

## **Forward to Incapacity Benefit Handbook for Approved Doctors**

The following text [*Incapacity Handbook for Approved Doctors*] is a revised version of the above publication following changes to legislation in April 2000.

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## **1. Introduction**

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This handbook has been produced as a reference guide for doctors approved by the Secretary of State to undertake Incapacity Benefit assessments.

In compiling this handbook the authors have drawn on the experience of live running of Incapacity Benefit, and on feedback from various sources relating to those areas of assessment which have commonly caused difficulty. It also takes account of Commissioners' decisions and the amended Regulations which came into force on 6 January and 1 April 1997.

The handbook consists of four parts. The first part [Sections 1-4] sets out background information about the benefit and the role of the approved doctor.

The second part [Sections 5-7] deals mainly with office based file work.

The third part [Sections 8-14] deals with the major aspects of the medical assessment.

The final part [Sections 15-20] covers a number of situations which occur from time to time at examination centres, and provides a guide to dealing with these situations.

## 2. Background to Incapacity Benefit

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1. In April 1995, Incapacity Benefit replaced Invalidity Benefit and Sickness Benefit for those people unable to work because of disease, injury or impairment. Incapacity Benefit is paid to people who have the correct National Insurance Contributions Record and who, because of a specific physical or mental disease or disablement, could not be expected to work, or seek work, in the open labour market as a condition of receiving state benefit. Payment of Incapacity Benefit does not signify that the person is medically unable to do any work at all.
2. Incapacity Benefit introduced a new approach to the assessment of medical incapacity (originally referred to as the All Work Test) which from 4 April 2000 will be known as the **Personal Capability Assessment** [PCA]. The basis of the medical test of incapacity was developed by a panel of experts, whose key task was to establish a more objective test of incapacity, taking into account medical factors only, and not other factors such as age or skills; and to design a functionally based test which could be applied to the majority of medical conditions.
3. The panel undertook research to identify a set of **functional areas** relevant to the assessment of incapacity for work, and to develop within each functional area a ranked scale of **descriptors** identifying various levels of disability.
3. A sub-group of experts in the field of mental health problems developed this area of the assessment, by identifying four areas of psychological functioning which were important in the work situation, and developing a series of questions, the answers to which would describe how a person functioned in these four areas.
4. Entitlement to benefit is determined by **Benefits Agency Decision Makers** who score the level of disability on the basis of the descriptors in the physical and/or mental health areas, awarding benefit if the score reaches or exceeds a set threshold level. Benefit can be awarded without need for medical assessment if the Decision Maker is satisfied as to the level of disability on the basis of available documentary evidence; but benefit is never disallowed without the client being offered the opportunity of medical assessment.

## **2. Background to Incapacity Benefit**

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5. Where the Benefits Agency requests it, the Medical Services (IB approved) doctor will be required to complete two reports on clients summoned for a Personal Capability Assessment examination - the Incapacity Report [IR] which is the current IB85 report; and a Capability Report [known as the CR1] which will provide advice to a Personal Adviser. The Capability Report will not be seen by the Decision Maker. This document sets out guidance in relation to the medical advice to the Decision Maker on the incapacity aspects of the PCA, including completion of the IB85. Separate guidance for IB approved doctors deals with advice on the 'capability' aspects and completion of the CR1.

### 3. The Role of the Medical Services doctor

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1. All doctors who give advice relating to Incapacity Benefit must be approved by the Secretary of State. Approval involves specific training, successful completion of various stages of the approval process, and the ongoing demonstration that the work being carried out meets a satisfactory standard. The IB approved doctor is required to provide advice to the BA Decision Maker in accordance with the current guidance issued by the Department of Social Security. Approved doctors may be either an employed doctor, full or part-time - the Medical Adviser - or a contracted doctor who undertakes work on a sessional basis.
  
2. The role of both employed and contracted approved doctors is to help Decision Makers reach fair and proper decisions on benefit entitlement, by providing advice which is:
  - **legible and concise**
  
  - **fair and impartial**
  
  - **medically correct**
  
  - **consistent and complete**
  
  - **in accordance with the relevant legislation**
  
3. In carrying out this function, IB approved doctors act as specialist **medical disability analysts**. The role of the disability analyst is different from the more familiar clinical role of reaching a diagnosis and arranging treatment. For the disability analyst, a precise diagnosis is of secondary importance. The primary function is to make an assessment of how a person's day to day life is affected by disability, and to relate this to the legislative requirements.
  
4. Two basic concepts are important in understanding the role
  - **impairment, and**
  
  - **disability**

### 3. The Role of the Medical Services doctor

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5. The World Health Organisation's definition of **impairment** is:

*"any loss or abnormality of psychological, physiological or anatomical structure or function"*

This is a purely medical definition, and one which is usually subject to some form of objective measurement, but it does not really tell us much about how a particular individual is affected.

6. The WHO's definition of **disability** is:

*"any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being".*

This looks not just at what is wrong with a person, but at what the person is prevented from doing. People with the same impairment may have very different degrees of disability. For example, there are many people with identical lower limb amputations whose walking abilities are markedly different.

7. For Incapacity Benefit, the advisory role of the approved doctor falls into three main areas:

- Advising the Benefits Agency Decision Maker whether a client is suffering from certain conditions that would make it unreasonable to subject them to the Personal Capability Assessment (exempt conditions)
- scrutiny of medical evidence to advise whether a person to whom the Personal Capability Assessment applies should be examined.
- application of the Personal Capability Assessment or Own Occupation Test, providing an objective and impartial assessment of the client's functional ability in the form of a report for the Decision Maker.

### **3. The Role of the Medical Services doctor**

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In fulfilling these functions, approved doctors are required to sign a declaration to the effect that their advice has been prepared in accordance with the current guidance. By signing this declaration the approved doctor is able to provide an assurance to the Decision Maker that the advice has been given by a specially trained, approved doctor, whose advice is based on accepted guidelines.

8. In addition, approved doctors provide advice to the Decision Maker on a number of medically-related issues.

#### 4. The Decision Maker's Perspective

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1. Decision Makers have a very clear idea of the standard they expect from an IB report. The following elements are considered essential:

- legibility
- absence of medical jargon
- consistency.

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

2. The **Decision Maker** has a legal duty to ensure that their decisions are based on facts which are clearly established by evidence:

*"A definite distinction is made between fact and opinion and while an opinion on its own may have persuasive value it can never take precedence over an opinion which is based on clear and concise evidence. An example of this is the customer who told the approved doctor that he had his own lathe which he used in his hobby of wood turning. In relation to the 'standing' descriptor the approved doctor concluded that the customer could stand for 30 minutes and his only basis for saying this was that 'he uses his lathe and this would involve standing'. The Tribunal decided that because the approved doctor had used the word 'would' then he had made an assumption about the customer's ability to stand which he had not substantiated with evidence and his conclusion could not therefore be sustained. The Tribunal's view was that if the approved doctor had been able to say something like 'Customer says he stands at this lathe for half an hour or so at a time' the situation would have been different". [BA Decision Maker]*

## 4. The Decision Maker's Perspective

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## 5. Exempt Categories

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1. Incapacity Benefit legislation recognises certain categories of severe disease where it is considered unreasonable that a person with such a disease should be judged capable of work. Clients with disease in these exempt categories are not asked to complete a self-assessment questionnaire or undergo the Personal Capability Assessment.
  
2. There are two types of medically exempt categories:
  - conditions which can be determined by an *Decision Maker*, with or without further medical advice from Medical Services; and
  
  - conditions which require the *Decision Maker* to consider the advice of a doctor approved by the Secretary of State.

## 5. Exempt Categories

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### **Determination by an Decision Maker with or without advice of an Approved doctor**

3. The following medically exempt categories can be determined by an **Decision Maker**:
- people in receipt of the highest rate care component of Disability Living Allowance
  - people who are terminally ill (people suffering from a progressive disease where death as a consequence of that disease can reasonably be expected within six months)
  - people suffering from any of the following severe medical conditions:
    - tetraplegia
    - paraplegia, or uncontrollable involuntary movements or ataxia which effectively render the suffer functionally paraplegic
    - persistent vegetative state
    - dementia
    - registered blindness [that is registered blind in a register compiled by a local authority under section 29(4)(g) of the National Assistance Act 1948 (a) (welfare services) or, in Scotland, has been certified as blind in a register maintained by or on behalf of a regional or island council.]
    - clients who are assessed as 80% disabled for Severe Disablement Allowance, Industrial Injuries Disablement Benefit or War Pension Purposes

## 5. Exempt Categories

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### **Exemption requiring the Decision Maker to consider the advice of an approved doctor**

4. The following categories are determined by the **Decision Maker** who is required to consider the advice of an approved doctor.
- severe learning disabilities, defined in legislation as 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
  - severe and progressive neurological or muscle wasting disease
  - progressive impairment of cardiorespiratory function which severely and persistently limits effort tolerance
  - an active and progressive form of inflammatory polyarthritis
  - dense paralysis of the upper limb, trunk and lower limb on one side of the body
  - multiple effects of impairment of function of the brain and/or nervous system causing motor, sensory, and intellectual deficits
  - severe mental illness, defined in legislation as 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 and progressive immune deficiency states characterised by the occurrence of severe constitutional disease or opportunistic infections or tumour formation.

## **5. Exempt Categories**

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5. The majority of clients whose medical condition falls into one of the above categories will be identified by the BA District Office from information given by the client's GP on Med 3 or Med 5 statements using a list of diagnoses which has been approved by the Chief Medical Adviser as representing those diagnoses where exemption is most likely. The District Office will request a factual report on behalf of the Medical Adviser from the client's GP, who forwards this to the Medical Services Medical Adviser to give advice as to whether the client is suffering from an exempt condition.
  
6. The next section (Section 6 - Customer Service Desk) contains detailed information about all of the exempt categories listed above.

### **Action by the Approved Doctor**

7. Further guidance will be found in the section dealing with Customer Service Desk duties.

### **Action when an 'exempt' client is called for examination**

8. If a client arrives at a Medical Examination Centre for a Personal Capability Assessment examination, and the approved doctor believes the client to have a condition which falls into an exempt category, the doctor should halt the examination and provide written advice to the Decision Maker that the client's condition falls into an exempt category.

## 6. Medical Advice to BA Customers

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### Overview

1. This section:
  - explains the requirements of the Benefit Agency District Office (DO) in relation to advice given about diagnosis, exemption, prognosis
  - clarifies the medical issues regarding advice given about exemption and determination of prognosis
  - explains the DO requirements in relation to the referral types
  - clarifies the circumstances in which one approved doctor may review the decision of another.
2. The guidance in this section is for a doctor approved by the Secretary of State for Social Security to carry out file or examination work in relation to state incapacity benefits.

## 6. Medical Advice to BA Customers

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3. The following categories of referrals are sent to the Medical Services Customer Service Desk

- Illegible incapacity on medical certificates CS
- Incapacity in doubt CR
- Mental health reference CM
- Potentially exempt cases CP  
(Decision Maker required to consider approved doctor's advice)
- Exempt incapacities - requesting advice on evidence held (no IB113 sent to GP) CY
- Potentially terminally ill CQ
- Incapacity not listed in reference guide CU
- Terminal illness under the special rules CT
- Therapeutic work references CW
- Pregnancy related illness references (SB/MA) CN
- Clarification following dissatisfaction/appeal reference back CZ
- Scrutiny of medical reports for harmful information CV
- Med 6 received from the client's GP CH

### Diagnosis (CU Referrals)

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## 6. Medical Advice to BA Customers

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1. The DO refers cases for medical advice if the diagnosis on the Statement of Incapacity is unclear or unlisted.
2. Other referral types will also ask for the diagnosed cause of incapacity as part of the advice requested.
3. To enter a diagnosis on the Incap system, and decide how to progress the case, the DO requires a diagnosis from the Incapacity Reference Guide (IRG). You should:
  - note the exact diagnosis and provide the DO with an IRG diagnosis which is clinically equivalent, or
  - note the exact diagnosis in full, including the side if there is unilateral involvement of paired structures or unilateral damage to a single organ eg the brain. Indicate when you would expect a significant improvement to occur in the level of function to a point where it would be appropriate to assess the person for the Personal Capability Assessment. The period you give must be consistent with other periods in the IRG even where there is no clinically equivalent diagnosis.

## 6. Medical Advice to BA Customers

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### Exemption (CM; CP, CY CT & CQ Referrals)

1. Exempt categories are generally defined in legislation (Incapacity for Work (General) Regs 1995 amended January 1997) not by diagnosis but rather by the dysfunction that results from the person's disease or bodily or mental disablement.
2. Cases can be referred:
  - because the Decision Maker is required to consider the evidence of an approved doctor , eg referral codes CM, CP and CY, or
  - where the Decision Maker while not bound to consider the advice of an approved doctor requests advice eg referral code CT
  - merely for clarification of the certified cause of incapacity, eg CH, CR, CS, or CU.
3. A number of conditions are marked 'exempt' in the DO IRG but they do not appear in the categories that the Decision Maker can exempt without seeking medical evidence from a doctor approved by the Secretary of State'. These cases will be referred under referral code CY for you to consider advice on the evidence held, ie without the DO requesting an IB 113.
4. There are a few diseases where the diagnosis itself indicates that the resulting disease is severe it would be unreasonable to expect the person, as a result of their disease or bodily or mental disablement, to work in the open market. This does not mean that they could not work if they chose to do so. An example of such a condition is paraplegia.
5. Do not advise that the client has an exempt medical condition if you have inadequate clinical details to support your decision. If you cannot advise that the client falls into an exempt category on the information available then you must state this as your advice to the Decision Maker.

## **6. Medical Advice to BA Customers**

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6. If you cannot advise that the client falls into an exempt category on the information available you should suggest that an IB 113 report be requested from the certifying doctor for further medical evidence. The DO will then treat the case as 'CP - potentially exempt'.
  
7. Do not contact the client's GP for further information at this stage unless the client's true diagnosis is obscure and you are unsure whether an IB 113 should be sent

In these cases if you have details of the GP's telephone number, contact the GP to clarify the true nature of the diagnosis so that you can advise the DO. If you can advise that the client's condition falls into an exempt category, record full details of the telephone conversation in a minute to go in the file and complete the appropriate IB series form.

## 6. Medical Advice to BA Customers

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### Severe mental illness (CM referral)

The legislation defines a severe mental illness as:

"involving 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."

For the purpose of advising whether the client's condition meets these criteria it will be necessary to consider the detailed manifestations of the disease and the care needs which arise. As a general rule, clients living outside of hospital who meet the legislative criteria are very likely to require ongoing psychiatric care. This care may include:

- sheltered residential facilities where the person receives regular medical or nursing care
- day care at least one day a week in a centre where qualified nursing care is available
- care at home with intervention, at least one day a week, by a qualified mental health care worker, or
- long term medication with anti-psychotic preparations including depot neuroleptic or mood modifying drugs or equivalent modern oral medication.

### Social functioning and Risk to others

Where, as a result of their mental disease or disablement, the person's behaviour is so adversely affected that:

their ability to function socially is severely restricted; or

## 6. Medical Advice to BA Customers

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they are very likely to pose a real threat or danger to themselves or others (such as work colleagues or members of the public);

then you should consider advising that they meet the severe mental illness criteria.

### Medication

Anti-psychotic medication

- . Major tranquillizers (BNF Section 4.2) are frequently given by a depot injection which not only secures consistent serum levels but also helps compliance. Newer medications in this group have the advantage of fewer side effects as they are more specific in action but are currently available in oral form only. Examples of these include Risperidone, Sulpiride and the very potent Clozapine that requires careful monitoring of haematological values.

### Further medical evidence

- . If a medical report from the client's own doctor is held and there is clinical suspicion that the condition is more severe than the medical evidence allows you to be sure of, you should seek further information. This will usually be done by telephoning either the GP or the supervising day centre doctor or the Consultant.

## 6. Medical Advice to BA Customers

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### Severe learning difficulty (CP / CY referrals)

1. This is defined in legislation as the condition which results from the arrested or incomplete physical development of the brain or severe damage to the brain, which involves severe impairment of intelligence and social functioning.
2. The disability will have been present from birth if the brain did not develop properly and will never do so, or the client has suffered brain damage at birth. Alternatively the condition may have arisen because of disease or damage to the brain later in life.
3. It is characterised by one or more of the following:
  - an inability to learn more than the most 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 constant supervision to avoid danger to themselves or others
  - severe behavioural problems often so unpredictable that it is not possible to avoid situations that provoke it or to relax supervision, eg:
    - instance of self-harm or physical violence towards others
    - unpredictable behaviour when out or no awareness of danger, eg suddenly rushing across a busy street.

## **6. Medical Advice to BA Customers**

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4. Clients who are attending special courses for people with learning difficulties and who cannot be certified as suffering from Severe Learning Disability using the guidance above, will have the Personal Capability Assessment applied unless they can be treated as incapable of work under other paragraphs of the Social Security (Incapacity for Work (General)) Regulations 1995.
  
5. If after considering your advice the Decision Maker decides the client is not 'suffering from a severe condition' and they cannot be treated as incapable of work, the Personal Capability Assessment must be applied. Such action does not imply that the client will necessarily be found capable of work when the test is applied.

## 6. Medical Advice to BA Customers

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### Severe and progressive neurological or muscle wasting disease (CP / CY referrals)

6. Note that the wording of the Regulations allows a consideration of severe and progressive neurological disease or severe and progressive muscle wasting disease.
7. Any neurological condition which has resulted in a severe level of disability and which is by its nature progressive falls into this category of exemption. This category includes advanced states of the following conditions:
  - multiple sclerosis
  - motor neurone disease
  - Huntington's chorea
  - muscular dystrophy.
8. It may also include conditions such as:
  - Parkinson's disease
  - myasthenia gravis
  - Guillain-Barre syndrome.
  - Severe thalamic tract disorders (pain syndromes)
9. You will require evidence of the severity of the disability and the progressive nature of the condition.

## 6. Medical Advice to BA Customers

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### Active and progressive forms of inflammatory poly-arthritis (CP referrals)

10. It is important to note the differences between inflammatory polyarthritis and the more common osteoarthritis which is usually not inflammatory in nature and may affect only one joint.
  
11. **Osteoarthritis** is used to define a group of conditions affecting the synovial joints and characterised by the loss of articular cartilage and overgrowth and remodelling of the underlying bone due to increased activity of the subchondral bone. It is thought to be due to a disturbance of the balance between the stresses applied to the joint and its capacity to stand them. There are several factors leading to this condition:
  - Ageing
  - Inherited predisposition
  - Metabolic defects
  - Abnormal joint loading
  - Previous trauma to the joint
  - Abnormalities of the cartilage
  - Damage to the joint caused by one of the inflammatory joint diseases.
  
12. **Inflammatory arthritides** are a group of conditions which differ from osteoarthritis in a number of key respects. They are usually systemic illnesses which are the result of an immunological disorder. The features of the arthritis in these diseases differs from that in osteoarthritis. There is an inflammation of the synovial lining of the joint and erosion of bone rather than cartilage destruction and overgrowth of bone. The joint changes are often associated with vasculitis (inflammation of arteries), pericarditis (inflammation of the membranes surrounding the heart) and anaemia. Such diseases include rheumatoid arthritis, Systemic Lupus Erythematosus and psoriatic arthritis.

