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WCA Handbook

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Foreword

This training has been produced as part of a training programme for Healthcare Professionals (HCPs) who conduct assessments for the Supplier on behalf of the Department for Work and Pensions.

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

This training must be read with the understanding that, as experienced practitioners, the HCPs will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this training module.

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

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

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Introduction

1.1 Introduction

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

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

Much of the work carried out by HCPs is completed using the Logic Integrated Medical Assessment (LiMA) system. LiMA is an evidence-based computer programme which allows the HCP to document evidence gathering and supports the evaluation of data and provision of advice on levels of disability using logic based on ‘evidence-based medicine’ protocols.

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

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

The handbook consists of four parts.

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

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

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

Section 4 covers situations less commonly encountered at assessment, for example Home Consultations or procedures relevant to the “DWP Keep Customer Interactions Safe (KCIS) Process Guide”. It also provides guidance on issues such as potentially harmful and embarrassing information.

1.2 Background to Employment and Support Allowance

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

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

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

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

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

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

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

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

- There were areas of the assessment where the ability to adapt to a condition was not fully taken into account.
- The inclusion of the concept of “adaptation” would result in a more accurate reflection of the individual’s functional capability.
- There was scope to further simplify some of the descriptors to ensure transparency of the process for claimants and ensure that HCPs and Decision Makers (DMs) are able to clearly identify the applicable descriptor in each case.

In addition to the internal WCA review, a further technical review was undertaken with representatives of specialist disability groups and technical experts. This group considered that the

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impact of fluctuating conditions and the inability to complete tasks safely, reliably, and repeatedly due to the effects of exhaustion needed further emphasis in the descriptors.

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

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

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

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

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

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

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

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

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

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

1.2.1 Independent Reviews of the WCA

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

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

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

1.3 The Work Capability Assessment Structure

The outcome of a Work Capability Assessment (WCA) is used by a decision maker to determine the entitlement to benefit and rate of benefit paid in ESA. The WCA considers an individual's ability in various "activities" relating to lower limb function, upper limb function, sensory function, continence, consciousness, and mental function.

The assessment is based on "descriptors" in these activity areas. Descriptors are defined in the legislation and "describe" a restriction in an activity – for example "Cannot single-handedly use a suitable keyboard or mouse". The descriptor representing the most severe level of disability will attract 15 points meaning the person will be considered as having limited capability for work. In many situations, this will also mean the restriction is so severe that the person would also be considered as having limited capability for work-related activity.

Within the WCA, there are a number of assessments:

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

Note: Within the regulations, LCW is deemed to apply where LCWRA criteria applies.

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

The main aims of the WCA are to:

- Ensure that those who currently have limited capability for work or work-related activity are identified.
- Accurately identify those who, despite their condition, are fit to continue to work.

- Provide a fairer, more accurate and more robust assessment of the level of a person's functional ability in relation to capability for work in the modern workplace.

1.4 The Financial Structure of ESA

Following submission of a claim for ESA, the claimant enters the "Assessment Phase". The assessment phase continues until the DM determines LCW.

The DWP DM arrives at a decision about the level of entitlement based either on advice from evidence at the Filework stage or from the full assessment (either a "Face to Face Assessment", "Telephone Assessment" or "Video Assessment". The DM will decide on the evidence available whether the claimant should be determined as having limited capability for work, meets criteria for entry into the Support Group (limited capability for work and work-related activity) or does not meet the threshold of having limited capability for work. Additional payments may be payable once the DM determines LCW or LCWRA.

1.4.1 Overview of the ESA claim process

Previously the initial claim for ESA was made to Jobcentre Plus, by telephone in most cases. With the introduction of New Style ESA, (NSESA) most claims are made online; however, if a claim is being made through an appointee, this continues to be made by telephone.

All initial and re-referral claims are subject to a "Filework" process to determine whether a further full assessment is required. This "full assessment" can be conducted through differing channels namely "Face-to-Face Assessment", "Telephone Assessment" or "Video Assessment". Most Face-to-Face Assessments are completed in the Assessment Centre, however, in exceptional circumstances, some are completed as Home Consultations.

The HCP providing Filework advice can also advise on suitability of the differing assessment channel. For ease, in the remainder of the document, references will be made to a "full assessment" where required. This process aims to identify claimants where a recommendation can be made without the need for a full assessment.

If at the time of the claim, the claimant indicates they are terminally ill/nearing the end of life, the case is sent straight to the Supplier for HCP advice unless the Decision Maker has enough information to advise the client is terminally ill/nearing the end of life without further input from the Supplier. N. B. Following changes to the Regulations in 2022, Special Rules for Terminal Illness is now referred to as Special Rules for End of Life.

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

In most cases, the claimant is sent an ESA50 form to complete, and forms are available in various formats - including Braille. This form gives the claimant the opportunity to provide details of their condition, treatment and functional abilities and restrictions. Where a claimant has a mental function problem an assessment will be carried out even if the form is not returned, ordinarily this is not the case with customers who do not have mental health problems.

If, on the day of the appointment, the claimant is insistent that the assessment should continue despite the Questionnaire/113/FRR2/FRR3 not being available, this should be clearly documented in the PSS (as well as the body of the report) and the assessment completed in-line with the wishes of the claimant.

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

At Filework, a HCP, who has been trained in the Filework process, reviews the Med 3 details as well as any information made available by the claimant, and may decide that further medical evidence (FME) is required. The FME may be requested from any healthcare professional involved in the claimant's care. **FME must only be requested where valid consent is in place.** In line with GDPR requirements, a claimant can give consent or withdraw consent for FME to be gathered at any stage of the WCA process. All information is then reviewed, looking for any evidence that suggests the claimant does not require a full assessment to determine their level of disability.

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

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

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

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

The claimant is contacted, and an appointment made for them to attend a full assessment. The assessing HCP will complete an appropriate assessment on the ESA85 report form.

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

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

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

- 15 points in respect of the physical descriptors; **or**

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

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

If the DM accepts that a claimant reaches the threshold of having limited capability for work but **does not meet** criteria to be considered to have limited capability for work-related activity, the claimant will be required to attend a series of Work Focused Interviews (WFIs) with the Work Coach. The first WFI will take place after the decision on entitlement. During these sessions, the claimant will draw up an agreed action plan of activity which is intended to help them with a potential return to work at a point when they are able. For claims prior to 3rd April 2017 engagement in this process resulted in entitlement to the “work-related activity” component of ESA in addition to the ‘basic ESA’ allowance. For claims made after 3rd April 2017, this work-related activity component is not payable.

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

1.4.2 Universal Credit

Background to Universal Credit

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

UC was initially introduced in the form of a ‘Pathfinder’ exercise – a DWP term for a pilot which will inform future guidance and processes – in certain areas of north-west England. This was then gradually rolled out to selected areas and Universal Credit is now available for claimants in all Jobcentres across the country.

The UC “full service” was launched on an area-by-area basis from May 2016 and is now fully implemented for all new claims.

UC replaces 6 existing previous benefits

- Jobseeker’s Allowance (Income based).
- Income Support.
- Employment and Support Allowance (Income-Related).
- Working Tax Credit.
- Child Tax Credits.

- Housing Benefit.

Universal Credit and the WCA

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

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

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

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

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

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

The policy and process around the Filework and medical assessment is similar in UC and ESA. As in ESA, there will be Special Rules for End of Life, Filework and full assessment (WCA) elements. UC still considers Limited Capability for Work and Limited Capability for Work-Related Activity; however, the terms Support Group and Work-Related Activity Group are not used in UC.

Prognosis in UC is in terms of functional improvement rather than work and is referred to as the re-referral period. The Revised WCA Handbook will highlight the differences between the ESA and UC Regulations relevant to the HCP in providing WCA advice.

1.5 The Role of the Approved HCP

All HCPs who give advice relating to ESA or UC must be approved by the Secretary of State for Work and Pensions. Approval involves specific training; successful completion of various stages of the approval process, and ongoing demonstration that the work being carried out meets a satisfactory standard. (See 1.5.1 below.) The ESA/UC approved HCP is required to provide advice to the DWP DM in accordance with the current guidance issued by the Department for Work and Pensions.

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

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

- Legible and concise

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

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

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

- Advice to the DM to confirm that a claimant satisfies any one of the Limited Capability for Work Related Activity criteria or any of the criteria for treating the claimant as having limited capability for work.
- Further advice or clarification requested by the DM.
- Application of the ESA/UC LCW/LCWRA assessment, providing an objective and impartial assessment of the claimant's functional ability for the DM.
- In Filework cases, the HCP will review the available medical evidence, in order to advise whether a further LCW/LCWRA assessment is required or whether the appropriate advice can be given through the Filework process itself.

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

1.5.1 Maintaining the Standard – Audit

As part of the quality assurance process, a selection of HCP reports is audited against the agreed standards. Audit has a central role in ensuring that decisions on benefit entitlement, taken by DWP, are correct. It supports this by confirming that independent HCP advice complies with the required standards and that it is clear and medically reasonable. It also provides assurance that any approach to assessment and opinion given is consistent so that, irrespective of where or by whom the assessment is carried out, claimants with conditions that have the same functional effect will ultimately receive the same benefit outcome.

Various types of audit and similar checks are carried out as part of quality assurance Approval audit – for HCPs early in their learning journey after initial training; 100% of the reports completed are audited until they consistently demonstrate they are producing reports to the agreed standard and gain provisional approval. New entrant audit - once the HCP has achieved provisional approval, they will continue to be subject to 100% New Entrant Audit

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until final approval has been granted by the DWP. Other audit and quality assurance checks are carried out on a regular basis after approval and new entrant audit.

Suppliers should put in place processes to ensure that appropriate feedback is given to HCPs following case audit.

Audited full WCA reports are graded as follows:

A Grade (acceptable report) – the quality requirements are satisfied to the extent that the Assessment Report fully conforms to the required standards

B Grade (acceptable report with significant learning points) – the quality requirements are adequately satisfied but there are elements which would quantifiably enhance the quality of the Assessment Report

C Grade (unacceptable report) – the quality requirements are not satisfied to the extent that the Assessment Report fails to meet the required standards but does not lead to an incorrect recommendation

U Grade (unacceptable reports recommendation incorrect) - the quality requirements are not satisfied to the extent that the Assessment Report fails to meet the required standards and leads to an incorrect recommendation

Reports are audited by the Supplier auditors. All auditors undergo specific training for the role and are expected to maintain standards. A selection of audit outputs and feedback produced by the auditors is subjected to audit quality assurance checks (AQA).

In addition to audits and quality checks completed by the Suppliers, a random controlled sample of reports is regularly audited by the Independent Auditors appointed by the DWP.

HCPs should refer to the relevant Supplier process guidance and support documents for audit.

1.6 The Decision Maker's Perspective

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

- Legibility
- Absence of medical jargon
- Consistency

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

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

"A definite distinction is made between fact and opinion and while an opinion on its own may have

persuasive value it can never take precedence over an opinion which is based on clear and concise evidence”.

Non-Prescriptive Advice

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Filework

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

2.1 Special Rules for End of Life (SREL) (formerly referred to as Terminal Illness (TI) Check)

When a claimant contacts JCP indicating that they wish to apply for ESA/UC they may state that they are terminally ill/nearing the end of life/have been told they may have less than 12 months to live. Existing benefit claimants may also inform JCP that they have become terminally ill or are nearing the end of life. Prior to 4th April 2022, the definition of terminal illness in the Welfare Reform Act legislation was:

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

This definition was reviewed by the UK Government for ESA and UC and has been replaced by the following definition in the Universal Credit and Employment and Support Allowance (Terminal Illness) (Amendment) Regulations 2022

“that he is suffering from a progressive disease and his death in consequence of that disease can reasonably be expected within 12 months.”

The DWP are also changing the language used in connection with the Special Rules, moving away from the phrase ‘terminal illness’ and replacing it with ‘nearing the end of life’.

When a claimant is considered to potentially meet the criteria for the Special Rules for End of Life, a referral will be sent to the Health Assessment Advisory Service for advice in cases where the Decision Maker cannot determine that the Special Rules for End of Life have been met on the evidence held. The HCP will access the case using the Medical Services Referral System (MSRS) and follow a process which has been agreed by the customer (DWP). The advice provided to the Decision Maker will be generated using the LIMA application.

A detailed explanation of this process may be found in the Filework Guidelines, however, in summary, a check takes place to find out whether a DS1500 or SR1 (or Scottish BASRiS form) has been submitted by the claimant. If the DS1500/SR1/BASRiS confirms the claimant is terminally ill/nearing the end of life, this advice is submitted to the Decision Maker on form ESA85A or UC85A.

If no DS1500/SR1/BASRiS has been submitted with the ESA/UC claim, a check takes place to see if there has been a recent application for DLA, AA, or PIP under the Special Rules. In England and Wales, if a claimant has met the Special Rules criteria for DLA, AA or PIP, the claimant can be considered as terminally ill / nearing the end of life for the purposes of ESA/UC.

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In Scotland for PIP, there is no specific time period defined for terminal illness, therefore should a BASRiS form be received alongside an ESA/UC claim, the HCP must review this carefully to see if the evidence suggests that the claimant meets the Special Rules for End of Life for ESA/UC.

If no DS1500/SR1/BASRiS is available and there is no confirmation that the claimant has met the Special Rules criteria through a previous DLA/AA or PIP application, the HCP will seek further medical evidence from a practitioner involved in the medical care of the claimant.

It should be noted that a claimant who meets the criteria for the Special Rules for End of Life will be entitled to the higher rate of benefit while still in the 13-week assessment phase and from day 1 of the health-related UC claim.

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

If the claimant is considered to meet the criteria for the Special Rules for End of Life, the HCP will submit this advice to the Decision Maker. If the advice is accepted, the claimant will be determined as meeting the criteria of having Limited Capability for Work and Work-Related Activity (LCWRA).

There is no requirement for claimants who are terminally ill/nearing the end of life to participate in any form of work-related activity. After a 3-year period, the DWP will review the status of any claims where a decision was made that a claimant meets the Special Rules for End of Life.

If the claimant is not considered to be suffering from a terminal illness/nearing the end of life as defined in the Universal Credit and Employment and Support Allowance (Terminal Illness) (Amendment) Regulations 2022, there may be sufficient evidence that they satisfy one of the other LCW/LCWRA (Support Group) criteria or one of the criteria for 'Treat as LCW'. If not, the claim will continue to be processed in the normal manner.

2.2 Pre-board Check

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

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

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

2.3 Limited Capability for Work Related Activity (Previously known as The Support Group in ESA)

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

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

The criteria for being considered to have LCWRA are set out in legislation. To be considered as having limited capability for work and work-related activity, there should be evidence of a severe level of functional limitation.

However, there are also some additional categories that also fulfil the criteria for being considered to be treated as having limited capability for work and work-related activity (LCWRA). These are where, although the claimant may not have severe functional limitation, it would be considered inappropriate for them to be asked to engage in work-related activity (e.g., the terminally ill group). Where severe functional limitation can be justified, this should be considered first and applied ahead of any special circumstances.

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

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

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

With regards to face-to-face, video and telephone assessments:

An HCP should use their clinical knowledge and judgement to consider LCWRA criteria from the outset of an assessment - especially in cases where the diagnosis/diagnoses may suggest a severe problem - and tailor an assessment accordingly to ensure that a claimant is not unduly detained at an assessment. History and examination should always be to an extent that advice can be fully justified to the DM. Note: Legislation allows HCPs to curtail a non-paper-based assessment when advising functional, but not when advising substantial risk LCWRA criteria.

2.3.1 Limited Capability for Work and Work-Related Activity (LCW/LCWRA) – Severe Functional Limitation

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

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

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

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

If a person can perform a task but is unable to repeat it within a reasonable timescale the person should be considered unable to perform the task.

For example, the HCP should consider what would be expected of an individual, who did not have an impairment, of their ability to mobilise.

That is, a 'normal' individual would be able to perform this activity within a given time period and repeat that activity again after a reasonable rest period. The duration of the reasonable rest period can then serve as a basis for comparison to gauge the range of what is 'reasonable'.

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

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

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

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

The LCWRA descriptors relate to various areas of function including:

- lower limb functions.

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

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

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

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

- A. Where a claimant normally uses an aid or appliance, they must be assessed as if they were using it
- B. If an aid or appliance has been prescribed or recommended by a person with appropriate expertise, the claimant must be assessed as using it, unless it would be unreasonable for them to use it
- C. If a claimant does not use an aid or appliance, and it has not been prescribed or recommended, the claimant must be assessed as if using it **if**:
 - i. it is normally used by people in the same circumstances acting reasonably
 - and**
 - ii. It would be reasonable for the claimant to use it.

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

Each of the functional LCWRA categories will now be considered.

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

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

Cannot either:

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

or

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

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

The descriptor relates to the ability to independently move useful distances by any of the means listed above where the guidance on aids and appliances is followed.

If they are unable to walk or move on level ground to the degree stated, it would not be considered reasonable to expect the claimant to participate in work-related activity, because of their severe mobility restriction.

This LCWRA category could, for example, apply to a claimant with quadriplegia, who has upper and lower limb weakness, and therefore cannot walk or manually propel a wheelchair. A claimant who was paraplegic, had normal upper limb function and no other conditions such as cardiorespiratory compromise or severe fatigue, should be able to propel a manual wheelchair and therefore may not meet criteria for this LCWRA category unless the Decision Maker considers it reasonable for them not be using a wheelchair as a reasonable aid.

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

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

appliances (see section 3.2.1 and 3.2.2) for further information.

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

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

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

2.3.1.2 Transferring from one seated position to another

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

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

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

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

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

2.3.1.3 Reaching

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

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

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

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

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

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

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

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

2.3.1.5 Manual dexterity

Cannot either:

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

(ii) turn the pages of a book with either hand

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

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

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

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

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

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

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

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

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

2.3.1.7 Understanding Communication by

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

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

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

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

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

This descriptor relates to an individual's ability to understand communication at a very basic level. It is assumed that the language/accent used (whether written or verbal) is one that they are familiar with (including different versions of Braille). The descriptor reflects only basic comprehension of writing and is not intended to reflect any higher level of literacy. Restriction **in either vision or hearing** must be considered as an individual must have capacity to understand a simple message through **both the written and spoken word**. Ability to lip read, read **16-point** print or Braille must be considered.

For example, a person who has **normal hearing**, but severe sight restriction to the extent that they are unable to read a simple message in **16-point print**, nor read Braille would be likely to be awarded this descriptor.

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

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

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

At least once a week experiences:

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

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

sufficient to require the individual to clean themselves and change clothing

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

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

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

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

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

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

2.3.1.9 Eating and drinking

Conveying food or drink to the mouth:

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

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

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

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

(i) physical assistance from someone else, or

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

Chewing or swallowing food or drink:

(a) Cannot chew or swallow food or drink;

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

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

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

(i) chew or swallow food or drink; or

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

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

In 2016, clarification on the wording of Activity 16(b) (chewing or swallowing food or drink) was provided by the DWP.

This descriptor applies when the claimant:

- **Is unable to eat but could drink or;**
- **Is unable to drink but could eat or;**
- **Is unable to eat and is unable to drink**

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

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

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

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

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

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

2.3.1.10 Learning tasks

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

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

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

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

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

2.3.1.11 Awareness of hazards

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

(i) injury to self or others; or

(ii) damage to property or possessions,

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

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

This may result from learning difficulties, severe cognitive problems, or people with

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

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

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

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

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

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

The ability to complete personal actions was the subject of an appeal. The First-tier Tribunal cited ability to wash and brush teeth as evidence that no activity 13 descriptors applied. The Upper Tribunal Judge held that **habitual actions such as washing and brushing teeth should not be considered in isolation when determining whether a claimant was able to initiate and complete personal actions**, as their performance did not demonstrate the claimant's mental, cognitive, and intellectual functions.

Consideration of Activity 13 must relate to all the tasks of planning, organisation, problem solving, prioritising, or switching between tasks. Evidence need not be found of a single action involving all these tasks. Evidence from one action may demonstrate inability in respect of one task, evidence from another action in respect of another task, and so on.

Inferences may also be drawn from the nature of the claimant's condition or other factors.

The personal action considered need not be complicated, as long as all the tasks are taken into account. The UT Judge gave an example of the action of dressing. This may be routine if the person only puts on clothes got ready by someone else, but could equally demonstrate the tasks, e.g., choosing and getting ready appropriate clothes (planning and organising), deciding what to do if clothes need washing or ironing (problem solving and prioritising), and doing those before dressing if necessary (switching tasks).

The action must be effective. This may include where an action must be completed before the person can move on to the next action. Actions are undertaken for a purpose and if that purpose cannot be achieved, the action is ineffective. Effectiveness needs to be considered in the context of the purpose of the test which is to decide whether it is reasonable to require the person to work.

Consideration should be given as to whether a person can co-ordinate actions in the correct sequence such that they successfully complete any personal actions in a logical order for

example when preparing a meal or snack. This may be as a result of severe concentration or memory problems or very severe depressive illness. Those with active psychotic features may also have problems in this area. Those with severe compulsive behaviour may have problems in this area because of repetitive rituals - they repeat a task so often, they cannot effectively complete it. Consider whether a task can be considered to be complete. Remember to consider the concepts of repeatedly and reliably.

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

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

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

2.3.1.13 Coping with change

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

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

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

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

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

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

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

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

- “Always” does not mean “at all times”; claimants need not show that they fall within the descriptor all the time, every minute, twenty-four hours of every day**
- ESA Regs Sch 3 Activity 13 (and Sch 2 Activity 16a, as it is coapplied) or UC Regs

2013, Schedule 6 Activity 16a and Schedule 7, Activity 13 could therefore apply to a claimant whose condition is constant and continuing in its disabling effects, for the purposes of social engagement, albeit with short intermittent breaks in that being the case

- Advice should have regard to the need for steady and reliable engagement in social contact for the purposes of work and WRA and be mindful that evidence of some kind of social engagement by the claimant, would not necessarily prevent the descriptor being met.
- Social contact where the claimant requires to be accompanied should be disregarded. Due consideration should be made as to whether being accompanied is a requirement or a choice/preference.

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

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

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

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

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

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

This LCWRA descriptor represents those with extreme uncontrollable behaviour. The level of behaviour that this descriptor represents would be considered completely inappropriate in a general workplace. This may be violent, aggressive, or disinhibited behaviour. The behaviour must be as a result of a mental disorder/cognitive impairment and should not include behaviour that some people feel uncomfortable with personally.

People with conditions such as with head injury/Stroke etc who have developed disinhibited behaviour may have problems in this area, as may people with psychotic conditions and personality disorders.

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

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

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

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

When a person is called to assessment, the HCP conducting the full assessment must always ensure they consider the possibility of the LCWRA (either functional LCWRA or Special Circumstances) criteria from the outset, especially in cases where the diagnosis may suggest a severe problem. The HCP must use their clinical judgement to tailor any assessment where LCWRA is identified and decide on the amount of history and level of clinical examination required in each case in order that they can fully justify their opinion to the DM.

ESA Regulation 35 – “Certain claimants to be treated as having limited capability for work-related activity”

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

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

and the Secretary of State is satisfied that the claimant should be treated as having

limited capability for work-related activity.”

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

UC Regs 2013, Schedule 9– “Circumstances in which a claimant is to be treated as having limited capability for work and work-related activity”

Special Rules for End of Life (Terminal illness)

1. The claimant is terminally ill/nearing the end of life with an expectation of 12 months or less to live

Pregnancy

2. The claimant is a pregnant woman and there is a serious risk of damage to her health or to the health of her unborn child if she does not refrain from work and work-related activity.

Receiving treatment for cancer

3. The claimant is:
 - a. receiving treatment for cancer by way of chemotherapy or radiotherapy;
 - b. likely to receive such treatment within 6 months after the date of the determination of capability for work and work-related activity **or**;
 - c. recovering from such treatment, and the Secretary of State is satisfied that the claimant should be treated as having limited capability for work and work-related activity.

Risk to self or others

4. The claimant is suffering from a specific illness, disease, or disablement by reason of which there would be a substantial risk to the physical or mental health of any person were the claimant found not to have limited capability for work and work-related activity.

Disabled and over the age for state pension credit

5. The claimant has reached the qualifying age for state pension credit and is entitled to attendance allowance, the care component of disability living allowance at the highest rate or the daily living component of personal independence payment at the enhanced rate.

Guidance for “Treat as LCWRA” criteria (UC and ESA):

Special Rules for End of Life/Terminal Illness

Those meeting the LCWRA special circumstances criteria for terminal illness/nearing the end of life (Special Rules for End of Life) as defined in the Universal Credit and Employment and

Support Allowance (Terminal Illness) (Amendment) Regulations 2022, i.e., those with a life expectancy of less than 12 months should be identified at the SREL (previously TI) check. However, some individuals may not be identified at that stage due to lack of information, or because their condition has changed, or new information may become available in the time between the SREL (previously TI) check and the pre-board check phase.

Therefore, all information from the GP (or other practitioner involved in the care of the claimant), and the ESA/UC information must be considered to assess whether the claimant now fulfils the criterion for this LCWRA Criteria.

Pregnancy Risk

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

Mental/Physical Risk

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

Chemotherapy/Radiotherapy for cancer treatment

The revised criteria in **this** area within the ESA Regulations (as amended 2012), have been included in the UC Regulations and are intended to apply only to the treatment effects of cancer and conditions related to cancer. For example, myeloproliferative disorders such as myelofibrosis may be considered eligible. However, although not strictly cancer, benign brain tumours treated by radiotherapy may be eligible too.

This LCWRA criterion should be applied where claimants are:

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

With regard to “recovering from treatment for cancer” an Upper Tribunal has ruled that there must be evidence of ongoing recovery. If the cancer treatment has resulted in longstanding functional impairment which is not improving and there is no prospect of further improvement of function, the HCP cannot advise the LCWRA category - **chemotherapy/radiotherapy for cancer treatment**.

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

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

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

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

Each individual will be assessed initially at the Filework stage. In most cases where there is evidence of cancer treatment (ongoing or likely), advice is offered at the Filework stage to indicate the claimant satisfies the LCWRA criteria. In those cases where the evidence at the Filework stage does not support any debilitating effects of treatment, the claimant may need to attend a full assessment.

