical Services Doctor/HCP can authorise refusal of an examination

Identification presented is insufficient

If the client is unable to provide identification or the maximum three items requested, note the POID1 with the forms of identification the client has provided. If the client's signature matches, the examination should be carried out as normal.

Questionnaire not available

If the questionnaire is not available the examining practitioner should ask the client further in depth questions relating to the case history before deciding whether the assessment should continue.

If the examining practitioner 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 examining practitioner 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.

Appendix 1 - The Support Group Descriptors

SCHEDULE 1 (Regulation 34(1)) of the Employment and Support Allowance Amendment Regulations 2011)

ASSESSMENT OF WHETHER A CLAIMANT HAS LIMITED CAPABILITY FOR WORK-RELATED ACTIVITY

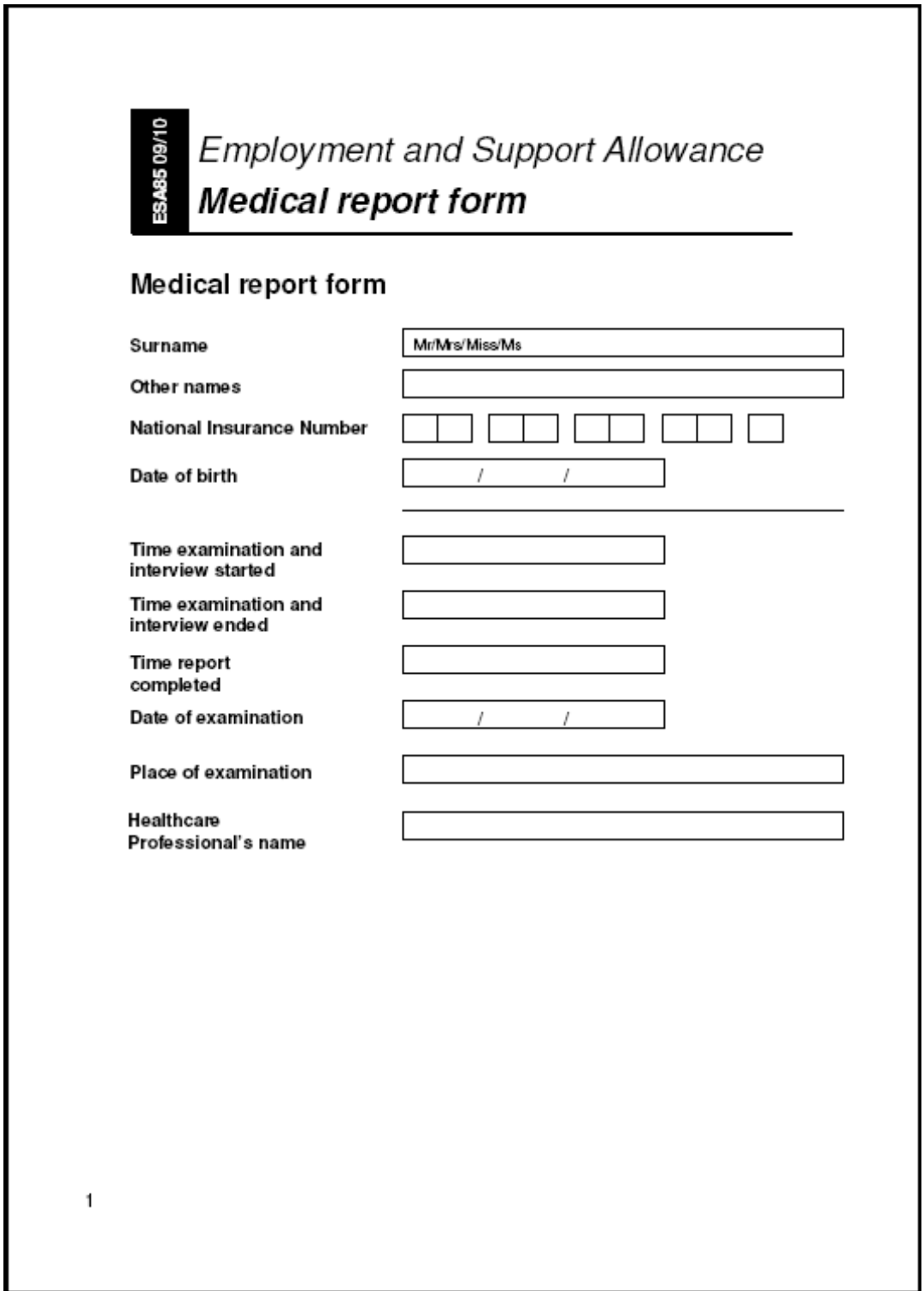
Activity	*Descriptors*
1. Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be used.	Cannot either (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (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 another person.
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.
6. Making self understood through speaking, writing, typing, or other means normally used.	Cannot convey a simple message, such as the presence of a hazard.