## 6. Medical Advice to BA Customers

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13. It may be helpful to differentiate these two types of arthritis by contrasting:
- i. osteoarthritis where any joint inflammation is secondary to the disease process, to the inflammatory arthritides where inflammation is the primary process and
  - ii an inflammatory polyarthritis where all the affected joints will be involved in the primary inflammatory process, to osteoarthritis where only some, or possibly none, of the joints are involved in any secondary inflammation.

### Rheumatoid Arthritis (RA)

14. Intervention in the form of the following drug therapy, surgery and physical treatment does change the outcome of RA, particularly in the early stages of the disease:
- simple analgesics such as paracetamol are commonly used as first line treatment but may be supplemented or replaced by non-steroidal anti-inflammatory drugs (NSAID)
  - second line treatments are increasingly being used earlier in the disease process, eg methotrexate, sulphasalazine and hydroxychloroquine
  - the results of replacement surgery are good and improving.
15. The overall picture for RA is an optimistic one. Extensive joint involvement and second line treatment does not mean the client will necessarily be exempt, particularly if the disease is of recent onset. However, long-standing disease with extensive joint destruction, or where there are systemic manifestations, may well fall into an exempt category.

## 6. Medical Advice to BA Customers

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### Ankylosing spondylitis

16. Modern treatment has a significant effect on the outcome. Severe scoliosis should now be rare. Regular physical exercise, taken in the form of work, can be positively beneficial.

### SLE

17. Do not assume that this diagnosis automatically equates with a poor prognosis. A painful, non-erosive arthritis is common.
18. The presence of renal and neuro-psychiatric disease are useful indicators as to the severity of the disease process.
19. People with early onset disease who are in receipt of modern drugs and therapies should have a good prognosis. Therefore you should advise that the client is only exempt for a period, probably 12-24 months, to allow their conditions to remit.

### Further control action on cases which meet this criterion

20. The intention is to exempt with no further application of the Personal Capability Assessment only those cases where there is evidence of end stage disease or the gross mechanical joint damage of burnt out disease.

### **Progressive impairment of cardio-respiratory function which severely and persistently limits effort tolerance (CP / CY referrals)**

21. This category covers disease of the heart, lungs and central circulatory system which severely and persistently limit effort tolerance despite optimum modern medical treatment. You must primarily consider the degree of impaired functional ability which results from the cardio-respiratory disease.

## **6. Medical Advice to BA Customers**

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22. The disease may be of the heart, lungs, or associated vessels, but by the time it reaches the severity to cause severe and persistent limitation of effort tolerance, it will usually have resulted in functional impairment in either or both of the other two.

### Heart disease

23. The important words are "severely" and "persistently".
24. Ischaemic heart disease is the commonest condition, either as angina, myocardial infarction or heart failure. Valvular heart disease is becoming less common.
25. If there is evidence of symptoms despite high doses of medication, multiple therapies or use of second line treatments, this should be taken as an indication that the condition probably falls into an exempt category and that significant improvement is unlikely.
26. In terms of prognosis, a short duration of severe symptoms, where a high level of therapeutic intervention is required is not per se an indication of chronicity; you should not normally advise exemption in such cases for more than 12 - 18 months. This allows stabilisation of the condition and assessment for surgical intervention. The results of this can be dramatic.

## 6. Medical Advice to BA Customers

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### Chest disease

28. Indicators that the effort tolerance is likely to be severely and persistently limited include:

- recent weight loss (without dieting)
- oxygen therapy
- regular use of nebulised drugs
- frequent hospital admissions
- frequent use of antibiotics and steroids.

A mixed picture of cardiac and respiratory disease causes greater disability than either component on its own.

### **Dense paralysis of the upper limb, trunk and lower limb on one side of the body (CP / CY referrals)**

29. The severity and extent of the disability are self-explanatory. The secondary consideration is the cause of the paralysis. When taken together with the extent of the disability and the client's age this gives an indication of a period in which a significant improvement in the level of disability can be expected, if at all.

## 6. Medical Advice to BA Customers

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### **Multiple effects of impairments of the function of the brain or nervous system causing severe and irreversible motor, sensory and intellectual deficits (CP / CY referrals)**

30. This category covers only those cases where there are severe and irreversible effects of the pathological process, eg:
- a severe stroke
  - a brain tumour, either benign or malignant
  - a major head injury
  - multi-infarct syndrome.
31. This is not an exhaustive list of possible causes.
32. The conditions may not necessarily be progressive or degenerative but must result in a severe level of disability and/or restriction of social functioning.
33. The degree of dependency on others may be a useful indicator of the level of disability.

## 6. Medical Advice to BA Customers

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### **Severe and progressive immune deficiency states characterised by the occurrence of severe constitutional disease or opportunistic infections or tumour formation (CP / CY referrals)**

34. This category does not relate solely to a diagnosis of Acquired Immune Deficiency State or HIV related conditions. When advising whether the claimant may be exempt the Personal Capability Assessment consider if one or more of the following medical conditions are present:
- severe constitutional disease over a period of at least one to two months with feature such as
    - loss of 5% or more of normal body weight
    - debilitating overactivity of the bowels
    - frequent fever and/or night sweats
    - idiopathic thrombocytopenia
    - falling CD4 count (where CD4 count is significantly below  $400 \times 10^6 / l$ )
  
  - opportunistic infections, which are recurrent or resistant to treatment, such as:
    - herpes zoster
    - aspergillosis
    - microsporidiosis
    - salmonella
    - recurrent pneumocystis carinii
    - aseptic meningitis
  
  - tumour formation which is often unresponsive to treatment such as:
    - Hodgkin's lymphoma
    - invasive anal carcinoma
    - testicular carcinoma
    - cerebral tumours
    - Kaposi's sarcoma.

## 6. Medical Advice to BA Customers

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### Prognosis Advice

34. When you offer advice that a client's incapacity falls into one of the categories of severe conditions that is to be treated as incapable of work, i.e exempt from the Personal Capability Assessment, the Decision Maker will require a prognosis on which to base a decision as to when, if at all, a significant change in functional ability or clinical condition can be expected such that it would be worth reviewing the case again (for the purpose of considering entitlement to benefit).
35. Give careful consideration to both the medical condition, the therapy currently being used and the developments in therapy, both recent and in prospect.

#### Example 1

Recovery of the CNS from the effects of an injury are limited and the greater part of the recovery will have occurred by 18 months after the injury. Little or no further recovery can be expected after two years. These cases should not usually be given a prognosis of more than two years in the first instance. Only advise the Decision Maker that no significant change is expected in conditions such as a massive stroke, where a poor prognosis is clear within a few weeks/days. If, two years after the injury, the disability is still severe enough to meet the criteria for exemption then in the absence of recent and prospective improvements in treatment it would be reasonable for you to advise that no significant change is anticipated. The Decision Maker can then reasonably decide that further consideration of the application of the Personal Capability Assessment will be unnecessary.

## 6. Medical Advice to BA Customers

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### Example 2

The first attack of multiple sclerosis may lead to a severe and progressive deterioration in function such that it would be reasonable to certify the client as falling into the exempt category of 'a severe and progressive neurological or muscle wasting disorder'. It is usually reasonable to give a prognosis of 12-18 months after the first attack/clinical episode.

It is not reasonable to give a prognosis in excess of two years until the client has shown a severe and progressive deterioration for a period in excess of two years. The consensus of medical opinion is that the likelihood of a significant remission after two years is small.

### Example 3

Patients in the early stages of one of the conditions certified as belonging to the category of 'active and progressive forms of poly-arthritis'.

Clients who are receiving modern disease-modifying drugs and therapies should have a good prognosis and therefore will only be exempt for a period, probably 12-18 months to allow their conditions to remit.

### Example 4

Cardiac problems of short duration and sudden onset which give rise to severe and persistent limitation of effort tolerance and, where a high level of therapeutic intervention is being used, may be exempt for a short period of 6-12 months while the condition is stabilised and the patient is assessed for surgical intervention. Results of surgery are good and are improving with experience and advances in techniques.

## 6. Medical Advice to BA Customers

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### Example 5

In conditions such as severe learning difficulties, and severe and progressive immune deficiency state, it is clear that in the light of current medical knowledge a prognosis of no significant change anticipated is reasonable once the exemption criteria are satisfied.

### Example 6

Manic depressive disorder may be satisfactorily controlled with modern medication and patients may have relatively few serious disabling episodes. After an episode of manic depressive disorder it would be reasonable to review their condition after a twelve month period as many may well be able to return to work. If, after review, the client appears to have a rapid cycling illness or chronic depressive disorder, a further review after two years would be reasonable. If after two such reviews the condition appears to be enduring and continuing, then it is likely that the claimant falls into the category of chronic ongoing mental illness and therefore further reviews are unlikely to be efficient.

### Example 7

After a first episode of schizophrenia the client should be reviewed after a period of 18 months because there is a 20% chance that the client may well have little residual disability.

In the case of an established diagnosis of schizophrenia for five or more years, the disability is unlikely to alter substantially within a further five year period.

## 6. Medical Advice to BA Customers

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### Terminal illness ( CT / CQ referral )

1. The criteria for terminal illness in Incapacity Benefit are the same as for DLA and AA that is:

*"A person is suffering from a progressive disease and their death in consequence of that disease can reasonably be expected within six months".*

2. You will consider any evidence that is submitted. This may be a:

- DS1500 form
- IB 113 (where the incapacity is marked PE (TI) in the IRG)
- Where there is a statement by, or on behalf of, the client that the client is terminally ill but no medical evidence is supplied.

### Referral Code CQ

3. The advice will be given based on the evidence in an IB 113 report. The Decision Maker needs advice on whether the criteria for terminal illness in Incapacity Benefit are satisfied or not.

### Referral Code CT

4. Advice may be requested based on a DS1500 form, an IB 113 or any other evidence the Decision Maker holds. The DO will need to supply details of 197th day. Further evidence may be sought from either the GP or the consultant.

## 6. Medical Advice to BA Customers

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5. The Decision Maker needs advice on:
- whether the criteria are satisfied or not; and if so
  - whether they have been satisfied since the 197th day of the incapacity, or if not
  - from what date they have been satisfied.
6. Guidance on prognosis for various diagnoses based on the most up to date medical data is contained in 'Medical Protocols for use in Special Rules Cases' (AA/DLA).

### Example 1

DS1500 dated 20 October

- evidence of disseminated carcinoma of the breast on Tamoxifen. Back pain 3 months post XRT to spinal secondaries requiring strong analgesics. Enlarged liver.
- Original Rx mastectomy and chemotherapy. Diagnosed 15 months ago
- 197th day 20 July.

It would be reasonable to advise that the claimant was, on the balance of probabilities, terminally ill on the 197th day.

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### Example 2

DS1500 dated 20 September

- malignant astrocytoma grade 3 diagnosed July. Post XRT. Undergoing CT. Progressive deterioration with spinal cord metastases.
- 197th day is 25 June.

It would be reasonable to advise that on 25 June the claimant was, on the balance of probabilities, terminally ill.

### Example 3

Clinical details as in Example 2.

- DS1500 dated 20 October
- 197th day is 7 May.

It would be reasonable to advise that on the balance of probabilities they were not terminally ill on the 197th day but they were terminally from 1 July (condition was diagnosed in July).

## 6. Medical Advice to BA Customers

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### Reconsideration following dissatisfaction/appeal/reference back (CZ referral)

1. Approved doctors who provide advice on these cases must have undergone the appropriate training to deal with Incapacity Benefit 'reconsiderations' and 'appeals'.
2. The DO may, on receipt of an expression of dissatisfaction or submission of further medical evidence, return the case to Medical Services for consideration in the light of the new evidence or expression of dissatisfaction.
3. In such a case the original papers, along with any submission of further evidence, will be referred under code CZ for reconsideration of the original medical advice.
4. These cases must not be treated as a request for a second opinion.
5. If a further examination is undertaken following a CZ referral it should be made clear that the examination refers to the condition as it is found to be up to the date of that examination rather than any previous date.
6. As a general guide, the advice of a doctor approved by the Secretary of State may be reconsidered by another doctor approved by the Secretary of State if they are satisfied by fresh evidence that the decision was:
  - given in ignorance of a material fact, or
  - based on a mistake as to a material fact.
7. **Fresh evidence** is evidence which was not made available to the approved doctor at the time the original advice was given.

**A material fact** is a fact which was in existence at the time the original medical advice was given and which, had it been presented to the approved doctor, would, more probably than not,

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have either:

- influenced the judgement of the approved doctor; or
- called for serious consideration by the approved doctor.

It need not necessarily be a fact which would have led to different advice but only a fact that the approved doctor would probably have wished to take into account when formulating the original advice.

8. A further medical opinion or diagnosis is not itself a fact, only another interpretation of the facts. Nevertheless it may contain evidence of some fact, eg the reports of an examination carried out after the date of the relevant decision may contain the results of haematological test or x-rays which establish the diagnosis of a previously unidentified condition **which was in existence at the time the original decision was made.**

## **6. Medical Advice to BA Customers**

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9. If you are presented with fresh evidence you then have to consider whether the fresh evidence contains material facts. If it does, you will reconsider the previous advice. Depending on careful consideration of all the evidence before you, and based on the balance of probabilities, you will then have to consider whether it is appropriate to **revise** the advice.
  
10. In relation to the non-functional descriptor covered by Reg 27(2)(c) as amended (awaiting major surgical operation or other major therapeutic procedure), the Regulation is so worded that the three month period must start from the date of the most recent Personal Capability Assessment medical examination.

## **6. Medical Advice to BA Customers**

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### Therapeutic work (CW referral )

1. It is for an Decision Maker to decide whether work can be accepted as exempt under Regulation 17(1)(a) - therapeutic work. The Decision Maker requests a factual report from the GP or certifying doctor, and may then refer the file to an approved doctor seeking clarification of the report from the GP.
2. You should limit medical advice to clarification of medical terminology or information given in the report by the GP/certifying doctor. Do not express any opinion on the question of whether or not the circumstance satisfy the criteria for exemption under Reg 17(1)(a) - therapeutic work.

## **6. Medical Advice to BA Customers**

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### **Med 6 received from GP (CH referral code)**

1. These referrals are made when the DO is informed by the certifying doctor that the true details of the certified cause of incapacity have not been entered on the Med 3/5. The DO sends an IB113 to the certifying doctor to allow them to supply full details of the certified cause of incapacity.
2. When considering the case you must provide advice on the true cause of incapacity, making sure that the diagnosis is one that the DO can use. (See paragraphs on diagnosis). Consider exemption and advise the DM where appropriate, and then advise on a prognosis.

## **6. Medical Advice to BA Customers**

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### **Incapacity doubtful (CR referral)**

1. Referrals are made under this code when the DO has reason to believe that the certified cause of incapacity is not a specific disease or bodily or mental disablement, eg bereavement or pregnancy. You need to be able to advise the DO on whether or not their client is suffering from a specific mental or physical disablement. If the GP has used a euphemism, advise on what the true cause of incapacity is.
2. You then need to consider whether the evidence indicates that you can consider advising exemption from the Personal Capability Assessment. Finally, advise on the prognosis for the certified cause of incapacity.
3. This may mean that you have to contact the certifying doctor to clarify the certified cause of incapacity. This may be an opportunity to remind the GP about appropriate certification and therefore the method of choice will usually be by telephone, with the use of a factual report request as a final resort.

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### **Illegible incapacity on Med 3/5 (CS referral)**

1. These referrals are made when the DO is unable to read and/or understand the certified cause of incapacity written on the medical statement.
2. Clarify the cause of incapacity in terms which the DO can relate to the IRG, then consider and offer advice in relation to exemption and advise on a prognosis.

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### **Incapacity unlisted in the Incapacity Reference Guide (CU referral)**

1. These referrals are made when the DO is unable to find the diagnosis in the IRG, which gives the DO the following advice:
  - the code needed to enter the diagnosis on the Incap system;
  - whether the diagnosis falls in an exempt or potentially exempt category, and if so which one; and
  - when they should start control action to refer the case for medical advice.
2. Medical advice should allow the DO to progress the claim, following the guidance on diagnosis, exemption and prognosis.

## **6. Medical Advice to BA Customers**

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### **Pregnancy related incapacities (CN referral)**

1. When considering switching a client from IB to Maternity Allowance the Decision Maker considers whether or not the client's absence from work is due wholly or partly to pregnancy or childbirth. This is a question that only needs to be addressed from the 34th week of pregnancy onwards.
2. The Decision Maker may request a factual report from the GP/certifying doctor . The role of the approved doctor is to clarify/interpret any medical terminology within the report so that it is clearly understandable to a non-medical Decision Maker.
3. No examination is required. No other advice or opinion should be given.

## 6. Medical Advice to BA Customers

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### Scrutiny of medical reports for harmful information (CV referral)

1. Guidance on what constitutes 'harmful information' can be found in section 16. All reports written by approved doctors must have harmful information clearly identified by the author at the time they are written. All reports received by Medical Services, where the author states that part or all of the report contains harmful information must have that information clearly identified at the initial scrutiny by the approved doctor.
2. The Decision Maker may refer back any documents which need to be available to be released to the client or their representative, for identification of harmful information. In view of the above comments this will not usually be necessary for reports that have been either written, or scrutinised, by IB approved doctors. The Decision Maker can always refer a report if they have doubts.
3. The Decision Maker is more likely to need to refer medical evidence not previously seen by an approved doctor, eg a report submitted by a social worker or GP direct to the Decision Maker, either unsolicited by the client or, as a result of a request from a client to support their claim or appeal against the adjudication decision.
4. Harmful information must be identified by:
  - ringing it in pencil on the report
  - marking the report "harmful information" and then
  - identifying the location of the harmful information on that and any other reports on form IB59(min).

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### The Personal Capability Assessment - medical scrutiny

1. Clients whose conditions do not fall within an exempt category complete an IB50 questionnaire which is analyzed and provisionally scored at the District Office.
2. If the provisional score is less than 15 the case is sent for medical examination. This is to ensure that no client who is understating their ability is inappropriately found capable of work. Prior to arranging the examination Medical Services will ensure there is no evidence of the client being in an exempt category.
3. If the provisional score is 15 or more, the case is sent for medical scrutiny. The objective of the scrutiny process is to provide advice to the Decision Maker or to advise that the client is summoned for a medical examination.
4. A number of people whose medical condition does not fall within an exempt category are nonetheless significantly disabled. Scrutiny involves the application of medical knowledge and experience to compare the medical evidence and the IB 50 questionnaire. If the available medical evidence is sufficiently consistent and compatible with the claimed level of disability, the case can be decided by the Decision Maker without a medical examination. **Current detailed guidance on the approach to PCA medical scrutiny, which has been agreed between the Authority (DSS) and Medical Services, should always be followed when giving such advice.**
5. Where the medical advice is that an examination is not required the approved doctor should also provide advice on prognosis to assist in deciding on future control of the claim.

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### Scrutiny Process

7. A Med 4 statement from the client's own doctor will usually accompany the IB50 questionnaire in initial referrals if there is no recent IB 113 on file. An IB113 provides additional information in those cases which were considered for exemption, or have had further evidence requested before an all work review.