For further information on the definition of chemotherapy/radiotherapy/effects of cancer, treatment and co-morbidity, side effects of chemotherapy/radiotherapy and other cancer treatments, all HCPs performing Work Capability Assessments must read the learning documents 'Common cancers and their management' and 'Review of cancer treatments and their functional effects'.

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

In some cases, while the claimant may not have significant functional impairment, they may be treated as having limited capability for work because they fulfil certain criteria set out in the ESA/UC legislation. Those claimants identified by the DM as having LCW will be referred to the Supplier for HCP advice about whether the claimant also has LCWRA. At the time of the referral, these claimants will be sent an ESA50A or UC50A form. This form is a type of questionnaire that asks the claimant for information about their abilities in various activities. The areas they are asked about are related to the activities in the WCA with particular focus on the LCWRA criteria and descriptors. The form also allows them to provide details of their medical conditions, their medication, and any health care professionals they see. The evidence will be reviewed by a HCP who will determine what, if any, further evidence is required, such as a report from the GP or other healthcare professional. Once sufficient evidence is gathered, the HCP may advise either that LCWRA criteria are satisfied, or, alternatively, that they are not satisfied (i.e., that the claimant does not have LCWRA). In rare cases where no definitive advice

can be given on LCWRA on the evidence held, the claimant may be referred for an assessment to establish whether LCWRA applies (see section 3.11).

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

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

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

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

Treat as LCW criteria in ESA

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

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

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

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

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

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

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

beginning with the first date of the 6th week before the expected week of her confinement

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

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

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

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

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

Documentary evidence of confinement dates should be obtained.

Hospital patients

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

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

It should be noted that:

The regulation applies to recovery from treatment.

There is no time limit to recovery although “recovery” assumes its normal dictionary definition i.e., there has to be a process of improving so if a claimant has stopped improving, they cannot be said to be recovering.

HCPs should consider each case individually and apply their clinical judgment to each claimant.

Refer to relevant guidance if you are unsure about the expected recovery times for any particular treatment or procedure.

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

For Example:

- A person is admitted to hospital as a day case for carpal tunnel decompression with discharge on the same day – this would not fulfil the ‘Treat as LCW’ hospital patient criteria.
- A person had total knee replacement (TKR) surgery and was discharged after 4 days. They developed an infection at surgical site two days later and had intravenous antibiotics for 7 days. Twelve weeks after the surgery they attend a full assessment and report they still have knee pain and swelling due to surgery and infection. Although normal recovery period following a TKR is 6-8 weeks ‘Treat as LCW’ criteria would be applicable as the person had complications following the surgical treatment and recovery period may be prolonged. Suggested prognosis would be 6 months.
- A person had total knee replacement (TKR) surgery and was discharged after 4 days. They developed an infection at surgical site two days later and had intravenous antibiotics for 7 days. Twelve weeks after the surgery they attend a full assessment and report they still have knee pain and swelling, and this is not improving anymore but are functioning well. ‘Treat as LCW’ criteria would not be applicable in this case as the person although still has some symptoms is not improving anymore and is fully functional.
- A patient who was booked to have an inguinal hernia repair as a day case surgery had procedure started and finished late in the afternoon and surgeon recommended, they should stay overnight in hospital for monitoring. They were discharged from hospital the next day, more than 24 hours after the admission. They attend a full assessment three weeks after the surgery. ‘Treat as LCW’ criteria are met in this case as they stayed in hospital for a period longer than 24 hours. Suggested prognosis would be 3 months.
- A patient who was booked to have an inguinal hernia repair as a day case surgery had excessive bleeding during the procedure and stayed in hospital overnight for monitoring. They were discharged from hospital the next day, more than 24 hours after admission. They are assessed three weeks after the surgery. ‘Treat as LCW’ criteria are met in this case as they stayed in hospital for a period longer than 24 hours. Suggested prognosis would be 3 months.

It should be noted that where the claimant is attending residential rehabilitation for the

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

When considering other forms of addiction, **such as** gambling, it has been agreed with the DWP that HCPs may recommend to the DM that a claimant might be treated as having LCW providing the claimant has been advised by a healthcare professional to stay in rehab for a period of 24 hours or longer. If the advice was issued by someone other than a health care professional, then it may be necessary to consider whether the claimant is at risk of deterioration and falls under the provision of regulation 29.

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

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

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

Please see section 3.8.2 for DWP policy pertaining to claimants who have undergone major surgery with a hospital stay of less than 24 hours.

Regular Treatment

1. Subject to paragraph (2), A claimant receiving:
 - a. Regular weekly treatment by way of haemodialysis for chronic renal failure
 - b. Treatment by way of plasmapheresis, or
 - c. Regular weekly treatment by way of total parenteral nutrition for gross impairment of enteric function

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

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

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

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

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

For claimants fulfilling criteria for 'Treat as LCW' due to infectious disease, pregnancy dates of confinement, hospital patients and regular treatment, there will be a requirement to advise whether LCWRA may also be applicable.

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

Claimants who are considered as 'Treat as LCW' in this category will be referred to the Supplier for HCP advice on LCWRA.

You should treat the referral, at Filework or full assessment, in the same way as any other LCWRA-only referral.

All evidence should be considered carefully and sought (if valid consent is in place) where necessary; you should justify your LCWRA advice fully.

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

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

Treat as LCW criteria in Universal Credit – UC Regs 2013, Schedule 8

"Circumstances in which a claimant is to be treated as having limited capability for work"

Note: these regulations are included for completeness. The guidance detailed above for ESA should be followed.

Receiving certain treatments

1. The claimant is receiving– (a) regular weekly treatment by way of haemodialysis for chronic

renal failure; (b) treatment by way of plasmapheresis; or (c) regular weekly treatment by way of total parenteral nutrition for gross impairment of enteric function; or is recovering from any of those forms of treatment in circumstances in which the Secretary of State is satisfied that the claimant should be treated as having limited capability for work.

In hospital

2. (1) The claimant is– (a) undergoing medical or other treatment as a patient in a hospital or similar institution; or (b) recovering from such treatment in circumstances in which the Secretary of State is satisfied that the claimant should be treated as having limited capability for work. (2) The circumstances in which a claimant is to be regarded as undergoing treatment falling within sub-paragraph (1)(a) include where the claimant is attending a residential programme of rehabilitation for the treatment of drug or alcohol dependency. (3) For the purposes of this paragraph, a claimant is to be regarded as undergoing treatment as a patient in a hospital or similar institution only if that claimant has been advised by a health care professional to stay for a period of 24 hours or longer following medical or other treatment.

Prevented from working by law

3. (1) The claimant – (a) is excluded or abstains from work pursuant to a request or notice in writing lawfully made or given under an enactment; or (b) is otherwise prevented from working pursuant to an enactment, by reason of it being known or reasonably suspected that the claimant is infected or contaminated by, or has been in contact with a case of, a relevant infection or contamination. (2) In sub-paragraph (1) “relevant infection or contamination” means – (a) in England and Wales – (i) any incidence or spread of infection or contamination, within the meaning of section 45A(3) of the Public Health (Control of Disease) Act 1984(a) in respect of which regulations are made under Part 2A of that Act (public health protection) for the purpose of preventing, protecting against, controlling or providing a public health response to, such incidence or spread, or tuberculosis or any infectious disease to which regulation 9 of the Public Health (Aircraft) Regulations 1979 (powers in respect of persons leaving aircraft)(a) applies or to which regulation 10 of the Public Health (Ships) Regulations 1979 (powers in respect of certain persons on ships)(b) applies; and (b) in Scotland any – (i) infectious disease within the meaning of section 1(5) of the Public Health etc (Scotland) Act 2008(c), or exposure to an organism causing that disease; or (ii) contamination within the meaning of section 1(5) of that Act, or exposure to a contaminant, to which sections 56 to 58 of that Act (compensation) apply.

Risk to self or others

4. (1) The claimant is suffering from a specific illness, disease or disablement by reason of which there would be a substantial risk to the physical or mental health of any person were the claimant found not to have limited capability for work. (2) This paragraph does not apply where the risk could be reduced by a significant amount by – (a) reasonable adjustments being made in the claimant’s workplace; or (b) the claimant taking medication to manage their condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant.

Life threatening disease

5. The claimant is suffering from a life-threatening disease in relation to which – (a) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure; and (b) in the case of a disease that is uncontrolled, there is a

reasonable cause for it not to be controlled by a recognised therapeutic procedure.

Disabled and over the age for state pension credit

6. The claimant has reached the qualifying age for state pension credit and is entitled to disability living allowance or personal independence payment.

Treat as LCW criteria consistent between ESA and UC

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

Infectious Disease

Hospital Inpatient

Regular Treatment

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

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

Pregnancy:

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

Those in Education and Entitled to DLA

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

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

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

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

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

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

2.5 Re-referral Scrutiny

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

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

The HCP may request further medical evidence from a relevant Healthcare Practitioner involved in the care of the claimant. These requests can only be made providing the claimant has given his or her consent to do so.

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

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

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

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

2.6 IB Re-assessment Filework

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

readiness to work.

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

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

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

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

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

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

Those who meet criteria of having LCWRA will have no requirement to participate in work-related activity.

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

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

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

2.7.1 Advice provided by Supplier HCPs

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

1. Before the initial decision is made.

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

2. After the decision is made.

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

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

2.7.2 The Role of the HCP

The appropriately trained HCP will provide advice to the DM using all their skills as a Disability Analyst. They will review all the evidence on file and provide advice on likely functional implications of any medical evidence provided. The HCP must take into account that the primary role of the GP or hospital doctor is to diagnose and treat any medical conditions that the patient/claimant presents to them.

Any information or medical report that the doctor provides to the Department for Work and Pensions in relation to disability benefits is a purely secondary activity to his/her therapeutic role. A clinician does not routinely consider the functional restrictions or disabling effects of the medical conditions that they treat. The HCP must take into consideration that the clinician may have no specific training in assessing disabilities in their medical education and may have considerable difficulty in giving an accurate assessment or forming an opinion in relation to the functional restrictions experienced by their patient. In addition, clinicians usually have at best, very limited knowledge of entitlement criteria to ESA/UC through the WCA process.

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

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

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

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

3 The Functional Assessment

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

Note: Most details in this section assume full Face-to-Face AC Assessment where references to observations and examinations are made. Any assessment must be adapted in accordance with the assessment channel and any relevant examination protocols for the other assessment channels (Telephone Assessment and Video Assessment).

3.1.1 Introduction

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

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

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

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

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

3.1.2 Reading the Documents

Document Review

In preparation for the interview, the HCP should read carefully the documents in the file, held electronically on DRS or on MSRS as applicable. All the medical evidence should be considered, including any medical certification, Factual Reports, previous papers, and other documents, including Tribunal documents (if available). Particular attention must be paid to the current claimant questionnaire [ESA50 or UC50] and all areas where the claimant indicates that there may be a problem must be fully explored.

Consent

Remember that in compliance with GDPR requirements, consent for suppliers to request further evidence can be altered by the claimant at any stage of the WCA process. The claimant has the right to consent to the Supplier approaching a Healthcare Practitioner involved in their care or withdraw their consent at any stage of the WCA Process.

This withdrawal of consent may come directly from the claimant or be notified to the Supplier via the DWP and the case file and WCA55 will be updated.

The HCP must therefore ensure they check that consent for FME remains valid at the time of assessment and only utilise FME where consent remains valid.

Evidence Noted as Returned on File

HCPs must also check MSRS and DRS to check what evidence is noted as returned on file.

Where the HCP has a case where MSRS or DRS indicates that medical evidence (such as - but not necessarily limited to - a claimant Questionnaire/113/FRR2/FRR3) should be available in the referral file but is not, it is inappropriate to proceed with an assessment. In this rare situation the appointment should be cancelled with three exceptions:

1. **If** Supplier administration staff can assure the HCP that the MSRS marker or DRS information is incorrect, and no such evidence was received. This should be clearly documented in the PSS (as well as within the body of the report).
2. **If** on the day of the appointment, the claimant is insistent that the assessment should continue despite the medical evidence not being available. This should be clearly documented in the PSS (as well as within the body of the report).
3. **If** the medical evidence in question is shown on MSRS or DRS but not present due to consent being withdrawn (and thus the medical evidence is destroyed). This will be recorded on consent proforma/MSRS by administrative staff. It should be clearly documented in the PSS (as well as within the body of the report).

It is never appropriate for a claimant to complete a questionnaire during their visit to the assessment centre.

It is never appropriate for anyone to try and persuade a claimant to continue with their appointment where their questionnaire or other medical evidence is missing.

Additional Evidence Presented or Referenced at Assessment

At times the claimant may also present additional written evidence during a face-to-face assessment or refer to such evidence during a Telephone or Video Assessment.

With the claimant's consent, any written evidence presented or referenced by the claimant must be reviewed. The report should make reference to the evidence that has been considered and justification provided if there is a conflict between the opinion of the HCP and the other medical evidence.

Any written evidence presented or referenced by the claimant, should be copied (or summarised) for the Decision Maker (see section 4.2.5 for further guidance).

3.1.2.1 Permitted Work in ESA

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

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

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

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

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

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

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

3.1.2.2 In-work Universal Credit claimants

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

In-work claimants with a health condition or disability can go through the WCA process to determine if the claimant has LCW or LCWRA.

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

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

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

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

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

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

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

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

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

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

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

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

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

of any aids or appliances at home or at work.

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

Conversely, is their work protective of their health? For example, structure/routine, social contact, self-esteem, supportive colleagues, etc.

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

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

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

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

3.1.3 Interviewing the Claimant

Disabled people face significant challenges during benefit assessments due to the impact of their health conditions. In addition, assessments are stressful, and this can affect behaviour, concentration, memory, and recall.

Healthcare professionals have an important role in helping claimants overcome these challenges and are trained to recognise, assess, and adjust for these issues as part of their assessment of claimants.

It is therefore essential to consider reasonable adjustments for claimants. Some suggestions on reasonable adjustments that may be required during an assessment are available in the document **DWP: Reasonable Adjustments for Benefit Assessments - Guidance for Healthcare Professionals**.

In cases where claimants have a named third party as an appointee, this could be due to the claimant being unable to manage their own affairs due to a serious mental health condition or cognitive/learning disability. Exceptionally, an appointee may also feature where a claimant is physically, but not mentally impaired, for example, if they have had a stroke which has resulted in a significant impact on their functional ability.

An officer acting on behalf of the Secretary of State will authorise an appointee to become fully responsible for acting on the claimant's behalf in any dealings with DWP or its contracted Suppliers. This includes:

- Claiming benefits including completing and signing any claim, providing consent to obtain further evidence, and providing information to the HCP on the functional impact of the claimant's health conditions.

- Collecting/receiving benefit payments.
- Reporting changes in the claimant's circumstances, or changes in their own circumstances that the DWP may need to know – for example, a change of name or address.

An appointee can be either a named individual, or an organisation (usually with an advocacy role), known as a corporate appointee.

Where it is noted that a claimant has an appointee all correspondence is issued to the appointee instead of the claimant, including any appointment letters.

It is not permissible for the appointee to deputise an individual to act as an interim appointee for a claimant. If the named appointee is unable to attend a WCA appointment, the Supplier should re-arrange the WCA appointment for a time/date or assessment channel which would allow the named appointee to attend. Where this is not possible this should be treated as if the claimant is unable to attend. Where it is clear the appointee is unavailable for an indefinite period, the Supplier should notify DWP that a new appointee is needed.

A full assessment (Face-to-Face AC or HC Assessment, Video Assessment or Telephone Assessment) cannot go ahead if the appointee does not accompany the claimant. If an appointee does not turn up, then normal Failed to Attend (FTA) action should be taken – the DWP will investigate the conduct of the appointee. The consultation can only take place if the claimant is accompanied by their appointee.

The appointee should be considered in line with guidance about companions being present at assessments, except that when the claimant has an appointee, the presence of an appointee is mandatory for the assessment to be conducted. (See 3.1.3.3 below for information on companions.) The interview should predominantly be between the HCP and the claimant where possible. However, the appointee may play an active role in helping claimants answer questions where the claimant or HCP wishes them to do so. This may be particularly important where the claimant has a mental, cognitive, or intellectual impairment. In such cases the claimant may not be able to give an accurate account of their health condition or impairment, through a lack of insight or unrealistic expectations of their own ability. In such cases it will be essential to get an accurate account from the appointee.

Where appointees report that a claimant is unable to attend and participate in an assessment, the Supplier should ascertain:

- whether this is temporary, and whether the assessment could be rearranged; or
- whether an alternative assessment channel would enable claimant attendance and participation.

Where a claimant's reasons for being unable to attend and participate are not temporary, an assessment may go ahead with the appointee only as long as all of the following conditions are satisfied:

- Issue relates to the claimant's health condition(s) or impairment,

- It is medically reasonable
- It is not due to choice or convenience.

If evidence to support non-attendance and non-participation is available, then it should be considered and noted within the advice for DWP.

Please refer to the relevant Supplier administration guides for full assessments for further details in relation to this process. Also refer to the relevant Supplier identification verification guidance/proof of identity guidance for further information.

3.1.3.1 The Nature of the Interview

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

A concise and relevant medical history is essential.

3.1.3.2 Interview Technique

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

For all assessment channels (Face-to-Face AC/HC Assessment, Video Assessment, or Telephone Assessment), establishing rapport is essential for an effective interview.

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

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

3.1.3.3 Claimant accompanied by relative, friend, carer

Claimants are encouraged to bring a friend or companion with them to the assessment. The claimant may feel more at ease if accompanied. Indeed, the companion may be a

prerequisite to enable them to come to an Assessment Centre or complete the video or telephone assessment.

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

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

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

If the companion is too intrusive, then you should point out that the claimant must be allowed to express their view. The claimant's consent is necessary for the presence of the friend or companion to be present and to contribute during the interview. Where an appointee is in place, the appointee must be present at the assessment. Specific guidance on appointees is provided in section 3.1.3.

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

3.1.3.4 Interpreters

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

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

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

3.1.3.5 Interview Skills

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

- Active listening.
- Effective questioning.

- The use of clear and understandable language.
- The use of positive body language.

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

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

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

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

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

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

The use of Clear and Understandable Language

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

The use of Positive Body Language

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

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

3.1.3.6 Recording Timings in the interview

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

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

3.1.3.7 Medical diagnosis

List all the current diagnoses. Ensure that **all conditions** entered in the ESA50/UC 50, or documented in other medical reports, such as previous benefit assessment reports, Med 3, 113, GP/Specialist/Consultant letters, are included. Previously unidentified conditions which are revealed during the assessment should also be added. These should be listed as either "Conditions Medically Identified" or "Other Conditions Reported".

The HCP should explore the current symptoms experienced by the claimant and enquire into any improvement or deterioration in each condition since they completed the ESA50/UC50 or since the other medical reports were completed. It is particularly important to carefully explore any change in conditions where the ESA50/UC50 for the current claim has been completed some time ago. Note the ESA50/UC50 must still be utilised regardless of age as long as it relates to the current benefit claim.

In many instances the entries will be symptoms rather than exact diagnoses. The role of the HCP during a WCA 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 there is good evidence of the diagnosis.

For example; if "Lumbar disc protrusion" rather than "Back pain" is entered into a report and it transpires at Tribunal that cause of the claimants symptoms is in fact "spondylolisthesis" rather than a "Lumbar disc protrusion", then the value of the evidence provided in the report to the DM is undermined.

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

3.1.3.7.1 Non-exploration of conditions that are not causing functional impairment

Frequently conditions are reported or listed in the questionnaire and other medical evidence, however, the client does not claim any symptoms or functional impairment caused by these conditions (e.g. High cholesterol, Vit D deficiency, previous wrist fracture etc.). Many of these conditions will be historic and are fully resolved and practitioners unnecessarily spend time on exploration of such conditions that are medically unlikely to cause functional impairment and where the client does not report any functional impairment arising from them. Clients whose main health problems are significant mental health issues may find exploration of such conditions a negative experience and may not feel they are being listened to. Clients may often object to exploration of conditions that are not their main issue and not causing them any functional impairment.

In cases where client reported/listed a condition in questionnaire or medical evidence mentions a condition, but client does not claim any functional impairment or symptoms the HCP can decide, based on the claim, medical knowledge, and evidence, whether a condition history exploration is needed or not.

HCPs will continue to record on LiMA all reported/listed conditions as per normal practice.

There are two sections on LiMA under Medical Conditions.

- The “**Conditions Medically Identified**” section: this is used to record conditions claimed to cause disability/functional impairment. These conditions must be fully explored.
- The “**Other conditions reported**” section: this is used to record all conditions (physical or mental health) that client or FME reported but did not claim to cause disability/functional impairment and medical knowledge and available evidence suggests they are unlikely to cause functional impairment. HCP is to clarify and confirm with the client that “Other conditions reported” are not causing functional impairment. If confirmed by client, HCPs will record for each condition that does not require exploration HCPs can record a LiMA phrase confirming that “I have discussed with the client and the client confirmed that this medical condition is not affecting their function at this time, and I have no evidence to the contrary.”

Some general principles:

- Where there are multiple conditions, each condition must be recorded separately to demonstrate clearly each has been confirmed with the client as not causing any symptoms or functional impairment - for example, hypertension and high cholesterol should not be grouped under one heading.
- If the claimant reports any problems or symptoms arising from any of the conditions recorded under “Other conditions reported” at any point, normal exploration of condition history will be carried out for that condition; there is no requirement to move from the “Other conditions” reported heading.

For example. If the claimant initially reports no functional impairment or symptoms during the condition history for underactive thyroid, but later within the typical day discloses a symptom (such as tiredness which the claimant states is secondary to this condition), a full condition history would need to be taken for the underactive thyroid.

- The guidance for HCP-type allocation still applies with reference to complex neurological conditions that is disclosed during the assessment even if the claimant states the condition causes no symptoms or functional impairment (e.g. transient ischaemic attack).
- If the condition entered generates a LiMA prompt for a physical examination, enter a phrase suggesting that the client has no symptoms or functional impairment relating to this area.
- The Personal Summary Statement (PSS) must cover all conditions including those not causing functional impairment.

When assessing a claimant with a mental health condition, be very careful when using the “I have discussed with the client and the client confirmed that this medical condition is not affecting their function at this time, and I have no evidence to the contrary” phrase. Carefully consider the following:

1. The claimant has no impairment of insight into their condition, noting all mental health conditions and a range of medications (including antidepressants, anxiolytics, and antipsychotics) can potentially impair insight.
2. That the claimant has no current or recent thoughts/acts of self-harm or suicide, **and this is specifically documented.**
3. That the claimant has no current or recent symptoms relating to this condition.
4. That the claimant is not on any medications for a mental health condition e.g. selective serotonin reuptake inhibitor, lithium, mood stabilising drug.
5. That if the condition relates to mental health, it is not on the acute/active problem list from additional medical evidence.

Only once points 1-5 above are satisfied the above can you apply the phrase.

Remember:

- Ask about current or recent thoughts/acts of self-harm or suicide ideation/attempts – **record the response in the ESA85/UC85, even if the answer is negative.**
- The claimant must not have any current or recent symptoms relating to the condition.
- Any mental health condition that is listed on the acute/active problem list from further medical evidence (FME) must be fully explored.
- **In all instances, if there is any doubt whatsoever a full condition history and mental state examination must be completed and documented.**

3.1.3.8 Medication

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

It is helpful to comment on any medication being taken. For example, the frequency analgesics are being taken may give an insight into the variability of the condition as many people may take them when required, rather than on a regular basis.

The phrase "Takes paracetamol as required" does not give enough detail and more information such as "He takes an average of 12 paracetamol (mild painkillers) a week, usually over three days" provides a better picture for the Decision Maker which will support your description of variability and pain later in the report.

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

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

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

"Becotide 100 inhaler - an inhaled preparation for asthma prevention"

"Voltarol Retard (diclofenac) - an anti-inflammatory drug for arthritis"

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

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

3.1.3.9 Clinical History

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

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

The clinical history should:

- List every condition identified/reported – a specific diagnosis should be given where possible, however if diagnosis is not known or is unclear from available information, then a less specific diagnosis should be recorded.
- Avoid grouping together unrelated conditions.
- Document symptoms – when they began, when condition was diagnosed, what the current symptoms are and how the symptoms affect function.

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- Document who is managing the condition.
- Give details of any hospitalisation.
- Give details on past/current/future treatment, including medication, various therapies, injections, surgery, etc, including any response to treatment and likely date of any proposed treatment/procedure/investigation; for example, "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks".
- Explore any previously identified conditions, if no longer symptomatic, to make it clear to the Decision Maker that the condition has resolved/responded to treatment.
- Where applicable, follow the guidance on non-exploration of conditions that are not causing functional impairment (see section 3.1.3.7.1).

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

Include a brief outline of the claimant's problems and the functional limitations imposed by them, for example "Claimant states they have variable pain in both elbows restricts their ability to lift and reach".

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

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

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

N.B – at times where a condition does not cause any functional restriction, it is possible to omit detailed recording of the condition. See Section 3.1.3.7.1

3.1.3.10 Social and occupational history

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

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

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

You should record the assessment channel used (Video Assessment, Telephone Assessment, Face-to-Face AC Assessment). For clerical reports, this should also be recorded on the cover page within the box "Place of examination".

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

You should also record who is present at the assessment (for example a companion, friend, interpreter or appointee).

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

3.1.3.11 The Typical Day

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

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

The account of the "Typical day" should be individualised to the claimant and particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and any other areas which may also be affected.

For example, in cases of shoulder pain, bear in mind activities which involve reaching and lifting and carrying. These activities are required in personal care tasks, and domestic and leisure activities. You should give specific examples of activities, e.g., "says she manages to self-care independently and is able to wash her hair in the shower using both arms". LiMA reports should contain appropriate amounts of free text and LiMA phrases in the typical day.

See also the paragraphs in relation to completing the section on activities of daily living in sections 3.2 and 3.5. When exploring the typical day, you should also ensure you cover

activities relevant to LCWRA criteria such as the person's ability to eat/drink/swallow.

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

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

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

At an early stage of the assessment, you may have identified a mental function problem.

Remember that many of the Mental Function Assessment descriptors can also be completed as a result of this exploration of the claimant's day-to-day life. Completing them will be very much easier if you keep in mind the seven areas involved, namely:

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

3.1.3.12 LCWRA/Treat as LCW

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

N.B in cases where LCWRA for Substantial Risk is identified, this advice can only be given when a full LCW/LCWRA assessment has been conducted.

