USE OF PERSONAL CAPABILITY ASSESSMENT INFORMATION IN CLAIMS FOR DISABILITY LIVING ALLOWANCE

A Handbook for Decision-Makers

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Forward
This Handbook has been prepared by the Department's Corporate Medical Group. It considers how Decision Makers (DMs) in Disability Living Allowance (DLA) can use information contained in the Personal Capability Assessment (PCA) in assessing benefit entitlement for DLA.

Analysis has shown that a large percentage of DLA claimants of working age already have a current or recent claim for an incapacity benefit. Valuable information relating to the claimant’s medical condition and functional limitations will be available from the Incapacity Benefit (IB) file. Using this information may save the claimant from having to undergo an examination in connection with their DLA claim and reduce the need for further clinical information from the claimant’s doctor or another Health Care Professional (HCP).

The Handbook contains information, which initially may appear of little relevance to a DLA Decision Maker. However it is useful to have a basic knowledge of the PCA process and principles of the test to put the IB85 medical report in context.
Section 1 - Background

1. The Personal Capability Assessment (PCA) is the Department’s method of determining a person’s ability to perform any type of work for state incapacity benefit purposes including:

**Incapacity benefit** - this is a benefit where entitlement is based on a person’s National Insurance contributions and is paid when a medical condition or disability prevents them from working. Benefit is paid at three different rates according to length of the spell of incapacity. The benefit is not ‘means tested’ but the two higher rates are taxable after 28 weeks of incapacity.

**Income Support – disability premium** - this is a non-contributory additional premium paid to people in receipt of Income Support and who are found incapable of work in accordance with the appropriate test of incapacity.

**Severe Disablement Allowance** - this is a benefit for people with severe disabilities, lasting at least 196 days, who could not be expected to work and who have insufficient National Insurance contributions to qualify for Incapacity Benefit. Since 2001 young people, aged between 16 and 19 have received ‘Incapacity Benefit in Youth’ instead.

**National Insurance credits** - people who are incapable of work can be credited with National Insurance, which helps to protect future entitlement to benefits such as state retirement pension.

2. For those in employment, the PCA is applied after 28 week’s incapacity. For those who are not working, it applies from the first day of incapacity. For employed persons entitlement during the first 28 weeks of illness is dependant on the person being unable to perform their usual occupation.

3. The PCA is a measure of the extent to which a person, by reason of some specific disease or bodily or mental disablement, is incapable of performing certain specified everyday activities laid down in legislation. The PCA test is satisfied when a specific level of disability has been reached. This is known as the **benefit threshold**. The level at which the threshold for benefit entitlement has been set has been designed to reflect the point at which a person's ability to perform work related activities is substantially reduced, rather than the point at which work becomes impossible. As a result of satisfying the PCA test, the person should not be required to seek work as a condition of benefit.
Section 2 - The Personal Capability Assessment

1. State incapacity benefits are paid to people who meet the necessary entitlement conditions and are unable to work because of physical or mental disability or illness.

2. The methods used in the PCA for assessing limitations in physical and sensory function differ from those for assessing the effects of mental health problems. Both methods are described below.

Physical and sensory health

3. The PCA assesses a person’s incapacity under fourteen specified activities (called functional areas). These assess physical and sensory function. These areas are grouped as follows:

6 largely lower limb/spinal functions:
- sitting;
- rising from sitting;
- standing;
- walking;
- walking up and down stairs; and
- bending and kneeling.

3 largely upper limb/cervical spine (neck) functions:
- reaching;
- lifting and carrying; and
- manual dexterity.

3 special functions:
- vision;
- hearing; and
- speech.

2 others:
- continence; and remaining conscious, without having epileptic or similar seizures during waking moments.

4. For each of these activities, there is a set of ranked statements, known as descriptors. They are defined as:

“Clearly worded statements of disability ranked according to their incapacitating effects”.
They illustrate different levels of functional limitation. For example, for the activity standing, there are seven descriptors:

- Cannot stand unassisted;
- **Cannot stand for more than a minute before needing to sit down**;
  Cannot stand for more than 10 minutes before needing to sit down;
- Cannot stand for more than 30 minutes before needing to sit down;
- Cannot stand for more than 10 minutes before needing to move around;
- **Cannot stand for more than 30 minutes before needing to move around**; and
- No problem with standing.

5. The outcome of the PCA is determined by the choice of the descriptors that most accurately reflect the person's level of functional limitation across all relevant physical and/or sensory areas:

- the descriptors can be compared to a meter of severity within each functional area;
- each descriptor has been assigned a specific points score from zero to a maximum of 15;
- a person needs at least 15 points from the physical and sensory areas to reach the benefit threshold; and
- the score rises as one moves up the scale of descriptors (though not necessarily in a linear fashion) until at a specific point, the benefit threshold is reached.

Using the example above of ‘standing’ descriptor (c) indicates the level of functioning where the medical grounds for entitlement to a state incapacity benefit would be met (i.e. the descriptor carries a score of 15 points). Descriptors (d) (e) and (f) represent lesser degrees of functional restriction, and hence scores of less than 15 points, but these points can be combined with scores in other activities to reach a benefit threshold score of 15.

**Mental health**

6. There are four specified activities, which relate to capacity for work in the assessment of the effects of mental health problems:

- daily living;
- completion of tasks;
- coping with pressure; and
- interaction with other people.

7. For each of these activities, there is a set of descriptors. Unlike those for the assessment of physical and sensory functions, these descriptors are not ranked on a rising scale of impairment. Instead, each set of descriptors covers a range of different problems that may be encountered within each activity. For example, for the activity **interaction with other people**, there are six descriptors:
Section 3 - How can the PCA be used in DLA

- Cannot look after himself without help from others;
- Gets upset by ordinary events and it results in disruptive behavioural problems;
- Mental problems impair ability to communicate with other people;
- Gets irritated by things that would not have bothered him before; he became ill;
- Prefers to be left alone for six hours or more each day; and
- Is too frightened to go out alone.

8. Each of these statements has been assigned a points score. The point’s total for each activity is the sum of the points attached to all the descriptors that apply to the claimant. The mental health descriptors are not part of the questionnaire that the claimant completes.

9. A person may qualify for benefit on the basis of limitation in mental health functions, or on the basis of a combination of limitations in mental, physical/sensory function.
Section 3 – How can the Personal Capability be used in DLA

1. The IB85 will contain valuable information including the claimant’s functional limitations in the prescribed activities and factual information. For example:
   - diagnosis;
   - history of condition;
   - medication;
   - recent hospital attendance’s and/or admissions together with details of any treatment;
   - a detailed description of the claimant’s daily activities, and how these relate to function (Typical Day enquiry);
   - clinical findings; and
   - advice regarding the functional limitations and restrictions in the prescribed activities.

2. These are described in more detail in the following sections.
Section 4 - Medical IB forms and their uses

1. The following forms are commonly used in Incapacity Benefit (IB). They are described here in order to understand the PCA process but only the IB85 medical report will be available to DMs:

   - Med 4;
   - IB113; and
   - IB85.

2. Med 4
This form is a medical statement issued by the claimant’s doctor. Form Med 4 should be issued to a patient on request prior to the 1st application of the Incapacity Benefit Test in a spell of incapacity. The patient will have been asked to complete the claimant questionnaire (IB50) giving details of their disability. Form Med 4 is usually issued after 28 weeks of incapacity. Although in some circumstances it may be issued earlier.

   The form should contain:

   - the patients name;
   - the date of examination by the certifying doctor (i.e. the doctor signing the sickness certificate);
   - an accurate diagnosis of the main incapacitating condition;
   - other relevant medical conditions; and
   - an indication of the disabling effects of the condition.

3. IB113
This form is a Factual Report provided by the claimant’s doctor, usually the GP. If the certifying doctor has indicated that the claimant is suffering from a prescribed severe medical condition such as a mental health problem, the potentially exempt procedures are carried out. Form IB113 is issued to the certifying doctor requesting factual details of the patients’ condition.

   This should include:

   - the date the patient was last seen for the condition causing incapacity;
   - diagnoses of all relevant conditions; and
   - brief details of:
     i. present medical condition;
     ii. medication and other treatments; and
     iii. outlook for the patient.

4. IB85
Form IB85 is the medical report form completed during examination of the claimant at a Medical Examination Centre (MEC).

   It will contain:
Section 3 - How can the PCA be used in DLA

- a list of all diagnoses (either previously diagnosed or found during the assessment);
- medication and reason for use;
- any side effects of the medication as reported by the claimant. (The doctor will give his or her own view regarding whether this is a recognised side effect.);
- any hospital treatment or investigations within the last 12 months;
- if mental health problems are claimed, details of specific therapy received within the last 3 months;
- details of the therapist(s) involved – name address and qualifications of mental health professionals consulted, if known;
- clinical history;
- typical day enquiry;
- the examining doctors’ choice of physical descriptors within each of the 14 Functional Areas justified by:
  i. features of relevant functional ability;
  ii. observed behaviour during the assessment;
  iii. relevant features of clinical examination; and
  iv. a reasoned summary of functional ability based on the evidence available.
- if appropriate, the Mental Health Test (MHT). This will only be applied if a specific mental disease or disablement has been diagnosed;
- advice on ‘Exceptional Circumstances’; and
- a prognosis on the duration of the functional limitations detailed in the IB85 report, together with justification for this advice.
Section 5 - The Personal Capability Assessment process

1. A basic knowledge of the PCA process is necessary to understand the information available in these cases. The following section lists the stages in the PCA process. Appendix 3 gives an overview of this process together with the information obtained at each step, and should be used in conjunction with the following information.

Exemptions

2. It is recognised that some medical conditions are so disabling that it is possible to treat the person as being incapable of work without the Personal Capability Assessment being applied. This avoids examination of very disabled or ill people.

3. The following categories can be determined by a Decision Maker without considering advice from a medical services doctor:
   - people in receipt of the highest rate care component of Disability Living Allowance;
   - an increase of disablement pension under section 104 of the Contributions and Benefits Act; a Constant Attendance Allowance;
   - people who are terminally ill, defined as suffering from a progressive disease and death in consequence of that disease can reasonably be expected within 6 months.
   - people suffering from the following severe medical conditions:
     - tetraplegia;
     - paraplegia, or uncontrollable involuntary movements or ataxia which effectively render the sufferer functionally paraplegic;
     - persistent vegetative state;
     - dementia; and
   - registered blindness, defined as where a blind person’s name appears on a register compiled by local authority under section 29(4) (g) of the National Assistance Act 1948 (a) (welfare services) or, in Scotland, he has been certified as blind (and in consequence is registered blind in a register maintained by or on behalf of a regional or islands council.
   - people who are assessed at 80% disabled for war pension, industrial injury or Severe Disablement Allowance purposes.

4. Evidence that the claimant suffering from one of these conditions may be contained on the Med 3 statement (sickness certificate) given by the certifying doctor, or other reports. Advice may be requested from Medical Services.