Activity	*Descriptors*
7. Understanding communication by hearing, lip reading, reading 16 point print or using any aid if reasonably used.	Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.
8. Absence or loss of control over extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the presence of any aids or adaptations normally 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.
10. Awareness of hazard.	Reduced awareness of everyday hazards, due to cognitive impairment or mental disorder, 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.
11. 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.
12. Coping with change	Cannot cope with any change, due to cognitive impairment or mental disorder, to the extent that day to day life cannot be managed.
13. 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.
14. 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.

15. 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 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 claimant's own mouth without receiving— (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.	(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.

Appendix 2 – ESA 85

>> Form ESA85 (PowerPoint version – read only)



ESA85 09/10

Employment and Support Allowance

Medical report form

Medical report form

Surname	Mr/Mrs/Miss/Ms
Other names	
National Insurance Number	
Date of birth	/ /
Time examination and interview started	
Time examination and interview ended	
Time report completed	
Date of examination	/ /
Place of examination	
Healthcare Professional's name	

1

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	1
2	2
3	3
4	4

Medication (including reason for use) 2

Side effects due to medication (including comment on functional relevance) 3

2

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

4

Description of functional ability - continued

Typical day continued 4

5

Medical Opinion – Physical

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be 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 ☐

6

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)

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)

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 ☐

7

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
Summary of functional ability	8

8

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	☐

9

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	☐
P_b	Cannot pick up and move a one litre carton full of liquid	☐
P_c	Cannot transfer a light but bulky object such as an empty cardboard box	☐
P_d	None of the above apply	☐

10

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 use a suitable keyboard or mouse ☐

M_e None of the above apply ☐

11

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	9
Behaviour observed during assessment	10
Relevant features of clinical examination	11
Summary of functional ability	12

12

Navigation and maintaining safety, using a guide dog or other aid if normally 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**	☐
V_b	**Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment**	☐
V_c	**Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment**	☐
V_d	**None of the above apply**	☐

13

Making self understood through speaking, writing, typing, or other means normally 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	☐
SP_b	Has significant difficulty conveying a simple message to strangers	☐
SP_c	Has some difficulty conveying a simple message to strangers	☐
SP_d	None of the above apply	☐

14

Understanding communication by both verbal means (such as hearing or lip reading) and non-verbal means (such as reading 16 point print) using any aid it is reasonable to expect them to use; 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	☐
H_b	Has significant difficulty understanding a simple message from a stranger due to sensory impairment	☐
H_c	Has some difficulty understanding a simple message from a stranger due to sensory impairment	☐
H_d	None of the above apply	☐

15

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	13
Behaviour observed during assessment	14
Relevant features of clinical examination	15
Summary of functional ability	16

16

Absence or loss of control leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting) despite the presence of any aids or adaptations normally 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 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 ☐

17

Continence – Activity 9

Medical evidence used to support your choice of activity outcome

Prominent features of functional ability relevant to daily living	17

Relevant features of clinical examination	18

Summary of functional ability	19

18

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** ☐

19

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	20

Relevant features of clinical examination	21

Summary of functional ability	22

20

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

21

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	☐
LT_b	Cannot learn anything beyond a simple task, such as setting an alarm clock	☐
LT_c	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	☐

22

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 ☐

23

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	☐
IA_b	Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time	☐
IA_c	Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions	☐
IA_d	None of the above apply	☐

24

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.	23
Relevant features of clinical examination	24
Summary of functional ability	25

25

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	☐
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	☐
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	☐
CC_d	None of the above apply	☐

26

Getting about (Activity 15)

Tick the first box that applies.