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

It is essential that adequate time has been spent with the claimant to obtain sufficient information to fully justify the advice that the claimant meets one of the LCWRA criteria. **The level of information will vary in each case.** For example, if a claimant is found to meet the LCWRA criteria for the Special Rules for End of Life, this is likely to be indicated by the clinical history and perhaps some observations. However, if the claimant is in one of

the functional LCWRA categories, you will need to fully justify functional restriction in this area, even though certain sections of the report can be curtailed. This may involve documenting some typical day information, some clinical examination findings and observed behaviour (where relevant, and available based on the assessment channel); this should be documented in the relevant sections of the report. Any documented information on history, clinical examination and observed behaviour will still be shown on the final report in the LiMA application where LCWRA is advised, however no descriptor choice outcomes will be shown in such a case.

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

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

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

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

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

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

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

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

3.1.4 Clinical Examination of the Claimant

The clinical examination completed must be in keeping with the relevant examination protocol for the assessment channel.

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

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

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

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

The precise extent and nature of the clinical examination will depend entirely on the circumstances of each individual case.

You must use your clinical professional judgement to decide what examination is indicated, and whether the claimant should be asked to remove any clothing in order to complete this assessment effectively.

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

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

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

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

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

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

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

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

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

This guidance assumes particular significance when the HCP and claimant are of the opposite sex.

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

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

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

3.1.4.1 Conclusion of the assessment

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

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

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

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

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

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

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

3.1.5 Dealing with Unexpected findings at the assessment

Situations arise when HCPs carrying out disability assessments may come across information that they feel should be reported to the claimant's General Practitioner or the most appropriate external health care professional involved in their care.

HCPs must refer to the relevant Supplier unexpected findings process guidance for details on both the processes and procedures to be followed. All HCPs must be aware of their relevant Professional Body Guidance (GMC, HCPC, and NMC) with reference to consent, confidentiality, and disclosure.

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

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

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

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

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

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

The Decision Makers will rely heavily on the report in coming to a decision on limited capability for work or limited capability for work and work-related activity, and their needs must be uppermost in your mind. The LCW/LCWRA assessment report must provide an

objective and fair assessment of the claimant's disabilities in the physical, sensory and mental function areas, as laid out in the ESA/UC regulations. It must make clear to the Decision Maker what descriptors you have chosen and why you have chosen them. Your choice must be supported by appropriate medical evidence.

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

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

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

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

3.1.6.1 Medical Terminology

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

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

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

3.1.6.2 Abbreviations

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

3.1.7 Choosing and Justifying Descriptors: The Overall Approach

The objective of the LCW/LCWRA assessment report is:

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

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

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

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

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

This aspect is dealt with in more detail later.

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

If your opinion on level of function in any area differs from that of the claimant’s, you must provide full justification for your opinion. You must comprehensively justify and support your choice of descriptor by giving examples from your clinical history, activities of daily living, observation of the claimant, and clinical examination. Your evidence must provide sufficient factual information to lead the Decision Maker to understand and accept your choice. It is insufficient to simply reiterate the wording of the descriptor as justification.

All the evidence provided in a functional category should give support to that particular descriptor, e.g. it would be illogical to describe how, in a typical day, the claimant sits through long films at the cinema under the category "Manual Dexterity".

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

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

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

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

It is inappropriate to simply “agree” with the opinion of the claimant in the consciousness section when they have provided information elsewhere that may impact on this.

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

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

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

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

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

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

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

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

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

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

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

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

- You need to read the questionnaire carefully to complete the questionnaire information page on LiMA with due consideration to the following:
- Anything that infers a problem on the ESA50/UC50 is a problem.
- If there is a 'No' or 'It Varies' tick anywhere in an activity area, it must be a problem.
- Any free text that infers there is a problem even if they tick "yes" or have not put any "ticks" to all areas in that activity would be recorded as a problem.

- Where a claimant has ticked “yes” to the questions in that activity area, but have written text, the text should be read with common sense judgment to decide if it remains – no problem, unclear or problem.

For example: if the claimant has COPD as the only condition, ticks to top box in the questionnaire to indicate no problem with personal action; but then writes in free text for the activity area, “I have no mental health problem, but my breathlessness stops me for doing things”. As the free text information confirms no mental health problem, the questionnaire information page on LiMA can be marked as ‘None Apply’ (no problem) providing there is no other information in the questionnaire to indicate there is likely to be a mental or cognitive problem with any of the other Understanding and Focus group activity areas.

Occasionally, a significant time may have elapsed between the claimant completing the questionnaire and the assessment. Any areas which indicate a problem on the ESA50/UC50 should still be recorded; however, you should ask the claimant whether their problems have changed in the intervening period *and* record their reply within the condition history or typical day information. Any completed live ESA50/UC50 must be utilised in the assessment regardless of age if it relates to the current benefit claim.

3.1.8 Completion of Functional Activity Area Pages

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

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

3.1.9 Variable and fluctuating conditions

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

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

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

- The ability to perform the activity safely.

The HCP'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?

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

The HCP should make it clear in the report to the DM how they arrived at their opinion.

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

This implies that the HCP should provide the DM with advice on:

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

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

The appropriate advice can only be given if variability has been adequately explored. It is not sufficient to say, "has good days and bad days".

Detailed exploration of the frequency of the "good" and "bad" days, what activities can be done on "good" days and on "bad", what makes a day "good" or "bad", any specific triggers/precipitating factors for the "bad" days, etc. is required in order to be able to choose the appropriate descriptors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.1.10 Activities of Daily Living

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

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

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

For example:

"Does the shopping/cooking", does not give any useful information about picking up and

moving or transferring; more detail is required:

"Says she does her own shopping and is able to load/unload various items such as a large 2 litre bottles of cola, and 2 kg bag of potatoes from the trolley without help."

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

3.1.11 Behaviour observed during the assessment

The type of observations depends on the assessment channel used. During a Face-to-Face Assessment AC/HC, the HCP is likely to obtain a range of informal observations. Observations obtained during assessments completed by Video Assessment or Telephone Assessment are also valuable in providing advice to the Decision Maker.

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

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

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

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

The report must contain sufficient detail. It is not enough to state, "sat comfortably at interview"; better is to state "appeared to sit 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".

For example, with reference to walking at a Face-to-Face AC Assessment, "He walked 25 metres to the assessment room at a slow pace, without stopping or apparent breathlessness".

For example, at a Telephone Assessment, "She was able to speak in short sentences, and appeared to stop to catch her breath".

For example, at a Video Assessment, "He was able to raise his left hand up to his face to adjust his glasses". For sitting at a Video Assessment, "He got up from sitting to standing unaided and walked away to retrieve his prescription slip".

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

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

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

3.1.12 Clinical findings

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

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

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

For example:

"Lumbar spine: forward flexion to knees; lateral flexion full on R but half normal level on L. Straight leg raise 90° (normal) on R but only 45° on L. Respiratory rate was 14 per minute (in the normal range)."

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

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

Or

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

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

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

Only findings from the formal clinical examination should be recorded in this section, any findings noted from observation should be recorded in the relevant 'observations' section.

Where the clinical examination findings differ from the behaviour noted on informal observation, then a clear explanation of this apparent inconsistency will have to be given to the Decision Maker.

3.2 Functional Categories (Physical)

3.2.1 Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2.1.1 Background to guidance on the use of aids and appliances

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

The facts of the Upper Tribunal decision were as follows:

The case was assessed under the ESA Regulations 2008.

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

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

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

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

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

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

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

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

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

This Guidance stated:

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

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

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

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

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

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

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

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

Where an Aid or appliance has been prescribed or advised

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

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

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

Example 1

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

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

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

Where an Aid or appliance has not been prescribed or advised

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

Factors include whether:

The claimant possesses the aid or appliance:

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

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

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

The health condition or disability is likely to be of short duration (Where a disability is likely to resolve in the short term, it is likely that only very simple aids that are very widely available should be considered; it is unlikely that claimants would be offered aids or appliances that require any form of specialised fitting or prescription, or structural alterations to property, would be relevant in this situation. So, if a claimant has sustained a fracture to their ankle, it would be reasonable to consider the use of crutches or a walking stick, as these would commonly be provided following an acute injury, but anything more complex than these would not be appropriate since the disability will resolve in the short term.)

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

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

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

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

Example 2

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

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

Example 3

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

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

3.2.1.3 HCP Guidance when considering aids and appliances within the WCA:

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

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

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

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

Claimants may have been advised to use aids or appliances, or indeed had these supplied, following assessment by various clinicians involved in their care.

For example, Health Visitors, District Nurses, and General Practitioners may provide incontinence products, commodes, and access to laundry services. Occupational Therapists can provide aids to daily living and advice on housing adaptations. The Physiotherapist can advise on appropriate walking aids and appliances. Communication aids can be supplied via a Speech Therapist.

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

problems such as synovitis may result especially if there is an inflammatory arthritis.

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

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

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

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

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

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

1. Remember that the use of aids and appliances should be considered in **all** the physical activities within the WCA. It should therefore become routine to specifically ask claimants if they have any aids or appliances that they use.
2. Where the claimant states they already use an aid or appliance, find out about any problems they may have with it as well as how it assists them. Assess all the relevant physical activities within the WCA taking into account the aid/appliance and any functional improvement it brings.
3. Where the claimant states they possess an aid or appliance but do not use it, find out why this is so. What problems emerged with the aid/appliance that led them to reject it?

Are there any circumstances in which they are able to use it successfully? What would have to change to enable them to use the aid/appliance successfully? Are they embarrassed to use it for example (as in Example 1 above where 'Billy' did not want to use the walking stick as he felt it made him look old)? Have they approached the clinician that provided the aid, or their GP perhaps, to report the problems and, if so, is anything being done about it (for example providing an alternative aid/appliance)? Assess all the relevant physical activities within the WCA, considering the claimant's stated reasons for not using the aid/appliance and offering your opinion as to whether it would be reasonable to expect they could use it successfully, based on the information available.

4. Where the claimant does not use an aid/appliance or has not been prescribed/provided with/advised to use one, consider whether any simple aid or appliance could be used to improve the claimant's function in any of the activities. Take into account the information that has been gathered during the assessment, in terms of other medical conditions and disabilities present which may make it difficult to use an aid/appliance, as well as details about the claimant's accommodation and access to it which may affect the recommendation given.
5. Ensure that the Personalised Summary Statement addresses the issue of aids/appliances where this is relevant. Make it clear when a particular activity has been assessed with/without an aid/appliance, giving justification in terms of the relevant evidence used and the descriptor chosen. This will be particularly relevant, of course, when recommending an aid/appliance that has not previously been used by the claimant, as well as when advising that a claimant's decision not to use a particular aid/appliance seems inconsistent with the available information.
6. Remember that the role of the HCP is to offer advice only: the DM will consider the evidence that is present and will come to their own conclusions as to the use of aids/appliances in each case. Likewise, the HCP is only expected to use such evidence as is reasonably available to them when offering advice: in many cases this will be solely based on the claimant's own account.
7. Finally, remember that issues such as affordability and availability of particular aids/appliances are out with the scope of the HCP role within the WCA assessment and need not be considered when offering advice.

Physical Descriptors:

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

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

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

Descriptors

Wa ***Cannot either***

- (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion***
- or***
- (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion***

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

Wc Cannot either:

- (i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion***
- or***
- (ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion.***

Wd Cannot either

- (i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion***
- or***
- (ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion***

We None of the above apply

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

Scope

This activity relates primarily to lower limb function, however; other factors such as cardiorespiratory issues and fatigue must also be taken into account.

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

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

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

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

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

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

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

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

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

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

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

propelled.

Although a bariatric wheelchair is also a manual wheelchair and as such needs to be considered as an appropriate aid, the HCP will need to give careful consideration into whether the claimant is able to reasonably use one. A claimant requiring such an aid is likely to have co-morbid conditions affecting their exercise tolerance and the power required to push such a wheelchair is likely to be considerable. It will be important to clarify whether they already use such an aid and if so whether they can effectively propel this themselves.

Details of activities of daily living

Consider the claimant's ability in relation to:

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

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

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

With reference to sitting and wheelchair use for mobilising, to totally preclude wheelchair use due to sitting issues, then there is likely to be very severe restriction in hip and spine function or significant problems with skin integrity or pressure area concerns.

The sitting time required to cover the distances defined in the mobilising descriptors is short. Studies have indicated that self-propelling a wheelchair at a relatively low speed of 0.5 metres per second means propelling 50 metres can be achieved in 100 seconds. With a speed of about 0.8 metres per second, a distance of 200 metres could be covered in under 4.5 minutes. (Journal of Rehabilitation Research and Development Vol 44, Number 4, 2007, pages 561-572).

Therefore, where there are no other issues such as cardiorespiratory problems, fatigue or upper limb problems the ability to sit for a reasonably short period should allow use of a wheelchair to facilitate mobilising.

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

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

Observed behaviour

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

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

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

Clinical examination

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

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

The Peak Expiratory Flow Rate (PEFR, Peak Flow) is not measured for the purposes of WCA. If relevant, you should ask the claimant if they keep a record of their PEFR. You should make a note of any PEFR readings provided in the history and be prepared to evaluate the readings as part of the analysis of evidence.

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

3.2.3 Standing and sitting - Activity 2

Descriptors

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

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

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

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

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

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

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

Sd None of the above apply.

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

Scope

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

Sa “Moving between adjacent seated positions” is intended to reflect a wheelchair user who is unable to transfer, without help, from the wheelchair. It reflects a substantial restriction of function important within the workplace and therefore the inability to transfer without assistance from another person implies the person has LCWRA. In considering their ability

to transfer the use of “reasonable aids” such as a transfer board should be taken into account. Use of situation specific aids such as a hoist should not be considered.

In Sb and Sc, the person does not have to stand or sit for more than 30 or 60 minutes. They can alternate between the two. For example, a person may only be able to sit for 30 minutes, but then stand for 15 and then sit for another 30 minutes, before standing again. In this case they would not attract a scoring descriptor as they are able to remain at the workplace **for in excess of 60 minutes**.

N.B. – the person must be able to stand with one hand free to make this effective standing in the workplace, so for example a person who needs 2 crutches to stand would not be considered as “effectively standing”.

Sitting

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

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

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

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

Details of activities of daily living

Consider the claimant's ability in relation to:

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

Observed behaviour

Record the claimant's ability to sit without apparent discomfort during a Face-to-Face AC/HC Assessment or at a Video Assessment, where this has been observed. Take great care not to give the impression in your report that the observed behaviour is the maximum

that can be achieved.

Standing

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

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

Details of activities of daily living

Relevant activities are:

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

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

Observed behaviour

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

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

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

Transferring

The inability to transfer between one seated position and another suggests significant disability. It reflects those who are wheelchair dependant and unable to transfer

independently. Upper limb function may be relevant in this activity. For example, a rehabilitated paraplegic who is able to transfer by use of his upper limbs would not satisfy the transferring descriptor.

Details of activities of daily living

Relevant activities may include:

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

Observed behaviour

Observe the claimant's ability to rise from sitting. For example, during a Face-to-Face AC Assessment, note the type of chair when they are collected from the waiting area. There is a further opportunity to observe this function following the interview. This will provide some information on their likely ability to transfer. Some observations may be possible during a Video Assessment to help inform the claimant's ability to rise from sitting.

Clinical examination

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

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

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

3.2.4 Reaching - Activity 3

Descriptors

- Ra** *Cannot raise either arm as if to put something in the top pocket of a coat or jacket*
- Rb** Cannot raise either arm to top of head as if to put on a hat.
- Rc** Cannot raise either arm above head height as if to reach for something.
- Rd** None of the above apply.

Scope

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

The functional category considers the claimant's ability to reach mainly in an upward direction through movement at the shoulder joint through forward flexion or abduction. The descriptors also reflect internal rotation of the shoulder. It is an evaluation of power, coordination and joint mobility in the upper limbs.

It reflects a **bilateral** problem.

Consider only the ability to achieve the described reaching posture and do not measure hand function, i.e. it is not necessary for the claimant to adjust the hat if he/she can achieve the reaching movement defined in Descriptor Rb "Cannot raise either arm to top of head as if to put on a hat".

Details of activities of daily living

Consider details of self-care which involve reaching e.g.:

- Dressing and undressing (including reaching for clothes on shelves/in wardrobes).
- Hair washing and brushing.
- Shaving.
- Household activities such as reaching up to shelves; putting shopping away at home; household chores such as dusting; hanging laundry on a washing line.
- Leisure activities such as aerobics, golf, painting and decorating.

Observed behaviour

Record any spontaneous movements of the upper limbs, particularly if these are in excess of those elicited by formal examination.

Consider the speed and efficiency of dressing/undressing. Apart from the removal of outdoor clothes there will usually be no direct observation of the claimant dressing or undressing. However, you should look for evidence of protecting a painful shoulder during any observed activity.

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

Examination

Ensure that the examination clarifies whether the disability is unilateral or bilateral. If unilateral, state which side is affected and document the normality in the opposite limb. The MSO should identify any requirement for a more focussed regional examination – especially of the shoulder joint if restriction is apparent.

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

Descriptors

- Pa ***Cannot pick up and move a 0.5 litre carton full of liquid.***
- Pb Cannot pick up and move a one litre carton full of liquid.
- Pc Cannot transfer a light but bulky object such as an empty cardboard box.
- Pd None of the above apply.

Scope

This activity relates mainly to upper limb power; however joint movement and co-ordination may also have to be considered. It is intended to reflect the ability to pick up and transfer articles at waist level, i.e. at a level that requires neither bending down and lifting, nor reaching upwards. It does not include the ability to carry out any activity other than picking up and transferring, i.e. it does not include ability to pour from a carton or jug.

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

Within the descriptors, the concept of adaptation exists. There is no requirement to have two hands to achieve the tasks outlined in the descriptors. However, safety, reliability and

repeatability must be carefully considered.

For example, in Pc, a person could reasonable manage this by using one hand and supporting the box against another part of their body.

In descriptors Pa and Pb, if the person could move the weight by using both hands together, they should be considered capable of performing the task.

The ability to carry out these functions should be considered with the use of any prosthesis, aid, or appliance.

Details of activities of Daily Living

To get a measure of what the claimant can do consider domestic activities such as:

- Cooking (lifting and carrying saucepans, crockery).
- Shopping (lifting goods out of shopping trolley or from the supermarket shelves).
- Dealing with laundry/carrying the laundry.
- Lifting a pillow.
- Making tea and coffee.
- Removing a pizza from the oven/ carrying a pizza box.

Observed behaviour

Relevant observations may be obtained during a Face-to-Face AC/HC Assessment or Video Assessment.

Watch for hand, arm, and head gestures.

Note the ease (or otherwise) with which any coat or jacket is removed and replaced. The claimant may hang up a coat or a jacket allowing observation of shoulder joint and arm action.

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

They may use a hand to open a door.

The claimant may be observed handling items during the Video Assessment. For example, may handle a cup of tea or a bottle of water.

Where there is a lack of co-operation in carrying out active neck and shoulder movements then informal observations, coupled with examination of the upper limbs, may allow an estimate of the usual mobility of the shoulder girdle. This may well be confirmed by evidence from the typical day.

Examination

Consideration should be given to joint movement and power. Reduced co-ordination or other neurological problems such as tremor may have to be assessed when considering these activities. Ensure that the physical examination clarifies whether the disability is unilateral or bilateral. If unilateral, state which side is affected and document the normality in the opposite limb. The MSO should identify any requirement for a more focussed regional examination if any restriction is apparent.

3.2.6 Manual Dexterity - Activity 5

Descriptors

Ma *Cannot either:*

- (i) press a button, such as a telephone keypad or;*
- (ii) turn the pages of a book with either hand*

Mb Cannot pick up a £1 coin or equivalent with either hand.

Mc Cannot use a pen or pencil to make a meaningful mark.

Md Cannot single-handedly use a suitable keyboard or mouse.

Me None of the above apply.

Since using a keyboard is usually a bimanual activity, the wording of descriptor Md has been amended to reflect the ability to use a keyboard or mouse singlehandedly.

Scope

This activity relates to hand and wrist function. It is intended to reflect the level of ability to manipulate objects that a person would need in order to carry out work-related tasks. Ability to use a pen or pencil is intended to reflect the ability to use a pen or pencil in order to make a purposeful mark such as a cross or a tick. It does not reflect a person's level of literacy. The same concept applies to use of a computer keyboard. When considering the use of a keyboard, ergonomic advances in equipment should be considered.

The actual familiarity with the use of a PC in technical terms is not considered in Md.

An upper tribunal decision (DG v SSWP (ESA) [2014] UKUT 100 (AAC) has clarified that activity 5/M(d) can only apply if a claimant is unable to use both a keyboard and mouse. So, if a claimant can use either a keyboard or a mouse with one hand, activity 5/M(d) will not apply.

In the context of activity 5/M(d), only one hand is required to adequately operate a keyboard. The upper tribunal have dismissed claims that use of a keyboard requires the use of both hands.

The HCP must therefore consider carefully if someone who is so impaired as to be unable to use a keyboard can use a suitable mouse and vice versa. In many cases such a severe limitation for one may well mean the other is equally severely limited.

For Example:

If a person can use a mouse with one hand but not a keyboard – activity 5/M(d) does not apply.

If a person can use a keyboard with one hand but not a mouse – activity 5/M(d) does not apply.

If a person cannot use a mouse or a keyboard with either hand – activity 5/M(d) applies.

The descriptors reflect that those with effective function of one hand have very little restriction of function in the workplace. The descriptor scoring in these areas is weighted quite highly as bilateral restriction of hand function is disabling even in the modern workplace. The ability to turn pages in a book is considered essential in the workplace, therefore a person meeting the criteria in M(a) would be considered to have limited capability for work-related activity.

Details of Activities of daily living

Consider activities such as:

Filling in forms (e.g. ESA50/UC50, national lottery ticket).

Use of phones, mobile phones, setting house alarms, light switches.

Paying for things with either cards or cash.

Coping with buttons, zips, and hooks on clothing.

Cooking (opening jars and bottles; washing and peeling vegetables).

Leisure activities such as reading books and newspapers; doing crosswords; knitting; do-it-yourself jobs.

Driving, including manipulating the fuel cap to refuel a car, using keys to open locks etc.

Observed behaviour

Relevant observations may be obtained during a Face-to-Face AC/HC Assessment or Video Assessment. You may have the opportunity to observe how the claimant handles tablet bottles, their expenses sheet, or a repeat prescription. You may also observe them lifting objects such as a pen, handling a newspaper/book, handling a mobile phone, drinking from a bottle, etc. Fine movements may be observed if the claimant adjusts their spectacles or their hair or scratches their head.

They may also adjust their watch or unbutton a shirt cuff for examination.

Examination

In addition to the examination of the upper limbs as subsequently described; where possible, inspect the hands carefully and document any evidence of ingrained dirt or callosities, indicating the possibility of some heavy domestic/manual work at some point in time (but be careful to consider that the callosities may not necessarily represent recent manual work).

Where possible, test grip. Assess the ability to perform pincer movements and opposition of the thumb.

Indicate whether the problem is unilateral or bilateral.

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

In view of the complexity of a hand/wrist examination provide a simply worded summary particularly if your descriptor choice is at variance with that of the claimed level of disability.

Example:

Consider the case of a man with mild, bilateral Dupuytren's contracture where the disability claimed is in excess of your descriptor choice. The following summary of your clinical findings would assist the Decision Maker:

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

3.2.7 Navigation and maintaining safety, using a guide dog or other aid if either is or both are normally, or could reasonably be, used – Activity 8

Descriptors

- Va Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment.
- Vb Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment.
- Vc Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment.
- Vd None of the above apply.

The wording of the activity has been amended to reflect the policy intent on the use of aids and appliances relating to all the physical activities and descriptors.

Scope

Please note that as the Navigation activity area has no LCWRA descriptor, **it is important to consider whether those with visual restriction may meet LCWRA criteria in activity 6 or 7 (Communication Activities).**

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

When considering the descriptors, the HCP must always consider whether any task can be completed in a reasonable, reliable, and repeatable manner.

Within the modern workplace, many adaptations can be made to accommodate those with visual impairment.

Within the workplace, the key issue is the individual's ability to navigate and maintain safety in their environment.

The environment must be taken into account. Those who are able to navigate in familiar surroundings (such as their own street) but need the support of another person in an unfamiliar environment, will have a greater level of disability than those who have adapted to navigating in any area, whether familiar or unfamiliar.

The concept of safety awareness and the person's ability to safely negotiate hazards must be considered. This is an important issue in a workplace as provision of a companion throughout the working day to ensure safety may be considered an excessive adaptation for an employer to make.

The clinical history must be considered. The duration and speed of progression of visual loss is likely to impact on an individual's ability to adapt to navigation and safely negotiate hazards. For example, someone who has had sudden complete loss of vision very recently, perhaps as a result of trauma, is less likely to have adapted quickly than someone with congenital visual restriction or a slower progression of visual loss. Other medical conditions may have to be considered to assess the individual's likely ability to adapt – e.g. those with cognitive impairment may have more difficulty adapting to a visual impairment.

The person's ability must be considered in the context of using any aids such as spectacles, a long cane or guide dog they normally use. As a guide dog is not universally available/suitable for every person, the use of a guide dog must only be considered if the person already has a guide dog. The use of GPS devices would not be considered in this area.

The level of visual restriction is likely to impact on the person's ability to navigate. Visual field restriction is also important in maintaining awareness of hazard, but again, the ability to adapt should be considered – e.g., whether they have had formal mobility training to help their safety outdoors.

Any restriction identified must relate primarily to a sensory problem, and not cognitive issues as these are considered elsewhere.

Normal vision is taken as visual acuity of 6/6 at a distance of 6 metres from the Snellen

chart. To hold a class 1 driving licence in the UK, acuity of 6/12 on the Snellen chart is required. To have problems in navigation, it would be expected that the person would have a severe level of sight impairment. It is likely the person will be registered as sight impaired or severely sight impaired. A person registered as sight impaired or severely sight impaired will be given a certificate of vision impairment (CVI). These forms vary slightly depending on location:

- A Certificate of Vision Impairment (CVI) is used in England. This replaced the former BD8 form in 2003.
- A CVI(W) is used in Wales.
- A CVI-NI 2007 is used in Northern Ireland.
- A CVI (Scotland) was introduced in April 2018 to replace the BP1 (certificate of blindness or defective vision).