5. The following categories require the Decision Maker to consider the advice of a doctor approved by the Secretary of State (Medical Services doctor), as to whether the claimant is suffering from the condition:
• severe mental illness (see mental health section)

(For this purpose a severe mental illness is defined in the IB regulations as involving the presence of mental disease which severely and adversely affects a person's mood or behaviour, and which severely restricts their social functioning, or the awareness of their immediate environment);

• severe learning disabilities (see mental health section)

(Defined in the IB regulations as a condition which results from the arrested or incomplete physical development of the brain, or severe damage to the brain, and which involves severe impairment of intelligence and social functioning);

• severe and progressive neurological or muscle wasting diseases (may include Motor Neurone Disease, Multiple Sclerosis);

• active and progressive forms of inflammatory polyarthritis (may include rheumatoid arthritis, systemic lupus erythematosis – not osteoarthritis as not inflammatory arthritis);

• progressive impairment of cardio-respiratory function which severely and persistently limits effort tolerance (may include cardiomyopathies, severe ischaemic heart disease, severe Chronic Obstructive Airways Disease);

• dense paralysis of the upper limb, trunk and lower limb on one side of the body (may include strokes);

• multiple effects of impairment of function of the brain and/or nervous system causing motor sensory and intellectual deficits (may include Huntington’s Chorea); and

• manifestations of severe and progressive immune deficiency states characterised by the occurrence of severe constitutional illness or opportunistic infections or tumour formation (This category does not relate solely to a diagnosis of Acquired Immune Deficiency State or HIV related conditions).

6. Where the advice of an approved doctor is required, the process is as follows. When the diagnosis recorded on the Med 3 certificate indicates that the claimant may be suffering from a potentially exempt condition (for example depression, rheumatoid arthritis) a report (IB113) is requested from the certifying doctor, usually the GP. This report is returned to Medical Services who give advice regarding whether the claimant satisfies one of the exempt criteria.

If the DM agrees the claimant is exempt the process stops here and the claimant awarded benefit. If not exempt the process continues as for other groups who are not considered potentially exempt.

The IB50 Questionnaire and Med 4

7. Claimant’s whose condition(s) do not fall within an exempt category are sent an IB50 questionnaire to fill in. This asks the claimant to record their opinion of the problems they have in each functional area by choosing the most appropriate descriptor. The claimant is not asked to give their choice of
mental health descriptors but is invited to give details of their mental health problems. If this is the first time the PCA has been applied in a spell of incapacity, the claimant is asked to obtain a Med 4 from the certifying doctor. This is a brief report providing the diagnosis(es) of the disabling condition(s), and comments on the disabling effects of these conditions.

8. When the IB50 and Med 4 are returned, the questionnaire is scored based on the claimant’s choice of descriptors.

Claimant’s score is less than 15 (below benefit threshold)

9. These cases are referred to Medical Services for examination. This is to ensure that no claimant who is understating his or her ability is inappropriately found fit for work. Prior to arranging the examination, Medical Services will ensure that there is no evidence of the claimant being in an exempt category. It should be noted that all mental health cases, (unless the claimant has indicated descriptors in a physical problem scoring over 15, or is identified as having a “severe mental illness”) will be examined.

Claimant’s score is more than 15 (above benefit threshold)

10. If the provisional score is 15 or above, the case is sent to Medical Services for “scrutiny”. The objective of the scrutiny process is to decide whether the claimant’s functional limitations, as described on the IB50 (claimant’s questionnaire), is supported by medical evidence. If the evidence supports the claimed level of disability the case is returned to the district office where, in most cases benefit will be awarded. Those cases where the doctor is unsure will be sent for examination.

11. A specially trained examining Medical Services doctor (acting as a Medical Disability Analyst) will undertake an examination and complete a medical report form IB85, advising the DM of his or her choice of descriptors and explaining this opinion. This report will be sent to the DM who is required to choose descriptors, taking into account all the available evidence (claimant’s IB50 questionnaire, IB113, Med 4, and IB85 medical report).
Section 6 - Personal Capability Assessment activities and descriptors

1. **Appendix 1** contains details of the descriptors within each activity, the scope of each descriptor and factors the doctor considers when choosing the most appropriate descriptor. Much of this information is taken from the IB Handbook, which is issued to all doctors undertaking PCA examinations, and containing the Departments official guidance regarding these assessments.

2. The activities and descriptors are defined in the Regulations. It is important to understand the scope of each activity when applying to DLA decision making (see appendix 1).
Section 7 - What happens at the Personal Capability Assessment examination

1. Specially trained and approved Medical Disability Analysts, working for Medical Services, perform PCA examinations. They are experts in the field of Disability Assessment Medicine. Their role is different from the more traditional (or clinical) role of the GP or Hospital doctor, which is to diagnose and treat the patient. The clinician is an expert in arriving at a diagnosis, using physical examination and investigative techniques, as well as having a detailed knowledge of treatments. Clinicians are not experts in the assessment of disability, as they have not been trained to determine the disabling effects of a medical condition on a person's everyday life and activities.

2. The Medical Disability Analyst is a doctor who has received additional training in the disabling effects of medical conditions. The considerations of disability are of greater concern than diagnosis. The medical advisor has no responsibility for the treatment of the person being assessed, who is not a patient in this context. Medical Disability Analysts must satisfy an approval process before they can work on behalf of the Department. They are subject to ongoing monitoring, to ensure that the quality of their advice meets agreed standards. Disability Assessment Medicine is a recognised speciality with its own postgraduate Diploma awarded by the Faculty of Occupational Medicine of the Royal College of Physicians. Employment opportunities also exist in the insurance industry and other fields. Appendix 4 summarises and compares the roles of the Clinician and Medical Disability Analyst.

3. The doctor considers four stages when performing the Personal Capability Assessment, in order to evaluate the disabling effects of the claimant's medical condition, and advise the DM in accordance with the law:
   - Reading the documents;
   - Interviewing the claimant;
   - Appropriate examination of the claimant; and
   - Completing the medical report form IB85.

THE PROCEDURE

Reading the Documents

4. Upon attending the Medical Examination Centre (MEC), the claimant is first asked to report to the receptionist, provide proof of identification and sign the attendance register. Routine administrative matters including arrangements to offset the claimant’s travel costs are carried out. The claimant is then invited to be seated in the waiting room.

5. As soon as an examining doctor is available, he or she takes the next available file and reads the documents. All the medical evidence is considered including evidence from the GP, any previous examination of the claimant, and
SECTION 11 - PROGNOSIS

any Tribunal Documents. Particular attention is paid to the claimant’s IB50 questionnaire.

6. When the examining doctor has read the documents, he or she usually goes to meet the claimant, and accompanies them from the waiting room to the interview/examination room. This helps to put the claimant at ease, and in addition to being a natural courtesy, it provides the doctor with an opportunity to observe the claimant’s activities outside the examination room, and extends the period of contact with them. The doctor will observe how the claimant gets out of the chair, walks etc.

Interviewing the claimant

7. The interview differs from the traditional consultation of the GP or Hospital Doctor. The aim of the traditional interview of the clinician is to enable the doctor to diagnose and treat the patient.

8. In the PCA setting, the aim of the Medical Disability Analyst is to gather information to assess the disabling effects the claimant is experiencing in the relevant functional areas.

9. The interview is recorded on the medical report from IB85. Details of the medical condition are recorded, together with medication or other treatments, including any hospital attendance in the preceding 12 months. The doctor also records the time the claimant was first contacted, the time the claimant leaves, and the time the report is fully completed.

The Typical Day Enquiry

10. The most important and different aspect of the interview, which distinguishes the Medical Disability Analyst’s approach from that of the treating clinician, is the Typical Day enquiry.

11. The Typical Day enquiry is a record of the claimant’s everyday life, without interpretation by the medical examiner. It is also a factual description of how the claimant’s condition affects them in day to day life as elicited by careful interview. The Typical Day enquiry is of great help to the Decision Maker, and will be valuable in DLA as well for the IB decision maker. The doctor records the interview in note form; there is no statement as in DLA. Decision Makers may find this section particularly helpful.

The Examination

12. When the doctor has finished the interview, the claimant’s permission is sought for a physical examination of the relevant functional areas. A mental state examination is included in the interview where there is evidence of a mental disease or disablement (mental illness, learning difficulty or sedative medication).

13. Informal observations of the claimant are also considered by the doctor during the entire period of claimant contact and incorporated into the report. The doctor looks for consistency when considering informal observations, formal clinical examination findings, and the claimant’s medical condition. This will help
to inform the Medical Disability Analyst of the actual disabling effects of the claimant’s condition.

**Completing the Form**

14. The doctor then completes the medical report from IB 85, choosing and justifying where necessary the most appropriate descriptors.

15. The doctor also indicates in the IB85 whether he or she agrees or disagrees with the claimant’s own choice of descriptor on the IB50 questionnaire. The doctor will go on to:

16. Explain their opinion where either the claimant or doctor identifies a problem in the activity, paying particular attention to where the claimant and doctor choose different descriptors. The doctor will look for consistency, and will consider informal observations, relevant examination findings and his or her knowledge of the medical condition before giving this advice.

17. The completed report and file are then returned to the receptionist by the doctor, who takes the next available file, repeating the process until the end of the session.

18. The process from greeting the claimant to the end of the interview and examination typically takes 30 to 40 minutes, with 10 minutes on average to complete the report.

19. The Medical Disability Analyst will explain or justify his or her choice of descriptors on the IB85. Appendix 2 gives an example of relevant completed pages of an IB85 illustrating this process.
Section 8 - Choosing descriptors

1. The PCA requires the examining doctor to select his or her choice of descriptor in each of the 14 functional areas, provide medical advice on the most appropriate level of functional ability in each activity area and, if necessary, complete the MHT. In doing so they must take into account a number of factors including:

- any fluctuations in the medical condition (see section on variability) i.e. how the medical condition changes over time;

- 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 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;

- the ability to repeat the activity. If a person 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. It is however, not necessary to repeat the activity without a rest or break. For example a person would still be considered capable of going up and down stairs if he or she needed a few minutes rest before using the stairs again;

- the ability to perform the activity safely i.e. without substantial risk of harm to self or others. For example, if a person with vertigo is physically able to bend to touch his or her knees, but in doing so falls over due to giddiness, then that person should be considered incapable of performing that activity; and

- the ability to perform the activity without undue breathlessness. For example, a claimant who experiences significant breathlessness on carrying out an activity should be scored as if the activity cannot be undertaken.

2. In order to select the most appropriate descriptor, and take the preceding factors into account, the doctor will depend upon:

- consideration of all the medical evidence;

- the interview with the claimant;

- relevant physical examination; and

- the Disability Analysts’ medical knowledge of the likely effects of the claimed condition.
3. Only one descriptor may be chosen for each of the 14 functional areas. This descriptor should reflect the claimant’s level of functioning most of the time. Pain, stiffness, response to treatment and variability of symptoms are taken into account, as is the claimant’s ability to perform the descriptor task reliably, repeatedly and at a reasonable speed.