### Factors you should consider

#### *Consistency*

8. **Consistency is a key concept in IB.**

Consider whether the stated level of functional limitation is consistent with the expected clinical manifestations of the diagnosed condition(s); and with the activities that the person can perform in everyday life.

Consider whether the chosen descriptors are internally consistent, in other words do they agree with each other to form a recognisable pattern for the diagnosed cause of incapacity.

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### *Reported pain / fatigue*

9 Consider these aspects in relation to the points in section 9.

If the client cannot perform the activity effectively because of pain; or can perform the activity but tires so quickly they cannot repeat it; or can perform the activity but so slowly that they cannot effectively complete the task, they should be regarded as just as incapacitated as someone who cannot perform the activity at all.

Clearly the quality of medical evidence will need to be particularly strong to allow you to accept the stated level of incapacity on these grounds.

### *Consensus*

10. Is the stated level of disability medically reasonable for a person of this age/sex with this pathology at this stage of development? Consider:

- diagnosis
- investigations undertaken (or not undertaken)
- current or previous treatment, and
- current or previous care needs.

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### *Additional factors to consider*

11. If you are satisfied at medical scrutiny that there is a significant difference between the claimed level of functional limitation and the opinion you form based on the available medical evidence, then you must refer the case for examination. A significant difference would be if the likely choice of descriptors at assessment differ markedly from those indicated on the IB50 questionnaire. As a general rule, if someone has scored themselves in a number of activity areas on the IB50 questionnaire, you should first consider those areas with which you reasonably agree. If these are the minority of all descriptors chosen, you should normally refer the case for medical assessment.
  
12. On the other hand for example, consider a client with osteoarthritis who scores himself highly in walking, standing, bending, sitting and rising and the medical evidence (Med 4) is compatible with the stated limitations. However, the client has also scored himself highly in hearing and seeing and there is no supporting evidence. You would agree with the IB50 questionnaire in the majority of functional areas. As a result there would be little achieved by examining the person merely to confirm that he had overscored himself in the two sensory areas.
  
13. In medical conditions where there can be a wide range of functional disability, consider where in the range of disability the majority of people with that condition will be found. Examples include low back pain and Chronic Fatigue Syndrome. In these conditions there is a wide spectrum of disability, but only a small percentage are severely disabled. Good medical evidence is therefore required to prove that any particular case falls into this small group. Clients with such conditions should usually be summoned for assessment to obtain detailed evidence of their actual functional limitations.

## **6. Medical Advice to BA Customers**

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14. If the evidence is insufficient, either on medical grounds or regarding the level of disability, refer the case for medical assessment. If however there is clinical suspicion that the condition is more severe than the medical evidence available allows you to be sure of, you should consider seeking further information.
15. Only medical factors should be considered in relation to IB. The following information about the client is not relevant when considering the functional limitations set out in the Personal Capability Assessment :
- age
  - educational achievements
  - levels of training and skills
  - length of time away from job market, or
  - any other social factors.

### **Scrutiny of cases with a Mental Health Disability**

16. A majority of these files should contain an IB 113 (DLS 584 on older files) and IB59PYM. The decision not to advise that these cases are severely mentally ill, as defined, was taken on the evidence in the IB 113. The question of certification on the grounds of severe mental illness must now be reconsidered with the additional evidence available from the Med 4 and IB50. If there is evidence that the case falls into this category you should advise that the client is exempt and give medical advice on prognosis to assist in decisions as to future control of the claim.

## **6. Medical Advice to BA Customers**

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17. If the case does not meet the criteria on the grounds of severe mental illness the mental condition must be set to one side whilst consideration is given to any physical or sensory disabilities. Mental illness forms no part of the consideration of the physical or sensory disability.
18. If after consideration of all the evidence with regard to the physical and/or sensory disabilities, taking into account all the factors set out above, the evidence is compatible with the claimed level of disability, the case is returned to the DO with advice to that effect. Advice on prognosis is given in relation to the physical and sensory disabilities only. There is insufficient documentary evidence to advise in relation to the mental health disabilities.
19. If there is any doubt as to the compatibility of the medical evidence and the claimed level of disability in the physical and sensory functional areas the case must be referred for assessment. The examining MA will carry out a full assessment of all aspects of the case, mental, physical and sensory.

### **Substance abuse - drugs/alcohol**

20. Alcoholism is taken to be a form of altered behaviour that can cause mental or physical disease (World Health Organisation). Alcohol related disability is defined as any mental or physical harm resulting from excessive alcohol consumption due to physical dependence on alcohol.
21. Drug or other substance abuse must be considered in the same way as alcoholism - which is a specific case of substance abuse.

## **6. Medical Advice to BA Customers**

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22. An IB 113 will have been issued in all diagnoses related to substance abuse. Provided that the IB113 has been completed and returned this and the IB59PYM will be included in the IB55 file. Scrutiny of the case for evidence of a mental health incapacity resulting from substance abuse is carried out as described above. When considering any physical or sensory disabilities, include any which result directly from substance abuse due to physical dependence.

### **Regular Treatment** (Dialysis, Chemotherapy, Radiotherapy, total parenteral nutrition)

23. The IB Regulations allow a person 'receiving certain regular treatment' to be treated as incapable of work (for state benefit purposes) on any day on which he/she is engaged in that treatment. Such people are not exempt from the Personal Capability Assessment. The Regulations allow a person who wishes to work to do so and to claim state benefit on those days on which they are they are incapable of work as a result of being engaged in regular treatment. The decision on benefit entitlement is as always one for a DM.
24. "Engaged in treatment" includes the following:
- necessary pre-treatment tests
  - administration of the treatment
  - any necessary period of post-treatment recovery.
25. The IB tests have to be applied to days when the claimant is not accepted by the DM as being engaged in treatment.

### **Further Medical Evidence**

26. Consider obtaining further medical evidence only if there is a strong probability that such evidence will confirm the presence of significant disability, and hence enable advice to be given to the DM without medical assessment.

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27. Further medical evidence can be obtained by:
- telephoning the client's GP for clarification of evidence held, or to obtain information that was requested but not forthcoming, or
  - requesting written evidence from the GP, using forms IB 113 or a specially constructed factual report request.
28. If a request for a written report fails to obtain the evidence in a reasonable time (usually the B/F date), either a telephone request for information must be made, or the client must be summoned for medical assessment.

### **Pregnancy**

29. Pregnancy is a normal physiological process and therefore cannot alone satisfy the medical criteria of incapacity for work due to a specific disease or bodily or mental disablement.
30. All pregnancy cases referred for consideration of medical aspects of incapacity for work should be considered in the following way, regardless of the duration of pregnancy:

Is there any complication of pregnancy which would result in serious risk of damage to the health of the pregnant woman or to the health of her unborn child if -

- in a case where the OOT applies, she does not refrain from work in the occupation which is relevant for the purposes of that test; or
- in a case where the Personal Capability Assessment applies, she does not refrain from work in any occupation?

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If you can answer yes to either of the questions above advice should be given to that effect and the prognosis should reflect the length of time for which the risk is likely to continue.

31. If you are unable to advise that such a risk exists then the complication of pregnancy has to be considered on its own merits. eg. back pain. If the pregnant woman has back pain arising from the normal physiological response to pregnancy then the level of disability arising from the back pain must be assessed in the same way as back pain arising from any other cause and a report completed on the disability due to the back pain. Consider the evidence before you with regard to the cause of incapacity as described above when deciding whether to accept the stated level of incapacity or refer for examination.
32. Pregnant women between 34 weeks gestation and 2 weeks post delivery are considered incapable of work if they are not entitled to Statutory Maternity Pay (SMP) or Maternity Allowance (MA). Those eligible for SMP or MA may take their 8 weeks maternity leave and receive these benefits any time between 34 weeks gestation and the date of delivery. If a woman is unable to work due to a pregnancy related complication after 34 weeks then she must take SMP or MA. If she is unable to work due to another illness then she is entitled to a state incapacity benefit and can 'keep' all her maternity leave until after delivery.

### Re-referral cases

32. All the documentation from the previous referral; including
  - any IB 113 (or DLS letters on older files)
  - Med 4
  - IB50
  - IB85, if examined

## 6. Medical Advice to BA Customers

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should be read prior to reading the current papers. Advice should then be given, or the decision to summon for assessment made on all the available evidence.

### **Prognosis at Scrutiny**

33. If consideration of all the evidence allows you to accept the claimed level of disability, you should give advice about when, if at all, a significant improvement in the accepted level of disability can be expected. This advice will be used by the DO to decide when, if ever, the case should be reviewed. The DO will not wish to re-apply the PCA unnecessarily: they will wish to re-apply the test only to those clients where there is a reasonable expectation that they will score below the threshold and hence fall to be treated as capable of work.
34. A "significant improvement" therefore means that, after the recommended period, the client is likely to have improved to the extent that a re-assessment would be appropriate.
35. The duration of the prognosis should be appropriate to the condition in question. Advice that will lead the DO to decide that further review is inappropriate should normally only be given in the most severely disabled clients, where certification of exemption is appropriate, or where a similar level of irrecoverable or progressive disability is present. In all other cases an appropriate finite prognosis should be given. This should take into account the natural history of the disabling condition and the likely effects of any treatment which is being, or is about to be, given.
36. In cases where an operation is due, and a definite date has been given, consider accepting the client's assessment of their disability up to the date of operation, and for a period of 6-12 weeks postoperatively (depending on the type of operation) when advising about prognosis.

## **6. Medical Advice to BA Customers**

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### **Request for further Medical Evidence at Review**

37. Where there is a reasonable expectation that a condition will improve in a straightforward manner no further medical evidence should be requested for a future review. If the response to treatment is uncertain, or the natural history of the disease is unpredictable, further medical evidence should be requested to be obtained before any future review. This will be requested at the review if the client scores above the threshold on the IB 50 and the case is sent for medical scrutiny; (those cases below the threshold will be referred straight for assessment).
  
38. An IB 113 should be requested for PCA reviews in cases where the main diagnosed cause of incapacity is a mental illness. This applies whether or not the condition has been certified as exempt on the grounds of severe mental illness.

## **7. Advice to Certifying Doctors**

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1. Approved doctors are required to give advice to certifying medical practitioners. This includes:
  - advice regarding completion of statements of incapacity for work as detailed in IB 204 - A Guide for Registered Medical Practitioners
  - advice in connection with GP Terms of Service in relation to certification for state benefit purposes
  - queries in relation to medical reports requested for other state benefits.

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **Introduction**

1. The medical assessment process as a whole differs in many respects from the traditional history taking and examination in the general practice and hospital setting. It entails bringing together information gained from observation, questionnaire, medical evidence and examination in order to reach an accurate assessment of the disability of a client and so to provide the information and the opinion which the Decision Maker requires. It is a complex procedure, involving careful consideration, structured interviewing, lateral thinking and accurate observation, as well as the application of medical skills. With experience, the approved Medical Examiner will become expert at synthesising these aspects in a way which flows naturally.
  
2. There are four stages in performing the Personal Capability Assessment. These are:-
  1. Reading the documents;
  2. Interviewing the client;
  3. Examining the client and
  4. Completing the medical report form(s).

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **Reading The Documents**

1. In preparation for the interview, you should read carefully the documents in the file. All the medical evidence should be considered, including Med.4s, Factual Reports, previous papers and other documents, including Tribunal documents. Particular attention must be paid to the client's current questionnaire [IB 5O] and it is a useful practice to jot down on scrap paper the client's chosen descriptors. This will avoid any possibility of omitting a functional area from consideration and will act as an aide memoir during the interview so that information gathering can be focused on the relevant functional or mental health areas.

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **Interviewing The Client**

#### **The Nature of the Interview**

1. The interview differs materially from the traditional consultation in medical practice. The aim of the traditional interview is to arrive at a diagnosis and plan future medical management of a patient. In the PCA interview, you are gathering information which will be used to assess the effects of a disability on the client in all of the relevant functional areas .
2. Detailed medical history taking is time-wasting and unnecessary. The essential medical details which impinge on present function is all that is required.

#### **Interview Technique**

3. It is important that the interview is carried out in a friendly, professional and non-confrontational way, in keeping with good customer service and in line with the approved doctor professional standards.
4. If possible, you should meet the client and accompany them from the waiting room. This positive initial point of contact will help put the client at ease and is a natural courtesy. From your point of view, it provides an opportunity to observe the client outside the examination room, and extends the time spent in contact with them. Most importantly, it initiates the rapport between doctor and client which is so essential to an effective interview.

## **8. The Medical Assessment (The Personal Capability Assessment)**

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

### **Client accompanied by relative, friend, carer.**

6. Clients will often feel more at ease when accompanied, and indeed this may be a prerequisite to enable them to come to the Examination Centre.
7. Companions will be able to give useful information, particularly in cases where the client has mental health problems, learning difficulties, or communication problems, or people who stoically understate their problems.
8. Occasionally, a companion may wish to give too forcefully their own opinion on the client's disability, perhaps giving a biased view. You will use your own judgement in weighing the companion's evidence. If the companion is too intrusive, then you should point out that the client must be allowed to express their view. If this strategy is unsuccessful the companion should be asked to leave.
9. The actual physical examination is not normally done in the presence of the companion, but strictly with the client's consent, and if it appears a reasonable request, then the companion should be allowed to be present.

## 8. The Medical Assessment (The Personal Capability Assessment)

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### Interpreters

10. Where the client is not fluent in your language, it will be necessary for the client to be accompanied by an interpreter. You should make a note on the IB 85 on the front page, of the name of the interpreter and the language being interpreted.
11. Under these circumstances the assessment may take longer than usual as adequate time will be needed for questions and responses to be interpreted. Do not appear to rush or frequently interrupt the process. Be aware of the possibility that the interpreter may be expressing their own views and conclusions rather than those of the client.
12. If the client attends without an interpreter and you cannot continue satisfactorily, then the interview should cease and the client should be requested to attend again with an interpreter. A note of the circumstances should be made on the IB 85 report. [See also section on Exceptional Situations at Medical Assessments].

### Interview Skills

13. As an essential component of the examination process, the interview requires you to possess appropriate skills. These include:-
  - **Active listening**
  - **Effective questioning**
  - **The use of clear and understandable language**
  - **The use of positive body language.**

## 8. The Medical Assessment (The Personal Capability Assessment)

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14. **Active Listening** involves:-

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

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

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

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

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **The use of Clear and Understandable Language**

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

### **The use of Positive Body Language**

17. This is a skill which many doctors already possess. However, the interview of necessity involves you in a good deal of writing, and the client may feel isolated and excluded as a result. It is good practice to minimise the effects of this by interrupting your writing from time to time, however briefly, to restore direct contact with the client.

### **Recording the Interview**

18. Details about the client will have been entered on the report form by the administration staff, and you should check these.
19. The time of start of examination is when you first make contact with the client. The time the examination ends is the time when the client leaves you. You should also add the time at which the form was finally completed.
20. List all the current diagnoses. Ensure that all conditions entered in the IB 50, Med 4 or other medical reports are included. Previously unidentified conditions which are revealed during the assessment should also be added.

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

### **Medication**

22. Record all regular medication whether prescribed or bought over the counter. Record the dose without using shorthand or abbreviations.
23. It is helpful to comment on any analgesics being taken. This may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. "He takes an average of 12 paracetamol (painkillers) a week, usually over three days" provides a picture for the Decision Maker which will support your description of variability and pain later in the report. It is also useful to comment on the potency of the analgesic.
24. Note also any side-effects of medication reported by the client and explain any additional medication used to ameliorate them; eg the use of cimetidine in dyspepsia related to the use of NSAIDs.
25. It is also helpful to explain the purpose of the medication; for example:
- "Becotide 100 inhaler - an inhaled preparation for asthma prevention"
- "Voltarol Retard - an anti-inflammatory drug for arthritis."

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### **Details of any hospital treatment or investigations within the last 12 months**

26. Details of any hospital treatment or investigations within the last 12 months should be recorded. It is most important to keep this information brief, concise and relevant to the present disabilities. Note whether the client continues to attend hospital, and the likely date of any proposed treatment procedure or investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks' time".

### **Details of Specific Therapy for Mental Health Problems and Of Mental Health Professional**

27. It is important that details of therapy relating to a mental health problem are recorded. The name of the person providing such treatment should also be recorded in case an IB 113 is needed.

### **Clinical History**

28. A good history is the basis of the Personal Capability Assessment medical examination, and the following structure should be used:-
- A brief outline of the client's previous occupation and when and why they left.
  - A brief clinical history (details not already recorded in the 'hospital treatment section)
  - Brief details of the client's domestic situation, for example; "Lives in a 2-storey house with husband and two children aged 10 and 12".
  - A brief outline of the client's problems and the functional limitations imposed by them, for example "Variable pain both elbows which the client states restricts his/her ability to lift and reach".
  - *Most important is an outline of how a typical day is spent in the light of the reported*

## 8. The Medical Assessment (The Personal Capability Assessment)

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*limitations.*

### **The Typical Day**

29. Although not always easy to elicit, a careful and well-focused history of a typical day will greatly help you in completing the rest of the report. If you obtain and record appropriate information at this stage, it will provide you with factual evidence of the client's abilities, which you can then use to support your choice of descriptor.
30. You must write this section in the third person. It is a record of the client's everyday life, without interpretation by the medical examiner. You should make it clear that this is the client's account of his disabilities and not your opinion. It is also a factual description of how the client's condition affects them in day to day life as elicited by careful interview, using the recommended techniques referred to in the relevant section of this handbook. Properly completed, it is of great help to the Decision Maker.
31. The account of the "Typical day" should be particularly focused on the areas of activity which the client claims are affected by their medical conditions, and areas likely to be so affected. For example in cases of low back pain, bear in mind activities which involve sitting, rising from sitting, walking, walking up and down stairs, bending and kneeling, and standing. These activities are required in personal care tasks, and domestic and leisure activities. You should give specific examples of activities, eg "says she enjoys watching television sitting in an armchair for 30 minutes at a time". See also the paragraphs in relation to completing the section on activities of daily living.

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32. Avoid making a statement such as "Can only walk 50 metres" as this may well be taken as fact by the Decision Maker or Social Security Appeal Tribunal. Better would be; "Says he only walks 50 metres", then give an example of what the client actually does, as far as walking is concerned, on an average day: "Walks to the shops and back (about 200 metres in all) but says he has to stop at least twice due to back pain".
33. At an early stage of the examination you may have identified a mental health problem. Remember that many of the Mental Health Assessment questions can also be completed as a result of this exploration of the client's day-to-day life, and completing them will be very much easier if you keep in mind the four areas involved, namely:
- Completion of tasks
  - Daily living
  - Coping with pressure, and
  - Interaction with other people.

Do not feel confined by the space restrictions on this page. If necessary, use an extra blank sheet and afterwards date and sign it and attach it to the IB 85.

### **Exempt cases**

34. If it becomes clear to you that the client may be exempt, interrupt the examination and where appropriate consult with a Medical Adviser. If it is agreed that exemption is appropriate, do not subject the client to further examination, but explain the situation and conclude the interview. You must record sufficient details of the history and appropriate examination findings to justify your advice, on the IB 85. You must then complete the 'exemption at examination' form (EA1).