If the claimant has such a certificate and wants this to be considered as part of the assessment report for WCA purposes, the HCP must review the information on this and take it into account in their justification. HCPs must follow the guidance in section 4.2.5 to ensure a copy of the certificate is available for the DM to consider.

It should be noted any superseded forms such as the BD8 or BP1 brought to the assessment, should also be also considered as evidence in the same manner as the CVI.

Registration of a person as severely sight impaired or sight impaired is the role of the consultant ophthalmologist. This can be a complex procedure, but some examples are provided below.

People with acuity below 3/60 on the Snellen chart would be considered as severely sight impaired. People with acuity of 3/60 but less than 6/60 with significant visual field restriction may also be registered as severely sight impaired. People with acuity of 3/60 to 6/60 with a full visual field may be registered as sight impaired. Those who have a gross contraction of the visual field and vision of 6/18 or even better may also be registered as sight impaired.

More information can be found on:

<https://www.gov.uk/government/publications/guidance-published-on-registering-a-vision-impairment-as-a-disability>

<http://www.rcophth.ac.uk>

http://www.rnib.org.uk/livingwithsightloss/registeringsightloss/Pages/register_sight_loss.aspx

It may be useful to consider DVLA driving requirements in relation to functional ability. In order to have a class 2 driving licence in the UK, a full binocular field of vision is required. For a normal class 1 driving licence in the UK, specific standards are also required and, for example, someone with a homonymous hemianopia or bitemporal defect would not be allowed to hold a licence. Further information on driving standards can be obtained on the DVLA website:

<https://www.gov.uk/government/organisations/driver-and-vehicle-licensing-agency>

The LiMA repository contains extensive useful information on assessment of vision and visual fields and may be referred to.

The effect of many blinding eye conditions depends upon lighting levels and glare. This is noted in the CVI where the consultant is asked “Does sight vary markedly in different light levels?” Most eye diseases have a degree of fluctuation in terms of daily living. For example, an individual with severe glaucoma may be tested in a clinic and found to read a few lines on a test chart, but when he/she goes outside on a sunny day, he/she may have greatly reduced vision as what little he/she has is rendered non-functional by disabling glare.

Details of Activities of daily living

Consider activities such as:

- Driving – both from the visual acuity and visual field point of view.
- Ability to get around indoors.
- History of falls or accidents.
- Ability to use public transport - get on and off buses unassisted and read the bus name and number, get on and off correct tram/train.
- Mobilising independently outdoors.
- Going to a supermarket.
- Reading newspapers or magazines.
- Maintaining safety in the kitchen, ability to cook meals.
- Getting in and out of a bath.
- Caring for children.

Observed behaviour

Relevant observations may be obtained during a Face-to-Face AC or HC Assessment or Video Assessment.

Ask the claimant how they got to the AC and how they found their way around the centre. Note whether the claimant needed to be accompanied by another person.

Note any observed ability to manipulate belts and buttons – inability to do so would indicate very severe sight loss.

Observe whether the claimant manages to read their medication labels or repeat prescription sheet.

Record if any vision aids such as spectacles are in use.

Examination

Record the aided binocular vision and explain the significance of this to the Decision Maker.

If the claimant forgets their spectacles but there is evidence from the typical day activities and behaviour observed that there is no significant disability with vision, then this should be reflected in your descriptor choice. In these cases, or in cases where the Visual Acuity is poor, but you think it could improve with correction, measure it using a pinhole. Only in exceptional circumstances should a claimant be recalled for an eyesight test with spectacles worn.

Near vision should be recorded using a near vision chart during a Face-to-Face AC or HC Assessment. N8 print is the equivalent size of normal newsprint, although the high contrast of a near chart makes it easier to read than newsprint. **HCPs should ensure that they use a near vision testing chart with N16 print to accurately assess ability to read 16-point print in a reasonable, reliable and repeatable manner.** For Video Assessments, please follow the examination protocols.

It should be noted that claimants registered as Severely Sight Impaired/Blind will be unlikely to be able to read 16-point print, even with a low vision aid, and therefore whether they meet criteria for LCWRA in Communication activities should be considered.

HCPs should ensure that they use a near vision testing chart with N16 print to accurately assess ability to read 16-point print. It should be noted that the HCP should assess the ability to read a short sentence on the near vision chart and not just a single word.

Visual field testing

For all assessment channels, where there is a history of any visual field problem or where the HCP at assessment feels there may be a visual field problem the history must adequately cover these areas in sufficient detail.

For Face-to-Face AC or HC assessments, where there is a history of any visual field problem or where the HCP at assessment feels there may be a visual field problem, visual fields must be tested. However, this is unnecessary when it has been provided in the CVI (or equivalent).

Visual field testing can be a complex procedure requiring sophisticated equipment to aid diagnosis or to assess minor defects in the visual fields.

Minor defects in visual fields will rarely result in significant functional problems. Therefore, for the purposes of disability analysis, the traditional method of visual field examination by the “confrontation method” detailed below is adequate to detect gross defects in the visual fields that may be of functional relevance. If the person has a CVI, details of visual field restriction may also be detailed there.

A structured approach for performing visual field testing by the “confrontation method” is outlined below:

Ensure you have a piece of card for the claimant to cover up one eye.

Sit 60cm from the claimant and ask them to look directly into your eyes and keep looking

straight at your face.

Ask the claimant to cover their Right eye with the card provided.

Check there is no central defect by ensuring they can see your full face.

Cover your left eye and stretch your right arm (i.e. the arm that is on the same side as the claimant's uncovered eye) out in a plane equidistant between you and the claimant and at the outermost periphery of your vision.

Move the index and middle fingers on this hand and confirm the claimant can see your fingers moving and ask the claimant which hand is moving.

Move your hand to different positions to check the superior, inferior, nasal and temporal fields in order. You may wish to change the fingers being moved to ensure accuracy of response.

Repeat the process with the claimant covering their left eye, you covering your right eye and moving your left hand.

For the purposes of the LCW/LCWRA, you should consider any visual field loss in the context of whether or not it is likely to impact on the person's ability to safely navigate.

This should be in considered with visual acuity and the typical day and any information obtained from a CVI brought by the claimant. You must provide the DM with a detailed justification of your choice of descriptor.

3.2.8 Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person – Activity 6

Descriptors

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

SPb Has significant difficulty conveying a simple message to strangers.

SPc Has some difficulty conveying a simple message to strangers.

SPd None of the above apply.

The wording of this activity has been amended to reflect the DWP policy intent on the use of aids and appliances relating to all the physical activities and descriptors.

This activity relates to ability to express yourself rather than simply speech. **It assumes use of the same language as the person with whom communication is being attempted. Where speech is considered, local or regional accents are not taken into consideration.**

The scope of the descriptor includes impediment to communication due to physical causes, for example due to expressive dysphasia (inability to express one's thoughts) resulting from brain injury or generalised neurological conditions causing problems with speech and manual dexterity such as Motor Neurone Disease and advanced Parkinson's Disease. In considering expressive dysphasia, the person's ability to write, type or text would also have to be considered.

People who have had a Stroke may have both speech and upper limb problems such that they have significant problems with communication through speech or writing.

Speech is an extremely complex activity, involving intellectual, neurological, and musculoskeletal components. It may, therefore, be affected by any condition involving these areas. In rare cases, it may be that both psychological and physical factors play a part in the causation of speech difficulties. In every case, alternative methods of communication must be considered. It should be noted that the descriptors in this area infer a reduction in function due to physical limitations.

Occasionally people whose main diagnosis is panic disorder claim that they have difficulty making themselves understood during an episode of acute anxiety. Similarly, those with severe chronic fatigue syndrome may claim that speech becomes unclear when they are tired. Consider carefully whether such claimants should be assessed under the Mental Function Assessment. You should consider their ability to make themselves understood most of the time by any means. If problems with communication are purely due to mental health problems, then this would need to be addressed within the mental function activity areas and not in the physical sensory activities.

Some claimants who suffer from breathlessness due to physical causes will describe difficulty with speech. However, in many of these cases, the problem is transitory and only occurs during extra physical effort, for example walking quickly or climbing stairs.

Therefore, for the majority of the time, they will have normal speech. If the claimant is breathless at rest, you should consider advising that they meet LCWRA criteria for mobilising.

The level of communication in the descriptors represents a very basic level of communication and this can be achieved by writing or typing if speech is not possible. The concept of communicating a message such as a hazard is hypothetical and the immediate availability of a PC/Pen and paper to write a message would not be considered. Those with significant communication problems are likely to carry items such as a pen/paper to ensure they can communicate.

Details of activities of daily living

Consider:

- The ability to socialise with family and friends.
- The ability to ask for items e.g. order drinks at a bar or ask for items in a shop where self –service is not available – do they use speech or do they write a list and hand it over.
- Ability to use public transport/ taxis.

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- Ability to use a telephone.
- Ability to use text/e-mail.
- Ability to deal with correspondence, complete ESA50/UC50 may give information about written communication.

Observed behaviour

Relevant observations are likely to be obtained via any of the assessment channels.

Describe the quality of speech at interview and any difficulty you have in understanding the claimant.

If possible, during a Face-to-Face AC/HC Assessment or Video Assessment, note any abnormalities of the mouth and larynx and their effects on speech.

Hand function may have to be considered where speech is a significant issue. Upper limb function may have to be assessed to ascertain whether then person could communicate a simple message through the written means.

3.2.9 Understanding Communication by

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

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

iii) a combination of i) and ii),

**using any aid that is normally, or could reasonably be, used, unaided
by another person - Activity 7**

Descriptors

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

Hb Has significant difficulty understanding a simple message from a stranger due to sensory impairment.

Hc Has some difficulty understanding a simple message from a stranger due to sensory impairment.

Hd None of the above apply.

The wording of the activity has therefore been amended to make it clear that they could apply if a person has a hearing impairment alone, a visual impairment alone or a combination of hearing and visual impairment.

Scope

This activity relates to the ability to understand communication sufficiently clearly to be able to comprehend a simple message. It does not relate to being able to follow a complex conversation, the level of communication is basic. It is intended to take into account hearing aids if normally worn, ability to lip read and ability to read large size print or Braille to understand a basic message. When considering communication, it is assumed that the language/accents used (whether written or verbal) is one that they are familiar with (including different versions of Braille). It should be noted that when considering a person's ability to understand either a simple verbal or written message, the HCP must carefully consider if this can be achieved in a manner that is **reasonable** and whether the person could **repeat this on a reliable basis**. For example, if a person was clearly struggling to read a single word of 16-point print using a magnifying glass, they would not be considered as understanding the written message in a reasonable, reliable or repeatable manner.

It should be noted that in this activity, a person must be able to understand communication through **both** the written and spoken word. A restriction of understanding in either of these communication modalities may result in a scoring descriptor. For example, this means a person with normal hearing ability who understands the spoken word without difficulty but has visual impairment to the extent they cannot read 16-point print nor read Braille in a reasonable, reliable or repeatable manner would meet LCWRA criteria in this activity.

Considering Hearing

The methods used to assess the ability to understand communication involve considering a person's ability to hear a shout at one metre and their ability to lip read. The descriptors are intended to take into account hearing aids if normally worn. A "shout" is equivalent to 80dB of noise and therefore inability to hear a shout suggests a significant loss of hearing.

State the claimant's ability to wear a hearing aid. If the claimant has rejected the prescribed hearing aid, then state the reason why. Bear in mind that a claimant who has been inconvenienced by a hearing aid and has abandoned it should be assessed without aids.

People with bilateral hearing loss with an average loss of less than 30Db do not usually gain from any form of hearing aid as the small amplification needed creates distortion of sound. Hearing aids function by amplifying sounds, but they cannot help with the processing of sound.

For this reason, conductive hearing loss is more likely to be helped with an aid than sensorineural hearing loss.

For the same reason, hearing loss which is evenly distributed throughout the frequencies is more amenable to hearing aid use. Where the hearing loss varies over the frequencies, an aid can create sound distortion and discomfort.

Older claimants can have difficulties adapting to hearing aid use.

The level of lip reading required is very basic as it involves understanding only a simple message and it would be expected that the vast majority of people would meet this level of proficiency in lip reading. It is however important to be mindful that some people may not be able to lip read a simple message, for example those with severe profound pre-lingual deafness who have no experience of the spoken word. Also, people with a visual impairment may be unable to lip read as they cannot adequately see the persons face to lip read.

When considering the descriptors, the HCP must comment on lip reading ability which will be apparent from the assessment in most cases and document hearing ability.

Considering the use of Braille

In 2019 the RNIB brought forward a case for the Department to consider in regard to the Severe Conditions criteria (see section 3.10.1.3), specifically around how the ability to learn Braille affects the HCP's recommendation.

Claimants with severe visual problems who cannot read 16-point print using reasonable aids and cannot read Braille in a reasonable, reliable or repeatable manner will meet LCWRA criteria for Understanding Communication; if the visual problems are unlikely to improve in the foreseeable future, whether or not to advise "in the longer term" or a severe condition prognosis will be determined by the likelihood of the claimant being able to learn Braille in the future.

Remember that fewer than 1% of visually impaired individuals are users of Braille and that Braille users are usually those who have not been able to see from an early age and have been educated in Braille.

The HCP must consider multiple factors when providing prognosis or re-referral period advice for WCA purposes in relation to the use of Braille. Factors to consider include:

- Severe condition advice is likely to be appropriate if, for example any of the following factors apply -
 - Rapid onset or longstanding visual impairment.
 - Mental, cognitive or intellectual impairment likely to affect motivation or learning.
 - Hand problems including dexterity and sensory upper limb impairment.
- 1. When providing WCA advice, if a claimant reports that they do not read Braille, HCPs should obtain relevant information such as -
 - Are they aware of Braille as an available aid?
 - If they are aware, have they tried to use it?
 - If not, why not?
 - Do they intend to use Braille in the future?

- If not, why not?

Severe condition advice would be appropriate for claimants who have unsuccessfully tried Braille in the past or have a plausible reason for not using it in the future.

A long-term prognosis would be appropriate for claimants who are unaware of Braille or who may use it in the future.

Details of activities of daily living

Consider any restrictions reported in the typical day with communication such as difficulty socialising, shopping and engaging in hobbies.

Note the use of any accessory aids such as headphones or loop system amplification for TV, radio, or video; amplification for telephone handset; loud doorbells or adapted doorbells such as light doorbells.

Consider their visual abilities, such as reading a newspaper, e-mails, use of the internet, watching TV, using subtitles on the television etc.

Consider day to day tasks where contact with other people is likely such as in the supermarket, **using** public transport etc.

Observed behaviour

Relevant observations are likely to be obtained via any of the assessment channels.

The claimant's response to a normal conversational or quiet voice during interview is generally a good measure of their ability to hear. In Video Assessments and Telephone Assessments, interpret hearing a conversational voice during interview – with caution as this may be affected by quality of device and/or peripherals used etc.

It may be helpful to assess the level of restriction (some vs. significant) by considering whether they understand the main context of questions, just missing an occasional word, or whether their restriction is more significant in that they struggle to follow a conversation.

At Face-to-Face AC/HC Assessments, very deaf claimants often fail to respond to their call in the waiting area or answer the door; they may 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.

During a Face-to-Face AC/HC Assessment or a Video Assessment, a person who relies on lip reading may have problems understanding questions if you are not facing the person directly when you speak to them. The person may read/look at their tablets, repeat prescription to give you some information about visual acuity.

Where a BSL (British Sign Language) interpreter is used, it is essential that the HCP assesses the claimant's lip-reading ability.

Examination

At a Face-to-Face AC/HC Assessment, the most relevant examination technique to assess any restriction in hearing is the **conversational voice test**. One ear is masked with the claimant's hand and the claimant looks away from the HCP. The claimant is asked to repeat numbers or words or answer simple questions which are posed in a normal conversational voice. The furthest distance away from the ear that the words can be heard is recorded.

The normal ear can detect a conversational voice at 9 metres which is impractical in most examination centres. A distance of 3 metres is acceptable proof of hearing for the purposes of reasonable functional hearing ability.

Free field speech testing, also referred to as the Conversational Voice (CV) test will give a rough guide to hearing loss. It requires the person's response to quiet voice, and conversational voice. (Testing by whisper is not recommended). The person being tested should not be able to pick up visual clues, by lip-reading.

The following is a very rough guide to the noise level of speech:

- It is normal to hear a quiet voice at 60 cms from the ear.
- Conversational voice not heard over 4 metres – loss approximates to 30dB in both ears.
- Conversational voice not heard over 3 metres - loss approximates to less than 40dB in both ears.
- Conversational voice not heard over 2 metres - loss approximates to 50 –53 dB in both ears.
- Conversational voice not heard over 1 metre - loss approximates to 61-66 dB in both ears.
- Conversational voice not heard over 30cms – loss approximates to 73-79 dB in both ears.
- Shout from not beyond 1 metre away - loss approximates to 80dB.

In unilateral hearing loss the normal ear generally compensates for the deaf one, so the overall hearing loss in such a case is unlikely to be significant.

However, checking the hearing in each ear separately and then both ears together provide the opportunity to detect unreliable responses suggestive of non-organic hearing loss.

Tinnitus

Claimants may refer to tinnitus when discussing hearing.

This is the perception of sound where there is no external stimulus. In rare instances, such sound is transmitted from vascular sources such as aortic or carotid murmurs.

Much more commonly, however, tinnitus is non-pulsatile and is linked to high frequency sensorineural deafness, which may be so slight or at such high frequency that it cannot be evaluated in a functional assessment.

The use of hearing aids can, by recruitment of background noises, help to mask tinnitus. Claimants may also have developed their own masking techniques, for example, using background music.

Tinnitus maskers may also be prescribed in severe cases.

Severe and/or resistant tinnitus can be very disabling and may result in sleep disturbance, anxiety and depression. The following factors will give indication of disabling tinnitus:

- Referral to a specialist unit
- The prescription of maskers/hearing aids
- The need for night sedation
- The prescription of anti-depressant medication

Tinnitus on its own is unlikely to cause functional hearing loss, however, can significantly impact on concentration therefore consider applying the Mental Function test in cases of tinnitus where there is cognitive impairment or other mental disablement, such as anxiety.

Tinnitus on its own is unlikely to impact to such a degree to amount to substantial problems in understanding simple communication.

Considering Visual Restriction

The main assessment measures **are the ability to read 16-point print using reasonable aids and for those who cannot read 16-point print; an assessment of their ability to read Braille to understand a simple message** in a reasonable, reliable or repeatable manner must be considered. A severe restriction of visual fields, such as a hemianopia, or tunnel vision due to glaucoma will also cause difficulty with reading.

Again, as in hearing, the level of reading 16-point print or Braille is only to a level where a simple message can be understood. The HCP must therefore make specific enquiry into ability to read Braille where restriction of reading print is identified.

It should be noted that fewer than 1% of visually impaired people are users of Braille. Of those, a small minority read fluently in Braille. Braille users are usually those who have not been able to see from an early age and have been educated in Braille.

It is worth noting that in the modern world of work, there are new technologies to help people with visual impairment to keep and find employment.

Details of activities of daily living

Consider any restrictions reported in the typical day with communication or reading such as difficulty socialising, shopping and engaging in hobbies.

Note the use of any accessory aids such as reading glasses, large print books, magnifying glasses, talking books etc.

Consider their visual abilities, such as reading a newspaper, e-mails, use of the internet, watching TV etc, using subtitles on the television, reading numbers on buses, packaging in supermarkets etc. Consider that the person may indicate they deal with their own medication (or may even read/look at their tablets, repeat prescription at assessment) to give you some information about visual acuity. However, they may know their medication from memory so this should be backed up with formal near vision testing.

Consider day to day tasks where contact with other people is likely or there is a need to understand the written word such as in the supermarket, using public transport etc. Ask whether they can cope with such situations unaccompanied.

If the person uses Braille, enquiry should be made about their level of training they have had and what types of material they read in Braille – e.g. newspapers, any forms they complete that are provided in large print/Braille.

Observed behaviour

Relevant observations for vision are likely to be obtained at a Face-to-Face AC/HC Assessment, or during a Video Assessment.

Observation of ability to navigate, read newsprint etc should be recorded.

If a person has combined visual and hearing impairment where a BSL interpreter is used, the HCP should consider whether the claimant uses lip reading in addition to “sign” and how well they can see the sign language being used.

It may be useful to consider level of restriction in the context of how easily a person reads a paragraph in large print (N16) – for example if they struggle with some text but can still manage to understand the main content of the paragraph, vs. a person who struggles to such a degree that they may misunderstand the key concepts in the text.

Examination

At a Face-to-Face AC/HC Assessments, visual acuity both for near and distant vision should be tested, together with visual fields where appropriate, as indicated in section 3.2.7. For Video Assessments, please follow the examination protocols.

Summary

Thus overall, you must assess a person’s ability in both sensory modalities. Where a

restriction is identified in one area, it is likely they will be awarded a scoring descriptor.

The following table may help in considering the level of restriction likely.

Hearing Impairment			Visual Impairment		
Assessment of ability to hear a shout at 1 metre	Outcome (where the person is unable to lip read)	Outcome (where the person is able to lip read)	Assessment of ability to read 16-point print	Outcome (where person is unable to read Braille)	Outcome (where the person is able to read Braille)
Cannot hear a shout at 1 metre	Cannot understand	No difficulty	Cannot read 16-point print	Cannot understand	No difficulty
Significant difficulty hearing a shout at 1m	Significant difficulty understanding	No difficulty	Significant difficulty reading 16-point print	Significant difficulty understanding	No difficulty
Some difficulty hearing a shout at 1 metre	Some difficulty understanding	No difficulty	Some difficulty reading 16-point print	Some difficulty understanding	No difficulty
No difficulty hearing shout at 1 metre	No difficulty understanding	No difficulty	No difficulty reading 16-point print	No difficulty understanding	No difficulty

For example,

A person who has no restriction of hearing but has some restriction of reading 16-point print with no ability to read Braille is likely to attract descriptor Hc.

A person who has some restriction of hearing and struggles to hear a shout at 1 metre but in addition has some reduction of vision who can still read 16-point print in a reasonable, reliable or repeatable manner but struggles with lip reading, may be awarded Hc or Hb depending on the level of their difficulty in understanding the spoken word, despite being able to read 16-point print.

A person who cannot see 16-point print but can read Braille in a reasonable, reliable or repeatable manner and hears normally, would be likely to be awarded Hd.

A person who has normal vision and can easily understand the written word, but who cannot hear at all and is unable to lip read will be likely to be awarded Ha.

A person who has normal hearing but very poor sight to the extent of being unable to read

16-point print in a reasonable, reliable or repeatable manner with no ability to read Braille will be likely to be awarded Ha.

3.2.10 Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bedwetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used – Activity 9

Descriptors

Ca At least once a month experiences

- (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or
- (ii) substantial leakage of the contents of a collecting device;
sufficient to require cleaning and a change in clothing

Cb The majority of the time is at risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly.

Cc None of the above apply.

The wording of the continence activity has been amended to clarify that only problems with incontinence occurring whilst the person is conscious should be taken into account when considering this activity.

Scope

This functional area relates to the ability to maintain continence of bladder or bowel or prevent leakage from a collecting device.

When considering these descriptors, the review group considered social acceptability and personal dignity to be of paramount importance. Therefore, someone who has loss of continence monthly will be considered to have LCW. It should be noted that to be considered as having LCWRA, the loss of control should be weekly. It is therefore essential to ensure the history contains adequate detail to make this distinction.

These descriptors take into consideration loss of continence while the claimant is awake/conscious. Any problems with incontinence that occur during sleep or during episodes of altered consciousness such as during seizures or under influence of alcohol or drug misuse would not fulfil the criteria for these descriptors. Thus, for example:

- A person has epilepsy with grand mal seizures occurring 1-2 times a month, with complete loss of consciousness and bladder incontinence during the seizures – none of the scoring continence descriptors would apply in this case.

The descriptors relate to a substantial leakage of urine or faeces – such that there would be a requirement for the person to have to wash and change their clothing. The descriptors do not refer to minor degrees of leakage that could be managed by the use of pads and not necessitate a full change of clothing. If a person is not using pads, this issue should be explored in terms of why they choose not to use pads to allow the Decision Maker to determine whether these would be a reasonable aid.

Urgency, as typically associated with prostatism, will not usually meet the criteria for 'incontinence' or 'loss of control', as it can be controlled by regular voiding. Detrusor instability can cause significant symptoms; however, the condition is likely to be controllable with the use of aids and pads in which case the scoring descriptors would not apply.

The policy intent for risk of incontinence – Cb - is that this should only apply if the likelihood of loss of control is very high **for the majority of the time.**

For Example:

- A person has Crohn's disease which is usually well controlled with medication, however he/she has flare ups which occur about once every 6 months, during the flare ups he/she has severe diarrhoea with blood and mucus and has to stay in most of the time to be close to the toilet as he/she can have episodes of bowel incontinence when the diarrhoea is very bad. These flare ups usually last about a week and then gradually settle down. In this case, none of the scoring continence descriptors would apply as the episodes of bowel incontinence are infrequent and would not result in a significant impact on function for most of the time.
- Claimants with gastro-intestinal problems such as dumping syndrome should be considered as possibly meeting the criteria for Cb when their problem is unpredictable to the extent that they would become incontinent if they did not leave their workplace immediately or within a very short space of time and this is a regular occurrence.
- Irritable bowel syndrome can usually be controlled with medication and/or lifestyle changes and is not often associated with such urgency that a scoring descriptor is likely to apply. NICE guidelines indicate that diarrhoea prominent IBS can usually be managed with medication such as loperamide, however, all the evidence such as use of pads and restriction of lifestyle must be considered when providing advice in IBS cases.

In every case, the diagnosis history/nature of the condition must be carefully considered and the true risk of loss of control considered on the balance of medical probability and evidence. Medication, specialist input and aids used must be documented.