4. This ensures that the examining doctor’s opinion is not just a “snapshot” of the claimant on the day of examination, but reflects their functional ability over a period of time.

General rules of descriptor choice
5. The following are the general rules of descriptor choice;
   - only one descriptor in any functional area may be chosen;
   - where more than one descriptor applies, the highest, most disabling should be chosen; and
   - if the claimant’s ability falls between two descriptors, the lower (or least disabling) should be chosen. This is because by definition the disability is not severe enough to warrant the higher descriptor.

6. An example – Standing:
   - Cannot stand unassisted;
   - Cannot stand for more than a minute before needing to sit down;
   - Cannot stand for more than 10 minutes before needing to sit down;
   - Cannot stand for more than 30 minutes before needing to sit down;
   - Cannot stand for more than 10 minutes before needing to move around;
   - Cannot stand for more than 30 minutes before needing to move around; and
   - No problem with standing.

7. Descriptors are considered and chosen from the top down.

8. In this case, the claimant told the examining doctor that she collects her 2 children from school and stands to wait for them with other parents. After 15 minutes of waiting she said she had to move in order to ease discomfort due to sciatica. During the examination, she stood for a short period of time but soon appeared to be in discomfort. Clinical examination was consistent with the history obtained.

9. The correct descriptor choice is (g).

‘Cannot stand for more than 30 minutes before needing to move around’. 
This is because the claimant’s ability falls between two descriptors, (f) and (g); therefore the least disabling is appropriate, since by definition the claimant can stand for longer than 10 minutes.

10. Each functional area is considered in the same manner, and as stated earlier, the descriptors chosen from the top down, i.e. the most disabling are considered first. If the claimant’s function exceeds this, then the next descriptor is considered and so on. If the claimant’s function exceeds (or is better than) the least disabling descriptor.

11. Then “No problem” is chosen. This does not mean that the claimant has no disability, but that any disability present is not enough to score. The examining doctor also indicates in each of the functional areas whether his or her descriptor choice agrees or disagrees with the claimant’s own choice on the IB 50 questionnaire. Where either the doctor or the claimant identifies a problem in an activity, the doctor will justify his or her opinion of descriptor choice. This will be in terms of:

- history, including Typical Day;
- informal observations;
- examination findings; and
- the doctors knowledge of likely disabling effects of the condition.

The doctor will be looking for consistency, and will explain any inconsistencies in these considerations.
Section 9 - How it is addressed

1. The PCA requires that the examining doctor takes an overall assessment of functional ability over time, and not a “snapshot” on the day of examination. In other words could the person normally carry out the stated activity when called upon to do so?

2. The claimant’s ability to perform a task reliably, regularly and at a reasonable speed must be considered, taking variability of the condition into account. This will result in a choice of descriptor that reflects the claimant’s level of functioning most of the time. The examining doctor should make it clear in the report how they arrived at their advice. In such cases the doctor has to consider carefully whether the claimant’s claimed level of disability and ‘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.

Important factors in variability

3. Information will be recorded from the claimant directly concerning the levels of fluctuation of their medical condition. The examining doctor will provide an expert opinion to the DM taking the following factors into account:
   - fluctuations and changes over time;
   - pain;
   - stiffness;
   - response to treatment;
   - repeatability of the task under consideration; and
   - the ability to perform the task or activity safely.

4. For conditions that vary from day to day, the examining doctor should choose a descriptor that applies on the majority of the days. As stated earlier, the doctor should make it clear in the report how they arrived at their advice, and consider carefully whether the claimant’s 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.

5. The above implies that the doctor should provide the Decision Maker with advice on:
   - the claimant’s functional limitations on the majority of the days; and
   - the limitations found on the remaining days where the claimant’s condition is worse or better, with an indication of the frequency these days arise.
6. For conditions that vary through the day, the choice of descriptor should reflect the level of activity that can be performed for a reasonable continuous period within the day. Again, it should be made clear in the report how the doctor arrived at this advice.

7. If a person cannot repeat an activity with reasonable regularity i.e. when called upon to do so, or can only perform the activity once, then they should be considered **incapable** of performing that activity.

**Effects of pain**

8. When considering the effects of **pain**, the predictability of its onset and the effectiveness of treatment should be considered. Pain, which starts suddenly and without warning, is not the same as pain which is predictable, like angina, and which can be remedied or forestalled by treatment.

9. Consistency of the claimant’s account and presentation should be measured against the known diagnosis and stage reached by the disease. For example:

- Med 4 states "mechanical back pain". On examination, the doctor can find no abnormality. The claimant states that one-day a week, his back is so bad that he must stay in bed. This degree of variability is very unlikely, and is not consistent with the diagnosis and clinical findings; or

- Med 4 states "osteoarthritis – hands". On examination the doctor finds evidence of mild osteoarthritis of the fingers. The claimant says that the pain from her hand arthritis can strike anytime without warning, so that she cannot be relied upon to hold objects, turn taps, or self care. She also tells the doctor that she attends Bingo regularly every week at the same time, by public transport. This degree of variability is also very unlikely, and not consistent with the diagnosis, clinical findings or her reported activity at Bingo.
Section 10 - How to use the Personal Capability Assessment physical information

1. This section deals with the information contained in the IB 85, in particular use of the activity descriptors.
   - The IB 85 - Containing useful information:
     - History of condition;
     - Treatment;
     - Drugs;
     - Disabling effects of condition;
     - Typical day; and
     - Justified choice of descriptors in each activity.

2. Figure 3 gives details of ways to use descriptor information.

Examples

GETTING OUT OF BED

Mechanical Back Pain,

The claimant says his back is so painful he cannot get out of bed unaided and needs his partner to pull him up and swing his legs around to the side of the bed and then help him up by pulling on his outstretched arms.

Typical Day includes the following
   - drives partner to supermarket weekly for shopping;
   - walks with her to supermarket cafe and sits drinking coffee while she shops;
   - drives home, says he helps her unload light bags only;
   - does some light gardening, deadheading flowers and plants a few bulbs;
   - does not mow lawn but carries out lawn mower for partner to do; and
   - says needs help putting on socks and doing up shoelaces when dressing.

Holidays

Lanzarote last winter for 2 weeks – warmth eases his back. Planning another trip this winter.

Examination

Informal movements noted to be much freer and without obvious discomfort than those obtained on formal examination. But no objective clinical abnormality present.
Inappropriate signs present on examination:

- axial loading positive – pressure on head caused low back pain;
- simulated rotation caused low back pain;
- limited straight leg raising (SLR) but able to sit upright on couch with legs fully extended; and
- widespread superficial tenderness to light touch with groaning and grimacing.

These signs are strongly suggestive of a non-physical component to the condition. They do not, however, mean that no physical ailment is present.

The doctor may consider the following IB activities and descriptors:

- Rising from sitting - Rd;
- Walking up and down stairs - Stf;
- Lifting and carrying - Mhg; and
- Bending or kneeling - Bc.

**Mechanical Back Pain - comments**

The clinical findings are not consistent with the reported inability to get out of bed unaided. The degree and type of help reported is likely to increase any back pain present. Injudicious assistance of the type reported is likely to exacerbate back pain and is not consistent with a diagnosis of Mechanical Back Pain. The descriptors chosen on IB85 are indicative of normal upper and lower limb function. Some discomfort on bending is probable especially first thing in the morning, and some help with putting on shoes and socks would be reasonable. However, clinically this is not severely limiting and should not result in any need for assistance with getting out of bed, for the reasons stated above.

**FEEDING**

**Rheumatoid Arthritis**

The claimant reports painful swollen fingers, much worse in the morning with considerable stiffness. However, pain, swelling and weakness of grip are present throughout the day. She says that her ability to manipulate fine objects is considerably reduced.

**Typical Day includes the following:**

- needs husband’s help to wash and dress due to swelling pain and stiffness of fingers;
- can use taps with long handled adaptations;
- can use a tipping kettle but can’t fill it;
has great difficulty holding a pen and from afternoon onwards can sign her name; and

has special cutlery, can put food in mouth but can’t cut it up.

Examination
Swollen, hot, inflamed fingers, with deviation, finger movements limited and painful. Accompanied by husband, who had to open door and move chair for her.

Exemption advised
“Active and progressive forms of inflammatory polyarthritis”.

Feeding – comments
Significant impairment of upper limb function is present. This is likely to affect all activities of daily living including aspects of feeding. Exemption under the IB PCA process is appropriate, significant disability is present.

BATHING
Chronic Obstructive Pulmonary Disease (COPD)
The claimant, smokes 30 cigarettes daily despite medical advice (“it’s my only pleasure Doctor”) reports breathlessness on moderate exertion. He sleeps propped up with 5-6 pillows due to coughing. He reports that he gets very breathless if he exerts himself. He says washing or having a bath exhausts him completely. He has a strip wash daily but now only has a bath once a week when his ex-wife calls to deliver his shopping. She keeps an eye on him in case of danger. He walks slowly to his local pub once a week where he still belongs to the darts team. Sometimes he has to go outside the pub during a match due to bouts of prolonged coughing. He uses inhalers, which only help a little.

Peak flow on examination was 300 litres/minute. His chest had rattles on auscultation with widespread wheeze and inspiratory rhonchi. The effort of blowing/peak flow induced much coughing. There was no evidence of heart failure.

You may wish to consider the following PCA activities and descriptors:

- Sitting: - Sif;
- Rising from sitting: - Rd;
- Bending or kneeling: - Bd;
- Standing: - Sf;
- Stairs: - Stc;
- Manual Dexterity: - Dh;
- Reaching: - Rsg; and
- Lifting and carrying: - Mhg.
COPD – comments
He has some impairment of respiratory function. His peak flow is reduced at 300 litres/min (around 600 would be expected) but this should not result in significant disability. He is able to safely take a bath unaided but prefers someone nearby “just in case”. This activity does cause some breathlessness, but not sufficient to require assistance from another person. The clinical findings and Typical Day activities are not consistent with significant disability. There is no medical reason why he should be at risk of danger.
Section 11 - Prognosis

1. The PCA will provide a prognosis for the disabling effects of the claimant’s condition. The Medical Disability Analyst can select periods of 3, 6, 12 and 18 months, if a significant improvement in the effects of the condition is expected. If it is considered unlikely that the effects of the condition will improve in the shorter term, then 2 years or over the longer term, can be advised.

2. This entails bringing together information gained from observation, the claimant’s IB 50 questionnaire, medical evidence, careful interview and relevant examination, in order to reach an accurate assessment of the claimant’s disability.

Non-Functional Descriptors (Exceptional Circumstances)

3. Non-functional descriptors cater for a minority of medical conditions which are not severe enough to warrant exemption nor likely to result in a score of 15 or more, but would still render an individual unfit for work. e.g. an impending major operation or therapeutic procedure.