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Also make an explanatory note on the IB 85 along the following lines:

"This examination was concluded when it became apparent that I could advise that the client was in an exempt category"

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **Examining The Client**

1. Information about appropriate clinical examination is to be found in the section on examination of the musculoskeletal system and in the sections dealing with individual functional categories.

The most important thing to remember when recording your clinical examination findings is to interpret them for the Decision Maker by explaining in plain English the significance of the findings, eg.

"Forward flexion of L shoulder restricted to 90<sup>0</sup> (about half the normal range) and this means that the client cannot reach upwards above shoulder level with the L arm".

### **Conclusion of the examination**

2. After the interview and examination, the client should be invited to ask any questions regarding the procedure. It is appropriate to advise that the Benefits Agency office will be in touch with the client as soon as possible but a specific period of time in which this will happen should not be given. No indication should be given of the likely outcome of the claim. The client should be told that the decision will not be made by you, but by a Decision Maker.
3. Questions regarding their treatment should be politely evaded. Most clients will understand if they are told that without the results of tests, X-rays, etc., it would be impossible to venture an opinion on treatment or management and they should be advised to consult their GP on any medical issue. No criticism of the client's medical management, overt or implied, should ever be made.
4. Do not enter into discussions about entitlement to other benefits. The client should be encouraged to approach the staff in their local Benefits Office for further information.
5. Do not enter into any debate about the details of Incapacity Benefit or respond to criticisms of the administrative process.
6. If, during examination, a condition is identified which may be unknown to the client or his medical adviser, the GP must be notified.
7. In all cases of difficulty you should consult with an experienced Medical Adviser.

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### **Completing The Incapacity Report Form**

#### **Overview**

1. It is important when writing Incapacity Reports (currently the IB85 report) to bear in mind who will be the recipients. The report will always be seen by a lay Decision Maker and may also be read by an Appeal Tribunals, the client and their representatives, and future approved doctors.
2. Legibility is of paramount importance. A report which is difficult or impossible to read may be valueless to the Decision Maker and is bad customer service.
3. You should also remember that Decision Makers are not medically qualified, and your report must be clear enough for them and other non-medical readers.
4. The Decision Makers will rely heavily on the report in coming to a decision on entitlement to Incapacity Benefit, and their needs must be uppermost in your mind. The Incapacity Report must provide an objective and fair assessment of the client's disabilities in the physical, sensory and mental health areas, as laid out in the Personal Capability Assessment regulations. It must make clear to the Decision Maker what descriptors you have chosen and why you have chosen them. Your choice must be supported by appropriate medical evidence. Where your choice of descriptor is different from the client's choice, your supporting evidence must give the Decision Maker sufficient information to say why your choice should be accepted, rather than the client's.

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5. Without a clear, consistent and well-presented report, the Decision Maker will find it difficult to accept your choice of descriptors. The requirement is for a report which:-
- legible
  - consistent and without contradictions
  - is clear, concise, relevant and positive
  - contains sufficient detail to justify the descriptors chosen
  - explains why the medical opinion may in some circumstances differ from the client's own view of their disability
  - avoids unnecessary medical terminology
  - is easily presented at an Appeal Tribunal
  - in keeping with a consensus of medical opinion.
6. Doctors will develop their own style in completing the Incapacity Report. However, the following general guidance is based on practical experience. That part of the report relating to diagnosis, medication, treatment and clinical history can be completed while interviewing the client. The remainder should be completed when the client has left.

### **Medical Terminology**

7. The use of medical terminology should be avoided. When there is no alternative to the use of a medical expression, it should be clearly explained. For example, "Aortic stenosis (a defective heart valve)."
8. Some terms have passed into general use, and will be generally understood, such as angina, asthma, migraine, and schizophrenia. However, it is good practice to explain briefly the nature and effects of an unfamiliar condition.
9. Certain expressions should never be used, such as "Functional overlay". If you think that the disability is less than claimed, you must say so explicitly, supporting your opinion by the medical evidence.

### **Abbreviations**

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

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### Choosing and Justifying Descriptors; the Overall Approach.

11. The objective of the PCA Incapacity Report is for you to provide your opinion of the client's level of function in 14 functional categories and if necessary in the Mental Health assessment, to identify any of the 3 non-functional descriptors which may apply, and to provide a prognosis.
12. The choice of the most appropriate descriptor in the functional category area will depend upon:
  - consideration of all the medical evidence
  - the interview with the client
  - the medical examination.
  - your medical knowledge of the likely effects of the condition
13. For each of the physical and sensory areas you must choose only **one** descriptor, and that should be the descriptor which reflects the client's level of functioning **most of the time**, taking into account such factors as pain, stiffness, response to treatment and variability of symptoms. This ensures that your opinion is not just a "snapshot" of the client on the day of examination, but reflects their functional ability over a period of time. This aspect is dealt with in more detail later.
14. In certain functional areas, the descriptors do not conform to a simple hierarchical progression. In these areas the descriptor chosen should be that which most accurately reflects the **highest** level of disability experienced by the client. For example, in the functional area of Continence, when a client suffers from occasional loss of bladder control (Cn (g)) and occasional loss of bowel control (Cn (d)), the latter should be selected as it is the "higher" descriptor.
15. In each Functional Category, you should also indicate whether your descriptor choice AGREES or DISAGREES with the client's own choice, which they should have provided in the Questionnaire [IB5O].
16. If the client has not chosen a descriptor, or the choice is not clear you should tick the 'customer's choice unclear' box . Where several descriptors have been chosen in one area, you should assume that the client has chosen the highest descriptor.
17. Where the client has indicated on Form IB5O that he has "no problem" and you agree, then supportive evidence is not required. Simply tick the "No problem" descriptor and the "Yes" box agreeing with the customer's choice of descriptor. **Otherwise, justification of your choice is needed in every case.** This will be entered in the four boxes provided, and the use of these is discussed elsewhere in this section.
18. Where the client indicates he has a problem and you **agree** with that descriptor choice, then all boxes under that functional category require completion, albeit in less detail than where you and the client disagree.

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19. Where the client indicates he has a problem and you **disagree** with the descriptor choice, then all boxes under that functional category require completion and discrepancies must be explained. You must fully justify and support your choice of descriptor by giving examples from your clinical history, activities of daily living, observation of the client, and clinical examination. Your evidence must provide sufficient factual information to lead the Decision Maker to understand and accept your choice.
20. All the evidence provided in a functional category should give support to that particular descriptor, e.g. it would be illogical to describe how, in a typical day, the client sits through long films at the cinema under the category "Manual Dexterity". It is equally illogical to provide examination findings of a knee under "Reaching", or neck and shoulder findings under "Walking".
21. Functional areas on the IB 85 are linked eg sitting, rising and bending and justification for this group of functional areas should be justified in the relevant boxes. Clinical details can be cross referred to other relevant linked groups.
22. Be careful when cross-referencing your evidence from one functional group to another that the information is relevant to that particular group. Irrelevant cross-references are irritating, misleading and waste the readers' time.
23. Make sure that your evidence is consistent: that you do not contradict yourself, or appear to contradict yourself, in different sections of your report. You should explain any apparent contradictions in such a way that the Decision Maker is able to understand that two pieces of evidence which at first sight appear contradictory, are in fact compatible with one another.

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24. There will be occasions when it is necessary to choose a "No Problem" descriptor even though some disability has been identified but it is not severe enough to reach the lower threshold; i.e. the penultimate descriptor. In this circumstance you must make it clear to the Decision Maker that you have carefully considered the limitations which are present by recording all the relevant information. For example, the client may have indicated difficulty with walking, but you have evidence from the typical day that they only experience significant discomfort after walking at a reasonable pace for 20 minutes (ie well over 800m)
25. When completing the IB85, **you must not:**
- alter the wording of the descriptors: they are defined in the Regulations and cannot be modified
  - alter the client's questionnaire in any way
  - use correction fluid. If you make an error, it should be clearly scored out, the correct words substituted, and the alteration initialled and dated.
26. If in the client's questionnaire a functional category page is left blank, you must show on the corresponding page of your report that you have discussed the problem with the client, and write "The client states that there is no problem in this area". If however it emerges that the client is disabled in this area you should proceed to choose and justify your descriptor in the usual way.
27. In some cases (EX referrals) there may be no client questionnaire. You should make this clear in your report, and address every functional category page as described above.
28. In some cases a significant time may have elapsed between the client completing the questionnaire and the examination. It is necessary then to ask the client whether their problems have changed in the intervening period, and record their reply.

### Completion of Functional Category Pages

1. For each functional category (except where the client has ticked "No problem" and you agree with them - see above) you must record the relevant information to explain and justify your choice to the Decision Maker. Information is recorded in terms of
- features of functional ability relevant to daily living
  - behaviour observed during the assessment
  - findings at clinical examination.
  - summary of functional ability
- highlight an explain any inconsistencies between clients' account and the medical evidence

## 8. The Medical Assessment (The Personal Capability Assessment)

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- address variability repeatability and fatigue
- clarify medical basis for advising the chosen descriptors

### **Variable and fluctuating conditions**

2. Much of the information recorded here will be obtained directly from the client, and it is important to make this clear by writing something like: "Client states that ....., or Client reports that ....."
3. Approved doctors are required to provide the lay Decision Maker with medical advice on the most appropriate level of functional ability in each activity area. In doing so they must take into account a number of factors including:
  - any fluctuations in the medical condition i.e. how the condition changes over time.
  - 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.
  - any pain which results from performing the activity
  - the ability to repeat the activity
  - the ability to perform the activity safely - without substantial risk of harm to self or others
4. The approved 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.

## **8. The Medical Assessment (The Personal Capability Assessment)**

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5. For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days. Examining doctors should make it clear in the report to the DM how they arrived at their advice. In such cases the doctor has to consider carefully whether the client'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.
6. The above implies that approved doctors should provide the DM with advice on:
  - the client's functional limitations on the majority of the days
  - the limitations found on the remaining days where the client's condition is worse or better, with an indication of the frequency these days arise.
7. 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 to the DM how the doctor arrived at their advice.
8. Taking into account the above points, 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.
9. All activities must be capable of being carried out safely. 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.
10. The activities do not have to be performed without any discomfort or pain. However if the client cannot perform an activity effectively because of pain they should be considered incapable of performing that activity.

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11. When considering the effect of **pain**, take into account the predictability of onset, and the effectiveness of treatment. Pain which starts without warning and requires analgesia is very different from predictable angina of effort which can be forestalled, or rapidly remedied, with appropriate treatment.
12. **Breathlessness** is an important symptom to take into account, because it is not specifically reflected in any of the descriptors, but it may contribute significantly to disability in relation to walking and walking up and down stairs. For example, a client who experiences significant dyspnoea on carrying out an activity should be scored as if the activity cannot be undertaken.
13. You should comment on the consistency of the above factors with the diagnosis and with the stage reached by the disease. For example, the Med 4 says the client has mechanical back pain, and on examination you find no back abnormality. The client says that on one day a week his back is so bad that he has to stay in bed. This degree of variability is very unlikely; mechanical back pain does not normally vary to this extent.
14. If you decide not to accept the degree of variability, etc, you should say:

"In my opinion, the claimed (variability etc) is unlikely, given today's findings".

### Activities of Daily Living

15. You will already have focused your attention on the functional areas causing difficulty to the client, and will have structured your typical day details along these lines. Examples of activities appropriate to each functional area are given in the section on the functional categories.
16. The activity described must be relevant to the functional category, e.g. the ability to sit for an hour at a time watching TV is irrelevant to the category "Rising from Sitting".
17. The activity must be described in sufficient detail to support your choice of descriptor.

## **8. The Medical Assessment (The Personal Capability Assessment)**

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For example: "Does shopping/cooking" does not give any useful information about lifting and carrying; what is needed is something like:

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

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

## **8. The Medical Assessment (The Personal Capability Assessment)**

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### **Behaviour observed during the assessment**

18. The area relating to behaviour observed during the assessment should be completed next. It is of limited use in some functional areas, for example in standing, as the customer will rarely be required to stand for any significant period within the Examination Centre. However, they will certainly be invited to sit, rise from sitting [often on a number of occasions during the course of the physical examination], and walk. While it is not appropriate to observe clients undressing and dressing they may also be required to reach, and bend or kneel for example hanging up a coat or picking up a bag during the assessment. Manual dexterity can often be assessed at the same time as buttons and zips are manipulated on coats.
19. Informal observations can also be made regarding vision, hearing ability and speech, and any object carried by the client can be noted.
20. Entries must contain sufficient detail. It is not enough to state "sat comfortably at interview"; better is to state "sat comfortably for 25 minutes in an armless chair without fidgeting, and this indicates that there would be little likelihood of any problem with sitting for longer than 30 minutes".
21. Further examples of observed behaviour relevant to specific functional areas is given in the section on functional categories.

### **Clinical findings**

22. Clinical findings are entered next. They should be expressed simply and clearly and in non-technical terms. Ideally, they should be set out in a way which reflects the recommended approach to clinical examination, setting out inspection, with particular regard to muscle wasting; the results of palpation and auscultation if appropriate; PEFr where indicated, and the range of movement of joints, expressed as a percentage of normal. Such factors as power and reflexes should be addressed and the degree to which these findings depart from the normal should be explained.

## 8. The Medical Assessment (The Personal Capability Assessment)

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For example:

"Lumbar spine: forward flexion to half normal level; lateral flexion full on R but half normal level on L. Straight leg raise 90° (normal) on R but only 45° on L".

"Peak flow rate today 350 L/min, which is normal for a lady of her age."

23. **It is essential then to comment on and interpret the clinical findings.** You should say whether they are in keeping with the diagnosis, the stage of the disease, and most importantly, the disability and descriptor which the client claims. For example:

" These signs show that the client has severe back problems consistent with his chosen descriptor."

or

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

24. In clients who are unwilling, or unable to give a clear account of their day-to-day activities, the clinical examination and your comments thereon will form an important part of the evidence for the Decision Maker, and along with observed behaviour will form the basis for your own choice of descriptor.
25. Where the client refuses to give a history or declines to be appropriately examined, this must be recorded, together with any reason given by the client.

## 8. The Medical Assessment (The Personal Capability Assessment)

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### Summary of functional ability

26. This section should be used to provide the Decision Maker with a summary of the client's functional ability and therefore help justify your choice of descriptors. It is important to:
- highlight and explain any inconsistencies between the client's account of his disability and the medical evidence.
  - address the issues of variability, repeatability and fatigue particularly where the client suffers from a condition where such factors play an important part.
  - clarify the medical basis for your choice of descriptors.

### Cross - reference

27. 14 functional categories cover disability in physical and sensory areas. The first six functional areas (sitting; rising from sitting; standing; walking; walking up and down stairs; and bending and kneeling) are activities which predominantly involve conditions of the lumbar spine and lower limbs. The next three categories (reaching; lifting and carrying; and manual dexterity) are activities which predominantly involve the upper spine and the arms/hands. Some of the information obtained during interview and examination of the client will be relevant to more than one functional 'group' within the back/lower limb or neck/upper limb group, so it is logical to cross refer entries on the IB85 report within these groups, provided the evidence is relevant to the function.
28. **Details of variation/fluctuation, pain etc, and details of clinical evidence can be cross referred**, although it is usually necessary to add a sentence to render the account more specific to that function. For example, the main detail of back pain may be given for "sitting". When completing the page for the "walking group", refer to the "sitting group" page and add a comment about how the pain affects walking.
29. **However, details of the typical day and general observations at the examination centre are**

## 8. The Medical Assessment (The Personal Capability Assessment)

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**very function-related and do not lend themselves to referral across any of the categories.**

For example, the fact that the client sits comfortable through a 40 minute television programme is relevant to "sitting" but not to any other category.

### Efficient use of Time in the IB Examination

1. Thorough preparation prior to the commencement of the Personal Capability Assessment examination can save a great deal of time. You should identify the affected functions, including mental health if appropriate, and concentrate on those aspects of the history, typical day, and clinical examination which provide a firm ground for your advice and your choice of descriptors in these areas.
2. If it is evident early on that there is a mental health problem, the typical day enquiry should include areas encompassing the four areas of the Mental Health assessment. This will avoid "starting afresh" at the end of the physical component of the Personal Capability Assessment to enquire about the mental health topics.
3. Keep the account of past medical history to a **minimum**. It is rarely of interest to the Decision Maker and seldom adds value to the report.
4. If the client has considerable disabilities and you have chosen high descriptors in a number of areas, it is sensible to keep the remainder of the Incapacity Report concise. Having detailed well the evidence in one functional area, it is only necessary to give succinct and relevant details elsewhere.
5. Similarly, if it becomes evident during the assessment that a non-functional descriptor applies, and can be fully justified, you do not need to give lengthy details in justifying your choice of descriptors in the functional areas.
6. It may occasionally become apparent that a client falls into an exempt category. If this is the case, follow the procedure in the section on Exempt Conditions.

## 9. Functional Categories

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### Introduction

1. The 14 functional categories cover disability in physical and sensory areas.
2. The first six categories (sitting; rising from sitting; standing; walking; walking up and down stairs; bending and kneeling) are activities which predominantly involve the spine and lower limbs.
3. The next three categories (reaching; lifting and carrying; manual dexterity) are activities which predominantly involve the cervical spine and upper limbs.
4. For each functional category you must choose a descriptor, then provide all the necessary evidence which will make clear to the Decision Maker the facts on which your choice is based. If your choice of descriptor is different from the client's the Decision Maker needs to understand clearly why your choice is appropriate and the client's is not.
5. This section looks in detail at each functional category and at the meaning of the descriptors. It gives advice on the specific points in the typical day and observed behaviour which are relevant to the particular functional category, and which can be used to justify your choice of descriptor in that category.
6. Remember also to take into account the effects of variability, etc. These have been fully detailed in the section on completion of the Incapacity Report, and are not repeated here, but an appropriate entry must always be made.
7. Remember that in some instances it can be appropriate to cross-reference data relating to variability etc, and to clinical examination findings, but data relating to the typical day and observed behaviour are "function - specific".

## 9. Functional Categories

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### **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

## 9. Functional Categories

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involving the lumbar spine, hip joints and related musculature. Reported limitations for reasons other than these require thorough exploration and strongly supported evidence.

### Details of daily living

4. Consider the client's ability in relation to:-
  - watching television (for how long at a time and type of chair)
  - other leisure or social activities, eg listening to the radio, using a computer, sitting in a friend's house, pub or restaurant, reading, knitting
  - consider for how long the client 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.

### Observed behaviour

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

## 9. Functional Categories

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6. Referring to a case involving the Personal Capability Assessment activity of 'sitting' a Commissioner (CSIB/12/96) has stated that the doctor should make it clear how he has reached his conclusion especially if he does not see the person performing the activity. Where the examining doctor has not observed the client sitting in an upright chair with no arms, the doctor must set out carefully why they have reached their stated conclusion. For example:

'The client 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.'

## 9. Functional Categories

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

### Descriptors

- 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 Personal Capability Assessment 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; and

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

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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. Observe the client's ability to rise from sitting and note the type of chair when they are collected from the waiting area. There is a further opportunity to observe this function following the interview.

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**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 client requiring 2 walking sticks 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

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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

3. Relevant activities are:

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

You must comment on the length of time for which the client stands during any such activities.