It should be noted that in 2014, an Upper Tribunal decision determined that mobility issues must be taken into account when considering continence. This applies to both the Activity 9 LCW (Continence descriptors) and the Activity 8 LCWRA descriptor (Continence LCWRA). **Therefore, in cases where a continence problem is evident, HCPs must consider the impact of impaired mobility and provide advice accordingly.**

Further guidance on this issue is detailed below.

If a claimant is incontinent because they are unable to reach the toilet quickly enough as a result of mobility issues, then they should score against the relevant descriptor. So, for

example if a claimant with urge incontinence has to change their clothes at least once a month despite the use of incontinence aids because they are unable to reach the toilet quickly enough as a result of a lower limb/back problem, then the HCP should consider advising descriptor C(a).

This Upper Tribunal decision does not impact on how the actual “continence” problem is considered. The key issue is that the HCP must now take into account the impact of impaired mobility and how this impacts, on the continence problem.

As before, the claimant must have a medical condition affecting bladder or bowel function in order for the continence activity to be considered.

When considering a claimant with a medical condition affecting bladder/bowel function who in addition has impaired mobility, consider whether their mobility issue is sufficiently severe that their ability to access toilet facilities in a normal working environment, with reasonable adjustments, would be compromised. This assumes that toilet facilities are within a reasonable distance and on the level. If the history given is of continence issues where they have been unable to reach toilet facilities upstairs or a considerable walking distance away, then it is not relevant.

Within the history of daily activities, you should enquire about adaptations that they might be expected to have made to ensure they are not incontinent. Look for evidence of restriction in their ability to rise from a chair and move from the history gathered and based on any informal observations made within the AC or at a HC – if there are no restrictions then it seems unlikely that they would suffer continence issues due to mobility restriction within a workplace.

Within the history of daily activities, you should enquire about adaptations that they might be expected to have made to ensure they are not incontinent. The history of daily activities should also gather information about their ability to rise from a chair and move within the home. Depending on the mode of assessment, informal observations on the ability to rise from a chair and move within the assessment centre would be useful. If there are no significant restrictions, then it seems unlikely that they would suffer continence issues due to mobility restriction within a workplace.

As in all activity areas, careful exploration of the history is required to assess functional limitations and whether there are any reasonable adjustments or aids or appliances that should be considered.

Details of activities of daily living

Consider the frequency and length of any journeys or outings undertaken, together with any problems encountered in undertaking these activities, e.g.:

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

Observed Behaviour

During the Face-to-Face AC/HC Assessment, or Video Assessment, the claimant may show you pads or an extra change of clothing which they carry with them when they go out. The claimant may have to leave the room during the assessment to visit the toilet. Any such information should be documented in the relevant sections of the report.

3.2.11 Consciousness during waking moments - Activity 10

Descriptors

- Fa At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.
- Fb At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.
- Fc None of the above apply.

Scope

This function covers **any involuntary loss or alteration of consciousness resulting in significantly disrupted awareness or concentration** occurring during the hours when the claimant is normally awake, and which prevents the claimant from safely continuing with any activity. Such events occurring when the claimant is normally asleep should not be taken into consideration. The descriptors relate to the frequency with which such episodes of lost or altered consciousness occur. The working group reviewing the descriptors considered that seizures occurring on less than a monthly basis are unlikely to significantly impact on an individual's ability to work. It should be noted that the descriptors indicate that awareness must be significantly disrupted. This means the nature of the episodes and their effects on function must be explored to see if they fulfil the criterion of the descriptor.

In the context of disability assessments, the most likely causes of episodes of "lost consciousness" are:

- Generalised seizures (previously referred to as grand mal, tonic clonic and myoclonic seizures).
- Seizures which are secondary to impairment of cerebral circulation (e.g. as a result of cardiac dysrhythmias).
- Cardiac arrhythmia.

"Altered consciousness" implies that, although the person is not fully unconscious, there is a definite clouding of mental faculties resulting in loss of control of thoughts and actions.

The causes most likely to be encountered are:

- Focal onset seizures with impaired awareness (for example, temporal lobe seizures).
- Absence seizures which may be typical (petit mal) or atypical.
- Dissociative disorders, fugues and narcolepsy should be considered. Sleep apnoea is unlikely to meet the criteria for loss of consciousness as the person is in a state of sleep at the time and could be roused by noise or another person.
- Significant hypoglycaemia where the person requires the intervention of another person to manage the episode.

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

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

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

Migraine

Migraine is classified in the International Headache Classification of Headache Disorders, 3rd Edition (ICHD-3) in terms of "Migraine without aura" and "Migraine with aura". Migraine without aura is the commonest subtype.

The symptoms relating to migraine are wide ranging but do not usually result in a significant loss of consciousness **in most cases**.

One notable exception is migraine with brainstem aura (previously known as basilar artery migraine; basilar migraine; basilar-type migraine). Migraine with brainstem aura is **a rare condition** associated with aura. The symptoms relate to disruption at the brainstem and/or involvement of both hemispheres at one time without motor weakness. As a result of these headaches, several symptoms may occur. These include vertigo, tinnitus, hyperacusis, diplopia, ataxia, a variety of visual symptoms and decreased level of consciousness (ICHD – 3).

Thus, in cases where migraine with brainstem aura has **been formally established**, the HCP must carefully take note of symptoms to ascertain whether consciousness is disrupted to the degree described in the descriptors. The HCP must carefully enquire into frequency of episodes and the effect of treatment. (For example, verapamil has been shown to improve symptoms in some cases). Note, it is not the role of the HCP to attempt to diagnose migraine with brainstem aura.

The effect of migraine headache on any other functional category should be assessed in the same way as the effect of any other pain, bearing in mind the frequency and severity of the attacks.

Further information on migraine classification and symptoms can be found at:

<https://ichd-3.org/1-migraine/>

Variability

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

Details of activities of daily living

Consider:

- Whether the person drives - the DVLA will refuse to issue a licence to anyone who has had a daytime seizure in the past year.
- Potentially hazardous domestic activities such as cooking.
- Recreational activities e.g., swimming, contact sports.
- Whether the person has adapted in their lifestyle, e.g. taking a shower instead of a bath, making sure someone is home when they shower/wash, being accompanied when out, avoidance of supervising young children on their own, use of medical alert jewellery or cards, etc.

Observed Behaviour

No observations are usually useful for consciousness.

Examination

No formal examination is usually required for problems with consciousness, although a neurological examination may be appropriate and useful in certain situations.

3.3 Examination of the Musculoskeletal System

Introduction

This section deals with the formal clinical examination of the cervical, thoracic, and lumbar spine, and the upper and lower limbs, in the context of the assessment for functional disability

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assessment.

The back and lower limbs are relevant to the functional areas of:

- Walking and managing to negotiate steps.
- Standing and sitting and transferring.

The cervical spine and upper limbs are relevant to the functional areas of:

- Reaching.
- Picking up and moving.
- Manual dexterity.

It may be relevant in the ability to transfer from a seated position and to use a manual wheelchair or other aid.

General Principles of Examination

Remember that the clinical examination is only part of a disability assessment; clinical findings together with the interview and observation of the claimant build up a picture of objective evidence to support your choice of a descriptor, especially if your choice is different from that of the claimant.

The description provided below is mainly applicable to Face-to-Face AC/HC Assessments. Details on the examination in Video Assessment are available in the appropriate DWP approved examination protocols. Some aspects of the examination of the musculoskeletal may not be possible during a Video Assessment. A musculoskeletal examination is not completed during a Telephone Assessment.

Use of an unfocussed full top-to-toe examination without observations or a functional history will create an imbalanced report with weak justification for descriptor choices and lead to unnecessary examination of the claimant. A Musculoskeletal Overview is the examination of choice in most cases - full details at Section 3.1.4

It is essential to explain to the claimant the nature of the examination to be performed and explain that this examination is designed to look at general function of the musculoskeletal system. The Claimant will find the Musculoskeletal Overview very different from any routine examination undertaken by his GP and an explanation at the outset is valuable.

The MSO is intended to demonstrate normality. If an abnormal finding is identified, then a more detailed regional examination is likely to be required. If so, it is essential to avoid undue discomfort to the claimant.

Ask the claimant to indicate the site of the pain before palpating.

Observe active movements only, instructing the claimant not to perform or continue a movement if it becomes painful.

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There should be no reason to assess passive joint movements as part of the WCA as the examination being performed is based on function.

When examining the limbs, always examine the whole limb and not just the joint involved. If a unilateral problem is present, always compare the affected limb with the normal one.

Remember to record the findings in language that the Decision Maker will easily understand, i.e. do not use medical jargon and explain any medical terms used.

The examination should follow the standard clinical pattern of inspection, palpation, joint movements, muscle power, and sensation – if appropriate. The following notes should be read in conjunction with any appropriate DWP approved examination protocol.

Inspection

Observe any lack of symmetry and any evidence of trauma or disease. Look for muscle wasting; when assessing the cervical spine and upper limbs, look also for any evidence of muscle wasting of the scapular muscles. Inspect the joint contours and observe any evidence of swelling, deformity or inflammation.

Ask the claimant to point to, or otherwise identify, any painful areas, including sites of radiation of pain.

For accurate assessment of muscle wasting in the upper limbs, compare the circumference of the two limbs as follows:

Upper arm:	15cm above the lateral epicondyle
Forearm:	10cm below the lateral epicondyle

For the lower limb, the corresponding measurements are:

Thigh:	15cm above knee joint (most easily measured from medial joint space)
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Calf:	15cm below knee joint
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Palpation

Ask the claimant to identify any tender sites or areas of hypersensitivity, and obtain consent, before palpating. Palpate joints for any thickening, tenderness, or crepitus of the joints or tendon sheaths if appropriate.

Joint Movements

See below for details of the normal ranges of joint movement and the appropriate methods of assessing these.

Bear in mind that a claimant may purposefully or as a result of fear, limit the range of active movement at a joint.

Muscle Power

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

Sensation

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

Inappropriate Signs

Remember that psychological factors may influence the clinical picture presented by the claimant. The claimant's behaviour, whether consciously or unconsciously, may yield inappropriate physical signs and thus complicate the interpretation of physical signs. Behaviour by the claimant which is subconscious should not be construed as a deliberate attempt to deceive or be obstructive.

However, there may be instances where a claimant appears to be deliberately refusing to co-operate or may be consciously seeking to exaggerate the extent of their disability.

Signs which are often inconsistent with purely organic pathology include:

- Apparent muscle weakness without wasting or disturbance of reflexes (although reflexes are not tested during the examination for WCA purposes, this may be documented in FME).
- Regional sensory loss which does not follow any recognised dermatome when testing for nerve root compression.
- Overreaction to examination.
- Diffuse rather than localised tenderness.
- SLR reduced on active testing, but the claimant is able to sit up on the couch with knees extended.
- Jerky active movements.
- Refusal to co-operate with active movements of a joint, or lack of any serious attempt to move a joint.

If your assessment is that the examination findings are not consistent with the stated degree of functional disability, or that the claimant was deliberately not fully co-operating with the examination, this should be clearly indicated to the Decision Maker.

Negative or normal clinical findings can also be used to justify your choice of descriptor, e.g.:

"The lower spine and legs are clinically normal, and this is not consistent with the reported inability to sit for more than 30 minutes."

Normal Range of Joint Movements

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

Lumbar Spine

The movements to be considered here are:

- Forward flexion.
- Extension.
- Lateral flexion.
- Rotation.

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

Extension can normally be accomplished to 30 degrees from the vertical.

Restriction of lateral flexion is unlikely to result in significant functional restriction and should not routinely be performed.

Rotation measures the relationship between the plane of the shoulders and that of the pelvis. Normally 40 degrees can be achieved. This mainly reflects function of the thoracic spine, with only a small amount from the lumbar spine.

Remember that it is clinically unlikely for spinal movement to be limited in all directions.

Straight leg raising (SLR) is tested with the claimant lying on the couch, and asking the claimant to raise each leg in turn from the couch as far as can be achieved without pain. Limited straight leg raising may indicate sciatic nerve root pressure, resulting in pain when the nerve is stretched. Dorsiflexion of the ankle will worsen the discomfort; plantarflexion will lessen it. This can be assessed by asking the claimant to flex their ankle while the leg is raised. An appropriate reaction to plantar/dorsiflexion will help to exclude any apparent inconsistency.

It should be noted that straight leg raising must be assessed only from a supine position on the examination couch and not from a seated position as research suggests results from straight leg raising performed in a sitting position may be unreliable in terms of identifying sciatic nerve irritation.

Lower Limb

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

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

- Flexion $\geq 130^\circ$.
- Extension 10° .
- Abduction 50° .
- Adduction 25° .
- External rotation $\geq 45^\circ$.
- Internal rotation 45° .

External and internal rotation are most easily measured with the hip and knee flexed to 90° , and the lower leg used as a "pointer" to determine the angle.

In the **knee joint**, flexion and extension are assessed:

- Flexion $\geq 120^\circ$.
- Extension – full.

For the **ankle joint**, plantarflexion and dorsiflexion are assessed:

- Plantarflexion $\geq 50^\circ$.
- Dorsiflexion $\geq 20^\circ$.

Cervical Spine

Cervical pain can be referred to the shoulders and scapular regions and cause impaired function in the upper limbs. For this reason, no examination of the neck is complete without a check of the shoulders and a basic neurological check of the upper limbs.

Examination of the cervical spine can be carried out with the claimant either standing or sitting. The movements to be assessed are flexion, extension, lateral flexion, and rotation.

Lateral flexion is measured by asking the claimant to bend the neck to either side, rotation is measured by asking the claimant to turn the head to either side, whilst keeping the shoulders still.

The normal ranges of movement are:

- Forward flexion (Chin to chest) – no gap.
- Extension $\geq 80^\circ$.

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- Lateral flexion (ear to shoulder) – Full.
- Rotation $\geq 80^\circ$.

Upper Limbs

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

Shoulder movements are flexion and extension, abduction and adduction, and internal and external rotation. The following sequence can be used to show shoulder movements: clasp hands at full reach above the head to show abduction; touch fingers at back of neck to show abduction and external rotation; reach up the back with fingers to show adduction and internal rotation.

The normal ranges of shoulder joint movement are:

- Forward flexion 160° .
- Extension 40° .
- Abduction $\geq 170^\circ$.
- Adduction 40° .
- External rotation $\geq 70^\circ$.
- Internal rotation 95° .

Elbow movements include flexion and extension, pronation, and supination. For the latter two movements, the neutral position is with the elbow flexed to 90 degrees, with the thumb uppermost.

The normal ranges of movement are:

- Flexion $\geq 130^\circ$.
- Extension Full.
- Pronation (palm downwards) 70 - 80° .
- Supination (palm upwards) 70- 80° .

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

- Dorsiflexion $\geq 30^\circ$.
- Palmar-flexion $\geq 30^\circ$.

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- Radial deviation 20°.
- Ulnar deviation 45°.

Hands: The neutral position for the hand is with the fingers in extension and the thumb alongside the index finger. The normal ranges of movement are:

- Adduction/abduction between each finger 20°.
- Flexion at proximal interphalangeal joint 100°.
- Flexion at distal interphalangeal (DIP) joint 80°.
- Extension at DIP joint 10°.
- Flexion at metacarpophalangeal (MCP) joint 90°.
- Extension at MCP joint 45°.

For the **thumb** the ranges are:

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

In addition, assessment of hand function should also include a test of grip strength and the ability to oppose the thumb across the palm of the hand towards the little finger, and to touch the thumb to each fingertip.

3.4 Guidance on Specific Conditions - Physical

HCPs may utilise various learning modules available on Supplier systems. The modules contain key points about the aetiology, diagnosis, treatment, prognosis, and main disabling features of a number of medical conditions that are most commonly encountered in functional assessments and some conditions that may present challenges in the assessment of disability.

There is also extensive information on a variety of medical conditions available for reference through the LiMA application, on the LiMA repository, and on Supplier systems.

3.5 The Mental Function Assessment – Mental Functional Activity Categories

3.5.1 Introduction

Mental Health conditions can result in significant functional restriction for many individuals and the assessment of those with problems can be challenging. The presence of a mental health problem may be obvious from ESA50/UC50/medication/Med3 details, etc, but may not always be immediately apparent. In all cases, the HCP must consider whether there may be evidence of any mental function problem. They should be mindful that those with physical problems may also have subsequent mental health issues and careful and detailed exploration of these issues must be a part of any assessment. Some people will be reluctant to disclose mental health issues due to fear, embarrassment etc and HCPs must use all their communication skills to ensure they obtain all relevant information possible to ensure the claimant's true level of function is accurately reflected.

The HCP must have a high level of suspicion about the presence of any mental function issue and must carefully explore mental health symptoms that may not be overtly "provided" by the claimant.

Therefore, the mental function assessment should be applied in all cases where a specific mental disease or disability affecting mental function has been diagnosed or when there is a condition, whether mental, physical, or sensory, resulting in apparent impairment of cognitive or intellectual function.

This definition would include the following circumstances:

- Where the claimant is taking any medication which impairs cognitive function to a degree that causes impairment of mental function.
- Where there is evidence of an alcohol/drug dependency problem which has resulted in impairment of mental function.
- Where there is evidence of a physical or sensory disability such as tinnitus or chronic fatigue that may impact on mental function.
- Where there is evidence of learning disability or cognitive impairment.
- Where there is a previously unidentified mild or moderate mental function problem identified during the LCW/LCWRA assessment.

In LiMA the Mental Function descriptors must always be considered in the same way as the physical descriptors are considered.

When completing the clerical ESA85/UC85, if you choose not to apply the mental function assessment, you must justify your action to the DM. Examples of justification that may be used may include:

- There is no evidence from the assessment today of any condition diagnosed or

apparent that is likely to impair mental functional ability. The claimant is not on any medication likely to impair mental function.

- The claimant is on no medication for mental function problems, and he or she is not receiving any support from any Healthcare Practitioner for mental function problems.

It is essential that a Mental State Examination (MSE) is completed in each case where the mental function assessment is applied. It is best practice to complete a mental state examination in cases where the claimant indicates they are “depressed” but at assessment there is no evidence of functional limitation - (see section 3.7 for the mental state examination).

Self-harm and suicidal ideation should be sensitively explored in the history and mental state examination. It is not enough to just indicate “no self-harm ideation” in the mental state examination findings without ensuring that this would have already been addressed within the condition history or typical day. Where self-harm/suicidal ideation is present, then more details to explore any plans or intent or any previous attempts/behaviour should be documented. This will allow the appropriate well justified advice on LCWRA/descriptor choice/non-functional descriptor to be given.

There are seven mental function categories to be addressed in the LCW/LCWRA medical assessment. These categories cover areas relevant to those with a specific mental illness, or cognitive or intellectual impairment of mental function.

These categories cover:

- Understanding and focus (activities 11, 12, and 13).
- Adapting to change (activities 14 and 15).
- Social Interaction (activities 16 and 17).

For each functional category you must choose a descriptor, then provide all the necessary evidence in the Personalised Summary Statement which will make clear to the Decision Maker the facts on which your choice is based. If your choice of descriptor differs from the level of function indicated by the claimant, the Decision Maker needs to understand clearly why your opinion is appropriate and the claimant's is not.

This section looks in detail at each functional category and at the policy intent of the descriptors. It gives advice on the specific points in the typical day and MSE which are relevant to the particular functional category, and which can be used to justify your choice of descriptor in that category.

Remember also to take into account the effects of variability, etc. These have been fully detailed in the section on completion of the LCW/LCWRA, and are not repeated here, but an appropriate entry must always be made.

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

When considering the Mental Function descriptors, some of the higher-ranking descriptors reflect a very severe level of functional restriction. If choosing such descriptors you must always consider whether LCWRA advice may be appropriate.

In each of the activities, some examples of conditions where the descriptors may apply are given. These are for guidance only and the HCP must ensure that the assessment must reflect the person's function regardless of the actual diagnosis.

MENTAL FUNCTION ACTIVITY OUTCOME DESCRIPTORS

3.5.2 Learning tasks – (Understanding and focus) - Activity 11

Descriptors

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

LTb Cannot learn anything beyond a simple task, such as setting an alarm clock.

LTc Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes.

LTd None of the above apply.

Scope

This activity reflects the ability to learn a task. "Learning" assesses the ability to learn and retain information. The method that people learn by is not relevant - what is important is the ability to learn to do a task. It is therefore of no relevance whether a person learns a task by watching a visual demonstration, learns by reading or through verbal instruction. Within the workplace, the ability to learn tasks is vital. If the person needs to be shown how to do a task again, they have not learned it.

This activity may be relevant to conditions such as learning disability and organic brain disorders including acquired brain injury or stroke. People with severe and profound learning disability are unlikely to be able to learn how to complete a simple task and people with moderate learning disability are unlikely to be able to complete a moderately complex task.

It also may reflect difficulties in understanding language, such as receptive dysphasia.

Issues to consider

The length of time taken to learn a task and the ability to retain the information must be taken into account.

If a person learns a task on one day but is unable to repeat it the next day, they have not learned this task.

If a person takes a very long time to learn a task, for example takes 2 years to learn how to wash and dress themselves, this would not be considered reasonable, and that person would not be considered to have the ability to learn this task. The inability to learn a very simple task represents a very high level of disability such that they would also be considered to have limited capability for work-related activity.

A **simple** task may only involve **one or two steps**.

A **moderately** complex task may involve **3 or 4 steps**.

Details of activities of daily living

Consider basic functions of personal care and leisure activities.

Simple tasks may include:

- Brushing teeth. This would involve remembering to put toothpaste onto a brush and brushing all areas of teeth.
- Washing. This would involve the ability to use soap/shower gel and wash their body.
- Brushing hair.
- Turning on the television/ using basic functions on the TV remote control.
- Getting a glass of water.

Moderately complex tasks may include:

- Using a microwave oven.
- Making a cup of tea including filling kettle, putting tea bags in teapot, pouring into cup and adding milk and sugar.
- Playing CDs on a stereo.
- Using a games console (at a fairly basic level).
- Using a computer for basic activities such as playing a game
- Using a washing machine at a fairly basic level (Put washing powder in, put clothes in, select a pre-set programme, press start).

Technology and Simple, Moderate, or more Complex Tasks

When considering the complexity of tasks, especially with technology, it is vital to carefully explore the level of interaction with technology to ascertain whether this could be classified as simple, moderate, or more complex task.

Careful enquiry must be made during the history to ascertain the individual's true capacity to learn tasks and assumptions should never be made about capacity to learn.

Some examples of differing levels of interaction with technology are outlined below:

Mobile phone: Using a mobile phone may be considered as a moderately complex task if the person can text, set up speed dials, change ring tones etc, however, if a person can

only use the phone in a limited way to dial a number pre-set by a carer, this may be considered a simple task. With smartphones, the use of some functions may also reflect a much higher level of complexity if a person can download apps, set up pay functions, order goods online etc.

Television/remote control: If the person has simply learned to use the “on” button on the TV control and digital box, this does not necessarily mean they have an ability to learn very complex tasks. Enquiry should be made into what other things they can do. If someone can set up a TV/DVD player, programme channels, rearrange leads at the back of the TV, it suggests a much greater capacity to learn more complex tasks.

Washing machine: Using a washing machine in a standard fashion involving 4 basic steps may be considered a moderate task, however with technology advancing, some of the functions may be considered more complex; for example, setting a delay on the washing machine for spinning, setting a timer for the machine to come on at a specific time or evidence of an ability to use different functions and programmes may demonstrate a more advanced ability to learn.

Gaming machines: Where someone who can only put the disc in and press start and interact with a very simple game, this may be a moderately complex task. However, a person who can either select discs or download games and interact with advanced games is likely to be managing tasks considered more complex. It is important to explore the nature, type, and complexity of the games in addition to the persons understanding of the objectives of the game to understand the level of the task.

More complex tasks should also be considered such as driving should be detailed and any previous tasks learned in training and employment should be considered.

The key issue is to carefully explore very specific detail of tasks being completed in order to ascertain the true level of function in this area.

Mental State Examination

Relevant findings may be general memory and concentration, general decision-making ability at assessment, their ability to cope at interview, general intelligence, and requirement for prompting. It may be appropriate when considering this functional area to consider and document more specific tests of memory and concentration.

3.5.3 Awareness of everyday hazards (such as boiling water or sharp objects) – (Understanding and focus) - Activity 12

Descriptors

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

- (i) injury to self or others; or*
- (ii) damage to property or possessions,*

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

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

- (i) injury to self or others; or
- (ii) damage to property or possessions,

such that they frequently require supervision to maintain safety.

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

- (i) injury to self or others; or
- (ii) damage to property or possessions,

such that they occasionally require supervision to maintain safety.

AHd None of the above apply.

Scope

This activity is intended to reflect the ability to recognise risks from common hazards that may be encountered by people with reduced awareness of danger through conditions such as learning difficulties, or conditions affecting concentration, including detrimental effects of medication; or from brain injury or other neurological conditions affecting awareness. It may also apply to people with severe depressive illness and psychotic disorders as a result of a significant reduction in attention and concentration; however, it is unlikely to apply to people who solely have symptoms of anxiety or an anxiety disorder in the absence of other mental health conditions - such as the ones mentioned above.

Issues to consider

The activity reflects a lack of understanding and insight that something is dangerous or that there is an impaired ability to recognise that a situation will present a potential hazard. For example, a person with dementia may lack the insight to recognise why it may be dangerous for them to cook - they lack the ability to recognise that they are at risk of forgetting that the cooker is on.

The descriptors do not reflect simple accidents that may occur through lapses in concentration/distraction such as cutting a finger when chopping vegetables when the phone goes. If a person knows that there is a risk and therefore avoids the situation, they would not score in this category. There must be evidence that they do not realise there is a risk.

The level of severity of the descriptors reflects the amount of supervision that would be required to ensure the safety of the person and others.

The “majority of the time” would represent a need for “daily” supervision. “Frequently” would represent “several times a week”.

As substantial supervision in the workplace may pose problems, the level of supervision required has been taken into consideration when determining the LCW threshold. Thus, those who require supervision for the majority of the time should be considered for advice

on LCWRA.

If AHb is suggested, the HCP must consider whether the issues presented may present “risk” to the safety of the person or others and they must carefully consider whether LCWRA “substantial risk” is appropriate.

Details of activities of daily living

When considering this functional category details, you should ask about ability to cope with potential hazards. These may include:

- Ability to cope with road safety awareness.
- How they manage if they live alone.
- Driving.
- Ability in the kitchen.
- Awareness of electrical safety.
- Responsibility for children/pets.