4. By definition these exceptional circumstances do not relate to functional ability, and therefore are unlikely to assist the DLA DM. Further discussion is beyond the scope of this handbook.
Section 12 - Mental Health

Purpose
1. To consider how DLA DMs can use the mental health test and other clinical mental health information from the PCA can be used in assessing benefit entitlement for DLA.

Background
2. In claims for DLA, where a mental health condition is present or claimed, valuable clinical information relating to the claimant’s functional limitations due to mental health problems may be available on the IB85. The IB85 will include a completed mental health test examination, based on a typical day enquiry, informal observations of the client, and a mental state evaluation will be explained in more detail later.

The Mental Health Test
3. Four key areas of psychological functioning (or activity) are considered for this test. Within each area there are a series of questions (or statements), the answers to which would describe how a person functioned in these four areas.
4. These four areas of activity are:
   - Daily living;
   - Completion of tasks;
   - Coping with pressure; and
   - Interaction with other people.
5. For each of these activities there is a set of statements, which covers a range of different problems that may be encountered within each activity. For example, the activity **Daily Living** contains 5 statements:
   - Does he or she need encouragement to get up and dress?;
   - Does he or she need alcohol before midday?;
   - Is he or she frequently distressed at some time of day due to fluctuation of mood?;
   - Does he or she care about his or her appearance and living conditions?; and
   - Do sleep problems interfere with his or her daytime activities?
6. These areas and the statements they contain encompass a wide area of daily living activities. When combined with information from the Typical Day enquiry, much valuable information regarding functional limitations and likely care or supervisory needs can be extracted from the Incapacity Benefit file.
The Personal Capability Assessment Process – Exemption and Examination (Figure 3 for overview)

Exempt Categories

7. In IB, a claimant can be exempted from the assessment process and benefit awarded if the claimant falls into a medically exempt category. There are two exempt categories for mental health conditions:
   - Severe mental illness; and
   - Severe learning disabilities.

8. These categories are defined in Incapacity Benefit legislation as follows:

**Severe mental illness**

The presence of mental disease which severely and adversely affects a person’s mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment.

**Severe learning disabilities**

A condition which results from the arrested or incomplete development of the brain or severe damage to the brain and which involves severe impairment of intelligence and social functioning.

9. Where there is evidence of a mental health problem, a report (IB113) is requested from the certifying doctor, usually the GP. A Medical Services doctor checks these reports to determine whether the claimant falls into an exempt category. If the Medical Services doctor is satisfied that the conditions have been met, then advice supporting exemption together with a prognosis, will be sent to the DM and no examination will be arranged.

10. If the Medical Services doctor is not satisfied that exemption is advisable, then the claimant will be issued with a questionnaire, the IB50. The non-exempt procedures are then followed. This requires Medical Services to undertake scrutiny of the IB file containing the IB50, and any supporting medical evidence e.g. IB113 and/or Med4.

11. Following scrutiny, Medical Services may either recommend acceptance of the claimant’s stated level of disability, or that the claimant is called for examination at a Medical Services Examination Centre (MEC).

12. At examination, the doctor considers exemption at each stage of the process. An exemption can be applied at any time during the interview and/or examination.

13. Exemption from the IB process on mental health grounds could be consistent with high levels of need with personal care or supervision. Clarification could be obtained from either the detail provided from the IB85 or from Medical Services.

**Examination of the claimant**

As in the physical test, there are four stages in performing the assessment:
• Reading the documents;
• Interviewing the client;
• Appropriate examination; and
• Completing the medical report form IB85.

15. For mental health conditions, either previously diagnosed or identified during the course of the interview and examination, the MHT is carried out.

16. The information on the medical report form IB85 in mental health conditions should include:
   • all current diagnoses or stated problems;
   • all regular medication including any side effects;
   • details of any hospital treatment within the last 12 months;
   • details of specific therapy for mental health problems and mental health professional consulted;
   • clinical history;
   • a Typical Day enquiry, recording the claimant’s account of everyday life and stated functional limitations and disabilities;
   • a physical assessment;
   • a MHT;
   • details of mental state examination;
   • an assessment of the claimant’s level of disability together with a reasoned justification supporting the examining doctor’s opinion; and
   • the prognosis.

Use of IB85 mental health information

Is the claimant in an exempt category?

17. If the claimant is exempt on grounds of severe mental illness, then the following conclusions for DLA purposes may be drawn:
   • a severe and adverse effect on mood and behaviour is present; and
   • a severe restriction of social functioning, or awareness of the immediate environment.

Such a person may be:
   • attending day care at least once a week in a centre where qualified nursing care is available;
• living in sheltered residential facilities where the person receives regular medical or nursing care;
• receiving care at home with intervention, at least one day a week, by a qualified mental health care professional; and
• on long term medication with anti-psychotic preparations including injections, or modern oral medication.

18. If the claimant is exempt on ground of severe learning disabilities, then severe impairment of intelligence and social functioning is present. Such a person is likely to be characterised by one or more of the following:
• an inability to learn more than the basic skills such as feeding, dressing, and going to the toilet. Many will not reach even this level;
• the likely need for help with most of, if not all, their bodily functions;
• a failure to be aware of danger indoors or out, requiring supervision to avoid danger to themselves or others; or
• severe behavioural problems often so unpredictable that it is not possible to avoid situations that provoke it or to relax supervision, for example:
  i. self-harm or violence toward others; or
  ii. unpredictable behaviour or no awareness of danger, e.g. suddenly rushing across a busy street.

19. Exemption from the IB process on mental health grounds could therefore be consistent with high levels of need with personal care or supervision.

If the claimant is not exempt

20. A preliminary evaluation of likely care or supervision needs can be made from consideration of the medical report from IB85.

Diagnosis: This may give a clue into possible needs, for example Acute Schizophrenia, Severe Depression, or Obsessive Compulsive Disorder are likely to indicate considerable needs. Mild Anxiety or Moderate Depression are not.

Medication: This may also suggest the degree of impairment and possible needs. For example, a high level of need is likely if powerful antipsychotic drugs or high dose antidepressants are being taken.

Hospital Treatment (last 12 months): High levels of care needs could be inferred from recent admissions to Psychiatric Hospital or Wards especially if these involved compulsory admission under a Section of the Mental Health Act.

Specific Therapy within the last 3 months: If the claimant is receiving therapy at weekly intervals from a Community Psychiatric Nurse (CPN) or other qualified mental health professional (e.g. Clinical Psychologist or Psychiatrist) then a considerable impairment of mental health function and correspondingly high needs are likely to be present.
21. Information from the Clinical History and a Typical Day enquiry should provide medical details of the claimed diagnoses or problems, and the time scales involved, together with a record of the relevant aspects of the claimant’s everyday life. It is also a factual description of how the claimant’s condition affects them in day to day life as elicited by careful interview. This is of great help to the Decision Maker, and will be valuable in DLA as well as for IB.

22. Even if the IB claim is for mental health reasons only, the examining medical disability analyst will provide a physical assessment, completing the physical and sensory parts of the IB85, unless an exemption has been applied.

23. If exemption from the IB process has not been applied, then other information regarding the claimant’s mental disabilities will be found in the IB 85. Considerable information regarding everyday life, activities and any restriction or limitations involved, should be available from study of the Typical Day enquiry.

24. Further detail will be available from the MHT functional areas:
   - Daily Living;
   - Interaction with others;
   - Completion of tasks; and
   - Coping with pressure.

These are listed in order of likely usefulness to the DLA DM.

25. The following statements together with the examining doctor’s reasoned choice of applicability are likely to provide considerable insight to the DLA DM when considering the possible degree of care or supervision needs present. The statements considered being most useful for DLA purposes have been highlighted in bold.

It is important to state here that the doctor does not ask these questions directly. The choice of statement is the doctor’s option based on details from the typical day enquiry. Informal observation and mental health examination is used in order to provide a response to these questions.

**Daily Living**

- Does he or she need encouragement to get up and dress?
- Does he or she need alcohol before midday?
- Is he or she frequently distressed at some time of day due to fluctuation of mood?
- Does he or she care about his or her appearance and living conditions?
- Do sleep problems interfere with his or her daytime activities?
SECTION 11 - PROGNOSIS

Interaction with others

- Can he or she look after himself or herself without help from others?
- Does he or she get so upset by ordinary events that it results in disruptive behavioural patterns?
- Do mental problems impair his or her ability to communicate with other people?
- Does he or she get irritated by things that would not have bothered him or her before becoming ill?
- **Does he or she prefer to be alone six or more hours each day?**
- **Is he or she too frightened to go out alone?**

Completion of Tasks

- Can he or she answer the telephone and reliably take a message?
- **Does he or she often sit for hours doing nothing?**
- Can he or she concentrate to read a magazine or follow a radio or television programme?
- **Can he or she use a telephone book or other directory to find a number?**
- Does his or her mental condition prevent him or her from undertaking leisure activities previously enjoyed?
- **Does he or she overlook or forget the risks posed by domestic appliances or other common hazards due to poor concentration?**
- **Has agitation confusion or forgetfulness resulted in any potentially dangerous accidents in the last 3 months?**
- **Can his or her concentration only be sustained by prompting?**

Coping with pressure

- Was mental stress a factor in making him or her stop work?
- Does he or she frequently feel scared or panicky for no obvious reason?
- **Does he or she avoid carrying out routine activities because he or she is convinced they will prove too tiring or stressful?**
- Is he or she able to cope with changes in daily routine?
- **Does he or she frequently find there are so many things to do that he or she gives up because of fatigue, apathy or disinterest?**
- Is he or she scared or anxious that work would bring back or worsen his or her illness?
26. When completing the MHT, the examining doctor is required to give a ‘yes’ or ‘no’ opinion on the applicability of each statement by ticking the appropriate box. A reasoned justification is then given in the free text box provided. All statements must be addressed in this fashion.

27. It is important to emphasise here that the Medical Disability Analyst should only indicate that a problem exists under the appropriate statement if it is due solely to a mental disease or disablement. For example, a person who cannot take a message or use a telephone due to illiteracy, language or speech difficulties, or because they have hearing impairment, would not count.

Functional areas and statements

Attention

28. Actual physical help with bodily functions may be apparent from detail in the following areas and the highlighted statements:

- **Daily Living.** The highlighted statements in bold quoted above which deal with encouragement to get up, dressing, concern with appearance and disturbance of daytime activities, may reveal a need for actual physical assistance with these functions.

- **Interaction with others.** Similarly, can the disabled person physically care for himself or herself without the assistance of another person due to mental health impairment? Is there a history of disruptive behaviour requiring restraint?

- The person may be so agitated or profoundly depressed that actual physical assistance from another person may be required for self-care.

- **Completion of Tasks.** Someone who is so depressed that they sit around for hours doing nothing may require physical assistance with self-care tasks.