### Observed behaviour

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

"I observed him standing for 3 minutes only during my examination of his spine but he exhibited no distress and this, in conjunction with my clinical examination recorded below, would not be consistent with his stated inability to stand for less than 30 minutes. He may need to move around to work his spinal muscles but would not need to sit down."

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

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**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 swing through on crutches do not fulfil this definition, and therefore fall within descriptor W(a).
2. On estimating the distances over which a client can walk you should not take account of brief pauses made out of choice rather than necessity. The end point is when the client can reasonably proceed no further because of substantial pain, discomfort, or distress.

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3. **Walking ability may also be restricted by limited exercise tolerance** as a result of respiratory or cardiovascular disease. Note any restrictions due to breathlessness or angina, as well as any relevant musculoskeletal problems. The choice of descriptor must be 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 your medical report.

### Details of activities of daily living

5. Consider the client's ability in relation to:
  - mobility around the home
  - shopping trips, exercising pets.

Include details of distances and how long it takes to walk a given distance; does the client need to stop, and if so how often, and for how long?

6. The method of travel to the Examination Centre is relevant. You are likely, from local knowledge, to know the distance from the bus station etc. Record the time taken, the number of rests required, and the lengths of the rest periods.
7. 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.

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### Observed behaviour

8. Observe the client walking from the waiting area to the examination room, and note the gait, pace and any problem with balance. If appropriate look for evidence of breathlessness as a result of walking. **Clients who are clearly breathless walking within the examination centre require very careful assessment including consideration about whether they should be exempt the test on the grounds of a progressive impairment of cardio-respiratory function which severely and persistently limits exercise tolerance.**
9. Note the use of any aids eg walking stick, and whether the use was appropriate. 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 must 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 must be taken into account when choosing a descriptor.

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12. Peak flow may be measured, if appropriate, and the recorded measure interpreted for the DM, 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."

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### 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.

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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 handicap severe enough to make it necessary for them to hold on to a stair rail would satisfy a visual descriptor at or above 15 points (eg cannot see the shape of furniture in a room). Thus such people would satisfy the Personal Capability Assessment 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 client sleep upstairs or downstairs?
7. If the home has no stairs, consider how the client copes in friends' homes and in shops or other public buildings. Consider how the client copes getting on and off public transport.

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### 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 client's ability to climb on and off the couch unaided, including the use of a footstool if relevant, should be noted.

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### **BENDING AND/OR 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.

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### Details of activities of daily living

5. Relevant activities include:
  - dressing and undressing especially footwear
  - 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. Record general mobility. While it is not appropriate to directly observe the client undressing/dressing note the time taken and any help requested with certain items of clothing particularly shoes.
  
8. Note the client's ability to climb on and off the couch.
  
9. It may be possible to observe the client pick up an item such as a handbag or shopping bag from the floor of the examination room.

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### 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 client's ability to reach upwards and outwards, not downwards. It is an evaluation of power, coordination and joint mobility in the upper limbs.
2. Consider only the ability to achieve the described reaching posture and do not measure hand function, i.e. it is not necessary for the client 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.

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4. Descriptors RS(e) and RS(f) should only be applied when the client 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. 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. 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. Record any spontaneous movements of the upper limbs, particularly if these are in excess of those elicited by formal examination.
9. Consider the speed and efficiency of dressing/undressing. Apart from the removal of outdoor clothes there will usually be no direct observation of the client dressing or undressing. However you should look for evidence of protecting a painful shoulder during any observed activity.
- 10 The client may hang up a coat or a jacket allowing observation of shoulder and upper limb action.

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### Examination

11. Ensure that the examination clarifies whether the disability is unilateral or bilateral. If unilateral, state which side is affected and chart the normality in the opposite limb. 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.

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### 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<sup>e</sup> and MH<sup>f</sup> can only ever be applied when the client is unable to lift and carry with one hand (ie either the right or the left) but is capable of doing so with the other

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hand.

3. All the loads are light and are therefore unlikely to have much impact on spinal problems. However, due consideration should be given 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 client may record their disability in a way which does not correspond with any descriptor. For example the client 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 MHe.)

### **Details of activities of Daily Living**

5. In order to get a measure of what the client 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**

8. Watch for hand, arm and head gestures. Note the ease (or otherwise) with any coat or jacket is removed and replaced.
9. The client may hang up a coat or a jacket allowing observation of shoulder joint and arm action.
10. The client may lift their handbag or shopping bag several times during the interview process.

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11. 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.

## 9. Functional Categories

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### 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 Personal Capability Assessment 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.

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3. Descriptor D<sup>a</sup> "Cannot use a pen or pencil" - Social Security Commissioner's have held (Ref - CIS/50/97 [CIB/16237/96] ) that 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 client's literacy. The Decision Maker will need to consider the speed and reliability with which the activity is performed and the doctor should provide sufficient evidence for the DM to consider this issue fully.

On the same descriptor a Commissioner (CSIS/17/96 (\*26/97) has said

"...the question of the use of a pen...has to be determined in the light of reasonableness and some regularity".

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 client 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." or*

*"Client 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*

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*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. 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 client whose right-arm is in a plaster cast and can only complete tasks by supporting with the left arm.
6. "Either" hand in D<sub>a</sub> D<sub>b</sub> D<sub>c</sub> 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, eg 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.

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### Details of Activities of daily living

9. Consider activities such as:
  - 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. Preserve the balance of the client's privacy with your need to record observed behaviour.
12. If the client has laced shoes and you know they unlaced them then it is reasonable to record they have achieved this even though you have not formally observed it, by stating something like " Although not directly observed, the client was noted to have unlaced his shoes whilst undressing for examination and subsequently to have relaced them after the examination had been concluded ". This is especially so if they were able to undress/dress speedily without assistance.
13. You may have the opportunity to observe how the client handles tablet bottles.

### Examination

14. In addition to the examination of the upper limbs as subsequently described, always inspect the hands carefully and document any evidence of ingrained dirt or callosities, indicating the

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possibility of recent heavy domestic/manual work.

15. Test grip and the ability to perform pincer movements and opposition of the thumb.
16. Indicate whether the problem is unilateral or bilateral.
17. Where the problem is unilateral, record which side has the disability and report succinctly on the normality of the "good" limb.
18. In view of the complexity of a hand/wrist examination provide a simply worded summary particularly if your descriptor choice is at variance with that of the client 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 your descriptor choice. The following summary of your clinical findings would assist the Decision Maker:*

*"He has thickening of the tissues in the palms of both hands which is beginning to pull the ring and little fingers in towards the palm. However, he retains an effective range of fine finger movements and has unimpaired grip in both hands."*

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### 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 is contained in the "vision" section of IB50.
6. Normal vision is taken as visual acuity of 6/6 at a distance of 6 metres from the Snellen chart.

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7. Uniocular vision which is eg 6/ 9 means in the context of the Personal Capability Assessment that there is no problem with vision.
8. 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

9. Consider activities such as:
  - filling in forms
  - reading newspapers or magazines
  - helping children with homework or reading bedtime stories.
10. Consider also leisure activities, in particular participatory sports such as snooker or darts; and activities which require good vision such as knitting or sewing.
11. Consider whether the client 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.

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### Observed behaviour

12. Ask the client how they got to the examination centre, and how they found their way about within the centre. Note whether the client needed to be accompanied by another person.
13. Also note any observed ability when dealing with belts and buttons.

### Examination

14. Record the aided binocular vision, and explain the significance of this to the *Decision Maker*.
15. It may be appropriate to perform fundoscopy and do visual field testing, but again explaining the significance of any abnormality found is of importance.
16. If the client forgets their spectacles but there is evidence from the typical day activities and behaviour observed that there is no significant disability with vision, then this should be reflected in your descriptor choice. In these cases or in cases where the VA is poor but you think it could improve with correction measure it using a pinhole. Only in exceptional circumstances should a client be recalled to have their eyesight tested with spectacles worn.

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### **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 client wearing and using whatever aids they normally wear. The possibility that protective clothing worn at work might prevent use of an aid should not be considered.
2. The test is whether the client can hear and understand speech in a language and accent which is familiar to them.
3. Descriptor H(b) is intended for the client 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 eg with a binaural hearing threshold above 90db.

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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 client could hold such a conversation under these circumstances, or whether hearing is so diminished that background traffic noise would render conversation impossible.
5. Detail whether deafness is unilateral or bilateral as stated by the client, and how it affects them.
6. State the client's ability to wear a hearing aid. If the client has rejected the prescribed hearing aid then state the reason why. Bear in mind that a client who has been inconvenienced by a hearing aid and has abandoned it should be assessed without aids.
7. People with bilateral hearing loss with an average loss of less than 30Db do not usually gain from any form of hearing aid as the small amplification needed creates distortion of sound. Hearing aids function by amplifying sounds, but they cannot help with the processing of sound. For this reason conductive hearing loss is more likely to be helped with an aid than sensorineural hearing loss. For the same reason, hearing loss which is evenly distributed throughout the frequencies is more amenable to hearing aid use. Where the hearing loss varies over the frequencies an aid can create sound distortion and discomfort.
8. Older clients 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.

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### Details of activities of daily living

10. Significant deafness is such a disadvantage that the client 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 eg going to the cinema or theatre, playing bridge or bingo.
11. 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 client's response to an ordinary or quiet voice during interview is a good measure of their ability to hear.
13. Very deaf clients often fail to respond to their call in the waiting area; bring a companion with them to assist them with communication; or function poorly at the interview requiring you to raise your voice and repeat questions.

### Examination

14. The most relevant examination technique is the conversational and whispered voice test. One ear is masked with the client's hand and the client looks away from the examiner. The client 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 Personal Capability Assessment incapacity test.

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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 Personal Capability Assessment assessment.
19. The use of hearing aids can, by recruitment of background noises, help to mask tinnitus. Clients 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.

## 9. Functional Categories

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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. Consider applying the Mental Health test in cases of tinnitus where there is cognitive impairment or other mental disablement, such as anxiety.

### **MENIERE'S 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 Personal Capability Assessment, 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 Meniere's disease should be fully taken into account when choosing physical descriptors (ie the activity must be performed safely, reliably and repeatedly).
26. Remember to take into account any side-effects of medication.

## 9. Functional Categories

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### 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 client's speech?
- Can strangers understand the client's speech?

The question is whether, **ignoring language and accent**, the client could convey a message:

- to people who know them
- to strangers who do not.

## 9. Functional Categories

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2. Note that the term "strangers" means persons who do not know the client, 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. You should consider 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 client asserts that speech becomes unclear when they are tired. A similar claim may be made by clients suffering from panic attacks, who describe difficulty in making themselves understood during an episode of acute anxiety. Consider carefully whether such clients should be assessed under the Mental Health Assessment.
6. Some clients 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 client is breathless at rest, you will need to consider advising exemption.

## 9. Functional Categories

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### Details of activities of daily living

7. Consider:

- 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. Describe the quality of speech at interview and any difficulty you have in understanding the client. Note any abnormalities of the mouth and larynx and their effects on speech.

## 9. Functional Categories

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### **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 client is normally awake, and which prevents the client from safely continuing with any activity. Fits when the client 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.

## 9. Functional Categories

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2. In the context of PCA, the most likely causes of such episodes are:
  - grand mal (classical) epilepsy
  - a seizure which is secondary to impairment of cerebral circulation (eg 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.

## 9. Functional Categories

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6. **Giddiness, dizziness, and vertigo**, in the absence of an epileptic or similar seizure, do not amount to a state of "altered consciousness". These conditions are therefore not taken into account when assessing the functional area of remaining conscious. If they affect functional ability in other categories, they should be taken into account when considering the relevant activity categories.

### **Migraine**

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 to consider whether a client's claimed frequency of seizures is medically reasonable. For example, if there is no corroborative evidence from the GP and the client is not on any appropriate medication, this would raise doubts as to the claim of frequent episodes of lost consciousness.

## 9. Functional Categories

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### Details of activities of daily living

11. Consider:

- whether the person drives - the DVLC will refuse to issue a licence to anyone who has had a daytime fit in the past year.
- potentially hazardous domestic activities such as cooking
- recreational activities eg swimming, contact sports.

## 9. Functional Categories

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### 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 client 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.

## 9. Functional Categories

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3. 'No voluntary control' includes situations where there is no useful control eg. Continual dribbling incontinence of urine. Social Security Commissioners (Ref - CSIB/74/96) have stated 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, another Commissioner (Ref - C11/96(IB)NI) has held that those clients who have an ileostomy must be held to have 'no voluntary control' over their bowels. The Commissioner argued that the 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 client 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. Clients 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

## 9. Functional Categories

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time.

8. In situations where a client has problems of control with both the bladder and the bowels the highest descriptor should be applied, e.g. in a client 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 Personal Capability Assessment does not allow for the selection of two descriptors in one functional category.

## 9. Functional Categories

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9. The following Algorithm may be helpful when choosing continence descriptors:

Does the client have voluntary control\* of the bowels/ bladder?

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

if YES - does the client loose 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'.

## 9. Functional Categories

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### Details of activities of daily living

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

- shopping trips
- visits to friends or relatives
- other social outings

and any problems encountered in undertaking these activities.

## 10. Examination of the Musculo-Skeletal System

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### Introduction

1. This section deals with the formal clinical examination of the cervical, thoracic and lumbar spine, and the upper and lower limbs, in the context of the medical assessment for state Incapacity Benefit.
  
2. The back and lower limbs are relevant to the functional areas of:
  - sitting
  
  - rising from sitting
  
  - standing
  
  - walking
  
  - walking up and down stairs
  
  - bending and kneeling.
  
3. The cervical spine and upper limbs are relevant to the functional areas of:
  - lifting and carrying
  
  - reaching
  
  - manual dexterity.

## 10. Examination of the Musculo-Skeletal System

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### General Principles of Examination

4. Remember that the clinical examination is only part of the IB assessment; clinical findings together with the interview and observation of the client build up a picture of objective evidence to support your choice of a descriptor, especially if your choice is different from that of the client.
5. It is essential to explain to the client the nature of the examination which is to be performed.
6. It is essential to avoid undue discomfort to the client;
  - ask the client to indicate the site of the pain before palpating
  - as far as possible, observe active movements only, instructing the client not to perform or continue a movement if it becomes painful
  - if it is necessary to assess passive movements, do so after observation of active movements as giving an indication of the point at which discomfort is experienced.

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

7. When examining the limbs, always examine the whole limb and not just the joint involved. Always compare the affected limb with the normal one.
8. Remember to record the findings in language that the *Decision Maker* will easily understand, ie. do not use medical jargon and explain any medical terms used.
9. The examination should follow the standard clinical pattern of inspection, palpation, joint movements, muscle power, sensation and reflexes. The following notes should be read in conjunction with any appropriate Medical Services examination protocol.

## 10. Examination of the Musculo-Skeletal System

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### Inspection

10. Observe any lack of symmetry and any evidence of trauma or disease. Look for muscle wasting; when assessing the cervical spine and upper limbs, look also for any evidence of muscle wasting of the scapular muscles. Inspect the joint contours and observe any evidence of swelling, deformity or inflammation.
11. Ask the client to point to, or otherwise identify, any painful areas, including sites of radiation of pain.
12. For accurate assessment of muscle wasting in the upper limbs, compare the circumference of the two limbs as follows:  
  
Upper arm: 15cm above the lateral epicondyle  
Forearm: 10cm below the lateral epicondyle
13. For the lower limb, the corresponding measurements are:  
  
Thigh: 15cm above knee joint (most easily measured from medial joint space)  
Calf: 15cm below knee joint

### Palpation

14. Ask the client to identify any tender sites before palpating. Palpate joints for any thickening, tenderness, or crepitus of the joints or tendon sheaths.

## 10. Examination of the Musculo-Skeletal System

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### Joint Movements

3. See below for details of the normal ranges of joint movement and the appropriate methods of assessing these.
16. Bear in mind that a client may purposefully limit the range of active movement at a joint.

### Muscle Power

17. Compare the muscle strength in the affected and normal limb. When assessing muscle strength in the upper limbs, a comparison can also be made with your muscle strength, bearing in mind any expected differences due to a difference in age or gender between yourself and the client.

### Sensation

18. In disorders of the musculoskeletal system, remember that lost or altered sensation will almost always follow a dermatome pattern. **Never** use a pin or similar sharp object when testing sensation. Test for light touch using a fingertip, a wisp of cotton wool, or a blunt object such as the point of a pencil or a paper clip.

### Reflexes

19. Remember that the joint in question must be in a relaxed position. In the upper limbs, the biceps and triceps reflexes are assessed with the elbow flexed to 90°. In the lower limbs, the easiest way of assessing the knee reflex is with the client lying on the couch, knees slightly flexed and supported on your forearm. The easiest way to assess the ankle reflex is probably to invite the client to kneel on a chair. An alternative is to ask the client to sit on the couch with their legs dangling.

## 10. Examination of the Musculo-Skeletal System

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### Inappropriate Signs

20. Remember that psychological factors may influence the clinical picture presented by the client. The client's behaviour whether conscious or unconscious may thus complicate the interpretation of physical signs. Behaviour by the client which is subconscious should not be construed as a deliberate attempt to deceive or be obstructive.
21. However, there may be instances where a client is apparently deliberately refusing to co-operate or may be consciously seeking to exaggerate the extent of their disability.
22. Signs which are inconsistent with purely organic pathology include:
  - Apparent muscle weakness without wasting or disturbance of reflexes.
  - Regional sensory loss which does not follow any recognised dermatome when testing for nerve root compression.
  - Overreaction to examination.
  - Diffuse rather than localised tenderness.
  - Spinal movements which are reduced equally in all directions. Degenerative disease of the lumbar and lower thoracic vertebrae/intervertebral discs limits forward flexion and extension but rarely affects lateral flexion or rotation. Inflammatory disease (e.g ankylosing spondylitis) on the other hand, limits lateral flexion and rotation but not forward flexion or extension. Equal limitation in all planes of movement suggests purposeful exaggeration of disability.

## 10. Examination of the Musculo-Skeletal System

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- SLR reduced on active testing, but the client is able to sit up on the couch with knees extended.
  - Jerky active movements.
  - Refusal to co-operate with active movements of a joint, or lack of any serious attempt to move a joint, or voluntary resistance of passive movements.
22. If your assessment is that the examination findings are not consistent with the stated degree of functional disability, or that the client was deliberately not fully cooperating with the examination, this should be clearly indicated to the *Decision Maker*.
23. Negative clinical findings can also be used to justify your choice of descriptor, eg:
- "The lower spine and legs are clinically normal and this is not consistent with the reported inability to sit for more than 30 minutes"

### Normal Range of Joint Movements

24. Note: Where movements are quoted in degrees, zero is taken as the normal anatomical position of rest.

## 10. Examination of the Musculo-Skeletal System

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### Lumbar Spine

25. The movements to be considered here are:

- forward flexion
- extension
- lateral flexion
- rotation.

For the purposes of IB assessment, the fingertip to floor distance gives a reasonable assessment of forward flexion; a person with no back problems should get to within 30cm (12") of the floor.

26. Extension can normally be accomplished to 30° from the vertical.

27. Lateral flexion is tested by asking the client to slide each hand alternately down towards the knee; normally the popliteal crease can be reached.