It may be useful to consider the concept of whether the person could be safely left alone to manage basic daily life when you consider this functional category.

Mental State Examination

Cognitive issues will be important in assessing this issue.

Insight will also be an important factor. You should consider whether the claimant has adequate insight into their problems to recognise the risks present and therefore whether they are able to avoid potential hazardous situations.

3.5.4 Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks) - (Understanding and Focus) – Activity 13

Descriptors

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

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

IAc Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions.

IAAd None of the above apply.

Scope

This activity reflects the ability to **initiate and successfully complete tasks** without need for external prompting. This activity represents a significant restriction of an individual's ability to understand how to co-ordinate actions in the correct sequence such that they successfully complete any personal actions in a logical order for example washing before dressing.

It is intended to reflect difficulties that may be encountered by people with conditions **such as** psychosis, OCD, autism, and learning disability. A very severe depressive illness that results in apathy, or abnormal levels of mental fatigue, may result in problems in this area. It may be compounded by the effects of medication.

Issues to consider

The ability to complete personal actions was the subject of the appeal. The First-tier Tribunal cited ability to wash and brush teeth as evidence that no Activity 13 descriptors applied. The Upper Tribunal Judge held that habitual actions such as washing and brushing teeth should not be considered in isolation when determining whether a claimant was able to initiate and complete personal actions, as their performance did not demonstrate the claimant's mental, cognitive and intellectual functions.

Consideration of Activity 13 must relate to all the tasks of planning, organisation, problem solving, prioritising, or switching between tasks. Evidence need not be found of a single action involving all these tasks. Evidence from one action may demonstrate inability in respect of one task, evidence from another action in respect of another task, and so on. Inferences may also be drawn from the nature of the claimant's condition or other factors.

The personal action considered need not be complicated, as long as all the tasks are taken into account. The UT Judge gave an example of the action of dressing. This may be routine if the person only puts on clothes got ready by someone else, but could equally demonstrate the tasks, e.g. choosing and getting ready appropriate clothes (planning and organising), deciding what to do if clothes need washing or ironing (problem solving and prioritising), and doing those before dressing if necessary (switching tasks).

The action must be effective. This may include where an action must be completed, before the person can move on to the next action. Actions are undertaken for a purpose and if that purpose cannot be achieved, the action is ineffective. Effectiveness needs to be considered in the context of the purpose of the test which is to decide whether it is reasonable to require the person to work.

For example, someone with OCD may initiate many actions, but due to rituals they may not actually be able to complete them and therefore should be considered not capable of personal action. Similarly, if a person perhaps with bipolar illness manages to wash and dress but then goes out and spends all their money on non-essential activities, giving no consideration to issues such as bills, rent, food etc, they would not be considered to be initiating effective personal action.

The issue of whether a person can repeatedly, and reliably complete tasks must also be

considered.

Where a claimant indicates that there is impairment related to activity 13 (Personal Action), the healthcare professional must ensure that they gather sufficient and appropriately detailed evidence to demonstrate and justify their advice regarding all of the tasks of planning, organising, problem solving, prioritising and switching of tasks.

It may be preferable to utilise more complex personal actions that demonstrate all of the tasks required. These actions may include meal preparation or a visit to the shops.

More basic actions, such as simply getting up, may not demonstrate the required tasks in every case.

Practitioners must make a judgement, based upon the evidence, as to which actions are simply undertaken through habit and do not demonstrate mental, cognitive and intellectual functions. Such a task may be brushing teeth. Habitual actions that do not demonstrate the required tasks should not be considered when justifying Activity 13.

The expected level of impairment as a result of the claimant's mental health condition, including the effects of any treatment, should be interpreted in terms of whether it is likely to affect personal action. Remember that both over and understating must be considered.

For example, although a claimant may state that they have a very limited and sedentary lifestyle and do not perform anything other than routine personal actions, their mental health might be such that it would be unlikely to affect their ability to initiate and complete personal actions.

Alternatively, their mental health might be such that it would be likely to affect their ability to initiate and complete personal actions. For example, a claimant may be able to perform routine actions such as washing and dressing but be unable to manage more complex actions such as managing finances.

The key is an adequately explored history that allows justification to show that effective personal action involving the tasks of planning, organisation, problem solving, prioritising, or switching between tasks is reasonable.

“Personal action” may include:

- ability to plan and organise a simple meal.
- ability to cope with simple household tasks e.g. sorting laundry and using a washing machine.
- dealing with finances.
- arranging GP appointments, picking up prescriptions, taking medication.

Note: The ability to get up, washed, dressed, and clean one's teeth in the morning can also be considered as personal actions, but in the absence of other activities within the typical day they could also be regarded as habitual activities. Therefore, in isolation they would not be sufficient to robustly advise a descriptor choice under Activity 13.

Details of activities of daily living

Areas to consider should include any behaviour that involves a decision to plan or organise a personal action to enable them to perform it.

Activities may include:

- Making travel arrangements.
- Writing shopping lists.
- Organising finances.
- Planning a simple meal.
- Getting washed and dressed (including choosing appropriate clothing).
- Ironing clothes for the next day.
- Caring for children: preparing clothing, lunches etc.

Mental State Examination

General memory and concentration will be important areas to consider. Intelligence and severity of depression should be considered. It would be expected that the MSE findings should be consistent with significant impairment of mental function if choosing a descriptor in this functional category. Where depression is present, evidence of psychomotor retardation would be likely if these descriptors were applicable.

Further Cognitive testing - if someone doesn't have a condition that would cause cognitive impairment i.e. someone who lacks motivation, provided sufficient information is gathered to be sure that there is no cognitive deficit, then there is no requirement to carry out detailed cognitive testing. However, the standard MSE should be completed, including an assessment of general memory, concentration, and insight.

3.5.5 Coping with change - (Adapting to change) – Activity 14

Descriptors

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

CCb Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.

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CCc Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.

CCd None of the above apply.

Scope

This activity reflects the flexibility needed to cope with changes in normal routine. It is intended to include difficulties that may be encountered by people with conditions such as moderate/severe learning disability, autistic spectrum disorder, brain injury, OCD, severe anxiety or psychotic illness. It is not intended to reflect simple dislike of changes to routine, but rather the inability to cope with them.

The permanence of the change is not relevant to the descriptors.

Issues to consider

This activity reflects a significant level of disability where small changes result in the individual's day to day life being significantly affected i.e. day to day life is made significantly more difficult or cannot be managed.

The highest descriptor represents a level such that a change to routine would mean that life would stop for everyone involved and basic activities could not continue.

More specific short-lived episodes such as leaving the supermarket as it is too crowded would not be considered if this was the only change to their planned day. Similarly, a person who has a panic attack but manages to do most usual tasks in a day after the episode of panic would not attract a scoring descriptor in this area.

It is important to obtain examples of when change occurred and what happened to the person when this occurred.

Activities of daily living

In this functional area you should consider the person's ability to cope in situations where some change is possible. Areas to consider may include:

- Use of public transport.
- Shopping.
- Dealing with appointments at hospital, GP or Jobcentre Plus.
- Coping with children and their out of school activities.

It may be useful to consider some of these activities in terms of the level of disability intended, for example:

- A claimant with a severe form of mental disablement who may become so distressed

by the supermarket being out of stock of their usual brand of breakfast cereal that they cannot continue with other activities or complete the rest of their shopping.

- A claimant who would be unable to cope with the train being cancelled and would return home rather than wait for the next train.

Mental State Examination

It is expected that the MSE findings would be consistent with the type of conditions this descriptor is intended to reflect. They may have poor rapport and be extremely anxious at interview.

It may be that they have been completely unable to attend the AC for assessment. It would seem unlikely that a claimant who manages to attend the AC alone and coped with the assessment would meet the level of severity of functional restriction for anything other than CCd to apply, although all the evidence should be taken into account.

3.5.6 Getting About - (Adapting to change) – Activity 15

Descriptors

- GAa Cannot get to any place outside the claimant's home with which the claimant is familiar.
- GAb Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person.
- GAc Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person.
- GAd None of the above apply.

The wording has been amended to reflect the inability to get to most places rather than a single specified place.

Scope

This activity is intended to reflect inability to travel without support from another person. This may be as a result of disorientation or vulnerability in conditions such as cognitive impairment or learning disability where substantial problems may be encountered. Those with a significant anxiety disorder may also have problems in this activity area. The descriptors do not reflect planning and timekeeping.

The highest descriptor (GAa) represents a complete inability to leave the home environment, while GAc may represent a person who has been unable to travel to any new locations unaccompanied for a significant period of time.

Issues to consider

General Considerations

For people with anxiety, panic disorder and agoraphobia there should be supporting evidence that corroborates the severity of the condition. Evidence may include confirmation of the anxiety disorder on the Med 3 or other FME, evidence of medical intervention such as medication, counselling, CBT/other therapies or referrals to psychiatric services (both past and present).

As detailed above, those with conditions such as significant anxiety disorders or agoraphobia, learning disability or cognitive impairment may have restriction in this activity area. The descriptors do not reflect lesser degrees of anxiety about going out.

Key Issues to Consider

The following are key issues to consider for Activity 15. Further information on these key points is detailed below.

- The entire end to end journey must be considered from leaving home until arriving at the final destination.
- You must ascertain whether the place they travel to is **familiar** or **unfamiliar**
- What is the mode of transport used to get to a place? (walking/cycling/bus/train/local authority transport/taxi etc.). Is the mode of transport through choice or necessity?
- Does the person need to be accompanied throughout this journey or just parts of it?
- If they require to be accompanied, is Substantial Risk advice applicable? Do they have a reliable companion to take them to places **and will that companion be available within the next 3 months.**

Further information

1. End to end journey:

The entire end to end journey must be explored and taken into account. For example, a person may say they walk to the local shops most days. It is important to ascertain if this is one specific shop, or do they manage to go into multiple shops such as new stores or a new coffee shop. This level of detail is required to help ascertain whether the journey is taking them only to familiar or unfamiliar places.

When details of this journey are explored, it is essential to detail whether the person is accompanied throughout the journey or whether they can manage aspects of the journey on their own.

The reliability of a companion to accompany the person on a journey must also be considered and whether they will be available over the next 3 months.

2. Familiar vs Unfamiliar:

When taking the history, it is imperative to establish whether the place a person travels to be considered as familiar or unfamiliar to them. Again, it is important to explore the full end

to end journey as some parts of the journey may be familiar locations, but other elements may be new places to a person. For example, a person may take a bus to the next town. The bus station in the next town may be familiar to them, however they then walk to a new bank branch in a part of the town they have never been to before. Therefore, in this case, the journey would constitute both familiar and unfamiliar locations.

Specified places with which the claimant is familiar would normally be locations in their local area such as the GP surgery, dentist, bank, post office, local shops etc. If a person simply avoids the large supermarket in the town but manages to go to other local shops etc, they would not score in this area. While normally familiar places would be close to a person's home, there could be locations further afield that may be considered "familiar" to the person. It is therefore important to explore details of a location a person can travel to in terms of whether this is a familiar location regardless of geography.

3. Mode of transport:

It is important to explore the mode of transport used and whether this is chosen as a result of personal choice/convenience or required due to mental health issues. When considering this activity, the means that the person arrives at their destination should be considered. For example, individuals who are unable to use public transport but are able to arrive at their destination unaccompanied by other means, such as driving or walking alone are likely to meet criteria for GA(d) – none apply.

Where the claimant's evidence is that they are unable to get to familiar or unfamiliar places on their own and use transport where they are accompanied (e.g. a taxi, local authority assisted transport, a friend's car) to get about, the DM will need to consider whether this is due to personal preference, or due to an impairment of mental, cognitive or intellectual function arising from a specific mental illness or disablement.

The mode of transport becomes important in establishing whether the journey is considered as being completed alone or accompanied. It is therefore essential to establish all the facts. For example, if they say they take a bus to college, it is important not to assume that this is a standard public transport bus. It could for example be a special local authority bus arranged for those attending places such as a special needs college where the driver has more specific "care duties" for the individual.

4. Concept of Being Accompanied:

There must be careful exploration of whether a stated need to be accompanied reflects just preference or choice; or whether the presence of another person is required to ensure safety or to overcome significant anxiety symptoms.

N.B. The minimum age of the "third party" that can be considered safe to accompany a claimant to familiar and unfamiliar locations is 16 years old and over.

In relation to considering the concept of being "accompanied", there have been two upper tribunal decisions regarding the meaning of being accompanied. One decision defines "accompanied", and the other covers aspects of Substantial risk (covered further on).

In terms of the definition of "being accompanied" you should consider the following details:

When advising on activity 15 you will need to carefully explore the circumstances regarding journeys undertaken, the mode of transport and if the presence of another person is required

due to mental health impairment or simply preferred. The DM will need to understand the evidence that you have used to reach your justified descriptor choice.

If the claimant's mental health prevents them from being able to undertake a journey to familiar or unfamiliar places without the presence of a third party in a vehicle, for example providing reassurance by their presence, or acting as a guide, then they are being accompanied by another person. If a claimant can only undertake such a journey because they have to make that journey in the presence of another person or because they require the assistance of that other person, then the journey is an accompanied one.

The role of the third party accompanying the claimant on journeys is an important part of that consideration. If the person is unable to get about without reassurance by the **mere presence** of another person, they should be considered as accompanied on the journey. However, when considering public transport then a bus driver or a train guard (etc.) **would not** be considered as being accompanied even if the person felt reassured by their presence. This is because a standard bus driver is not there to specifically ensure one person's individual welfare. For example, on a standard bus journey the driver would not routinely notify an individual that it was their "stop" or assist them in completing their journey, such as getting from the bus stop to their final destination. The following examples may help in understanding this concept:

Example 1

Dawn suffers with anxiety and depression. She takes a taxi from her home to a large hospital to attend an outpatient appointment as she has not been to this hospital before and is not sure of the route. When she is dropped off by the taxi at the main entrance to the hospital, there is still a considerable distance to navigate through the complex of buildings to reach the specific department where her appointment is. Dawn is able to ask for directions and find her own way from the entrance to the appointment location.

The DM determines that Dawn does not score any points for getting about.

Example 2

Jake suffers from severe anxiety. He can get out of the house to places like the GP, or the hospital for counselling sessions, but only if he goes there by taxi. He can't travel by bus or train because he gets panic attacks in crowds of people, and he feels he can't get away. Jake also has problems dealing with people he doesn't know due to his anxiety, and he will cancel appointments if his regular driver isn't available, or the GP or counsellor is someone he doesn't know.

The DM determines that Jake has LCW and scores 9 points for getting about, and 6 points for social engagement.

Example 3

Zarina suffers from severe psoriasis and associated psoriatic arthritis. She has difficulty walking because of the pain in her knees and ankles from the arthritis and her upper limb pain precludes the use of aids to increase mobility. She has low self-esteem because a significant amount of her body is covered in red and scaly plaques. She does not drive and chooses to travel everywhere by taxi as she does not like to use public transport due to the feeling that she is being stared at.

The DM determines that Zarina scores 6 points for mobilising but no points for getting about, so she does not have LCW.

Availability of a Companion within the next 3 months in relation to Substantial Risk

Consideration & Advice (see also section 3.8.2)

An Upper Tribunal (UT) decision implemented in guidance in 2022 concerned a claimant who was found fit for work but scored 6 points under Activity 15, Getting About (GAc), on the grounds that they were unable to get to an unfamiliar place without being accompanied. The UT ruled that the First Tier Tribunal, when considering the substantial risk criteria, should have:

- Considered the claimant’s journey to work, work interviews or the Jobcentre; and Enquired about the availability of a third party to accompany them on such journeys.
- In light of the decision, for claimants who attract scoring descriptors in Activity 15 (GAb or GAc) HCPs are required to:
 - Ask claimants if a third party is likely to be available to accompany them to familiar or unfamiliar locations in the future (**within the next 3 months**) and/or assist them with trial runs; **and**
 - Consider advising risk LCW if no third-party support is likely to be available and there are no other mitigating factors that might prevent substantial risk arising.

Where risk LCW is advised, the HCP should consider whether risk LCWRA should also be advised, bearing in mind that work coaches are able to tailor work-related activity to individual claimant circumstance. When exploring the typical day history there is no requirement to allude to work or work-related activity when asking the client about availability of a third party to accompany them. To clarify, if client meets criteria for GAb or GAc (needs to be accompanied going to familiar or unfamiliar places) and HCP explores in TDH that the client will **not have** someone to accompany them in future to familiar or unfamiliar places Risk LCW also needs to be applied. In justification of LCW risk, the HCP must indicate that the claimant has no reliable access to a third party to accompany them to familiar or unfamiliar places, thus LCW risk is being advised.

As per above, Risk LCWRA needs to be considered but if the evidence suggests that the client is able to undertake appropriate, tailored work-related activity Risk LCWRA is unlikely to apply.

N.B. The minimum age of the “third party” that can be considered safe to accompany claimant to familiar and unfamiliar locations or assist them in trial runs is 16 years old and over.

3.5.7 Coping with social engagement due to cognitive impairment or mental disorder - (Social Interaction) – Activity 16

Descriptors

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

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- CSb Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual.
- CSc Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual.
- CSd None of the above apply.

Scope

This activity is intended to reflect a significant lack of self-confidence in face-to-face social situations that is greater in its nature and its functional effects than mere shyness or reticence. Clarifications from the DWP confirm that the ability to interact must be in person rather than through any “virtual face to face interaction” such as a video conferencing app. Those with conditions such as significant anxiety, autism, personality disorder, psychosis, significant depression or learning disability may have problems in this area.

It reflects levels of anxiety that are much more severe than fleeting moments of anxiety such as any person might experience from time to time.

Issues to consider

The level of anxiety referred to suggests a specific and overwhelming experience of fear, resulting in physical symptoms or a racing pulse, and often in feelings of impending death such as may occur in a panic attack.

There must be evidence that the social engagement results in significant distress to the individual. CSa represents almost total social isolation.

For people with anxiety, panic disorder and agoraphobia there should be supporting evidence that corroborates the severity of the condition, for example, level of medication/psychiatric input.

In 2015, a Court of Session Judgement advised on the meaning of “always” within this descriptor. (See also section 2.3.1.14 – LCWRA Social Engagement Descriptors).

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

“Always” does not mean “at all times”; claimants need not show that they fall within the descriptor all the time, every minute, twenty-four hours of every day.

ESA Regs Sch 3 Activity 13 (and Sch 2 Activity 16a, as it is coapplied) could therefore apply to a claimant whose condition is constant and continuing in its disabling effects, for the purposes of social engagement, albeit with short intermittent breaks in that being the case

Advice should have regard to the need for steady and reliable engagement in social contact for the purposes of work and work-related activity; and be mindful that evidence of some kind of social engagement by the claimant, would not necessarily prevent the descriptor being met.

Social contact where the claimant requires to be accompanied should be disregarded. Due consideration should be made as to whether being accompanied is a requirement or a choice/preference.

Activities of daily living

Consider any form of social contact such as:

- Use of public transport.
- Shopping.
- Talking to neighbours.
- Use of phone.
- IT activities such as a video conferencing app.
- Hobbies and interests.
- Social interaction with family.

Mental State Examination

The MSE findings would be expected to reflect significant anxiety or communication problems. Rapport is likely to be poor with lack of eye contact. The claimant may be sweating and finding the consultation difficult. They may be somewhat timid in demeanour at interview. It would seem likely the person would require a companion to attend at the AC due to the level of anxiety/communication restriction that these descriptors would normally be expected to reflect.

Examples

An example of a scenario where CSa may apply is as follows:

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

An example of a scenario where CSb may apply is as follows:

This may apply to a person who rarely interacts with unfamiliar people but may do so on exceptional or rare occasions. For example, they struggle to interact with unfamiliar people and usually avoid them, but once every couple of weeks goes to the shops and manages to speak to the checkout assistant.

An example of a scenario where CSc may apply is as follows:

A person who struggles to interact with unfamiliar people, but has days when anxiety is not too bad and is able to go alone and speak to checkout assistant weekly.

When considering CSb or CSc. The following should be considered:

1. What is relevant is the frequency with which the person can interact when they try to do it.
2. There is a need to consider all relevant activities when social activity takes place. So, for example, if a person can only interact with an unfamiliar person rarely in one situation but can interact with an unfamiliar person occasionally in another then CSc is likely to be the most appropriate descriptor choice.
3. If the person is only able to engage with unfamiliar people rarely out of necessity, for example in order to obtain benefit e.g. attend a WCA assessment but is otherwise unable to engage, then HCPs should consider whether these occasions are so infrequent that the claimant cannot effectively engage in social contact with unfamiliar people.

“Always” should be considered in the context of work or work-related activity.

If a person was only able to rarely engage in contact with **familiar** people with extreme difficulty and only because they had little or no choice then that is likely to meet the definition of “always” in the context of work or work-related activity and CSa should be considered. An example might be someone who is effectively a recluse but can occasionally interact with their GP or a family member for life’s essentials.

If a person was only able to rarely engage in contact with unfamiliar people with extreme difficulty and only because they had little or no choice, then that is likely to meet the definition of “always” in the context of work or work-related activity and CSb should be considered. An example might be someone who again is severely limited but when absolutely necessary can interact with an unfamiliar person such as a shop assistant and was able to attend an assessment and provide a history albeit with some difficulty. Due consideration needs to be made as to whether this does meet the threshold to be considered meaningful interaction.

If a person was able to engage with unfamiliar people more frequently or with less difficulty, then consideration must be given to whether CSc would apply. An example might be someone who can visit a shop occasionally, perhaps travelling by bus and on the way can interact with an unfamiliar neighbour or other passenger. The majority of the time should be interpreted as more than 50% of the time. Pragmatically, as no one socially interacts 100% of the time, this should be considered as majority of days of the week.

If someone can interact meaningfully with someone unfamiliar to them 2 days a week without causing significant distress but has no interaction the rest of the time and is effectively a recluse, then due consideration should be given to advising CSc.

Whilst the mental state exam findings, observations and the medical history are all key areas, a focussed functional history is key to an accurate and justified descriptor choice.

The activity is only relevant where problems with social contact are due to cognitive impairment or mental disorder, and lead to a difficulty relating to others, or to significant distress.

Assessing quality of engagement in social contact

HCPs must consider not just whether social engagement occurs but the quality of such engagement.

Social contact is not limited to contact for pleasure or leisure. It includes contact for the purposes of work (or WRA). The nature and quality of the claimant's engagement with social contact needs to be considered, including elements of give and take, and initiation and response.

Social contact does not need to be friendly or genial, nor does it need to involve choice, and can be demonstrated without those elements being present, such as might be the case in professional situations or in the workplace.

The DM is required to consider how the quality of the social contact would impact on the claimant's ability to work, and whether it would be a barrier to work. Therefore, the HCP must explore this during the assessment.

If someone has an absolute requirement to be accompanied to be able to engage in meaningful social contact, then they cannot be regarded to be able to engage in social contact. In order to argue that they could, due consideration would have to be given to how such an adjustment would be reasonable in the workplace.

3.5.8 Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder - (Social Interaction) - Activity 17

Descriptors

- IBa** *Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.*
- IBb** Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.
- IBc** Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.
- IBd** None of the above apply.

Scope

This activity is intended to reflect difficulties in social behaviour which might for example, be encountered by people with psychotic illness or other conditions such as brain injury that result in lack of insight. The activity also includes the difficulties people with autistic spectrum disorder may have in social behaviour. It is intended to reflect the effects of

episodic relapsing conditions such as some types of psychotic illness, as well as conditions resulting in consistently abnormal behaviour.

Issues to consider

There should be evidence of a disorder of mental function for this descriptor to apply. This may be as a result of a specific mental illness or a condition, whether mental, physical, or sensory resulting in cognitive or intellectual impairment of mental function. The descriptors do not simply relate to aggressive behaviour/anger management issues where there is no underlying mental health issue.

The descriptors relate to behaviour that would be considered in an average workplace such as a call centre as this provides a more general concept rather than applying “reasonable” to one person’s standards as this may be subject to considerable variability. It is likely that the behaviour would extend beyond verbal aggression for the descriptors to apply.

There must be evidence that the individual is unable to control their behaviour for the descriptors to apply.

The history and nature of the events should be detailed along with the frequency in which they occur.

Where the episodes occur frequently and the episodes are major, the “risk” LCW/LCWRA criteria must be carefully considered and whether or not it is applied fully justified.

Activities of daily living

Consider any activity involving interaction with others:

- Previous occupational history.
- Shopping.
- Childcare.
- Parents nights at school.
- Relationships with neighbours.
- Ability to cope at appointments: GP/ Hospital etc.
- Ability to cope with bills and on the phone.
- Dealing with finances and bills at the post office.
- Appointments with official persons such as the Bank Manager/Social Worker/Benefits Personnel.

Mental State Examination

There is likely to be evidence of reduced insight. Cognitive function should be carefully addressed. Evidence of addiction or thought disorder should be carefully assessed. Rapport may be poor and communication difficult.

3.6 Guidance on Specific Conditions – Mental Health

HCPs may refer to various learning modules available on Supplier systems. The modules provide advice on Mental Health conditions commonly seen during benefit assessments. They are updated regularly and based on current research.

For each documented condition they provide guidance on:

- Aetiology.
- Diagnosis and clinical features.
- Treatment.
- Prognosis.
- Main disabling effects relevant to function.

There is also extensive information available for reference through the LiMA application, LiMA repository.

3.7 The Mental State Examination (MSE)

HCPs will be familiar with conducting a MSE from their previous training.

A MSE should be applied in all relevant cases. The extent of the mental state examination conducted will be determined by the HCP; however, it must in all cases be adequate to justify the chosen mental function descriptors. For example, it may not be necessary to perform a full “addictions” assessment where the history does not indicate any addiction issues whereas in cases such as head injury or learning difficulty or other conditions affecting cognitive function, more formal tests of concentration and memory may be required. It should be noted that in circumstances where a claimant indicates a history of self-harm, the HCP should not ask the claimant to demonstrate evidence of this, by asking them to reveal scars as this may distress the individual.

The following categories are used in LiMA for a structured MSE:

- Appearance.
- Behaviour.
- Speech.
- Mood.
- Cognition general.
- Insight.