GA_a	Cannot get to any specified place with which the claimant is familiar	☐
GA_b	Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person	☐
GA_c	Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person	☐
GA_d	None of the above apply	☐

27

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.	26
Relevant features of clinical examination	27
Summary of functional ability	28

28

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	☐
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	☐
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	☐
CS_d	None of the above apply	☐

29

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	☐
IB_b	Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace	☐
IB_c	Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace	☐
IB_d	None of the above apply	☐

30

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.	29
Relevant features of clinical examination	30
Summary of functional ability	31

31

Exceptional Circumstances (Non-functional descriptors)

My advice based on the Limited Capability for Work and Limited Capability for Work Related Activity medical examination I have carried out as a healthcare professional approved by the Secretary of State, is that this person 32

- is suffering from a life threatening disease in relation to which- **No** ☐

(a) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure, and **Yes** ☐

(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

- 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 **No** ☐ **Yes** ☐
(If 'Yes,' please also complete an ESA85A)

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 .....

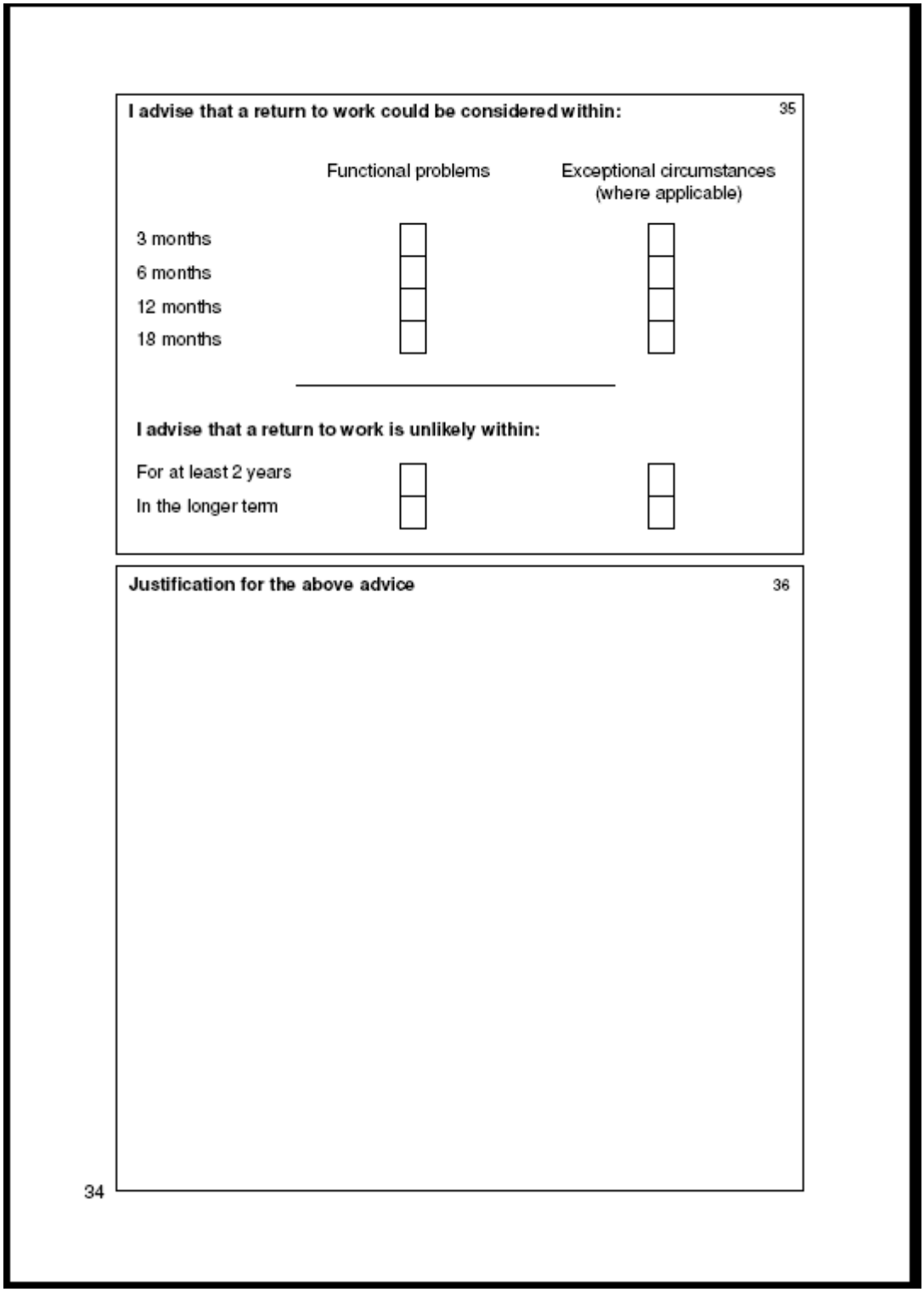
Please justify the answers you have given above in relation to exceptional circumstances. 33