Supervision

29. The need for supervision in the form of prompting, or watching over to prevent danger to the disabled person or others, may be apparent from detail in the following areas and the highlighted statements:

- **Daily Living.** The disabled person may be capable of performing the tasks of getting up, dressing, and maintaining adequate appearance and nutrition, but lack the desire to do so. (For example, in chronic schizophrenia.) Prompting may be required. This may be apparent from detail contained in this section.

- **Interaction with Others.** Again, the need for prompting with self-care may be apparent here, as well as issues concerning risks to others, or of personal safety.

- **Completion of Tasks.** As well as the need for prompting, issues of personal safety and risks to others may be evaluated further in this area.
• **Coping with pressure.** Any need for prompting with issues of personal hygiene may be deduced from comments in this area.

**Mental State Examination**

30. The examining doctor at the end of the MHT will give an overview of the claimant’s mental health. This should contain further important detail on any likely care or supervisory needs.

For example:

**Moderate Depression**

Has lost confidence since made redundant. Unshaven. Low mood with poor eye contact. Slow speech. No suicidal ideas. No response to 9 months of antidepressants. Has some insight i.e. he knows he is unwell. Gave a reasonable account of himself.

**Mild Anxiety**

Anxious mood and suspicious of the examination process. Fast speech and easily startled. Avoids going out on his own. Able to give a clear account of his problems. Relaxed as interview progressed. Knows why he is off work and full insight is present.

**Active Psychosis/Acute Schizophrenia**


**Moderate Learning Disabilities**

Lives with mother who brought her today. Needed prompting during interview and at one point became very flustered. Cognitive function reduced. Very little insight present.

**Prognosis**

31. The medical report from IB85 contains a section for the prognosis. The examining doctor is provided with a set of periods for significant improvement of the functional effects of the current medical condition (3, 6, 12, and 18 months.) If significant improvement within at least the next 2 years is unlikely, this can also be indicated.

32. If further advice or clarification is required on any of the above points, this can be sought from Medical Services.
Appendix 1

General Principles in choosing descriptors

1. Doctors are required to choose descriptors and provide 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 over time (see below).
- The variation of functional ability i.e. how the person's function ability changes over time and in relation to changes in the underlying medical condition (see below).
- Any pain which results from performing the activity. The activities do not have to be performed without any discomfort or pain. However if the claimant cannot perform an activity effectively because of pain they should be considered incapable of performing that activity.
- The ability to repeat the activity. If a person 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. It is however not necessary to repeat the activity without a rest or a break. For example a person would still be considered of being able to go up and down stairs if he needed a few minutes rest before using the stairs again.
- The ability to perform the activity safely - without substantial risk of harm to self or others, for example, if a person with vertigo is physically able to bend to touch his knees but in so doing falls over due to giddiness then he should be considered incapable of performing that activity.
- The ability to perform the activity without undue breathlessness. For example, a claimant who experiences significant breathlessness on carrying out an activity should be scored as if the activity cannot be undertaken. For example, a claimant who experiences significant breathlessness on carrying out an activity should be scored as if the activity cannot be undertaken.

Variable and fluctuating condition

2. The doctor's 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.

3. For conditions which vary from day to day the doctor will choose the functional descriptors which apply for the majority of the days. The examining doctor should make it clear in the report how they arrived at their advice. In such cases the doctor has to consider carefully whether the claimant's 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.

4. The above implies that doctors should provide the Decision Maker 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 these days arise.

5. For conditions which vary through the day the choice of descriptor should reflect that level of activity which can be performed for a reasonable continuous period within the day. Again it should be made clear in the report how the doctor arrived at this advice.
Appendix 2

Activities and descriptors

SITTING - in an upright chair with a back but no arms

Descriptors
Si(a) Cannot sit comfortably
Si(b) Cannot sit comfortably for more than ten minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting
Si(c) Cannot sit comfortably for more than 30 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting
Si(d) Cannot sit comfortably for more than 1 hour without having to move from the chair because the degree of discomfort makes it impossible to continue sitting
Si(e) Cannot sit comfortably for more than 2 hours without having to move from the chair because the degree of discomfort makes it impossible to continue sitting
Si(f) No problems with sitting.

Scope
1. This category involves the ability to maintain the position of the trunk without support from the arms of a chair or from another person.
2. 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.
3. 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. Doctors are advised that where there are reported limitations for reasons other than these require thorough exploration and strongly supported evidence.

Details of daily living
4. The doctor should 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, reading, knitting
   - consider for how long the claimant sits at meal times (which may involve sitting in an upright chair with no arms)
   - also relevant is the time spent travelling in cars or buses.
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Observed behaviour

5. The doctor will record claimant's ability to sit without apparent discomfort within the examination center, both in the waiting area and during the interview. The doctor will record the type of chair.

6. Where the examining doctor has not observed the claimant sitting in an upright chair with no arms, the doctor must set out carefully why they have reached their stated conclusion. For example:

'The claimant sat in an upright chair with arms for 20 minutes of the interview. His posture was upright and he did not use the arms for support. He reports being able to drive to visit his parents every week, a trip of 1 hour without stopping. Examination detailed below showed that he had a good range of pain free back movements with no other relevant abnormalities. These findings are consistent with the ability to sit comfortably as defined for at least 2 hours.'

RISING FROM SITTING - from an upright chair with a back but no arms, without the help of another person.

Descriptor
R(a) Cannot rise from sitting to standing
R(b) Cannot rise from sitting to standing without holding on to something
R(c) Sometimes cannot rise from sitting to standing without holding on to something
R(d) No problem with rising from sitting to standing

Scope
1. This means rising from sitting without help from someone else, but possibly with help from equipment.

2. The use of the word 'sometimes' should be used in the context of the PCA to imply:

- that the person will, at times, be unable to do the activity because of the severity of their medical condition, rather than the circumstances in which they may find themselves
- that the more severe functional limitation or restriction occurs with some frequency -i.e. it is not a rare event and there would have to be definite spells when the person could not manage the task.

In the case of rising from sitting (descriptor R(c)) there must be definite occasions or instances where the person's medical condition is so bad that they could not rise from sitting without holding on. Such occasions must be likely to occur with reasonable frequency such that they are not rare events.

3. The functions of the major leg joints have perhaps more relevance than lower spinal function with this activity, as rising can be achieved with the back straight.
Details of activities of daily living
4. Relevant activities may include:
   - Getting on and off the toilet unaided;
   - Getting in and out of a car; and
   - Getting out of chairs or off the bed.

Observed behaviour
5. The doctor will 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 for the doctor to observe this function following the interview.

STANDING - the ability to stand without support from another person or from anything more than a single walking stick, and to continue standing for a period of time.

Descriptors
S(a) Cannot stand unassisted
S(b) Cannot stand for more than a minute before needing to sit down
S(c) Cannot stand for more than 10 minutes before needing to sit down
S(d) Cannot stand for more than 30 minutes before needing to sit down
S(e) Cannot stand for more than 10 minutes before needing to move around
S(f) Cannot stand for more than 30 minutes before needing to move around
S(g) No problem with standing

Scope
1. This means the ability to stand and perform some other task at the same time, e.g. a claimant requiring 2 walking sticks when standing will be unable to use the hands for any other useful functions at the same time.

2. The duration of standing is the point at which it has to stop irrespective of whatever other activity is being carried out. Any discomfort felt should be of sufficient severity so that it would be unreasonable to expect standing to continue.

3. The descriptors which relate to the need to 'sit down' after a period of standing score higher than the descriptors which relate to the need to 'move around'. The first group of descriptors represent a greater degree of disability.

Details of activities of daily living
4. 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.

The doctor will comment on the length of time for which the claimant stands during any such activities.

**Observed behaviour**

5. It is usually only possible for the doctor to observe the claimant standing for short periods of time but even these are of value in the 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 work his spinal muscles but would not need to sit down."

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

**WALKING - on level ground, with a walking stick or any other aid which would normally be used**

**Descriptors**

W(a) Cannot walk at all
W(b) Cannot walk more than a few steps without stopping or severe discomfort
W(c) Cannot walk more than 50 metres without stopping or severe discomfort
W(d) Cannot walk more than 200 metres without stopping or severe discomfort
W(e) Cannot walk more than 400 metres without stopping or severe discomfort
W(f) Cannot walk more than 800 metres without stopping or severe discomfort
W(g) No walking problems

**Scope**

1. Walking is bipedal locomotion, that is movement achieved by bearing weight first on one leg and then the other. Those who rely on a wheelchair or can only swinging through on crutches do not fulfil this definition, and therefore fall within descriptor W(a) – cannot walk at all.

2. On estimating the distances over which a claimant can walk 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, or distress.

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

4. Walking may 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 the medical report.

Details of activities of daily living
5. The doctor will consider the claimant's ability in relation to:
   - Mobility around the home
   - Shopping trips, exercising pets.

The doctor will include details of distances and how long it takes to walk a given distance; does the claimant need to stop, and if so how often, and for how long?

6. The method of travel to the examination centre is relevant. The doctor is likely, from his local knowledge, to know the distance from the bus station etc. He will record the time taken, the number of rests required, and the lengths of the rest periods.

7. The doctor will bear in mind that a person who can easily manage around the house and garden is unlikely to be limited to walking less than 200 metres; a person who can walk around a shopping centre/supermarket is unlikely to be limited to walking less than 800 metres.

Observed behaviour
8. The doctor will observe the claimant walking from the waiting area to the examination room, and note the gait, pace and any problem with balance. He will look for evidence of breathlessness as a result of walking. Claimants who are clearly breathless walking within the examination centre require careful assessment, including consideration about whether they should be exempt from the test on the grounds of a progressive impairment of cardio-respiratory function which severely and persistently limits exercise tolerance.

9. The doctor should note the use of any aids eg walking stick, and whether the use was appropriate. He will record any assistance which was needed from another person.

Clinical examination
10. 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.

11. Where relevant, an appropriate examination of the heart and lungs will be carried out, assessing for cyanosis, dyspnoea at rest or on minimal exertion, the presence of wheezing, any evidence of heart failure, and the state of peripheral blood vessels. Any respiratory or cardiovascular factors affecting exercise tolerance will be taken into account when choosing a descriptor.
12. Peak flow will be measured, if appropriate, and the recorded measure interpreted for the Decision Maker, for example

"Despite optimal treatment his peak flow today was 300 litres per minute which is about half the normal value in a man his age. He has moderately severe asthma causing him to be breathless on exertion. This is consistent with his claimed inability to walk more than 400 metres."

**WALKING UP AND DOWN STAIRS**

**Descriptors**

St(a) Cannot walk up and down one stair

St(b) Cannot walk up and down a flight of 12 stairs

St(c) Cannot walk up and down a flight of 12 stairs without holding on and taking a rest

St(d) Cannot walk up and down a flight of 12 stairs without holding on

St(e) Can only walk up and down a flight of 12 stairs if they go sideways or one step at a time

St(f) No problems in walking up and down stairs

**Scope**

1. Walking up and down implies that both tasks can be managed, but not necessarily one after the other.

2. In applying the test, stairs of an average and acceptable standard must be assumed. The speed of ascent or descent must be within the range normally found.