- Thoughts.
- Perceptions.
- Addictions.
- Involuntary movements.
- Cognitive tests.
- Formal tests.

3.8 Exceptional Circumstances (Non-Functional Descriptors) in the LCW/LCWRA Assessment

Note – the term NFD is not used in the UC Regulations, however; both the ESA and UC Regulations have similar wording in the descriptors and the same policy intent in these areas. For ease of understanding, these regulations will be referred to as NFDs in this Handbook.

In the development of the WCA it was acknowledged that there may be a very small minority of conditions that would not fulfil the criteria for having LCWRA or produce a functional score of 15 or more but may still be considered as having limited capability for work. To take account of these conditions, a non-functional descriptor (NFD) has been incorporated into the LCW assessment to cover the following scenarios:

3.8.1 Life-Threatening, Uncontrolled Disease.

1. The claimant is suffering from a life-threatening disease in relation to which;
 - (a) there is medical evidence that the disease is uncontrollable, or uncontrolled, by a recognised therapeutic procedure, **and**
 - (b) in the case of a disease that is uncontrolled, there is a reasonable cause for it not to be controlled by a recognised therapeutic procedure.

This non-functional descriptor (relating to life threatening disease) is very specific in its wording and all the evidence must be carefully considered before applying this non-functional descriptor. Any advice given to the Decision Maker that application of this NFD is appropriate must be in keeping with the medical knowledge of the condition and current medical guidance. It should be noted that **this NFD only applies to LCW and not LCWRA** i.e., it would still be considered reasonable for the person to engage in WRA.

For example, when considering hypertension,

A claimant who attends the AC with no previous history of hypertension and on no treatment where the blood pressure is measured and found to be high would not fulfil criteria for this NFD as there is no evidence that their disease is uncontrollable.

However, where a claimant who attends a tertiary referral centre and whose condition, despite intensive intervention, remains severe and uncontrolled and is life-threatening, would be considered as satisfying the criteria for this NFD to be applied.

Another example of where this NFD may apply is in those with Motor Neuron Disease (MND). If the condition has not progressed to a level where there is significant functional impairment, a non-functional descriptor would be applicable, as the implication of having a diagnosis of MND is severe. Given there is no form of “treatment” to prevent progression it would be appropriate for this NFD to be applied.

3.8.2 Substantial Risk.

A second non-functional descriptor (relating to substantial risk) is also listed in the ESA85A/UC85A.

2. The claimant suffers from some specific disease or bodily or mental disablement and, by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work.
 - (a) This does not apply where the risk could be reduced by a significant amount by reasonable adjustments being made in the claimant’s workplace, or
 - (b) By the claimant taking medication to manage the claimant’s condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant

It should be noted that **regulations specify that this NFD must be considered separately for LCW and LCWRA.**

Therefore, HCPs must give careful consideration as to whether it applies to both LCW and LCWRA or to LCW alone.

The LCWRA equivalent Substantial Risk Descriptor is listed in section 2.3.2 of this Handbook.

3.8.2.1 Background information on Substantial Risk

The 2014 substantial risk guidelines were developed by the DWP in association with various experts. The aim of this guidance was to achieve greater consistency to the way “substantial risk” was assessed.

However, the guidance failed to place this risk in the context of the work-related activity or work that the claimant might carry out although this is a key element of this provision.

The DWP has reviewed these guidelines and developed new guidance. The main change is that the focus on suicide has been reduced and the question of substantial risk placed in the context of work-related activity (WRA). The Department’s approach is that tailored WRA may be appropriate for most people with mental health conditions, including for people with suicidal thoughts.

The revised guidance reflects the flexibility available to work coaches when supporting claimants who are deemed capable of work-related activity.

The Revised Substantial Risk Guidance was issued by the DWP in 2015 and implemented early 2016.

3.8.2.2 Guidance on advising on Substantial risk for LCW or LCW/LCWRA

Advice on Limited Capability for Work or both LCW and LCWRA as a result of substantial risk can only be given after conducting **the full LCW/LCWRA functional assessment**.

DWP policy intent is that substantial risk for work should only be applied if there are no workplace adjustments or other interventions, such as medication, which could be put in place to significantly reduce the risk. If the substantial risk could be reduced by a significant amount, the provision for substantial risk would not be satisfied. Therefore, the wording in the ESA regulations as amended 2012 and the UC Regulations clarifies that workplace adjustments or other interventions must be taken into consideration when providing advice on substantial physical/mental risk.

HCPs must take into account any information which may reduce any substantial risk in the workplace. It is therefore essential that a comprehensive history is obtained.

In addition to considering whether being found fit for work may cause a substantial risk, HCPs must also consider the concept of work-related activity and whether engaging in some activities, that may assist the claimant towards an eventual goal of work when the claimant is able, would be likely to cause a substantial risk to the person.

Appendix 7 provides information from the DWP on work-related activity. It is essential the HCPs reads this information and understands the concept and extent of work-related activity before providing advice.

HCPs must be mindful of the wording of the legislation in that it refers to a substantial risk to the person's health when they provide advice to the Decision Maker.

It should be noted for persons claiming UC, the Substantial Risk guidance should be considered in exactly the same manner and the appropriate advice on LCW or LCWRA risk should be provided in accordance with current risk guidelines, regardless of the fact that the claimant has chosen to continue to work.

In summary, the HCP must consider:

- If a person was found to be fit for work – would there be a substantial risk to their health?
- If a person was asked to undertake work related activity, would there be a substantial risk to their health?

In order to offer the Decision Maker advice in these areas, the HCP must carefully gather and consider all the evidence available and identify key issues such as whether the person's condition means that there is significant vulnerability or whether there is potential for relapse if required to carry out work-related activity or to seek work.

Key areas to consider in evidence gathering are:

Key to provision of advice on Substantial Risk remains a well explored detailed typical day. Exploring the activities that a person manages day to day such as interaction with other

people, will assist the HCP in formulating their opinion and advice on whether work related activity may be possible for the person.

In terms of assessing whether substantial risk may apply, the HCP must evaluate aspects of self-harm or deterioration. The HCP must carefully explore the history of any previous episodes of self-harm or any current plans. This issue must be addressed sensitively but the HCP must obtain adequate detail to be able to consider the evidence in order to advise on substantial risk in terms of LCW or LCW/LCWRA.

The HCP must ensure they carefully explore and obtain information on risk factors for self-harm and evaluate this evidence when providing advice to the Decision Maker.

Protective factors can also be considered by the HCP when providing their advice to the Decision Maker, however; these factors must be considered within the context of all other evidence and risk factors. **Note: It would not be appropriate for the HCP to directly probe aspects of religious beliefs.**

The review and evaluation of all previous evidence, such as previous reports, FME and the ESA 50/UC50 is critical to providing advice to the Decision Maker. It is imperative that the HCP considers all the available evidence before providing advice to the DM. **Where FME is held on file, the HCP must ensure consent is in place for this.**

The HCP must carefully consider the level of clinical input such as past hospital admissions, variability of condition, relapses, current and past CMHT input. HCPs must carefully consider issues suggesting severe illness such as regular input from the home treatment team.

The HCP must carefully explore occupational history for claimants who are currently employed whether that being part time or full time. It is imperative to explore the following details of current employment:

- How long they have been in current employment?
- Have they had any absences from work, and do they regularly go to work?
- Do they receive any special support at work from mentors, “work buddies” or line management?
- What is the level of support they receive?
- How are they coping with work?

In terms of ability to get to familiar or unfamiliar places, the HCP must establish whether the claimant needs to be accompanied and whether a companion is readily available to accompany the claimant. Where there is nobody available to accompany the claimant to appointments etc on a regular basis, substantial risk for LCW must be considered. (See section 3.5.6 for further detail)

The DWP Revised Risk Guidelines contained in Appendix 6 must be read in

conjunction with this information.

Much of the above information relates to Substantial Risk in people with a Mental Function problem, however; it must be noted that Substantial Risk may apply in those with physical problems, although this would be expected to be an uncommon situation.

In **physical problems**, evidence gathering remains key to provision of advice.

For example:

- **A claimant with a latex allergy.** The following information would need to be considered to provide a fully justified opinion:
 - Medication – Do they have an adrenaline auto-injector and are they able to self-administer? Do they use any other medication for allergies? How often have they needed to administer?
 - Condition history - details of the allergy, investigations, and results; details of any anaphylactic reactions; details of any treatment e.g., desensitisations.
 - Occupational history - previous occupations and any adjustments to the workplace.
 - Typical day – Are there any precautions taken to avoid the allergen in daily life? Are there any precautions (that the person takes or not) that can reasonably apply to the workplace?

- **Claimants with Alcohol and Substance Addiction.**

The potential impacts on physical health where a claimant has a history of alcohol or substance misuse issues resulting in physical sequelae must be carefully considered.

For example, a claimant may have recently been an inpatient for management of liver cirrhosis and is now abstinent from alcohol for 3 months with improving liver function. The risk to their physical health must be carefully considered in terms of whether being found fit for work or work-related activity could potentially cause a relapse and thus consequential deterioration of their physical health. Careful exploration of the clinical history must be detailed including aspects of any physical health issues, management and follow up treatment. Justification of Substantial Risk should include any reference to physical health along with mental function impacts where relevant.

- **Claimants undergoing major surgery with a hospital stay less than 24 hours.**

In recent years, the treatment of major surgery for some conditions has advanced and hospital stays may be less than 24 hours where previously this was not the case. As a result, treat as LCW criteria for hospital stays of 24 hours or more may not be fulfilled for cases where these requirements would previously have been met.

Examples include, but are not necessarily limited to, hip replacement, knee replacement, and abdominal surgery such as laparoscopic hysterectomy. Discharge may occur on the same day if the surgery is in the morning, or for cases completed in the late afternoon/evening discharge may occur the following morning. Persons undergoing major surgery as a day case would be expected to follow very strict and detailed post-operative instructions on discharge.

Due to the nature of the surgery and likely recovery period, claimants who have undergone major surgery and were discharged the same day or within 24 hours, should

be considered as at substantial risk of deterioration to their physical health if not found to have LCW.

- **Epilepsy and other physical problems.**

Other physical problems must be considered case by case, however considering a condition such as epilepsy, this NFD is unlikely to apply. In most cases, the condition can reasonably be controlled with medication, and even in cases where seizures are fairly regular (e.g. weekly), reasonable workplace adaptations such as avoidance of working at heights, in confined spaces or lone working can be put into place to maintain the safety of the individual.

This clearly covers everything up to “fairly regular”. The question remained about more frequent fitting perhaps with evidence of injuries.

Consider this scenario:

Claimant with no warning of seizures, a history of injury whilst fitting and a seizure frequency, despite medication, of more than once a week.

In this example, assuming that no other relevant factors are present, it would not be expected that risk would apply given reasonable adjustments in an adapted safe working environment.

It is important to emphasise that each case needs to be assessed individually and a ‘one size fits all approach’ is not appropriate. Consider any other factors that may make one of the functional LCWRA criteria appropriate such as:

- Evidence of significant cognitive impairment.
- Sequelae of injuries sustained during seizures.
- Comorbidity.

Other factors that may justify application of risk such as sudden deterioration in condition, awaiting urgent MRI with suspicion of a space occupying lesion.

In justifying advice to the Decision Maker, the HCP has to consider whether any reasonable precautions/interventions/adaptations could be made within the workplace. If any of these reasonable provisions could be applied to reduce the risk by a significant degree, then substantial risk for LCW would not apply. In each case, the HCP must also consider whether suitably tailored work-related activity would be likely to pose a substantial risk to the health of the person if risk for work were to be identified and advised.

The Decision Maker will assess the information provided and will determine the level of benefit entitlement.

3.9 Personal Summary Statement (PSS)

A key part of the report is the Personal Summary Statement. This section of the report is the area where you must fully justify your opinion on the claimant’s functional ability. This

summary must contain enough detail for the Decision Maker to understand your reasoning and therefore allow them to be able to make a determination on an appropriate descriptor for each activity and LCWRA criteria.

The summary is completed on form ESA85S/UC85S, which is a separate page from the ESA85/UC85 has an equivalent in LiMA. This is generated automatically by LiMA, however must be completed separately in clerical reports.

3.9.1 Clarify the medical basis for your choice of descriptors.

Your summary needs to draw together the most pertinent information that you have gathered from the clinical history, typical day history, observations, and clinical findings, and requires that you consider the individual's functional ability in a holistic manner. It needs to encompass the justification for all activity areas where you or the claimant have identified a problem.

It needs to be written in free text, not drawn from pre-populated fields within the LiMA platform. The summary must be personalised.

In LiMA, if you advise that having LCWRA is likely, the summary of functional ability will be automatically transferred to the ESA85A/UC85A. However, when completing the report clerically, you need to complete both the ESA85A/UC85A and the summary on form ESA85S/UC85S. It is important when completing the summary where LCWRA is being advised that you make it clear to the Decision Maker what criteria is being advised.

When completing the summary, the following key principles should be adhered to:

- Spelling and Grammar must be of a standard that the intent of the message is clear.
- The summary should be easy to read. This is best achieved through use of concise spaced paragraphs. Using "bullets" is not acceptable as this does not allow the summary to read in a personalised manner.
- No new information should be introduced in the PSS.
- The claimant should be referenced by surname once with subsequent use of any relevant pronoun, avoid use of the term 'claimant' in PSS.
- All listed conditions must be referenced at some point within the summary.
- There is no requirement to list the stated restrictions from the ESA50/UC50 as this will be available to the Decision Maker to review, however you have to ensure that all 'problem' areas are adequately justified.
- With conditions that are medically unlikely to cause any functional impairment a simple statement will suffice.
- Where physical conditions have been referenced for mental function descriptors, or vice versa, a simple statement will suffice.
- Avoid where possible the use of the exact wording of the descriptors, however

if advising on LCWRA, then it should be made clear as to which criterion applies.

- Relevant functional areas should be addressed in the same order as they appear on the ESA85/UC85.
- Justification should contain an outline of the medical condition, main difficulties reported by the claimant, relevant observed behaviour/examination findings and key issues in the typical day.
- Variability and tasks being completed reliably and repeatedly should be addressed.
- Extensive repetition of the same evidence is not required.
- Examination findings should be expressed as a broad overview. The full findings are available to the DM in the report.
- While it is important to address conflict within the report, you do not need to reference every single piece of contradictory evidence.
- An overview approach, particularly in the mental function areas may well be preferable to addressing each individual descriptor that may or may not apply.
- An overall ending statement around the likely severity of disability is unlikely to add value.
- Where Substantial Risk is advised, the PSS should contain clear justification of this advice and in particular there must be clarity on whether your advice relates to LCW alone or both LCW and LCWRA

Ten functional categories cover disability in physical and sensory areas. The first two functional areas (mobilising, incorporating stairs) and standing and sitting (incorporating transferring), are activities which predominantly involve conditions of the lumbar spine and lower limbs, however, upper limb function should be considered in mobilising and transferring. The next three categories (reaching; picking up and moving; and manual dexterity) are activities which predominantly involve the upper spine and the arms/hands.

You will write a more effective justification if you group together these descriptor groups - the information about daily activities, clinical findings, variation/fluctuation, pain etc are likely to be common to all the activities within the back/lower limb or neck/upper limb group.

For example, in a case where there is an upper limb problem, but you consider that the appropriate descriptor choices are “none apply”, an example of a useful summary may be:

Mr A is on mild pain killers for his frozen shoulder and has not required specialist input. His typical day history indicates good function with ability to self-care independently, read the newspaper and use a cooker, microwave and standard kettle for making snacks. Examination of upper limbs (including power) was normal apart from slight restriction of abduction in one shoulder. Observations were consistent with good upper limb function. Overall, the evidence suggests that despite his left shoulder problem he has good overall function in his upper limbs.

Remember that if you are considering the use of aids and appliances in choice of descriptor,

the reason you feel the claimant could use these or could not use these should be clear to the Decision Maker.

3.9.2 Justifying your advice on LCWRA

The justification of all the functional descriptors excluding eating and drinking is intrinsic to the Personalised Summary Statement and to the LCW functional descriptors. For example, where the HCP has chosen “none apply” for mobilising, this information is used to justify that the “mobilising LCWRA” criteria is not appropriate. However certain categories of LCWRA would not be included in the justification of the functional activities and would need to be justified separately. This section is included within the ESA85/UC85 report, on the LiMA report each category is listed, however on the clerical ESA85/UC85 report, the HCP will need to ensure all relevant areas are justified (Box 26 of the clerical ESA85/UC85). The categories which need to be addressed are:

- Special Rules for End of Life (Terminal Illness)
- Pregnancy “risk”
- Chemotherapy/Radiotherapy
- Specific substantial physical or mental risk
- Eating and drinking

3.9.3 Efficient use of Time in the LCW/LCWRA Assessment

Thorough preparation prior to the commencement of the LCW/LCWRA assessment can save a great deal of time. You should identify the affected functions, including mental health if appropriate, and concentrate on those aspects of the history, typical day, and clinical examination which provide a firm ground for your advice and your choice of activity outcome descriptors in these areas.

If it is evident early on that there is a mental health problem, the typical day enquiry should include activities and behaviours which are used in the seven functional activity areas of the Mental Function assessment. This will avoid "starting afresh" at the end of the physical component of the assessment to enquire about the mental health topics.

If the claimant has considerable disabilities and you have chosen high descriptors in a number of areas, it is sensible to keep the remainder of the LCW/LCWRA concise.

In LiMA, curtailment will often apply in these circumstances and the application will invite you to provide examples of the prominent features of daily living in only some of the activity areas. The application will record a phrase indicating that curtailment applied in the curtailed areas.

Having provided robust evidence in one high scoring functional area, it is only necessary to give succinct and relevant details elsewhere.

Curtailment does not apply to clerical reports and all relevant sections will need to be completed.

It may occasionally become apparent that a claimant meets criteria for LCWRA. If this is the case, follow the procedure for LCWRA as detailed in sections 2.3 and 3.1.3.12.

3.10 Medical Advice on the Re-referral Period or Prognosis at Assessment

It should be noted that in Universal Credit, we refer to the term “re-referral period”.

In ESA was referred to as “prognosis advice”.

For those claiming ESA or for those claiming UC who are not in work, the re-referral period advice for the purposes of LCW/LCWRA, whether during the Filework process or during the full assessment, refers to the time frame for when the claimant could be considered fit for work or fit for work-related activity. It does not refer to the prognosis of the actual medical condition itself.

For claimants in work claiming UC, the re-referral period should be based on when you consider that there will be a substantial improvement in the claimant’s functional ability, or that they may have further adapted to their condition, such that they would benefit from reassessment.

When considering prognosis or re-referral period, the HCP has to consider whether the condition or its functional effects are likely to improve.

This may be due to the natural resolution of the condition, or improvement with treatment, with adaptation or with the use of appropriate aids and appliances.

However, there is an acceptance that this approach does not work for all claimants. There will be a small number of those for whom their health condition or disability is such that there can be no realistic expectation that they would move towards work or take part in work-related activity at any point in the future. To that end, in October 2016, the Secretary of State announced that the Department would stop reassessments for claimants in the ESA Support Group/UC LCWRA Group (those with Limited Capability for Work-Related Activity) with the most severe and lifelong health conditions or disabilities for whom reassessments are likely to provide no further new information. This change was implemented in 2017 and HCPs may advise that no further review is required where the claimant meets a number of criteria set out by the DWP. (See Appendix 8)

For claimants who are found not to have limited capability for work or work-related activity, i.e. those who are below the benefit threshold, who also do not fulfil any of the LCWRA or exceptional circumstances criteria, there is no longer a need to give advice on prognosis. The prognosis advice is automatically omitted in LiMA reports, in clerical ESA85/UC85 reports; the HCP should draw a line through the prognosis box and indicate “Not Applicable” in the prognosis justification section.

It should also be noted that a claimant who feels that their health condition has deteriorated such that their functional capability should be reassessed prior to the re-referral period or prognosis period can contact DWP to request that a WCA referral be made ahead of time.

3.10.1 LCW/LCWRA - Advice on when work could be considered.

Main points:

Under the LCW/LCWRA procedures approved HCPs are required to give advice on prognosis without reference to the outcome of the decision-making process.

When the claimant is deemed to meet the criteria for being considered to have LCW or LCWRA (either functional or “treat as criteria”) the LCW/LCWRA assessment, the medical advice on prognosis provided by approved HCPs is often used by the Decision Maker to determine when subsequent re-referral to the Supplier is appropriate.

The DWP will wish to refer a claimant for reassessment of LCW/LCWRA at the point where there is a reasonable expectation that their prospects of engaging in work have improved or their condition may have improved such that re-assessment may be appropriate. Whether the outcome of the case is meeting LCWRA criteria, application of Exceptional Circumstances or advice on a functional condition, the Decision Maker will require a reasonable prognosis for engaging in work activity. In assessing when a claimant may be able to engage in work, the approved HCP should provide this advice based upon their assessment of the claimant, their knowledge of the natural progression of the identified medical conditions, and the time they feel a claimant may need to adapt to their condition. It should be noted that when providing a prognosis on a claimant where LCWRA is advised, it should be clarified on the ESA85A/UC85A that the prognosis applies to work-related activity.

Where possible the HCP should advise when any disability identified would be expected to significantly improve. This may be because the key functional problems are expected to improve (with further treatment or with time); or because it would be appropriate to reassess the person on the basis that there is a reasonable chance that the overall medical condition will have improved significantly. In those with chronic problems where functionally no change is anticipated e.g. congenital deafness, the HCP should advise when they feel engaging in work might be possible once they have adapted to their condition and other adjustments have been put in place.

For those deemed to be terminally ill/nearing the end of life there is no requirement to include a prognosis.

If there is more than one relevant functional condition, the HCP should aim to provide an opinion on the likely timescale for engaging in work, taking account the effects of all conditions.

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

In all cases your opinion on when engaging in work or there is likely to be an improvement in the persons condition could be considered must be fully and comprehensively justified. It is important to consider each case individually and to choose and justify the appropriate time period.

For example:

1. A claimant with mild mechanical, intermittent back pain scoring below the threshold of LCW and no LCWRA or exceptional circumstances apply – no prognosis advice is given in this case.
2. A 25-year-old claimant who has a traumatic sudden complete loss of vision with severe problems understanding communication and in navigating. He is still under specialist care and undergoing treatment. You may have indicated an 18-month prognosis in this case.

Justification may be: The claimant has experienced a sudden onset of complete visual loss. He is still undergoing treatment and there may be some improvement in his condition. He may also with time be able to adapt to his visual loss and with input and training, may be able to engage in work or work-related activity within about 18 months.

3. 58-year-old claimant who was diagnosed with epilepsy several years ago. The frequency of seizures has recently increased, and he has been referred back to the specialist for review. Despite medication he is still having frequent seizures, occurring on average once or twice a week, with complete loss of consciousness, at present. He has adapted his lifestyle to avoid hazardous tasks and makes sure he is accompanied if he has to go out. He has been found to have significant problems due to loss of consciousness and given a 12-month prognosis.

Justification may be: The claimant has a long history of epilepsy, with recent increase in seizure frequency. He has been referred back to the specialist and the seizure frequency may improve with appropriate medication.

3.10.1.1 Advice that engagement in work is unlikely within 2 years.

If in your opinion the medical condition, level of function and the claimant's ability to adapt is unlikely to change significantly in the next 2 years but there is still a possibility of some change with time or further therapy then you should suggest a 2-year prognosis. For example, a claimant with rheumatoid arthritis with a significant degree of functional problems, where you would not expect any improvement of note within 2 years, **but** where surgery or other treatment in the medium term may change the clinical picture.

3.10.1.2 Advice that engagement in work is unlikely In the Longer Term

Where at assessment you find a substantial degree of functional impairment resulting from a serious medical problem which is chronic and unlikely to improve even with optimal treatment, you should select "in the longer term".

In other cases, such as in the case of a young adult with a very significant degree of learning disability, where cognitive impairment in a number of functional areas mean that he requires a high level of support, you may feel that all management and support strategies have been exhausted and further adaptation is unlikely to occur. You would then reasonably advise "in the longer term" prognosis.

3.10.1.3 Severe Conditions Prognosis

This re-referral period will apply to those with LCWRA only. If a claimant has LCW but not LCWRA, the process remains as above.

The principles behind the implementation of the 'severe conditions' prognosis advice were to:

- Reduce any unnecessary disruption caused to claimants by a repeat assessment when we do not expect re-assessments to tell us anything new for the purposes of administering their benefit.
- Reduce the burden placed on claimants to continue to produce evidence confirming

the impact of a health condition or disability.

- Reduce the need for the Department or Suppliers to conduct unnecessary assessments when resource could be better focused.

The Department has set out the criteria for when to apply the severe conditions re-referral period. This can be applied at filework and following a full assessment. See Appendix 8 for DWP guidance on the Severe Conditions Prognosis criteria.

Please see Section 3.2.9 for specific guidance on considering the use of Braille in those with severe visual impairment.

3.10.1.4 Exceptional Circumstances

When an Exceptional Circumstance Descriptor is applied you must give advice on “functional prognosis” and “exceptional circumstances prognosis”. If the claimant does not have significant functional problems, the functional prognosis will usually be for 3 months. The prognosis for the exceptional circumstances should reflect when the claimant might be able to consider engaging in work activity. It would not be unusual to have two very different prognoses under the Functional and Exceptional lists, but the Decision Maker will take whatever control action is appropriate under the circumstances of that particular case. You should add a brief explanatory note of justification for your advised prognosis period.

3.11 LCWRA Assessments

3.11.1 Introduction

Occasionally you will be asked to see a case for the Revised WCA where the claimant has been identified, either by a DWP (DM) or an HCP, as ‘Treat as LCW’.

That is, the claimant falls into one of the categories where LCW is accepted, but LCWRA has still to be established, and cannot be advised on the basis of documentary evidence alone.

This guidance clarifies what is required of an HCP for completion of the ESA85/85S/85A (and UC equivalent forms) where a full assessment is required to establish whether LCWRA may apply.

These “LCWRA only” assessments will be completed clerically, not using LiMA. Therefore, only HCPs trained in the completion of clerical reports will be able to carry out the assessment.

3.11.2 Background

Within the ESA and UC legislation, certain claimants, who may not have significant functional impairment, may be treated as having LCW because they fulfil certain criteria set out in the legislation. These are:

- Infectious disease inclusion by Public Health Order.
- Pregnancy around dates of confinement (**Only in ESA – not UC**).