## 10. Examination of the Musculo-Skeletal System

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28. Rotation measures the relationship between the plane of the shoulders and that of the pelvis. Normally 40° can be achieved. This mainly reflects function of the thoracic spine, with only a small amount from the lumbar spine.
29. Remember that it is clinically unlikely for spinal movement to be limited in all directions (see section on "Inappropriate Signs").
30. Straight leg raise is tested with the client lying on the couch, by asking the client to raise each leg in turn from the couch as far as can be achieved without pain. Limited straight leg raising indicates sciatic nerve root pressure, resulting in pain when the nerve is stretched. Dorsiflexion of the ankle will worsen the discomfort; plantarflexion will lessen it. This can be assessed by asking the client to flex their ankle while the leg is raised. An appropriate reaction to plantar/dorsiflexion will help to exclude any apparent inconsistency.
31. An alternative way of testing sciatic nerve stretch is to ask the client to slump forward in a chair with both legs extended. This manoeuvre stretches the nerve and consistency can again be checked by asking the client to plantar/dorsiflex the ankles.
32. Femoral nerve root irritation is assessed by asking the client to lie prone on the couch and flex first one knee, then the other.

### Lower Limb

33. Hip, knee and ankle movements are tested with the client lying on the couch.

## 10. Examination of the Musculo-Skeletal System

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34. For the hip, flexion, extension, abduction, adduction, internal and external rotation are assessed. The normal ranges are:

- Flexion  $130^{\circ}$
- Extension  $10^{\circ}$
- Abduction  $50^{\circ}$
- Adduction  $25^{\circ}$
- External rotation  $35^{\circ}$
- Internal rotation  $45^{\circ}$

External and internal rotation are most easily measured with the hip and knee flexed to  $90^{\circ}$ , and the lower leg used as a "pointer" to determine the angle.

35. In the knee joint, flexion and extension are assessed:

- Flexion  $150^{\circ}$
- Extension  $5^{\circ}$

36. For the ankle joint, plantarflexion and dorsiflexion are assessed:

- Plantarflexion  $40^{\circ}$
- Dorsiflexion  $25^{\circ}$

## 10. Examination of the Musculo-Skeletal System

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### Cervical Spine

37. Cervical pain can be referred to the shoulders and scapular regions and cause impaired function in the upper limbs. For this reason no examination of the neck is complete without a check of the shoulders and a basic neurological check of the upper limbs.
38. Examination of the cervical spine can be carried out with the client either standing or sitting. The movements to be assessed are flexion, extension, lateral flexion and rotation. Lateral flexion is measured by asking the client to bend the neck to either side, rotation is measured by asking the client to turn the head to either side, whilst keeping the shoulders still.
39. The normal ranges of movement are:
- Forward flexion  $40^{\circ}$
  - Extension  $40^{\circ}$
  - Lateral flexion  $40^{\circ}$
  - Rotation  $60^{\circ}$

### Upper Limbs

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

## 10. Examination of the Musculo-Skeletal System

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### Shoulder Joint

41. Shoulder movements are flexion and extension, abduction and adduction, and internal and external rotation. The following sequence can be used to show shoulder movements: clap hands at full reach above the head to show abduction; touch fingers at back of neck to show abduction and external rotation; reach up the back with fingers to show adduction and internal rotation.
42. The normal ranges of shoulder joint movement are:
- Forward flexion  $160^{\circ}$
  - Extension  $40^{\circ}$
  - Abduction  $180^{\circ}$
  - Adduction  $40^{\circ}$
  - External rotation  $60^{\circ}$
  - Internal rotation  $95^{\circ}$

### Elbows

43. Elbow movements include flexion and extension, pronation and supination. For the latter two movements, the neutral position is with the elbow flexed to  $90^{\circ}$ , with the thumb uppermost.

## 10. Examination of the Musculo-Skeletal System

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44. The normal ranges of movement are:

- Flexion  $150^{\circ}$
- Extension  $5^{\circ}$
- Pronation (palm downwards)  $80^{\circ}$
- Supination (palm upwards)  $85^{\circ}$

### Wrist

45. The neutral position for the wrist is with the palm down and the hand in line with the forearm. The movements to be assessed are dorsiflexion, palmarflexion, radial and ulnar deviation. The normal ranges are:

- Dorsiflexion  $70^{\circ}$
- Palmarflexion  $70^{\circ}$
- Radial deviation  $20^{\circ}$
- Ulnar deviation  $45^{\circ}$

## 10. Examination of the Musculo-Skeletal System

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### Hands

46. The neutral position for the hand is with the fingers in extension and the thumb alongside the index finger. The normal ranges of movement are:
- Adduction/abduction between each finger  $20^{\circ}$
  - Flexion at proximal interphalangeal joint  $100^{\circ}$
  - Flexion at distal interphalangeal (DIP) joint  $80^{\circ}$
  - Extension at DIP joint  $10^{\circ}$
  - Flexion at metacarpophalangeal(MCP) joint  $90^{\circ}$
  - Extension at MCP joint  $45^{\circ}$
47. For the thumb the ranges are:
- Abduction  $60^{\circ}$
  - Flexion at IP joint  $80^{\circ}$
  - Flexion at MCP joint  $50^{\circ}$
  - Flexion at carpometacarpal joint  $15^{\circ}$
48. In addition, assessment of hand function should also include a test of grip strength and the ability to oppose the thumb across the palm of the hand towards the little finger, and to touch the thumb to each fingertip.

## 11. The Mental Health Assessment

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### Introduction

1. All clients who are affected by a mental health incapacity will normally have their case referred to an approved doctor for advice before a questionnaire is issued. Further evidence will have been sought from the certifying doctor on Form IB 113. The approved doctor will offer advice to the *Decision Maker* to identify those clients who have a severe mental health problem.
2. Severe mental illness is defined in legislation for state incapacity benefits as:

"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".
3. Clients who have not been identified as having a severe mental health problem will be asked to complete the IB50 questionnaire so that any physical and sensory problems may be taken into account. The questionnaire also gives the client the opportunity to give information about the effects of their mental health problems. If called for examination the client will undergo a mental health assessment and where appropriate a physical/sensory assessment. A client may qualify for a state incapacity benefit on the basis of limitation in mental health functions alone or on the basis of combined mental and physical / sensory impairments.

## 11. The Mental Health Assessment

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4. There are four areas of activity in the assessment of the effects of mental health problems:
- daily living
  - completion of tasks
  - coping with pressure
  - interaction with other people.
5. For each of these activities there is a set of statements. Unlike descriptors for the assessment of physical and sensory functions, these statements are not ranked. Rather, each set 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 statements:
- cannot look after himself without help from others
  - gets upset by ordinary events and it results in disruptive behaviour 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
  - is too frightened to go out alone.
6. Each of these statements has been assigned a points score. The points total for each activity is the sum of points attached to all the statements which apply to the client. The mental health statements are not currently part of the questionnaire which the client completes.

## **11. The Mental Health Assessment**

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7. Where a client is receiving treatment for a psychiatric condition, further evidence will have been sought from the certifying doctor.

### **When to apply the Mental Health Assessment**

8. Clients who meet the criteria for a severe mental illness are exempt from the Personal Capability Assessment, including the mental assessment. You must complete a mental health assessment for all other cases where the client is suffering from a specific mental illness or disablement. In addition the mental health assessment should be applied to a client:
- taking any medication which impairs cognitive function to a degree which causes mental disablement.
  - who has an alcohol/drug dependency problem which has resulted in mental illness or disablement.
  - who has certain physical or sensory disabilities which have produced mental disablement by impairing cognition and/or mental function e.g tinnitus
  - who has mild/moderate learning disability
  - where a previously unidentified mild or moderate mental health illness or disability is discovered during medical assessment.

Commissioners have ruled that the mental health descriptors must be applied only where there is mental disablement rather than a mere disturbance of mood (CIB14202/96\*).

9. The mental health assessment should not be applied where:
- the normal emotional response to a client's physical condition leads to the client being 'fed up' with the condition. The mental health assessment should only be applied where

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## 11. The Mental Health Assessment

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there is an **abnormal** psychological response to a physical condition, **which significantly affects or adds to the overall disablement.**

- the client indicated either during the interview or on the questionnaire that they have a mental health problem but in your opinion there is no clinical evidence of this. **You must be able to fully justify this opinion**, and to explain to the *Decision Maker* your reasons for not applying the mental health assessment.

11. If you decide not to apply the mental health assessment, you should explain why in the following terms:

"I have considered whether this client has a specific mental disease or disablement. I have not applied the mental health descriptors because:

- there is no recent history of a specific mental illness having been diagnosed or treated; and
- there is no medical evidence before me, nor any clinical findings of mental disease or disablement".

You must justify your reasons for giving this advice in your report to the *Decision Maker*.

For example:

'client states he is depressed but has not consulted his GP about this and there is no evidence of a mental illness at examination today. What he describes is a normal reaction to his condition.'

## 11. The Mental Health Assessment

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### How to apply the Mental Health Assessment

12. The mental health assessment is designed to give a composite picture of a person's mental and social abilities in relation to everyday activities.
13. Unlike the physical/sensory section where only one descriptor is appropriate in each category, the mental health assessment statements interlink over the four areas to provide a complete picture on which an opinion can be based. No question stands on its own. Appropriate and accurate answers to all the mental health descriptors are required to assess the overall effects of the mental health problem. The fact that a client scores highly on the assessment, though indicating a mental health problem, does not allow any particular diagnosis of any mental condition to be made. It is possible, of course, that there may be indications of a specific mental condition, but it is the effect of the condition, not the diagnosis, which is of relevance to the IB legislation.
14. The Mental Health questions are completed on the basis of the client's responses during the interview, your assessment of the mental health condition and your knowledge of the likely effects of the condition. **All questions** in each section must be answered with a 'yes' or 'no' response, and you must give a clinical opinion justifying each answer.
15. **Only the effects of the client's mental disease or disablement must be taken into account in completing the assessment.** Do not justify your response with reasons due to physical causes. Literacy, visual acuity, lifting and carrying ability are frequent sources of confusion and should be discounted.
16. Clients, particularly those with less severe nervous disorders, may present stereotyped symptoms and behaviour reflecting their perception of how they expect others to see them. For a thorough assessment it is necessary to get behind this presentation. To achieve this an understanding and empathic approach is vital. This is more than just having a good 'bedside manner' and requires an open mind and a willingness to allow some time (however brief) in

## 11. The Mental Health Assessment

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order to build rapport.

17. Collecting the client from the waiting room provides an opportunity for friendly introductions and an initial assessment of their behaviour and appearance. Often the client will feel more confident and secure when accompanied by a relative or friend. Companions may, with the consent of the client, give useful information which contributes to the assessment.
18. Giving the client an opportunity to settle down and allaying fears about the assessment will often allow the interview to progress more fruitfully.
19. Initially, relevant details of the client's work, social, physical and mental history should be obtained. Record current therapy and names of therapists (to include general practitioner/psychiatrist, mental health worker).
20. **Asking direct questions, using the mental health statements as a check list, will invariably produce false results** (both positive and negative). The key to obtaining the information required is to assess the client's mental state by getting relevant information about everyday activities and experiences. You should then ask any additional questions which are needed in order to gain further detail.
21. The use of open questions is crucial when dealing with mental health problems. Examples include:
  - What do you think is wrong with you?
  - How have things changed for you?
  - How do you pass the time?
  - Tell me about your social activities

## 11. The Mental Health Assessment

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- What stops you from doing things?
  - How do you think work would alter things for you?
22. Attitudes and beliefs should be explored in order to uncover genuine fears and distress.
23. It is always better to ask "how" questions rather than "why" and to flesh out the answer with clarifying questions such as "could you give me an example of that?" This process helps the individual to give concrete examples and also gives an opportunity to answer the specific questions that are used as statements.
24. However, in certain areas one or two of the questions are of a factual nature and in these instances direct questions may be unavoidable. For example, "have there been any mishaps or accidents in the last three months?" You should not merely accept the answer when choosing this descriptor if your examination and knowledge of the mental condition/illness indicate that there is no medical reason for the mishaps.
25. While interviewing the client you should assess relevant parameters, eg.
- appearance - in relation to self-care
  - behaviour
  - mood - is there any evidence of anxiety or depression?
  - thought content
  - insight - what understanding does the client have of their condition?

## 11. The Mental Health Assessment

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### Language

26. Persons for whom English is not their mother tongue may not always be able to be interviewed in that language. Certain languages have few words to describe emotional conditions, for example there are not equivalent words in some of the Northern Indian languages to describe depression. In these circumstances metaphors are used such as "a sinking feeling" or "heart is troubled". Problems with energy, interest and concentration may be described as tiredness or malfunctions of that part of the body thought to be responsible, such as "my eyes won't read properly".

### Culture

27. In many cultures mental illness is thought to carry some disgrace or stigma. Thus the client may desire to demonstrate to the doctor that they are a good person and therefore worthy of receiving benefits. Such a person may well minimise their difficulties and thus lead to a false impression as to their incapacity. This can be discerned if the client's reply to open questions appears to indicate that there are no problems. In such cases it is important to explore details pertinent to that question before considering other areas.

### Somatisation

28. This can cause considerable problems and has a variety of causes. As indicated above language may well not be sufficiently capable of describing emotional experiences, but this is also true of people who are unsophisticated in the use of psychological language, and therefore have difficulty in expressing their problem clearly. Older people in particular tend to use physical explanations, or expressions such as "mithered" or "mardy" which do not translate effectively as "muddled" or "out of touch" but are generic expressions of mental agitation or dysfunction.

## 11. The Mental Health Assessment

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29. Depressive illness and some paranoid disorders may also present with predominantly somatic symptomatology and indeed may be the cause of unnecessary physical investigations before the true cause of the disability is identified. You will need to be alert to this possibility as some clients presenting solely for physical examination may in fact require mental assessment as well.
30. At the end of the assessment, give the client an opportunity to ask questions and explain what happens next.
31. Check that you have gathered sufficient information to be able to answer and justify all the mental health questions. Ensure if the client has received mental health treatment within the previous 3 months, that there is sufficient information on file for other relevant professionals to be contacted if necessary.

### Completion of the Mental Health Report

32. It is best practice to fully complete the mental health report after the client has left the examination room. You will be able to consider all the evidence carefully, including the client's IB 50; medical reports on file; and observations of the client and the information obtained at the interview.
33. It is vital that all the questions are answered and you enter your reasons for the answers based on the evidence gathered. It is not sufficient to enter "no problems" or "client says no" or "client denies this". Your justification is obtained from information based on the interview questioning and your observations. Read each question of the mental health section carefully, ensuring you cover all points raised by the questions.

## **11. The Mental Health Assessment**

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34. For example question DL(c) in the area of Daily Living: "Is he or she frequently distressed at some time of the day due to fluctuation of mood?": You must consider the word "frequently" and the concept of "fluctuation through the day". A commissioner has defined 'frequently' as 'a substantial or significant number of times' (CSIB 2/96).

35. In another example, in the area of Interaction with Other People: "Do mental problems impair his or her ability to communicate with other people?" (Question OP(c)): If the answer is `NO', the comment might be:

"He shops for himself, uses public transport and answered questions well at the interview today."

If the answer is `Yes', the justification could be:

"She has moderate learning difficulties. Speech somewhat retarded. Poorly developed social skills. Father answered most of the questions for her".

### **Further action**

36. Rarely a further report from the certifying doctor maybe required. This is where there is no IB 113 (or there has clearly been a deterioration in the client's condition since the IB 113 was completed) and you are unable to give advice concerning the possibility of a severe mental illness exemption or exceptional circumstances without further medical evidence.

37. Where a mental health problem has been assessed and was previously not identified, a letter should be sent to the client's general practitioner giving details of the condition. The client should be advised to see their doctor and told you are sending a report to their doctor. The degree of urgency is a matter for your clinical judgement.

## **11. The Mental Health Assessment**

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### **Cases of severe mental health problems presenting at MSEC**

38. If it becomes apparent that the client has a severe mental health problem you should consider whether they may be exempt on that basis.

**See also Chapter 12 – Paragraphs on Mental Assessment and assessment of suicide risk.**

## 12. Assessment of clients who are abusing alcohol and/or other substances

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### Overview

1. Alcoholism (or drug addiction) is taken to be a form of altered behaviour that can cause mental or physical disease [World Health Organisation]
2. For example: alcohol related disability is defined as any mental or physical harm resulting from excessive alcohol consumption due to physical dependence on alcohol. The Personal Capability Assessment and procedures assess someone with alcohol related disability as follows:

Is there excessive or uncontrolled drinking and/or physical dependence on alcohol resulting in:

- physical disease (as assessed by the physical, sensory or mental descriptors)?
- mental disease (as assessed by the mental descriptors)?
- a severe life threatening disease in relation to which there is medical evidence that it is uncontrollable or uncontrolled (Reg 27(2)(a) amended).

## 12. Assessment of clients who are abusing alcohol and/or other substances

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### Severe manifestations of alcohol abuse

3. You should be alert to the possibility of the following:
  - Cortical atrophy, resulting in failure of memory, deterioration of personality, loss of intellectual ability
  - Cerebellar degeneration causing ataxia of gait without unco-ordination of limbs, dysarthria and nystagmus
  - Physical effects of alcohol withdrawal eg. convulsions, delirium tremens
  - Disorders resulting from malnutrition
  - Alcoholic polyneuropathy: a subacute, symmetrical, painful sensorimotor neuropathy affecting the motor nerves, with distal weakness and wasting, sometimes with muscle tenderness. There may be a burning sensation in the feet; patchy loss of pain sensation; and absent ankle jerks
  - Alcoholic myopathy - acute myopathy produces muscle pain and tenderness; subacute myopathy presents with painless symmetrical proximal muscle weakness.
4. If marked physical or mental symptoms/signs relating to the abuse of alcohol or drugs are found, consider exemption under the most appropriate heading:
  - Severe mental illness; or
  - Severe and progressive neurological and muscle wasting disease; or

## 12. Assessment of clients who are abusing alcohol and/or other substances

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- Multiple effects of impairment of function of the brain or nervous system causing severe and irreversible motor, sensory and intellectual deficits.

### Functional Assessment

5. Where there is a current history of alcohol or drug abuse it will almost always be necessary to perform both physical and mental assessments. Asking the right questions in the right way will enable you to obtain the most reliable information possible regarding the use of 'drugs' and alcohol. For example, where you judge it appropriate the questioning might be:

Do you smoke? What do you smoke? How much? For how long have you done so?

Do you drink? What do you drink? Roughly how much? For how long have you done so?

Do you use any other non-prescribed drugs?

### Physical assessment

6. Where there is suspected alcohol abuse you should pay special attention to the following factors:
- diet and nutritional status
  - gastro-intestinal symptoms
  - cardio-vascular symptoms and signs (including blood pressure)
  - nervous system (including history of convulsions).
7. For those clients who are, or have recently been, injecting drugs - look for evidence of abscess,

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## 12. Assessment of clients who are abusing alcohol and/or other substances

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thrombophlebitis, gangrene. Consider infectious status including Hepatitis B, Non A - Non B Hepatitis and Human Immunodeficiency Virus.

### Mental assessment

8. It is good practice to consider and assess any underlying depression/anxiety which may be present in such clients. As a minimum, make an assessment of the following factors in order to inform your choice of descriptors:

IN Interest lost in nearly all activities because of inability to obtain pleasure from them

S Sleep disturbance, early morning waking

A Appetite and weight lost

D Dysphoric mood

C Concentration problems

A Affect

G Guilt - excessive and inappropriate

E Energy lost, inhibition of thought and drive

S Suicidal ideation.