3. A common cause of confusion is the reference to "holding on" in St(c) and St(d). Most people hold on to a handrail or bannister out of habit when one is present. However these descriptors are only appropriate when there is evidence to support a history of balance problem, falling, etc which make the use of a handrail essential.

4. The choice of St(c) should indicate a considerably greater severity of problems than would be found under St(d) or St(e). Selection of St(c) is more likely to reflect the existence of functional limitations/restrictions additional to those due to impairment of lower limb joint functions. Impaired exercise tolerance due to cardiorespiratory problems and/or disturbances of balance and posture are likely to be present to some degree.

5. A person with a visual impairment severe enough to make it necessary for them to hold on to a stair rail would satisfy a visual descriptor at or above the benefit threshold (eg cannot see the shape of furniture in a room). Thus such people would satisfy the PCA on the vision activity alone. Those people who are below the benefit threshold in the vision activity (cannot see well enough to recognise a friend across the street) should have sufficient visual acuity and field of vision to enable them to use stairs safely.
Details of activities of daily living
6. Relevant details include information regarding the home:
   • Is it a flat or a house with stairs?
   • Is the bathroom/toilet upstairs?
   • Does the claimant sleep upstairs or downstairs?

7. If the home has no stairs, the doctor will consider how the claimant copes in friend's homes and in shops or other public buildings. He will also consider how the claimant copes getting on and off public transport.

Observed behaviour
8. It is very unlikely that this activity will be observed within the examination centre. However, general observations about mobility are relevant; they can be crossed reference to the "walking" category.

9. The claimant’s ability to climb on and off the couch unaided, including the use of a footstool if relevant, should be noted.

BENDING AND KNEELING
Descriptors
B(a) Cannot bend to touch knees and straighten up again
B(b) Cannot either, bend or kneel, or bend and kneel as if to pick up a piece of paper from the floor and straighten up again
B(c) Sometimes cannot either, bend or kneel, or bend and kneel as if to pick up a piece of paper from the floor and straighten up again
B(d) No problem with bending and kneeling.

Scope
1. This functional category includes a number of different activities of the spine and lower limbs involving the ability to manoeuvre the body from a standing position.

2. The descriptor B(a) implies a very severe condition, with lumbar spine and/or hip movements severely restricted, or restricted by pain.

3. This activity is very different from the one involved in descriptors B(b) and B(c). These descriptors consider the activity of bending and/or kneeling as if to pick something off the floor which involves a combination of flexing the lumbar spine, flexing the hip joints, and bending the knees to a squatting position.

4. Whilst the activity to squat and rise is not explicitly included in the wording of the descriptors, this is in fact one of the abilities which is being assessed.

Details of activities of daily living
5. Relevant activities include:
   • Dressing and undressing especially footwear
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- Getting in and out of the bath
- Bending to reach the oven, front loading washing machine, low cupboards or shelves
- Hanging laundry to dry
- Carrying out household cleaning chores

6. Bending to tend to babies and toddlers may also be relevant as may leisure and recreational activities involving bending eg gardening, tending to pets.

**Observed behaviour**
7. The doctor will record general mobility. While it is not appropriate for the doctor to directly observe the claimant undressing/dressing he will note the time taken and any help requested with certain items of clothing particularly shoes.
8. The doctor will note the claimant’s ability to climb on and off the coach.
9. It may be possible for the doctor to observe the claimant pick up an item such as a handbag or shopping bag from the floor of the examination room.

**REACHING**

**Descriptors**
RS(a) Cannot raise either arm as if to put something in the top pocket of a coat or jacket
RS(b) Cannot raise either arm to head as if to put on a hat
RS(c) Cannot put either arm behind back as if to put on a coat or jacket

RS(d) Cannot raise either arm above head as if to reach for something
RS(e) Cannot raise one arm to head as if to put on a hat but can with the other
RS(f) Cannot raise one arm above head as if to reach for something but can with the other
RS(g) No problem with reaching

**Scope**
1. This functional category considers the claimant’s ability to reach upwards and outwards, not downwards. It is an evaluation of power, coordination and joint mobility in the upper limbs.
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2. Consideration is only given to 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 RS(e) "Cannot raise one arm to head to put on a hat".

3. "Either arm" in Descriptors RS(a), RS(b), RS(c), RS(d) means disability in both arms.

4. Descriptors RS(e) and RS(f) should only be applied when the claimant is unable to raise one arm (either the R or the L) but is capable of raising the other arm.

Details of activity of daily living

5. The doctor will consider details of self-care which involve reaching eg:
   - Dressing and undressing (including reaching for clothes on shelves/in wardrobes)
   - Hair washing and brushing
   - Shaving.

6. The doctor will consider reaching up to shelves; putting shopping away at home; household chores such as dusting; hanging laundry on a washing line.

7. Relevant leisure activities include aerobics, golf, painting and decorating.

Observed behaviour

8. The doctor will record any spontaneous movements of the upper limbs, particularly if these are in excess of those elicited by formal examination.

9. He will consider the speed and efficiency of dressing/undressing. Apart from the removal of outdoor cloths there will usually be no direct observation of the claimant dressing or undressing. However the doctor should look for evidence of protecting a painful shoulder during any observed activity.

10. The claimant may hang up a coat or a jacket allowing observation of shoulder and upper limb action.

Examination

11. The examination clarifies whether the disability is unilateral or bilateral. If unilateral, the doctor will state which side is affected and chart the normality in the opposite limb. A simple summarising statement such as "normal power and a full range of pain-free mobility throughout the R arm" is usually enough to make the record clear.

LIFTING AND CARRYING by use of upper body and arms

Descriptors

MH(a) Cannot pick up a paperback book with either hand
MH(b) Cannot pick up and carry a 0.5 litre carton of milk with either hand
MH(c) Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity
MH(d) Cannot pick up and carry a 2.5kg bag of potatoes with either hand
MH(e) Cannot pick up and carry a 0.5 litre carton of milk with one hand but can with the other
MH(f) Cannot pick up and carry a 2.5kg bag of potatoes with one hand but can with the other
MH(g) No problem with lifting or carrying

Scope

1. Lifting and carrying is a measure of power, co-ordination, grip and joint mobility in the hands, wrists and upper limbs. The Social Security (Incapacity for Work and Miscellaneous Amendments) Regulations 1996 11(a)(i) make it clear that activities in other functional areas are excluded from consideration of lifting and carrying ability. Lifting and carrying relate only to the ability to lift and hold an object from table top height in order that it may be carried from A to B. **It is not a measure of the ability to bend, reach or walk since these activities are considered under other functional categories.**

2. Statements referring to either hand means disability in both hands rather than one or the other. The descriptors MH(e) and MH(f) can only ever be applied when the claimant is unable to lift and carry with one hand (i.e. either the right or the left) but is capable of doing so with the other hand.

3. All the loads are light and are therefore unlikely to have much impact on spinal problems. However, due consideration should be give to neck pains and the associated problems arising from cervical disc prolapse and marked cervical spondylitis. These conditions may be aggravated by lifting weights in exceptional circumstances.

4. In this and in other categories involving the upper limb, the claimant may record their disability in a way which does not correspond with any descriptor. For example the claimant may record inability to pick up a paperback book with the left hand. In this situation you must choose the appropriate descriptor (which in this example could be MH(e).)

Details of activities of Daily Living

5. 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)
   - Dealing with laundry.

Observed behaviour

6. The doctor will watch for hand, arm and head gestures. He will note the ease (or otherwise) with which any coat or jacket is removed and replaced.
7. The claimant may hang up a coat or a jacket allowing observation of shoulder joint and arm action.

8. The claimant may lift their handbag or shopping bag several times during the interview process.

9. Where there is a lack of co-operation in carrying out passive 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.

MANUAL DEXTERITY

Descriptors
- D(a) Cannot turn the pages of a book with either hand
- D(b) Cannot turn a tap or control knobs on a cooker with either hand
- D(c) Cannot pick up a coin which is 2.5 centimetres or less in diameter with either hand
- D(d) Cannot use a pen or pencil
- D(e) Cannot tie a bow in laces or string
- D(f) Cannot turn a sink tap or control knobs on a cooker with one hand, but can with the other
- D(g) Cannot pick up a coin which is 2.5 centimetres or less in diameter with one hand but can with the other
- D(h) No problem with manual dexterity

Scope
1. This category relates to the function of wrists and hands and is a measure of the ability to grip and to perform fine manipulations.

2. The task needs to be done reliably, safely, at reasonable speed, and could be repeated. In the context of the PCA the word "repeatable" implies that it can be done more than once without great discomfort in a session. This does not mean that the action needs to be performed continuously during that period.

3. Descriptor Dd "Cannot use a pen or pencil". This should be a test of the person’s ability to use a pen or pencil for the purpose for which a pen or pencil is normally used with either the right or the left hand, depending upon which is the dominant hand. The test is whether the person would be able to write with the pen or pencil. However it is not a test of the claimant’s literacy. The Decision Maker will need to consider the speed and reliability with which the activity is
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performed and the doctor should provide sufficient evidence for the Decision Maker to consider this issue fully.

Completion of the IB 50 Questionnaire is frequently cited as evidence of the ability to use a pen or pencil. The speed with which an IB 50 questionnaire is completed depends upon a number of factors of which manual dexterity is only one. It is therefore very important for the examining doctor to be precise when providing evidence to the Decision Maker.

Some examples of the type of medical advice may help to illustrate the point. The approved doctor may provide the following evidence:

- "Despite the medical problems with his dominant hand the claimant is able to use a pen or pencil. He was able to complete his IB 50 form - stating that it took him 'a couple of hours because he did not understand a number of the questions and had to seek and advice help from relatives."  
- "Claimant was able to use a pen to complete his IB 50 questionnaire but states that it took him 'days' because of frequent muscle cramps in his dominant hand. However he is able to use a pen for everyday tasks such as writing shopping lists, filling his pools / national lottery coupons and entering competitions. The clinical nature of this particular medical problem makes it most unlikely that he could not use a pen without discomfort for a reasonable period. Furthermore there are no clinical signs of nerve, muscle or joint problems in his dominant hand. The evidence before me therefore indicates that he can use a pen or pencil "

4. The use of a walking stick in the dominant hand should have no effect on manual dexterity if the upper limb function is normal.

5. The doctor should consider the efficiency of hand function in relation to the other limb, ie, it should not be accepted that one limb can complete a task when this can only be accomplished with the support of the other limb. For example, the claimant whose right arm is in a plaster cast and can only complete tasks by supporting with the left arm.

6. "Either" hand in D_a D_b D_c means they cannot do the action with their right hand and they cannot do it with their left hand.