32

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.
Please provide evidence in support of your opinion for each area of functional activity. 34

33



I advise that a return to work could be considered within: 35

	Functional problems	Exceptional circumstances (where applicable)
3 months	☐	☐
6 months	☐	☐
12 months	☐	☐
18 months	☐	☐

I advise that a return to work is unlikely within:

For at least 2 years	☐	☐
In the longer term	☐	☐

Justification for the above advice 36

34

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** ☐

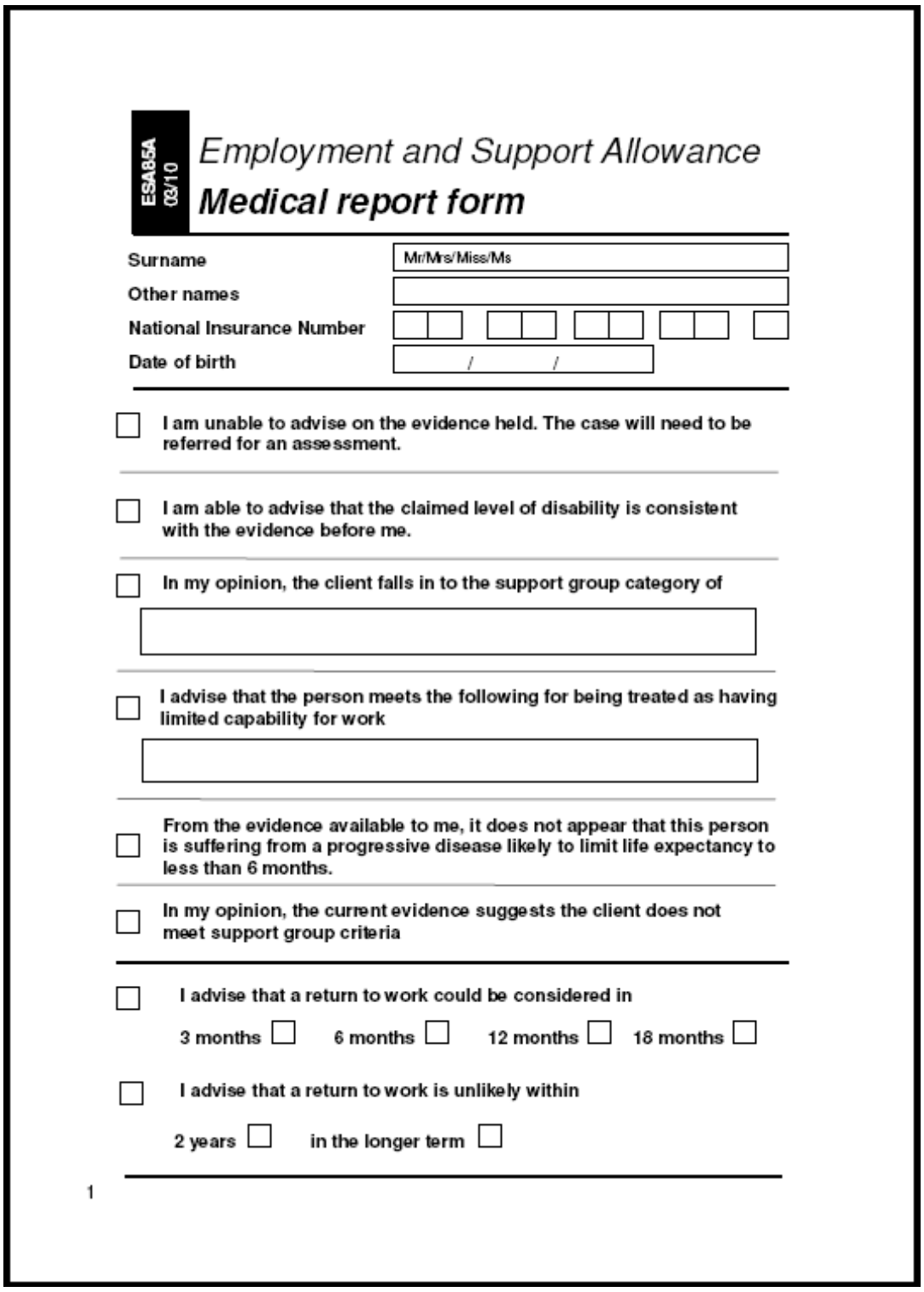
Registered Occupational Therapist ☐ **Registered Physiotherapist** ☐