## **12. Assessment of clients who are abusing alcohol and/or other substances**

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9. These are not easy clients to assess and it can be very difficult to develop rapport. In order to maximise the information which can be obtained from such an interview you should make a special effort to ensure that:
- there is good eye contact
  - presenting symptoms/problems are clearly established
  - the examination proceeds from open to closed questions
  - an empathic style is adopted
  - you are sensitive to verbal and non verbal clues.

### **Mental functions**

10. Assessment of the mental function in people who have an addiction problem requires an examination of the following psychiatric parameters:
- Appearance and behaviour - looking for information relating to self care
  - Speech - looking for signs of intoxication or inability to communicate
  - Mood - looking particularly for any underlying symptoms of depression or anxiety
  - Thought content - is there evidence of organic disease or underlying psychotic illness?
  - Beliefs - what is the client's view of the progress/prognosis for their condition?
  - Cognitive status - is the client alert, fully orientated and able to process information?

## 12. Assessment of clients who are abusing alcohol and/or other substances

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- Insight - what understanding does the client have of their medical condition?
- Addictive behaviour - what, and how much, substance is consumed? Over what time period has this pattern of behaviour been followed?

### **Risk factors**

11. In people who abuse alcohol or other substances risk of suicide is relatively high. The following points may should also be considered in people with moderately severe psychiatric conditions who do not meet the criteria for exemption on the grounds of severe mental illness. You should assess the client for excess risk factors including:

- Intense feelings of hopelessness and worthlessness
- Depression with marked sleep disturbance
- Poor physical health
- Living alone
- Male > 45 or isolated younger male
- Previous suicide attempts
- Strong family history of mental illness, suicide or alcoholism.
- Clients with a mental illness where substance abuse is not a feature may also present a risk of suicide. The degree of risk may be assessed using these same criteria as a guide.

## **12. Assessment of clients who are abusing alcohol and/or other substances**

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12. Examples of specific questions to explore suicide risk:

- Do you sometimes feel so bad that you feel you cannot take any more?
- Do you ever feel it is not worth going on?
- Have you ever thought about doing anything about it yourself?
- What have you thought of doing?
- What do you think stopped you from carrying it through?
- Would that work if you felt like that again?

Also consider these points in relation to clients where there is any history of overdose (accidental or deliberate).

### **Mental health statements**

13. In considering the choice of the mental health statements it is particularly important to assess:

- the client's ability to interact with others
- any risk or hindrance they might pose to others at work
- whether they would be able to present themselves appropriately.

## **12. Assessment of clients who are abusing alcohol and/or other substances**

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14. Information which is elicited by specific Personal Capability Assessment mental descriptors and which may discriminate between people with alcohol/drug problems who are generally unfit for all types of work includes:
- leisure activities - what is undertaken and how has this changed?
  - irritability - what factors cause irritability and what are the consequences?
  - level of underlying anxiety - how does this manifest itself ?
  - fluctuation in mood - what is the daily/weekly pattern of the person's mood?
  - ability to communicate with others - what specific problems have there been?
  - concentration - what can the person do, read, watch TV, hold conversation ?
  - daily activity - how is time occupied, how would they like it to be occupied?
  - daily pattern of alcohol consumption
  - sleep problems
  - problems which led to loss of work.

## 12. Assessment of clients who are abusing alcohol and/or other substances

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### Alcohol - Non Functional Descriptors (Exceptional Circumstances)

15. When assessing such clients you should also consider Reg 27 (2)(a) and in particular whether there is evidence of a severe life threatening disease which is uncontrolled, or uncontrollable, by any recognised therapy. In assessing whether the disease is uncontrolled it is appropriate to consider whether there is very likely to be a deterioration in health to a degree which would threaten life. Examples would be where, as a result of their alcohol consumption there was a substantial likelihood of suicide or actual evidence of severe life threatening physical disease.
16. Before considering Reg 27(2)(a) you will already have considered exemption, and have reached the conclusion that the client does not fit any of the defined exempt categories.

### Prognosis

17. In formulating advice on prognosis to the *Decision Maker* you should consider the following:
  - how much does the person accept that there is a problem?
  - what is their motivation for change taking account of medical and behaviour history?
  - whether the client is currently on stable treatment/maintenance

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### Exceptional Circumstances - Overview

1. During the development of the Personal Capability Assessment functional descriptors it became clear that there are a minority of medical conditions which would not warrant prior exemption nor be likely to produce a functional score of 15 or more, but could still render an individual unfit for work on medical grounds. To take account of these conditions, a number of **non-functional descriptors** were proposed. These are designed to cover the following situations:
  - where a previously undiagnosed potentially life threatening condition is detected at the PCA examination
  - where the individual suffers from a severe (life threatening) disease which is uncontrolled, or uncontrollable, by recognised therapy
  - where the individual is due to have a major surgical operation or other major therapeutic procedure within the next three months.
2. The precise criteria by which these conditions can be treated as exceptional circumstances, and the person may be treated as incapable of work even though they have failed the Personal Capability Assessment (test of incapacity), are set out in Regulation 27 of the Social Security (Incapacity for Work) General Regulations 1995, amended 1996. The law stipulates that before these criteria can be applied by *Decision Makers* medical evidence must be sought from a doctor 'approved' by the Secretary of State.
3. As a general principle your advice should be based upon the medical evidence before you at the end of a reasonable functional assessment. The test of "reasonableness" is that you have carried out an examination for the purpose of providing an opinion on the functional issues as set out in the relevant legislation. The examination is not intended to be a full clinical assessment for diagnostic or screening purposes. However it is very important that all the medical evidence available to you, including any from the client's own doctor or hospital, is considered before you give your advice.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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4. As with all aspects of providing advice on the extent of the client's incapacity under the Personal Capability Assessment, you are expected to apply judgement which could be supported by medical peers and is based upon a current consensus of medical knowledge and evidence.
5. During a PCA examination if it becomes clear, even at the start, that a non-functional descriptor might apply, the assessment **must** continue until enough evidence is available for the *Decision Maker* to provide a functional assessment and score the client. The Regulations provide that the *Decision Maker* must make a determination on the PCA functional descriptors listed in the Schedule to the Incapacity for Work Regulations before considering the non-functional descriptors and may only do so then if the score is below the benefit threshold as defined by those Regulations.
6. If the client is clearly severely ill and it is apparent that to continue the assessment would be unprofessional, harmful or distressing to the client, then the process should be halted. You should still complete the report as fully possible and in enough detail to allow the *Decision Maker* to decide the relevant questions.
7. A prognosis should be given in all cases. Where the prognosis for the non-functional element differs from that for the overall functional 'score' the difference should be explained. Advice on prognosis should always be justified with reference to the evidence on which you have based your opinion.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### Reg 27 (2) (a) - Uncontrolled or uncontrollable disease

- . This is defined as a severe life threatening disease where -
  - (i) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure, and
  - (ii) in the case of a disease which is uncontrolled, there is a reasonable cause for it not to be controlled by a recognised therapeutic procedure
- . In order to justify applying this criterion you must be satisfied that the disease is both severe (life threatening) and is uncontrolled or uncontrollable. Every case must be considered on individual medical circumstances.
- . As a guide, the medical condition may be considered uncontrolled if a deterioration in health is very likely to occur. This may be where there would be a worsening of the condition from which recovery could only be effected by some form of further medical intervention. Severe and progressive disease which would be likely to proceed to death, but where the person may not yet meet the criteria for exemption on the grounds of terminal illness, would be covered by this category.
- . The following examples serve to illustrate some of the important principles underlying the application of this non-functional descriptor.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### Mental health

- . This is the criterion which can be applied in mental health cases if the client has recently been receiving treatment and there is evidence that their mental disease is at present uncontrolled to a degree that they might represent a substantial risk to their own life. There may be evidence from the client, their GP or treating mental health professional and from the PCA examination. The risk to the person may be through self-harm or self-neglect.
- . You need to assess all the available evidence and structure your approach to the assessment in order to identify evidence that the disease process is not satisfactorily controlled. It may be necessary to ask specific questions to explore suicide risk (see section on alcohol/substance abuse).
- . In every case where the mental health assessment is applied you should also consider carefully whether the criteria for exemption on the grounds of Severe Mental illness are met. In particular you should consider whether, as a result of their mental disease or disablement, the person's mood or behaviour is so adversely affected that:

their ability to function socially is severely restricted; or

they are very likely to pose a real threat or danger to others (such as work colleagues or members of the public).

In such cases you should consider advising that the client meets the criteria for exemption on the grounds of severe mental illness.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### Heart Disease

- . Return to work after an acute myocardial infarction, or following coronary artery bypass graft, transluminal coronary angioplasty and similar procedures is considered to be the major objective of cardiac rehabilitation in people of working age. Patients, and their families, are often anxious but the likelihood of a further life threatening event is usually very small. In particular, where a post-infarct exercise test is normal and there are no other complicating medical factors the disease process can be considered to be under control.
  
- . Where the evidence is available, the following factors should be considered when making an assessment about whether the disease is uncontrolled:
  - the presence of cardiac complications (eg heart failure, valvular disease)
  - the presence of other medical conditions (eg lung disease or peripheral vascular disease)
  - the continuing presence of exercise induced angina pectoris
  - intolerance of beta blockade
  - objective evidence of extensive myocardial damage (eg ECG changes, perfusion scan)
  - the presence of ventricular dysrhythmias
  - the results of exercise testing following a myocardial infarction.

### **13. Exceptional Circumstances (Non - Functional Descriptors)**

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#### Further examples

. Further examples include:

- malignant disease which is not in remission or currently controlled
- malignant hypertension
- severe inflammatory bowel disease (such as Crohn's disease) which is poorly controlled medically.

#### Further medical evidence at review

. Further medical evidence prior to any subsequent review would be helpful in these cases.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### **Reg 27 (2)(b) - A previously undiagnosed potentially life threatening condition**

. This category will be used infrequently since it refers entirely to medical conditions which come to light as the result of the PCA examination. Any such condition discovered must have the potential to cause death and must warrant further investigation or treatment as a matter of urgency.

. The details given in justifying your advice on this non-functional descriptor may well contain harmful information. If that is the case the harmful information must be clearly marked for the *Decision Maker*. [See also Section 16]

Examples of circumstances where this criterion may be invoked:

- the client is found at examination to have evidence of malignant hypertension with a very high blood pressure (eg > 200 systolic / > 120 diastolic), fundal changes and /or other evidence of organ damage
- an undiagnosed mass with sinister features is found on palpation of the abdomen
- the symptoms presented are strongly suggestive of malignant disease
- the client reports painless haematuria which has never before been diagnosed or investigated.

. Details of clinical findings should be made available urgently to the client's GP whom the client should be advised to consult in the near future.

### 13. Exceptional Circumstances (Non - Functional Descriptors)

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#### **Reg 27(2) (c) - the person requires a major surgical operation or other major therapeutic procedure**

The criteria for this descriptor are that: “there exists medical evidence that the person requires a major surgical operation or other major therapeutic procedure and it is likely that the operation or procedure will be carried out within three months of the date of a medical examination carried out for the purposes of the Personal Capability Assessment”. This medical evidence must include medical evidence from a doctor approved by the Secretary of State.

The intention behind this non functional descriptor is different to the other two Regulation 27 categories in that it was intended to cover people who are:

- not exempt from the Personal Capability Assessment
- not functionally limited (enough to score > 15 points), and
- for whom the other (Reg 27) non-functional descriptors do not apply;

but who were shortly to undergo a ‘major’ therapeutic procedure/operation because of a bodily or mental disease or disablement.

In other words, these are people who are fit for work at the moment but will shortly be incapacitated by major therapy. Before advising that this descriptor applies you must be reasonably satisfied that the operation or procedure is required **and it is to occur within three months of the date of your examination.**

There is no legal definition of ‘major surgical operation’ or ‘major therapeutic procedure.’ Your opinion has to be reasonable and based upon the facts relating to the individual case.

It is not possible to give a definitive list of ‘operations’ and ‘procedures’ which would medically be thought of as major since other circumstances, such as the diagnosis, the form of

### **13. Exceptional Circumstances (Non - Functional Descriptors)**

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operation and presence of any other related treatments, would reasonably need to be considered.

For example, an inguinal hernia repair in an otherwise 'fit' individual would not normally be considered a major procedure: inguinal hernias (even bilateral ones) are usually repaired as a day case or very short in-patient stay in otherwise fit people. With modern anaesthesia a patient can be mentally alert very quickly; and with modern surgical techniques for hernia repair the patient can be up and about immediately (albeit in some discomfort), can return to light work in a few days and is prohibited only from heavy lifting for about 4 weeks.

In contrast the following procedures may serve to indicate what is intended by a major operative procedure:

- an open cholecystectomy
- a major cartilage operation on the knee
- a hip replacement
- a hysterectomy.

## 14. Medical Advice on Control Action at Examination

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### PCA Incapacity Report - Advice on future outlook

#### Main points:

1. Under the PCA medical procedures 'approved' doctors are required to give advice on prognosis without reference to the outcome of the decision making process.
2. Where the client currently satisfies the PCA incapacity test, the medical advice on prognosis which 'approved' doctors provide to District Offices is often used to determine subsequent 'case control' action.
2. The DO will normally wish to re-submit a client to the PCA where there is a reasonable expectation that their function will have improved to the extent that the PCA incapacity test score would fall below the threshold for benefit payment; or the condition causing an exemption or Non functional descriptor to be applied has improved.
4. The approved doctor should provide the Secretary of State's representative with medical advice based upon their assessment of the client and their knowledge of the natural progression of the medical conditions found.
5. Where possible the doctor should advise when any disability found would be expected to significantly improve. This may be because the key functional problems are likely to have improved (with further treatment or with time); or because it would be appropriate to medically reassess the person on the basis that there is a reasonable chance that the overall medical condition will have improved significantly.
6. If there is more than one relevant functional condition, the approved doctor should aim to give the overall functional prognosis.
7. If an early improvement is expected, a short prognosis should be given.

## 14. Medical Advice on Control Action at Examination

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### Change unlikely within 18 months

8. If the medical condition is unlikely to change significantly within the limitation of the time periods (currently up to 18 months) indicated on the Incapacity Report (IB 85), but nevertheless there remains a possibility of some improvement or adaptation over a longer period of time or with further therapy, the approved doctor should provide a note to this effect on the report. In these cases the disease process and functional problems are unlikely to be of the most severe or progressive type.

For example,

a client with moderately severe osteoarthritis of the knee causing limitations in walking and standing - not currently advised to undergo joint replacement surgery but such a referral might be expected within the next 2-3 years

9. Where the approved doctor has found a substantial degree of functional or non-functional impairment resulting from a serious medical problem which is severe, chronic, and/or will inevitably deteriorate further despite optimal treatment this should be detailed on the IB 85 report . These cases will be those where your assessment indicates that functional capacity is severely and permanently reduced by the underlying medical condition. The Benefits Agency may find this information valuable when deciding which cases warrant a further review of incapacity.

For example:

a client with wide spread arthropathy where symptoms are poorly controlled by treatment;

a client with a well developed and clearly progressive neurological condition (eg Parkinson's disease, multiple sclerosis);

a client with moderate learning disability.

## 14. Medical Advice on Control Action at Examination

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### **Request for further medical evidence at Review**

10. Where there is a reasonable expectation that a condition will improve in a straightforward manner no further medical evidence should be requested for a future review (eg. a simple fracture.)
11. If the response to treatment is uncertain, or the natural history of the disease is unpredictable, further medical evidence should be requested to be obtained before any future review. This will be requested if the client's IB50 scores above the threshold, at the time of review; those physical cases scoring below the threshold will be referred straight for assessment without further medical evidence.
12. Further medical evidence on IB113 should always be requested for reviews in cases where the diagnosed cause of incapacity is a mental illness. This applies whether or not the condition has been certified as exempt on the grounds of severe mental illness.

## 15. Exceptional Situations At Medical Assessment

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1. It is important to make every effort to apply the relevant medical assessment - Own Occupation Test or Personal Capability Assessment - to every client that attends for examination.

### The uncooperative client

2. If a client arrives at a Medical Services Examination Centre (MSEC) exhibiting abnormal behaviour, suggestive either of mental illness, intoxication as a result of substance abuse, including alcohol or any other cause, you should if possible be accompanied by a Medical Examination Attendant (MEA) throughout the assessment. The MEA should be prepared to leave the room to summon assistance at all times during the assessment.
3. If the uncooperative behaviour of the client is arising from their medical condition then the report **must** be completed detailing the behaviour and applying the appropriate descriptors or exemption criteria. If a non-functional descriptor is appropriate it can only be applied **after** completion of the report by selection of descriptors.
4. There are two circumstances in which you may terminate an assessment **without completing the test**:
  - the behaviour of the client poses a threat to you or to other staff or clients
  - persistent uncooperative behaviour by the client.

Examples of situations causing either of the above may include an inappropriate and threatening attitude, or intoxication - from either alcohol or other substance abuse.

5. In such circumstances, particularly if the problem arises as a result of intoxication, consideration should be given to making a further appointment for the client, for the purpose of completing the test.

## 15. Exceptional Situations At Medical Assessment

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6. If the assessment and reports cannot be completed then you should consult an experienced MA for advice about how to complete a full and detailed account of the client's behaviour, giving the reasons for terminating the assessment. These must be recorded on the front of the IB85, continuing on an IB59 (Min) if necessary.

If an MEA is present during the interview they should countersign the statement as being an accurate record of the events.

7. Where an interview is terminated without completion of the assessment in the circumstances described at (4) above, the *Decision Maker* may wish to consider disallowance on the grounds of failure to submit to examination (SS Conts and Benefits Act 1992 171a(3)(b)). They depend on the information being comprehensive enough to support their decision if the client appeals against it.
8. If a client is threatening or abusive, for whatever cause, including as a result of illness, the appropriate Potentially Violent Situation procedures should be followed.

### **Lack of an Interpreter**

9. If a client attends for assessment and they do not speak English (or any other language which you speak) and are not accompanied by an interpreter, you should establish the client's native language and take the following action:
- If possible pass the case to a doctor who speaks the client's language to enable the assessment to continue, or
  - Find an interpreter from amongst the examination centre staff, if any, to allow the assessment to continue, or
  - If neither of the above is possible the client should be told that a fresh appointment will

## 15. Exceptional Situations At Medical Assessment

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be made when an interpreter can be present.

10. This information should be written down clearly for the client to take away for a friend or relative etc. to translate, to make sure they understand.
11. The front of the IB85 should be annotated 'initial appointment abandoned due to lack of interpreter. Client speaks ..... Further appointment to be arranged with interpreter'. You should sign and date this note.

### **Audio and video taping of examinations**

12. Should a client attend the assessment requesting permission to either audio or video tape the medical assessment you should politely refuse on the following grounds:
  - it is not possible to ensure that the full examination is recorded properly
  - facilities do not exist to produce two copies of the recording at the same time, which in the interest of natural justice must be done in order that both the client and the examining doctor can have a copy.
13. Should the client then decline to undergo an assessment a full record of the events and conversations should be recorded in a minute which you should sign. If the client is agreeable to also signing the minute as a true record of the events they should be allowed to do so. The file and accompanying minute should then be returned to the District Office.