7. Tying a bow in laces requires two hands - one to stabilise the loop and the other to do the finer movements.

8. An individual in a forearm plaster may still have good movements of their hands but the level of pain experienced should be taken into account when choosing a descriptor, e.g. an individual with a fractured wrist may have good fine movements of their hand but turning a knob on the cooker may cause severe pain in their wrist.

Details of Activities of daily living

9. The doctor will consider activities such as:
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- Filling in forms (e.g. IB 50, national lottery ticket).
- Coping with buttons, zips, and hooks on clothing
- Cooking (opening jars and bottles; washing and peeling vegetables).

10. Relevant leisure activities include reading books and newspapers; doing crosswords; knitting; manipulating the petrol cap to refuel a car.

**Observed behaviour**

11. If the claimant has laced shoes and the doctor knows they unlaced them then it is reasonable to record they have achieved this even though the doctor has not formally observed it, by stating something like "The claimant tells me he laced and unlaced his own shoes". This is especially so if they were able to undress/dress speedily without assistance.

12. The doctor may have the opportunity to observe how the claimant handles tablet bottles.

**Examination**

13. In addition to the examination of the upper limbs as subsequently described, the doctor should always inspect the hands carefully and document any evidence of ingrained dirt or callosities, indicating the possibility of recent heavy domestic/manual work.

14. The doctor should test grip and the ability to perform pincer movements and opposition of the thumb.

15. The doctor will indicate whether the problem is unilateral or bilateral.

16. Where the problem is unilateral, record which side has the disability and report succinctly on the normality of the "good" limb.

17. In view of the complexity of a hand/wrist examination the doctor should provide a simply worded summary particularly if the descriptor choice is at variance with that of the claimant in the IB50.

**EXAMPLE**

Consider the case of a man with mild, bilateral Dupuytren's contracture where the disability claimed in the IB50 is in excess of the doctor's descriptor choice. The following summary of his 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."

**VISION**

Descriptors
V(a) Cannot tell light from dark
V(b) Cannot see the shape of furniture in the room
V(c) Cannot see well enough to read 16 point print at a distance greater than 20 centimetres
V(d) Cannot see well enough to recognise a friend across the room at a distance of at least 5 metres
V(e) Cannot see well enough to recognise a friend across the road at a distance of at least 15 metres
V(f) No problem with vision.

Scope
1. This means vision in normal daylight or bright electric light, with glasses or other visual aids which would normally be worn.
2. The descriptors relate to vision only, and not to literacy.
3. "Recognising a friend" implies the ability to recognise a friend's features, not to recognise them for example from the clothes they are wearing.
4. An example of 16 point print
5. Normal vision is taken as visual acuity of 6/6 at a distance of 6 metres from the Snellen chart.
6. Uniocular vision which is eg 6/9 means in the context of the PCA that there is no problem with vision.
7. Vision has to be useful vision in the context of a normal environment. A condition causing severe tunnel vision where, despite reasonable visual acuity, an individual cannot read whole sentences or scan a page, causes significant disability. An appropriate descriptor in this situation would be V(c).

Details of Activities of daily living
8. The doctor should consider activities such as:
   - Filling in forms
   - Reading newspapers or magazines
   - Helping children with homework or reading bedtime stories.
9. The doctor will also consider leisure activities, in particular participatory sports such as snooker or darts; and activities which require good vision such as knitting or sewing.
10. The doctor will consider whether the claimant drives. The standard of visual acuity required to hold an ordinary driving licence is such that person can read in good daylight with glasses if worn a number plate at a distance of 20.5 metres. This corresponds to 6/10 on a Snellen chart. **Any person who holds a driving licence should satisfy the 'no problem with vision' descriptor.***
Observed behaviour

11. The doctor may ask the claimant how they got to the examination centre, and how they found their way about within the centre. He will note whether the claimant needed to be accompanied by another person.

12. He will also note any observed ability when dealing with belts and buttons.

Examination

13. The doctor will record the aided binocular vision, and explain the significance of this to the Decision Maker.

14. If appropriate the doctor may examine the retina ('screen' at back of eye) and do visual field testing, explaining the significance of any abnormality found and its importance.

15. 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 the doctor’s descriptor choice. In these cases or in cases where the vision is poor but the doctor considers it could improve with correction he will measure it using a pinhole. (In effect this replaces the lens as in a pin-hole camera.)

HEARING - with a hearing aid or other aid if normally worn

Descriptors

H(a) Cannot hear sounds at all
H(b) Cannot hear well enough to follow a television programme with the sound turned up
H(c) Cannot hear well enough to understand someone talking in a loud voice in a quiet room
H(d) Cannot hear well enough to understand someone talking in a normal voice in a quiet room
H(e) Cannot hear well enough to understand someone talking in a normal voice on a busy street
H(f) No problem with hearing.

Scope

1. Hearing should be considered with the claimant wearing and using whatever aids they normally wear.

2. The test is whether the claimant can hear and understand speech in a language and accent which is familiar to them.

3. Descriptor H(b) is intended for the claimant who cannot hear the sound even when maximum volume is used, implying a very severe degree of hearing loss, which will only apply in exceptional cases e.g. with a binaural hearing threshold above 90db.
4. A "busy street" does not mean one rendered intolerably noisy by exceptional machinery such as a juggernaut or earth-moving equipment. None of us would be able to hold a conversation under such circumstances. It is however commonplace for pedestrians to talk to each other while busy traffic passes by. Consider whether the claimant could hold such a conversation under these circumstances, or whether hearing is so diminished that background traffic noise would render conversation impossible.

5. The doctor will record whether the deafness is unilateral or bilateral as stated by the claimant, and how it affects them.

6. The doctor will state the claimant's ability to wear a hearing aid. If the claimant has rejected the prescribed hearing aid then state the reason why. He will bear in mind that a claimant who has been inconvenienced by a hearing aid and has abandoned it should be assessed without aids.

7. It should be remembered that hearing aids can cause distortion of sound and do not give 'normal' hearing to people with hearing impairments.

8. Older claimants can have difficulties adapting to hearing aid use.

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

Details of activities of daily living

10. Significant deafness is such a disadvantage that the claimant can be expected to readily impart details of social isolation and domestic difficulties, such as problems encountered in communication in shops or on family occasions, inability to continue particular hobbies e.g. going to the cinema or theatre, playing bridge or bingo.

11. The doctor should 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.

Observed behaviour

12. The claimant's response to an ordinary or quiet voice during interview is a good measure of their ability to hear.

13. 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 the doctor to raise his voice and repeat questions.

Examination

14. The most relevant examination technique is the conversational and whispered 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.
15. 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 the PCA.

16. The whispered voice is detected at 1.5 metres with a normal ear.

17. 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 opportunity to detect unreliable responses suggestive of non-organic hearing loss.

Tinnitus

18. This is the perception of sound without any 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 the PCA assessment.

19. The use of hearing aids can 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.

20. 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.

21. Other medication has been used in the control of tinnitus: betahistine; prochlorperazine; flecainide; and tocainide. All of these may have side effects, which must be taken into account if they contribute to disability.

22. The doctor will consider applying the Mental Health test in cases of tinnitus where there is cognitive impairment or other mental disablement, such as anxiety.

Menieres Disease

23. This condition is characterised by recurring bouts of profound, prostrating vertigo, nausea and vomiting with deafness and tinnitus. Such attacks can last for anything up to 24 hours, but unsteadiness and loss of confidence can persist for several further days. Sensorineural low/mid-frequency hearing loss and tinnitus can persist between bouts and if the conditions are chronic the deafness can be progressive. The attack rate is variable and unpredictable. Management
involves symptomatic treatment at the acute phase and prophylactic vasodilators are available.

24. For the purpose of the PCA assessment, the doctor will consider and carefully record the frequency and duration of the attacks, and also the therapeutic measures being taken to control the condition, and the effectiveness of the measures.

25. The effects of the Menieres disease should be fully taken into account when choosing physical descriptors (ie the activity must be performed safely, reliably and repeatedly).

26. The doctor will take into account any side-effects of medication.

SPEECH
Descriptors
SP(a) Cannot speak
SP(b) Speech cannot be understood by family or friends
SP(c) Speech cannot be understood by strangers
SP(d) Strangers have great difficulty understanding speech
SP(e) Strangers have some difficulty understanding speech
SP(f) No problem with speech

Scope
1. There are two key abilities:-
   - Can family or friends understand the claimant’s speech?
   - Can strangers understand the claimant’s speech?

The question is whether, ignoring language and accent, the claimant could convey a message:
   - To people who know them
   - To strangers who do not

2. Note that the term "strangers" means persons who do not know the claimant, but speak in the same language using a similar accent.

3. Speech is an extremely complex activity, involving intellectual, neurological and musculo-skeletal 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.

4. The doctor considers both the psychological and physical factors using the physical and mental health tests. However it is essential that only physical
factors affecting speech are considered in the physical test and mental health factors in the mental health test to prevent double scoring.

5. Claims to Incapacity Benefit which include this functional area are uncommon. However, it is occasionally claimed that speech is affected in cases of Chronic Fatigue Syndrome, where the claimant asserts that speech becomes unclear when they are tired. A similar claim may be made by claimants suffering from panic attacks, who describe difficulty in making themselves understood during an episode of acute anxiety. Consider carefully whether such claimants should be assessed under the Mental Health Assessment.

6. 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, like 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 will need to consider advising exemption.

Details of activities of daily living
7. The doctor considers:
   - The ability to socialise with family and friends
   - Any difficulties with activities such as shopping, or travelling on public transport
   - Ability to use a telephone.

Observed behaviour
8. The doctor should describe the quality of speech at interview and any difficulty he has in understanding the claimant. He will note any abnormalities of the mouth and larynx and their effects on speech.

REMAINING CONSCIOUS WITHOUT HAVING EPILEPTIC OR SIMILAR SEIZURES DURING WAKING MOMENTS

Descriptors
F(a) Has an involuntary episode of lost or altered consciousness at least once a day
F(b) Has an involuntary episode of lost of altered consciousness at least once a week
F(c) Has an involuntary episode of lost or altered consciousness at least once a month
F(d) Has had an involuntary episode of lost or altered consciousness at least twice in the last six months
F(e) Has had an involuntary episode of lost or altered consciousness once in the last 3 years
F(g) Has no problems with consciousness.

**Scope**

1. This function covers an involuntary loss or alteration of consciousness which results from the person having *epileptic or similar seizures* during the hours when the claimant is normally awake, and which prevents the claimant from safely continuing with any activity. A seizure is an abnormal discharge of neurons. Fits 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.

2. In the context of Incapacity Benefit, the most likely causes of such episodes are:
   - Grand mal (classical) epilepsy
   - A seizure which is secondary to impairment of cerebral circulation (e.g. as a result of cardiac dysrhythmias); or hypoglycaemia
   - Other seizures of an epileptiform nature

3. "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:
   - Temporal lobe epilepsy
   - Absence seizures (petit mal)

4. For both lost and altered consciousness, establishing an exact diagnosis is less important than establishing whether or not any disability is present.