Harmful Information – not to be copied to the client

35

Appendix 3 - ESA 85A

>> Form ESA85A (PowerPoint version – read only)



ESA85A 03/10

Employment and Support Allowance

Medical report form

Surname | Mr/Mrs/Miss/Ms

Other names

National Insurance Number

Date of birth / /

☐ I am unable to advise on the evidence held. The case will need to be referred for an assessment.

☐ I am able to advise that the claimed level of disability is consistent with the evidence before me.

☐ In my opinion, the client falls in to the support group category of

☐ I advise that the person meets the following for being treated as having limited capability for work

☐ From the evidence available to me, it does not appear that this person is suffering from a progressive disease likely to limit life expectancy to less than 6 months.

☐ In my opinion, the current evidence suggests the client does not meet support group criteria

☐ I advise that a return to work could be considered in

3 months ☐ 6 months ☐ 12 months ☐ 18 months ☐

☐ I advise that a return to work is unlikely within

2 years ☐ in the longer term ☐

1

ESA85A 03/10

Employment and Support Allowance
Medical report form

Surname	Mr/Mrs/Miss/Ms
Other names	
National Insurance Number	
Date of birth	/ /

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 health care 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 health care 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** ☐

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Appendix 4 - POID 1

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

PROOF OF IDENTITY SLIP

Please complete part 1 with the claimant's details.

PART 1

Full Name (please print)……....

Date of Birth……...

Signature…….. Date……..

PART 2
For office use only

PP	ECID	SAL	HOID
DP	CGC	BC	HODOC
WS	BANK	MC	TU
BSOC	TP	PRV	AC
BILLS	GV3	DVLC	HMFC
LARC	LAP	CB	CRED

Acceptable Forms of Identification

Atos Healthcare will accept as evidence of identity one of the following:

Type of Identity	Code
☐ Claimant's own passport	PP
☐ European Community identity card	ECID
☐ Standard Acknowledgement (for those seeking asylum in UK)	SAL

Alternatively, Atos Healthcare will accept any three of the following documents as proof of identity:

☐ Birth certificate	BC
☐ Marriage certificate	MC
☐ Travel pass	TP
☐ Form GV3 (one way travel document issued by UK embassies abroad)	GV3
☐ Local Authority rent card	LARC
☐ Certificate of identity issued by the Home Office to the claimant	HOID
☐ Forms issued by the Home Office to the claimant	HODOC
☐ Police registration certificate	PRC
☐ Full driving licence	DVLC
☐ Life assurance policy	LAP
☐ Divorce/annulment papers	DP
☐ Recent wage slip	WS
☐ Trade union membership card	TU
☐ Adoption certificate	AC
☐ Cheque book	CB
☐ Cheque guarantee card	CGC
☐ Bank statements	BANK
☐ Building society pass book	BSOCY
☐ Paid household bills in the name of the claimant	BILLS
☐ Certificate of employment in Her Majesty's Forces	HMFC
☐ Store or credit cards	CRED

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: Angie Rhodes
Training and Development Co-ordinator
Atos Healthcare
3300 Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YQ

"Because we care about the environment we have chosen a material that comes from a well managed source"