### **Medical assessment of pregnant women**

14. Pregnancy is a normal physiological process and therefore cannot alone satisfy the medical criterion of incapacity for work due to a specific disease or bodily or mental disablement.

## 15. Exceptional Situations At Medical Assessment

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15. When appropriate a full Personal Capability Assessment examination will be carried out to assess the functional limitations due to the diagnosed cause of incapacity, regardless of whether or not it is related to the pregnancy. A pregnant client will need to be treated with considerable sensitivity at examination.
  
16. The *Decision Maker* can consider a woman to be incapable of work on any day on which because of her pregnancy there is a serious risk to her health or health of her unborn child if she did not refrain from her own occupation, or work in general as assessed under the Personal Capability Assessment, as appropriate. If an approved doctor considers such circumstances apply the *Decision Maker* should be advised.

## 16. Sensitive Information

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1. Certain information which may be encountered in benefit work is of a sensitive nature, and you should know how to deal with such information. It is conveniently categorised as:
  - Harmful information
  - Embarrassing information
  - Unauthorised information
  - Confidential information.

### Harmful Information

2. This is information which has not been disclosed to the client by their medical attendant, and of which they are unaware. It is information which would be considered as harmful to their health if divulged to them and is the **only type of information which under the regulations may be withheld from the client in the event of a review or appeal.** Examples are details of:
  - malignancy
  - progressive neurological conditions
  - major mental illness.

## **16. Sensitive Information**

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3. Try to avoid writing Harmful Information in your reports. If however it is unavoidable (as may happen if the first Non-functional Descriptor is chosen), it should be entered on the final page of the IB85 report. So you should write down the harmful information clearly identifying it as such only on the final page of the IB85 report and, if omitting an entry from the body of the report would leave a gap, write a "harmless synonym" at the relevant place. For example:

"Bronchial trouble and persistent headache".

"HARMFUL INFORMATION

True Diagnosis: Bronchial carcinoma with cerebral metastases."

4. If you encounter Harmful Information in a report prepared by another doctor you should discuss it with an experienced Medical Adviser before meeting the client.

### **Embarrassing Information**

5. This is information which could not be considered harmful to the client's health, but which may well upset or anger them and embarrass you and the Benefits Agency. Such information may not legally be withheld from the client.

Examples of this type of sensitive information include:

- criticism of treatment given elsewhere
- suspicion of malingering which you cannot substantiate
- previous criminal convictions. Mention of convictions or prison sentences may prove embarrassing or even, in the case of "spent" convictions, lead to the risk of prosecution under the Rehabilitation of Offenders Act, 1974.

6. Therefore you should not write embarrassing information in your reports. If you encounter any
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## 16. Sensitive Information

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information which you consider potentially embarrassing, and are unsure how it should be dealt with, you should seek advice from an experienced Medical Adviser.

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

### Unauthorised information

8. Unauthorised information comprises letters written from one doctor to another and forwarded to a third party without the express permission of the author of the letter. Hospital discharge letters for example are often sent along with factual reports from general practitioners. Unless the General Practitioner has first sought the permission of the author of the letter it should be regarded as unauthorised. If you encounter such information, you should take the same measures as described under Embarrassing Information.

### Confidential Information

9. Confidential Information relates to any document received in respect of a claim and marked "Confidential" or "In Confidence". Such a document cannot be used in the consideration of a case, and if one is encountered you should take the same measures as described for Embarrassing Information.
10. A client may attempt to give you information which they do not wish to have recorded on the report; that is they wish certain facts to be treated "In Confidence". It should be explained that such information cannot be taken into account as it cannot be made available to the *Decision Maker*.
11. A client may present a letter or medical report for you to read. You should accept that the client is the "owner" of the document and that the permission of the author for its use has been obtained. You should ask the client whether they wish to have the letter included in their file in

## **16. Sensitive Information**

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

## 17. Chronic Fatigue Syndrome

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1. There is a spectrum of conditions where the prominent symptoms are fatigue, both physical and psychological, which may affect both physical and psychological functioning. At one end are people whose condition is indistinguishable from that of a depressive illness. At the other are people with fatigue in the apparent absence of any readily identifiable psychiatric disorder.
2. A number of names, including post-viral fatigue syndrome and myalgic encephalomyelitis (ME), have been used to describe one of these conditions. More recently the term Chronic Fatigue Syndrome (CFS) has been universally adopted.
3. There is a range of medical opinion over the causes of CFS. This is particularly the case when considering whether CFS has a physical basis, a psychological basis or is due to a combination of factors.
4. The main symptom, as the name suggests is extreme fatigue, both physical and psychological, following even normal activity. Other common symptoms include myalgia, sleep disturbance, lack of concentration, and intolerance of light or noise. Depression is often part of the syndrome, requiring a mental health assessment to be carried out. A characteristic feature is day to day variability of severity of symptoms; **this must be taken into account during assessment.**
5. As a rule, there are no abnormal clinical signs, except in those rare cases where prolonged immobility has resulted in muscle wasting.
6. The nature of the disability is such that it is rarely, if ever, possible to give advice on the basis of documentary evidence alone. At examination, because of the absence of clinical findings, full and detailed information about activities of daily living is essential, and accurate observation of the client during the interview and examination is very important. A mental health assessment will almost always be appropriate, bearing in mind the common claim that CFS leads to poor concentration and other forms of mental disablement. You will find it quicker and easier in the long run to approach the assessment on the basis that the mental health section will

## 17. Chronic Fatigue Syndrome

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need to be completed. If you do not complete a mental health assessment you must fully explain your reasons for not doing so.

7. The approved doctor will need to be aware that there is a developing consensus on the medical management of CFS which emphasises gradually increasing activity together with cognitive behavioural therapy. However every case will depend on the precise circumstances encountered by the treating clinician.

### **Prognosis**

8. In a majority of cases the condition will eventually improve to a point where the person could resume work; this should be borne in mind when advising about prognosis.
9. Indicators of a good prognosis (as described in a report of the DSS Chief Medical Adviser's expert group on CFS) are:
  - a definite history of some acute viral illness (particularly glandular fever) at the onset and occurring on an uncomplicated psychological background
  - clinical features showing a pattern of evolution towards functional recovery
  - early diagnosis aimed at eliminating associated physical disorders and identifying psychiatric illness along with other complicating psychological or social factors
  - a management regime which encompasses physical, psychological and social elements. One which concentrates on lifestyle modification and strikes a balance between overactivity and the risks of deconditioning, and which takes a stepwise approach to achieving functional improvement.

## 17. Chronic Fatigue Syndrome

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10. Indicators of a poor prognosis are:

- onset of symptoms without any clear precipitating factor but set against a complex background of adverse psychological and social factors, or with an onset following a severe infective illness.
- clinical features characterised by severe and unremitting symptoms particularly if lasting over four years. The presence of multiple symptoms especially those suggesting somatisation.
- delayed diagnosis and especially self diagnosis where the sufferer becomes convinced of a single cause to the exclusion of all others.
- a management regime which overemphasises the importance of either complete rest or which advocates a rapid return to pre-illness levels of physical activity. One which does not recognise the need to treat such features as depressive illness or sleep disturbance.

## 18. Fibromyalgia

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1. Fibromyalgia is a term applied to a syndrome in which the commonest symptom is diffuse muscle pain, felt predominantly in the neck and back. Other symptoms are variable, and may include generalised morning stiffness, fatiguability after minimal exertion, disturbed sleep, headache, anxiety and depression. There may be dysaesthesiae of the extremities. The condition may cause significant disability such that affected people are unable to cope with ordinary domestic activities.
2. The condition is most commonly seen in women aged between 40 and 60.
3. There is a marked discrepancy between symptoms, disability, and objective clinical findings, the main finding being of widespread, symmetrical, diffuse areas of hyperalgesia and muscle tenderness. The areas of tenderness are those which in a normal person are uncomfortable to firm pressure; in a person with fibromyalgia the reaction to firm pressure is exaggerated.
4. The commonest tender site are:
  - the lower cervical and lower lumbar spine
  - the base of the skull
  - the mid-point of the upper trapezius muscle
  - the second costochondral junction
  - the lateral epicondyle of the elbow
  - the upper outer quadrant of the buttock
  - the greater trochanter of the femur

## 18. Fibromyalgia

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- the medial fat pad of the knee.
5. The cause of the condition is unknown. There is no clear evidence of a physical cause, and there may be overlap with other conditions such as Chronic Fatigue Syndrome.

## 19. The Own Occupation Test

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### Overview

1. The Own Occupation Test (OOT) applies during the first 28 weeks of incapacity to most in employment. To be considered as having recently worked for the purposes of applying this test, the client must have worked at least 16 hours per week for at least 8 of the past 21 weeks. Those working for an employer will usually receive Statutory Sick Pay (SSP) from that employer when they are too ill to perform their contractual duties. The Benefits Agency can be asked to give an opinion on the employee's capacity for their own occupation in cases of dispute. Those not entitled to SSP but fulfilling all the other criteria (eg the self employed) may be entitled to short term lower rate Incapacity Benefit.
2. The Personal Capability Assessment applies during the first 28 weeks for people who are unemployed or who have not worked for at least 16 hours per week for at least 8 of the previous 21 weeks.
3. The OOT specifically evaluates whether the client is capable of performing their own work.

### The Medical Assessment

4. The report is written on form IB84. The documents available to you will include the Decision Maker's decision regarding the client's normal occupation for the purposes of the test, and will give details of the main duties involved in carrying out this occupation. For OOT assessments the client is **not** required to complete an IB50 questionnaire.

### Completion of Form IB84

5. **Part A** of this form will have been completed by the District Office, and provides information relating to the client and their normal occupation.

## 19. The Own Occupation Test

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6. The main difference of form completion between the OOT and the Personal Capability Assessment is the client's statement which is required for the OOT Assessment, and is recorded on Part B of the IB 84. This statement **must be:**
- recorded at the time of the interview
  - in the client's own words and in the first person
  - read back to and agreed by the client
  - signed and dated by the client.

The client should be given the opportunity to amend or add any details to the statement before signing.

7. The statement should paint a "pen picture" of the client and must include details about their illness or injury, including details of treatment and any effects of the treatment. It must also include details of how the illness or injury affects the client's normal functions.
8. **Part C** of IB84 continues the statement and expands Part B by detailing a typical day; variability of symptoms; and if appropriate, information about medication, past medical history, and hospital appointments. The statement must refer to the certified caused of incapacity as stated on Med 3. It must be taken with reference to the client's occupation as detailed by the DM.
9. **Part D** of the form is for the doctor to set out the findings from the medical examination. The examination involves an assessment of the appropriate system areas in order to reach an opinion concerning incapacity. If any of the systems are irrelevant to the incapacity, they can be marked N/C (no complaints).

## 19. The Own Occupation Test

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10. **Part E** relates to the functional categories, which are the same as those used for the Personal Capability Assessment. Each functional category is completed in order to illustrate any restriction or limitation in function. Care should be taken in completing this section, not to use the descriptors detailed in the PCA Incapacity Report (IB85). For example, in completing the functional category "Walking," reference should not be made to the distances of 50, 200, 400, or 800 metres, all of which are contained in the IB85 descriptors. If there are no problems within a functional category, the box should be marked "none".
11. **Part F** of the form allows for diagnosis of the client's complaint to be given. This is a medical diagnosis and the language used should reflect that, but an explanation must be given in plain English afterwards.
12. The final part of the form is your opinion as to whether or not the client is capable of performing their normal work as stated by the *Decision Maker*. Your opinion should be based on all the information that you have gathered during the medical assessment process, and it should be consistent with the information which you have recorded. Your reasons should be given, and must be fully justified.
13. If your opinion is that the client is incapable of work, the *Decision Maker* should be advised about the prognosis, whether fresh medical evidence will be required in the event of a further referral and which functional descriptors from the PCA Incapacity Test currently apply.

## 20. Severe Disablement Allowance and Incapacity Benefit

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1. SDA is an incapacity benefit. The criteria referred to Medical Services for advice are:
  - the incapacity for work question
  - the disablement question.
2. The standard tests for incapacity is the Personal Capability Assessment [Social Security (Incapacity for Work) (General) Regulations 1995 – as amended] but if the person is assessed as 80% disabled or has a 'passport' benefit the PCA is considered satisfied.
3. The disablement question is considered by a specially trained and approved doctor following the guidance in the **Severe Disablement Allowance Handbook for Medical Advisers**.
4. Cases will be referred for advice regarding disablement (referral code SI) where the DM has either already applied the appropriate test of incapacity, or has no need to apply an incapacity test (eg. they are exempt from the PCA incapacity test or are transitionally protected and the disablement assessment has expired), or the appropriate test of incapacity is not yet due.
5. Any documents relating to a previous application of the PCA incapacity test should be available to the assessing doctor and included in the IB file. This may include any, or a number of the following:
  - An IB 113 and matching IB59 series medical advice form
  - An IB50 (questionnaire) completed by the client
  - An IB85A or IB85 (Medical Services report form).
6. Some cases will be referred for an advice on disablement and on the level of functional capacity

## 20. Severe Disablement Allowance and Incapacity Benefit

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(referral code SI containing a minute requesting an opinion on the level of functional capacity). These cases will be referred with the request for a report on an SDA16 and form IB82. They will be referred where the Personal Capability Assessment does not fall for consideration until week 28 and the case is referred before that point. If the client is found to be 80% disabled, and therefore exempt the Personal Capability Assessment the IB 82 need not be completed.

7. The opinion in the IB 82 will, if it results in a score above the benefit threshold, permit the *Decision Maker* to accept incapacity without making a further referral for application of the Personal Capability Assessment when the test falls due, but it will not be used to disallow if the score is below the threshold.

8. **Form IB82 should be completed as follows:**

**Part A:** should be completed to cross reference the IB82 to the SDA16 on which the statement/history and clinical findings are recorded.

**Part B:** should contain a summary of how the clinical findings relate to the functional areas of the PCA Incapacity test so that the *Decision Maker* can understand how the descriptor chosen in Part C has been arrived at i.e. it is the justification.

**Part C:** should contain a descriptor, in words, from those defined in relation to the PCA, which reflects the client's level of function, e.g.

- 'loses control of bladder at least once a month', or
- 'cannot walk more than 800 metres without stopping or severe discomfort'.

## 20. Severe Disablement Allowance and Incapacity Benefit

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9. Clearly, as the mental health statements were not addressed in full, an opinion can only be given in relation to the severity of the mental illness. This will however allow the *Decision Maker* to refer the documentation for medical advice, at the appropriate time, in those cases where exemption is likely to be appropriate.
  
10. Those cases which fall for application of both the Personal Capability Assessment and consideration of the 80% disablement question will, where possible, be referred for a single assessment (referral code SJ) at which **both** the SDA16 and IB85 will be completed **in full**. The two forms should **not** be cross-referenced. However if the client is medically assessed as 80% disabled and therefore exempt the Personal Capability Assessment there is no need to proceed with an incapacity assessment involving completion of an IB85 report.

## Appendix 1

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### **General Professional Standards expected of an IB approved doctor**

Advice given by IB approved doctors is expected to be:

- fair and impartial, in accordance with the Benefits Agency's Equal Opportunities policy
- medically correct
- complete, justified, and consistent
- expressed in terms readily understood by the District Office customer
- legible, where given in writing
- within the consensus of current medical opinion.

When carrying out examinations, the IB approved doctor is expected to:

- act in accordance with the Benefits Agency's Equal Opportunities policy
- make the client welcome and feel at ease
- introduce him - or herself to the client
- be polite at all times
- encourage a person accompanying a client to be present during the examination if so desired by the client
- allow the client time to give their history, asking any questions in a non-adversarial manner

## Appendix 1

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- explain the purpose of the examination
- explain what the examination entails
- carry out the examination gently to avoid any unnecessary discomfort to the client
- carry out a relevant examination to provide the information necessary for decision making on benefit entitlement
- answer questions posed by the client, without compromising the subsequent decision making process.

## Appendix 2

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### Forms used in Incapacity Benefit

AT3	Appeal tribunal notification of decision to the <i>Decision Maker</i>
IB50	Incapacity for work questionnaire
IB55	Referral file cover
IB57	Requests for the opinion of an approved doctor concerning the client's fitness for own occupation
IB59(min)	Report minute by approved doctor for general use
IB59RUGS	Report by approved doctor in response to DL/S 612 (Med 6 from GP), unlisted incapacity question, illegible incapacity and incapacity doubtful question.
IB59PYM	Report by approved doctor in response to IB 113 from GP or on evidence already held by the DO
IB59T	Report by approved doctor in response to terminal illness question
IB60	Request for approved doctor advice only
IB62	Further Section 102 information
IB62A/B	Section 102 scrutiny reports
IB84	Medical assessment report on own occupation test
IB84A	Own occupation scrutiny report

## Appendix 2

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IB85	Incapacity Report for the Personal Capability Assessment – advice to the <i>Decision Maker</i> from a doctor approved by the Secretary of State
IB85A	Personal Capability Assessment medical scrutiny report
IB86	Notification of client not attending for assessment
SDA14	Request for Medical Services advice on assessment of disablement
SDA15	Medical advice on assessment of disablement based on documentary evidence.
SDA16	Medical examination report on assessment of disablement
DL/S586	Report from GP for OOT referrals
IB 113-DLS	Report completed by certifying doctor at the request of a DSS ‘medical officer’
DL/S 595	Letter to GP from DO re pregnancy related incapacity
DL/S 612	Med 6 from GP, DO send DL/S 612 to GP who then sends it to Medical Services
PV1	Gives details of a violent or potentially violent episode.

## **IB Referral Types**

### **Referrals sent to the Customer Service Desk**

The following types of referral are sent to Customer Service Desk:

- CS Illegible incapacity on medical certificates
- CR Incapacity doubtful
- CM Mental health reference
- CP Potentially exempt cases
- CY Exempt incapacities for medical advice
- CQ Potentially terminally ill
- CU Incapacity not listed in reference guide
- CT Terminal illness under the special rules
- CW Therapeutic work references
- CN Pregnancy related illness references (SB/MA)
- CZ Second opinion following dissatisfaction/appeals/reference back
- CV Scrutiny of medical reports for harmful information
- CH Med 6 received from the client's GP

**Referral sent for assessment**

The following referrals arrive direct from the District Office:

- EB Personal Capability Assessment case
- EE Claim within 16 weeks of disallowance (own occupation)
- EF Doubt on continuing incapacity (own occupation)
- EX Personal Capability Assessment without questionnaire (mental health).

The following referrals arrive from Medical Services - medical scrutiny:

- SA Own occupational control
- SC Personal Capability Assessment for medical scrutiny
- SD First application of the Personal Capability Assessment – case without Med 4
- SG Change in incapacity (Section 102 cases)
- SL Request from employers/employees (including cases where the employer refuses to pay SSP)
- SK Repeated Short period claims
- SJ SDA plus the Personal Capability Assessment incapacity test

## Appendix 3

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- SI SDA 80% disablement test
  
- SO Pregnancy relates illness SSP/SMP (employee appeal against employer's decision to start the maternity pay period).