5. Any disability due to side effects of medication taken to control seizures needs to be taken into account. A mental health assessment should be performed if the side effects of medication are sufficient to interfere with cognitive ability or produce other mental disablement.

6. **Giddiness, dizziness, and vertigo**, in the absence of an epileptic or similar seizure, do not amount to a state of "altered consciousness" and are not due to an 'abnormal discharge of neurones'. 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**

7. Migraine, even when headache is preceded by an aura, does not result in altered consciousness or epileptic type seizures.

8. 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.

9. 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**

10. It may be necessary for the doctor 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 the claim of frequent episodes of lost consciousness.

**Details of activities of daily living**

11. The doctor should consider:

- whether the person drives - the DVLC will refuse to issue a license 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.

**CONTINENCE - OTHER THAN ENURESIS**

**Descriptors**

Cn(a) No voluntary control over bowels
Cn(b) No voluntary control over bladder
Cn(c) Loses control of bowels at least once a week
Cn(d) Loses control of bowels at least once a month
Cn(e) Loses control of bowels occasionally
Cn(f) Loses control of bladder at least once a month
Cn(g) Loses control of bladder occasionally
Cn(h) No problem with continence

**Scope**

1. These descriptors cover an assessment of continence while the claimant is awake. Incontinence which occurs only while asleep (enuresis) is not regarded as incontinence in terms of the Social Security (Incapacity for Work) (General) Regulations as, with the appropriate personal hygiene, this will not affect the person’s functioning whilst awake.
2. Similarly, incontinence occurring during a fit happens during a period when no activity is possible on account of the fit, so incontinence will not of itself affect functioning.

3. `No voluntary control' includes situations where there is no useful control e.g. continual dribbling incontinence of urine. This means that:

The use of pads would do no more than contain the effect of the lack of voluntary control. Satisfaction of a descriptor is not ever dependent upon a claimant's ability to cope with or mitigate the effect of the disability which make the descriptor applicable to that claimant.

Therefore a person who normally has to resort to pads or special clothing in order to maintain personal hygiene as a result of a lack of control over the bladder would rate descriptor Cn(b).

4. Similarly, those claimants who have an ileostomy must be held to have 'no voluntary control' over their bowels. An ileostomy acts as a receptacle for the waste and the person does not have any control over when the ileostomy should discharge. The same principle would apply to any claimant with an artificially created bowel stoma or similar device.

5. In a person who normally has voluntary control of the bowel or bladder, `loss of control' implies an actual loss of control of the voiding activity. Minor leakages such as might be associated with the terminal dribbling of prostatism would not necessarily represent an overall loss of control.

6. `Occasionally' implies less than once a month or, happening irregularly with an overall frequency of less than once a month.

7. 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. Claimants with gastro-intestinal problems or frequency of micturition should be considered as having no voluntary control 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.

8. In situations where a claimant has problems of control with both the bladder and the bowels the highest descriptor should be applied, e.g. in a claimant who loses control of bladder function at least once a month (Cn(f)) and who also loses control of their bowels at least once a month (Cn(d)) the higher of the two descriptors (Cn(d)) should be chosen. Medically it might be appropriate to select both descriptors but the PCA assessment does not allow for the selection of two descriptors in one functional category.

9. The following Algorithm may be helpful in explaining the continence descriptors:

**Does the claimant have voluntary control* of the bowels/ bladder?**

  if NO - choose Cn(a) or Cn (b) as appropriate
SECTION 11 - PROGNOSIS

if YES - does the claimant lose voluntary control at times?
if NO - choose Cn(h) (= no problem with continence)
if YES -

Bowels:
- loss of control at least once a week - choose Cn(c)
- loss of control at least once a month - choose Cn(d)
- occasional loss of control - choose Cn(e)

Bladder:
- loss of control at least once a month - choose Cn(f)
- occasional loss of control - choose Cn(g)

No voluntary control - means that the person is unable to determine, by conscious effort, when the bladder or bowels discharge. Social Security Commissioner's have decided that no aid or appliance is able to render a person continent (meaning to give voluntary control of the bladder or bowel where there is none). Pads or appliances (such as a stoma bag) do not provide voluntary control, they merely alleviate the effects of lack of control. For example, it is likely to be held that there is 'no voluntary control over the bladder' where there is constant leakage of urine such that the person always has to resort to pads in order to maintain personal hygiene. Mild stress related incontinence, where the person has voluntary control over the bladder for most of the time but such control is lost at certain times, would not normally amount to 'no voluntary control over the bladder'.

Details of activities of daily living
The doctor will 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.
Appendix 3

Personal Capability Assessment Process

**Figure 1**

**PCA PROCESS**

MED 3 (Sickness certificate)

Diagnosis

Potentially Exempt

MED 113 report from certifying doctor

Advice Medical service Doctor IB 51 PVM

Whether exempt Brief justification

Disallow

Exempt

Decision Maker

IB &S Examination

History: Typical day Medication/Clinical findings Choice descriptions (justified)

Unsure

Medical Services

Agree

Provisional score based IIB 58

11 - 15+

Not Exempt

IB50 Questionnaire to claimant

MED 4 From certifying doctor

Diagnosis Brief statement disabling effects of condition

11 - 15+

BENEFIT
Appendix 4

Comparison of the roles undertaken by Clinicians and Medical Disability Analysts

<table>
<thead>
<tr>
<th>Role</th>
<th>Clinician (GP/Consultant)</th>
<th>Medical Disability Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Makes Diagnosis</td>
<td>Assess</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>- Impairment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Functions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limitations/restrictions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Disability</td>
</tr>
<tr>
<td>How</td>
<td>History</td>
<td>History</td>
</tr>
<tr>
<td></td>
<td>- tends to take what the</td>
<td>- diagnosis from clinician</td>
</tr>
<tr>
<td></td>
<td>patient says at “face</td>
<td>- brief history of illness</td>
</tr>
<tr>
<td></td>
<td>value”</td>
<td>- symptoms</td>
</tr>
<tr>
<td></td>
<td>- concentrates on</td>
<td>- asks how the illness</td>
</tr>
<tr>
<td></td>
<td>symptoms</td>
<td>affects function</td>
</tr>
<tr>
<td></td>
<td>Examination</td>
<td>- daily living activities</td>
</tr>
<tr>
<td></td>
<td>- tends to take findings</td>
<td>- looks for consistency</td>
</tr>
<tr>
<td></td>
<td>at “face value”</td>
<td>in the overall picture</td>
</tr>
<tr>
<td></td>
<td>- usually ignores</td>
<td>Examination</td>
</tr>
<tr>
<td></td>
<td>informal observations</td>
<td>- informal observations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>often very important</td>
</tr>
<tr>
<td></td>
<td></td>
<td>objective examinations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>looking for consistency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and inappropriate signs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(finding which do not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>indicate disease)</td>
</tr>
<tr>
<td>Specific Skills</td>
<td>Diagnostic techniques</td>
<td>Objective assessment</td>
</tr>
<tr>
<td></td>
<td>Detailed knowledge of</td>
<td>‘disability’</td>
</tr>
<tr>
<td></td>
<td>treatments</td>
<td>Opinion fully justified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knowledge of legal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>framework when giving</td>
</tr>
<tr>
<td></td>
<td></td>
<td>advice</td>
</tr>
<tr>
<td>Other</td>
<td>Usually the patients</td>
<td>- not acting as patient’s</td>
</tr>
<tr>
<td></td>
<td>advocate</td>
<td>advocate</td>
</tr>
<tr>
<td></td>
<td>- acting in patients best</td>
<td>- objective advice when</td>
</tr>
<tr>
<td></td>
<td>interest</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- doctor/patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationship</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 11 - PROGNOSIS

<table>
<thead>
<tr>
<th>given in accordance with the law</th>
</tr>
</thead>
<tbody>
<tr>
<td>- advice based on a detailed functional assessment</td>
</tr>
</tbody>
</table>
## Appendix 5

### How to use PCA Physical Information

<table>
<thead>
<tr>
<th>Needs</th>
<th>Functional Activity Groups</th>
<th>PCA Primary Activity to Consider</th>
<th>Cautionary Notes</th>
<th>Other Activities to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting out of bed</td>
<td>Legs, lower back, arms</td>
<td>Rising from sitting</td>
<td>Refers to an upright chair with no arms</td>
<td>Walking up and down stairs, Bending, Lifting and carrying (ability to push up)</td>
</tr>
<tr>
<td>Dressing</td>
<td>Arms, vision, bending</td>
<td>Manual Dexterity, Vision</td>
<td>Should be able to dress if vision Vc or better</td>
<td>Reaching, bending or kneeling, rising from sitting, vision</td>
</tr>
<tr>
<td>Bathing/use of shower</td>
<td>Arms, legs, lower back, vision</td>
<td>Sitting, standing</td>
<td>Sitting refers to an upright chair with no arms</td>
<td>Rising, bending, stairs, manual dexterity, reaching, lifting and carrying, vision</td>
</tr>
<tr>
<td>Getting up from a chair</td>
<td>Legs, lower back</td>
<td>Rising from sitting</td>
<td>Refers to an upright chair with no arms</td>
<td>Standing, walking, bending or kneeling</td>
</tr>
<tr>
<td>Using the toilet</td>
<td>Arms, lower back, legs</td>
<td>Sitting, rising from sitting, manual dexterity</td>
<td>Bending or kneeling, vision, reaching</td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td>Arms</td>
<td>Manual dexterity</td>
<td></td>
<td>Reaching, vision, lifting and carrying</td>
</tr>
<tr>
<td>Preparing a main meal</td>
<td>Mental Health (planning), arms, Mental Health, manual dexterity</td>
<td></td>
<td></td>
<td>Lifting and carrying, vision</td>
</tr>
<tr>
<td>Getting into bed</td>
<td>Legs, lower back, arms</td>
<td>Bending or kneeling</td>
<td></td>
<td>Rising from sitting, walking</td>
</tr>
</tbody>
</table>
## SECTION 11 - PROGNOSIS

<table>
<thead>
<tr>
<th>Continence</th>
<th>This refers to sphincter control</th>
<th>Continence</th>
<th>A colostomy or ileostomy counts as &quot;no voluntary control over bowels.&quot;</th>
<th>No voluntary control over bowels/bladder does not indicate ability to deal with incontinence independently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility – Walking</td>
<td>Walking</td>
<td>Walking</td>
<td>On the flat with aids if used. Must walk safely, reliably and at reasonable speed</td>
<td>Stairs</td>
</tr>
<tr>
<td>Mobility – Finding Way Around</td>
<td>Vision, Hearing, mental Health</td>
<td>Vision, Mental Health</td>
<td>Should be able to find way around if vision Vd or better</td>
<td></td>
</tr>
</tbody>
</table>