- Hospital patient.
- Regular treatment.
- Claiming income related ESA, in education and in receipt of DLA (**ESA only – not UC**).
- Older claimants in receipt of PIP/DLA/AA in specific circumstances (**UC only**).

(See section 2.4 of this Handbook for further detail)

If an HCP has given advice that a client can be 'treated as LCW' at Filework, they must also consider the LCWRA question. If there is sufficient evidence available that they can fully justify their opinion across all of the LCWRA categories, then they should offer this advice, providing full justification to the DM. However, in a small number of cases the HCP will be unable to provide advice on LCWRA; this should be indicated in the justification. The file should then be passed to the administration section to arrange an LCWRA only assessment. This situation should only arise after the Filework HCP has made every possible attempt to obtain evidence in order to provide definitive advice.

In some cases, the DM will request that an assessment is carried out. Where this situation arises, it is appropriate to proceed to full assessment.

3.11.3 LCWRA Assessment Process

The following process should be followed by a suitably trained HCP when completing an LCWRA assessment.

All full assessments to establish LCWRA will be conducted either as a Face-to-Face AC/HC Assessment, or as Telephone Assessment or Video Assessment

If the assessment is conducted as a HC, the HCP should follow the guidance in section 4.4 with regard to notifying the claimant of appointment time and date.

If the HCP contacts a claimant and establishes that they have a special need that the HCP is unable to fulfil, the case should be returned to allocations at the Supplier with the details of the special need recorded.

If the HCP contacts a claimant and they are a hospital patient, they should try to establish the name of the hospital, the supervising consultant's name and the likely duration of admission. The file should then be returned to the Supplier to allow further scrutiny to be conducted.

Where a HC is to be conducted, a HC pack should be obtained from the Supplier administration staff. This will contain an ESA85, ESA85S, ESA85A, ESA85A min, DVN1, SL1, BF223, UE1 and POID1 (or equivalent UC forms). Any previous information recorded on an ESA85A/UC85A will be printed from MSRS and included in the pack. If there is no ESA50/50A/UC50/50A in the file due to non-return, there should be an ESA51 or ESA53 form (or UC equivalent) - these forms confirm the request for a questionnaire.

The HCP should check the content of the pack prior to conducting the visit.

The HCP should conduct the assessment in accordance with Professional standards.

The following scenarios provide guidance on completion of the assessment:

Scenario 1- LCWRA applies:

If at any point during the assessment, the HCP considers that they have adequate information to advise on LCWRA, they should complete the relevant sections of the ESA85/UC85 and complete form ESA85A/UC85A, providing sufficient information to allow the DM to consider their decision. They should then **also** complete a Personalised Summary Statement on ESA85S/UC85S for the DM. This summary only needs to provide justification for the LCWRA category that is considered appropriate.

All contracted HCPs must first contact the CSD helpdesk for approval if they consider that it is appropriate to advise that the claimant meets LCWRA criteria.

All information gathered on form ESA8/UC85 which is relevant to whether LCWRA applies must be included on the ESA85A/ESA85S/UC85A/UC85S.

Scenario 2 – LCWRA does not apply:

If the evidence suggests that LCWRA does not apply, the following sections of the ESA85/UC85 should be completed:

- Box 1 (claimant and examination details and diagnoses list).
- Box 2 (medication).
- Box 3 (side effects of medication).
- Box 4 (history of conditions, social and occupational history, and typical day history).

You would then proceed to any appropriate physical examination. The physical examination should be tailored to the conditions listed in box 1. The findings of both observed behaviour and formal examination findings should be documented in the relevant sections of the ESA85/UC85 report.

The following section should then be completed:

Box 26

You must justify why none of the Treat as LCWRA Criteria (SREL, Chemotherapy/Radiotherapy, Pregnancy Risk, and Substantial Risk) apply. You must also justify why the LCWRA category for Eating and Drinking does not apply.

When you have completed the relevant sections of the ESA85/UC85, you must then ensure you complete the final page of the ESA85/UC85 (Name of HCP, signature etc).

You do not have to complete the descriptor pages, exceptional circumstances and

prognosis pages.

You must now complete the ESA85S/UC85S. The summary must include justification of why each of the relevant functional LCWRA areas does not apply. The “relevant functional areas” will be dictated by the diagnosis, ESA50/ESA50A (or UC equivalent) details and information obtained at the assessment.

You should record pertinent aspects of the history, observations and examination findings in the summary for **each relevant** LCWRA area to robustly justify why LCWRA does not apply.

The level of detail and clinical examination should be tailored to each individual case and the assessment channel as per the applicable WCA examination protocol. The extent of detail and justification will depend on the conditions described and also information that may be present in the ESA50/ESA50A/UC50/UC50A.

If you need more space, further ESA85S/UC85S forms should be included in the pack or at the AC.

For example, if a claimant has indicated significant problems only with walking and in no other areas of the ESA50/ESA50A/UC50/UC50A, you should justify your opinion in the Personalised Summary Statement with information such as:

“Mrs B has knee pain for which she takes a mild pain killer. The typical day indicates she walks for 5 minutes on a daily basis and other reasonable distances several times a week unaided. Observed behaviour suggests a slow pace but no other substantial restriction. Examination of the lower limbs was entirely normal other than minor restriction of knee flexion. Therefore, while some restriction of mobility is possible, the evidence suggests that she should be able to safely and without distress mobilise reasonable distances most of the time”.

Scenario 3 – No longer satisfies criteria for ‘Treat as LCW’:

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

- Indicate on the ESA85/UC85 that ‘Treat as LCW’ would no longer appear to apply providing detail of the change of circumstances for the DM.
- You should then proceed to complete a full LCW/LCWRA assessment on the clerical ESA85/ESA85S/UC85/UC85S in the usual manner taking into account any information present in an ESA50/ESA50A/UC50/UC50A.
- The normal procedures for completion of the LCW/LCWRA forms should be followed.

Non-completion of any part of assessment

Should a circumstance arise where any part of the assessment cannot be completed (LCW/LCWRA), then a full explanation should be recorded on an ESA85A/UC85A minute

form.

If an assessment cannot be completed because an interpreter is required, this should be recorded on a minute detailing the language requirement and a further appointment should be made in accordance with the guidelines.

4 Miscellaneous

4.1 Exceptional Situations at Assessment

It is important to make every effort to fully assess all claimants attending for assessment. There are some situations where a full assessment may prove to be challenging. It is important when assessing claimants who exhibit more challenging behaviour that full account is taken of any medical conditions that may be influencing their behaviour before any assessment is abandoned.

4.1.1 Clients Unfit to be seen

There are several circumstances where it may be that a claimant is unfit to be seen. This may be identified before the assessment commences or during the course of the assessment.

Identified before the assessment starts

If a claimant is identified as being unfit to be seen before the assessment begins consideration must be given as to whether they can be given a second appointment.

If this is their first appointment, the claimant should be sent home unseen. Supplier administration staff will follow their normal Claimant Sent Home Unseen (CSHU) procedures using reason "Claimant Unfit to be examined" and a second appointment scheduled.

If this is their second appointment, the referral must be withdrawn. The referring DWP Office should be contacted by administration staff to inform them that the claimant is unfit to be assessed and that the referral is being withdrawn. Before returning the Case File to the DWP, a note should be attached explaining why it has been returned.

Identified after the assessment has begun

There are a number of scenarios where a claimant becomes unfit to be assessed once the assessment has begun.

If the claimant is unfit to be fully assessed for reasons related directly to their medical condition, but enough clinical detail can be obtained or observations recorded, the HCP should make all attempts to complete the assessment, providing full details of the incident and recording any appropriate descriptors or advice on LCWRA criteria.

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

If the assessment has to be terminated due to violence or persistent uncooperative behaviour, this process is described below.

4.1.1.1 The uncooperative claimant

If a claimant arrives at an Assessment Centre (AC) exhibiting abnormal behaviour, suggestive either of mental illness, intoxication as a result of substance abuse, including alcohol or any other cause, you should if possible be accompanied by one of the Supplier AC reception staff members throughout the assessment. The reception staff member should always be prepared to leave the room to summon assistance during the assessment. Every HCP should familiarise themselves with local security policies and ensure they are aware of how to summon help if required. Many assessment centres will have “panic” buttons or alarms and rooms are set up to minimise risk. Information on safety can usually be obtained from the designated officer for safety.

If the uncooperative behaviour of the claimant is arising from their medical condition, then the report **must** be completed detailing the behaviour and applying the appropriate descriptors or advising on LCWRA. If a non-functional descriptor is appropriate, it can only be applied **after** completion of the full report by selection of descriptors.

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

1. **The behaviour of the claimant poses a threat to you or to other staff or claimants.**
2. **Persistent uncooperative behaviour by the claimant.**

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

In such circumstances, particularly if the problem arises as a result intoxication, administration staff should be informed and the CSHU procedures followed as detailed above.

If the assessment and reports cannot be completed then you should consult an experienced disability analyst for advice about how to complete a full and detailed account of the claimant's behaviour, giving the reasons for terminating the assessment. A full account of the reasons for failing to complete the assessment should be recorded on an ESA85A/UC85A min.

If a Supplier AC reception staff member is present during the interview, they should countersign the statement as being an accurate record of the events.

Where an interview is terminated without completion of the assessment in the circumstances described at (4) above, the *Decision Maker* may wish to consider disallowance on the grounds of failure to submit to assessment or may wish to consider “good cause” for failing to comply with assessment.

They depend on the information being comprehensive enough to support their decision if the claimant appeals against it.

If a claimant is threatening or abusive, for whatever cause, including as a result illness, the appropriate DWP Keep Customer Interactions Safe Process Guide processes should be followed and put in place immediately.

The assessing HCP should complete the relevant incident forms/accident forms as soon as practicable following the incident. Details of the incident should also be entered into the Supplier accident book.

A Health and Safety Incident Report form should also be completed if any incident occurs in keeping with the relevant Health and Safety policies.

Please see the DWP Keep Customer Interactions Safe Process Guide.

4.1.2 Lack of an Interpreter

If a claimant attends for assessment and they do not speak English (or any other language which you speak), or they communicate in BSL and are not accompanied by an interpreter, you should establish the claimant's native language and take the following action:

- If possible, pass the case to an HCP who speaks the claimant's language to enable the assessment to continue, or
- Check if any of the assessment centre staff speaks the claimant language; if agreed, ask them to act as an interpreter, to allow the assessment to continue, or
- **If neither of the above is possible** the claimant should be told that a fresh appointment will be made when an interpreter can be present.

This information should be written down clearly for the claimant to take away for a friend or relative etc. to translate, to make sure they understand.

An ESA85A/UC85A min should be annotated 'initial appointment abandoned due to lack of interpreter. Claimant speaks Further appointment to be arranged with interpreter'. You should sign and date this note.

4.1.3 Audio recording of WCA assessments

HCPs have the facility to audio record telephone and face to face assessments upon request.

There is currently no facility for audio recording in video assessments.

At a face-to-face assessment, the claimant and/or their appointee must sign a consent form in which they agree to not use the audio recording for unlawful purposes. At a telephone assessment, consent should be captured verbally on the recording.

The claimant may record their assessment using their own equipment, where they advise the Supplier in advance of the consultation. The Supplier must also record the assessment, seeking consent as above. The Supplier will ensure that recordings are stored securely for the appropriate retention period.

Suppliers must publicise these conditions and include them in communications sent to claimants before they attend an assessment. When invoking LIMA within MSRS, MSRS will prompt the HCP conducting the assessment to confirm if the audio recording request has

been met and the HCP should acknowledge this check. The HCP should also note that the assessment has been audio recorded within the assessment report. WCA administrative staff should also record this information on the WCA IT system/Smart when the assessment is cleared.

A video recording of a consultation is not permitted. This is to ensure the safety and privacy of staff and other claimants.

Unauthorised use of recordings

The DWP reserves the right to take appropriate action where the recording of an assessment is used for unlawful purposes – for example, if it is altered and published for malicious reasons.

4.1.4 Taking of Notes during an Assessment by Claimant or Companion

From time to time, you may encounter a situation where the claimant is accompanied by a companion and either the claimant or companion may wish to take notes during the assessment.

Persons who are entitled to be in attendance are always entitled to take notes. This is because it is for their own purposes and not an official record of the process.

To attempt to deny the right to do so is likely to be contrary to Human Rights legislation.

To request a copy of the notes is unlikely to be helpful – it will place you in the position where you will be obliged to review the notes and comment on their reliability.

However, you should record in the report, the fact that notes were being taken. The following warning should also be given, and the fact documented in the report. LiMA will offer the phrases as an optional addition.

For any handwritten report, on the rare occasions when this is necessary, the report should be annotated on the front cover.

The form of words you should use has been clarified on legal advice. Any current desk aids for this purpose should contain following form of words:

“Where notes are taken by you, we consider it of assistance to both myself, as the examining HCP, and yourself to point out the following:

1. It is your right to take notes for your own use and benefit.
2. The notes will not be included in the Report I make save for the fact that notes were taken and further, they are not accepted by myself or the DWP as an official record of this assessment.
3. If the notes are subsequently produced at any time for any purpose, such as part of an appeal process, I the Assessing HCP, my employer and the Department for Work and Pensions reserve all rights to challenge anything in the notes in the event we are asked to comment

on the content of the notes at a future time.

4. You are free to use your notes as you choose but if you chose to publicise the notes (other than in connection with correspondence with the DWP or under any appeal procedure) I would ask that you do not publicise my name.”

4.1.5 Functional assessment of pregnant women

Pregnancy is a normal physiological process and therefore **cannot alone** satisfy the criterion of limited capability for work or limited capability for work and work-related activity unless ‘Treat as LCW’ criteria in ESA apply.

When appropriate a full LCW/LCWRA assessment will be carried out to assess the functional limitations due to the diagnosed cause of incapacity, regardless of whether it is related to the pregnancy. A pregnant claimant will need to be treated with considerable sensitivity at assessment. For example, an MSO may well be appropriate, but an abdominal examination would never be appropriate.

Consideration should be given to whether or not the pregnancy-related LCWRA may apply – see sections 2.3.2 and 2.4. You should also consider whether treating the woman as having limited capability for work around the dates of confinement may be appropriate if being assessed under ESA regulations – see sections 2.3.2 and 2.4.

4.1.6 Retention of Notes containing Claimant Details

There may be rare instances where notes are taken, by the HCP, when assessing claimants. In line with DWP Security Accreditation, the following guidance has been put in place to ensure claimant’s data is adequately protected.

HCPs must note the following:

There should be no instance of notes relating to the content of the ESA85/UC85 or claimant details being retained by any HCP on any claimant. Only a NINo can be kept as a reference for payment purposes as any information needed could be provided on supply of the NINo. The recording of NINos for information, other than what is absolutely necessary for operational and medical purposes, is strictly forbidden. This includes written information pertaining to assessments HCPs have carried out (kept as records of assessments completed, as an example). Please be aware that there is a risk that any loss of sensitive information, including large amounts of NINos, could be referred to the Information Commissioner. All staff have a responsibility to handle DWP data in the correct manner. The policy is to restrict the handling of claimant data to the workplace in order to minimise the risk of loss or theft, unless this is not possible, e.g. with respect to authorised homeworking or Face-to-Face HC Assessments.

Any additional notes, (for example a note of inability to access a property) made on the day of assessment must never have any claimant identifying details recorded on them and should be destroyed in a secure manner* at the end of the session or working day.

Clerical report forms e.g., ESA85/UC85, ESA85A/UC85A or ESA85S/UC85S should be returned to the Supplier offices in the normal manner.

*Paper records containing protected personal data must be destroyed by incineration, pulping, shredding or placed in confidential waste so that reconstruction is unlikely.

Note: Claimant data should never be recorded or stored on any unauthorised electronic device.

All data must be handled using appropriate security measures as outlined in the relevant DWP and relevant Supplier security process and data control operating procedures. This applies to data handled at any location such as Supplier premises, Assessment Centres, HCs, home working etc.

4.2 Sensitive Information

Certain information which may be encountered in benefit work is of a sensitive nature, and you should know how to deal with such information. Suicidal ideation and attempts (and information about self-harm thoughts/actions) is one such area. This must be handled with empathy and appropriate details documented.

Other categories are conveniently categorised as:

- Harmful information.
- Embarrassing information.
- Unauthorised information.
- Confidential information.

4.2.1 Harmful Information

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

- Malignancy.
- Progressive neurological conditions.
- Major mental illness.

Try to avoid writing Harmful Information in your reports; however, if this is essential information for the DM to consider in relation to the claim, perhaps when advising if a claimant is terminally ill/nearing the end of life (Special Rules for End of Life), you should record the harmful information clearly identifying it as such only on the final page of the ESA85/UC85 report and, if omitting an entry from the body of the report would leave a gap, write a "harmless synonym" at the relevant place. For example:

"Bronchial trouble and persistent headache".

Harmful information:

"True Diagnosis: Bronchial carcinoma with cerebral metastases."

If you encounter Harmful Information in a report prepared by another HCP, you should discuss it with an experienced HCP before meeting the claimant.

4.2.2 Embarrassing Information

This is information which could not be considered harmful to the claimant's health, but which may well upset or anger them and embarrass you and the Department for Work and Pensions. If recorded in a report such information may not legally be withheld from the claimant.

Examples of this type of sensitive information include:

- Criticism of treatment given elsewhere.
- Suspicion of malingering which you cannot substantiate.
- Reference to any conviction.

Under the Rehabilitation of Offenders Act 1974, after the expiry of a rehabilitation period a conviction becomes "spent". The rehabilitation period varies in length, depending on the sentence imposed; some sentences can never be spent.

Once a conviction becomes spent, the person is treated for a number of purposes as if they had never been convicted of the offence in question. This subject merits further explanation.

The Rehabilitation of Offenders Act makes it an offence for anyone **with access to criminal records** to disclose a spent conviction **unless authorised to do so**.

The intention of the legislation is that, once a conviction becomes spent, any question relating to criminal convictions in, e.g., job or insurance application forms, can, with certain exceptions, be answered in the negative.

Only malicious allegations of spent convictions would carry a risk of legal action for defamation of character, if it could be proved by the claimant that the allegation was made with malice.

Within a WCA assessment it is necessary to avoid reference to any conviction - spent or otherwise - unless such information has a direct bearing on the claim.

4.2.2.1 Requirement of HCPs

HCPs may receive information that relates to current or spent criminal convictions, either in factual reports from a third party, e.g. a GP, or directly from a claimant during interview. HCPs need to understand the implications of the Rehabilitation of Offenders Act in order that they can deal appropriately with such information.

4.2.2.1.1 Medical reports provided by a third party

If a report submitted to the Department for Work and Pensions or the Supplier by a third party makes reference to a criminal conviction, the author will not contravene the Act unless they have access to the person's criminal records. In the case of a factual report from a GP or hospital, this risk would be so unlikely that it can reasonably be disregarded. The information in such a report is likely to have come from the claimant.

HCPs can therefore accept in good faith that reference to criminal convictions in third party reports, without risk of contravening Rehabilitation of Offenders legislation. Such information should, however, be treated like any other potentially embarrassing information, unless mention of the conviction is directly relevant to the benefit claim in question.

4.2.2.1.2 Medical reports provided by HCPs

Similarly, since neither the Department nor HCPs working with the Supplier will normally have access to a person's criminal record, any information about convictions will have come from the claimant. Hence, if there is good reason for the assessing HCP to record such information – i.e. it is materially relevant to the claim – he or she may do so, in good faith, without fear of contravening the legislation. If a claimant wishes to have mention of a conviction recorded on the medical report, the HCP should:

Confirm with the claimant that they are content for the information to be disclosed in the report; and

Record the information together with a note stating, "I confirm that this information has been incorporated at the request of the claimant."

You should not write embarrassing information in your reports.

If you encounter any information which you consider potentially embarrassing, and are unsure how it should be dealt with, you should seek advice from an experienced HCP.

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

4.2.3 Unauthorised vs. authorised information

Unauthorised information comprises letters written from one health professional to another and forwarded to a third party without the express permission of the author of the letter. When a person submits a claim for ESA or UC, the DWP is responsible for obtaining their consent for the release of any medical information necessary to process their claim. As part of the evidence gathering process for ESA/UC claims, GPs can forward hospital letters, etc. where consent is held by the DWP because they form part of the patient record. Therefore, hospital letters, specialist letters, etc. that are supplied with a claim or as a result of a request for FME where consent is held, should be considered as **authorised** information. They can be utilised by HCPs and subsequently by Decision Makers in the assessment process.

Remember that consent for FME can be withdrawn at any stage of the WCA Process and the HCP must ensure consent remains in place when considering FME.

4.2.4 Confidential Information

Confidential Information relates to any document received in respect of a claim and marked "Confidential" or "In Confidence".

Such a document cannot be used in the consideration of a case, and if one is encountered you should take the same measures as described for Embarrassing Information.

A claimant may attempt to give you information which they do not wish to have recorded on the report; that is they wish certain facts to be treated "In Confidence". It should be explained that such information cannot be taken into account as it cannot be made available to the Decision Maker.

A claimant may present a letter or medical report for you to read. You should accept that the claimant is the "owner" of the document and that the permission of the author for its use has been obtained.

4.2.5 Information brought by the claimant to the assessment or referenced by the claimant at assessment.

During an assessment completed at an AC, the claimant may have additional evidence they want to be considered as part of the WCA report. With the claimant's consent, the HCP must read the evidence and evaluate this additional evidence as part of the WCA report. A copy of the evidence submitted and considered must be made and placed on file for the Decision Maker to review as part of the body of evidence.

During Face-to-Face AC Assessments, to reduce any delay to the claimant, a process is in place where administration staff will photocopy the evidence with the consent of the claimant.

Some Face-to-Face AC/HC Assessments are completed at sites where no copying facilities are available; for example in casual hire sites. With the claimant's consent, the HCP must read the evidence and evaluate this additional evidence as part of the WCA report. The HCP must make a note of all relevant information related to the FME, including the type of FME and the body responsible for producing the FME, and with the claimant's permission issue a pre-paid envelope to the claimant for FME to be forwarded and considered as part of their claim by the decision maker. The HCP must also make a note in the report to indicate the claimant was advised to submit a copy of the FME.

Where the claimant provides FME at a Telephone Assessment or a Video Assessment, the Supplier shall ask the claimant to post the FME. If the claimant is unwilling to pay the postage cost, the Supplier shall send a pre-paid envelope to the claimant. The HCP should explain to the claimant why it is important to post the information, i.e., the Decision Maker cannot give the information proper consideration without a copy. At the time of the assessment, the HCP should summarise the information as far as possible, including the type of FME and the body responsible for producing the FME referenced by the claimant. The HCP must also make a note in the report to indicate the claimant was advised to submit a copy of the FME.

If the claimant does not want to submit a copy of the evidence, you should explain that the Decision Maker cannot give the information proper consideration.

Please refer to the relevant Supplier administration guides for full assessments for further details in relation to this process.

4.3 Identification of Claimants

In most situations when assessments are conducted in an Assessment Centre, the administration staff will confirm the identity of the claimant using the identification verification guidance issued by the Supplier. In certain circumstances, the admin staff will not be able to confirm the identity of the claimant and this task will be the responsibility of the HCP.

It should however be noted that in all circumstances it is the responsibility of the HCP to ensure that they are satisfied that correct identity of the claimant has been established before they proceed with any assessment. DWP approved identification forms (POID1) are included as embedded documents in Appendix 5 of this document.

When an assessment is conducted as a Home Consultation (i.e. Face-to-Face HC Assessment), Telephone Assessment, Video Assessment, or in some ACs where there is no administrative support, the HCP will be solely responsible for establishing the identity of the claimant. All HCPs are required to follow the identification verification guidance issued by the Supplier. This guidance must align with the relevant parts of the DWP Common Standards for Identity Verification and Authorisation.

Please refer to the relevant Supplier identification verification guidance or proof of identity guidance for further information.

4.4 Home Consultation(s) (HC(s))

Not all benefit assessments are conducted at the AC. On occasions a claimant will indicate that they are unfit to travel to or to attend the AC and a HC becomes necessary.

Any HCP who is undertaking an HC should ensure they have completed the any relevant Supplier provided mandatory health and safety learning modules including dealing with aggressive and potentially violent individuals and are fully familiar with the DWP Keep Customer Interactions Safe Process Guide.

If you are asked to visit a claimant in their own home, it is essential that the correct approach is made when arrangements are made by telephone.

Please refer to the Supplier identification verification guidance or proof of identity guidance for further information.

4.4.1 Policy on Passive Smoking

The assessing HCP should take note of the following guidance:

Due to potential health concerns associated when Healthcare Professional (HCPs) undertake Home Consultations within a passive smoking environment, guidance from the DWP policy on passive smoking is as follows: -

“When visiting customers:

- Employees can politely request that they don't smoke during the interview.
- Should they refuse, the employee may terminate the interview.
- Should the customer still need to be interviewed attempts should be made to reschedule the visit or as a last resort they will be required to attend a DWP office.

It is good practice to advise the customer of this request prior to the visit”.

If the claimant refuses to stop smoking during the assessment, the HCP can terminate the assessment. The claimant should then be offered an appointment to attend an Assessment Centre (even if they fall under the category that would normally not be required to attend an AC). It can then be shown that you have offered them an alternative. If they refuse or can't attend because of their health, they should be offered another home visit, but warned that this will only take place if the customer agrees not to smoke during the visit. If at the next home visit, the customer again refuses to stop smoking, the HCP should terminate the visit.

It should be noted that it is a personal choice of the HCP whether to proceed with the assessment if the assessment is to take place in a smoke-filled environment.

4.5 Evidence gathering after the Assessment

While carrying out Work Capability Assessments (WCAs), HCPs may sometimes omit important information when gathering evidence which may significantly impact the quality of the report and lead to incorrect/inconclusive advice and sometimes even lead to a re-assessment of the claimant. This is usually identified via quality assurance (audit/case review) of the report but can also be self-identified by an HCP. In order to improve claimant care, quality of the report and to avoid re-assessments of claimants, HCPs can (by exception) call the claimant following their assessment to gather omitted/extra evidence.

General instructions for the gathering of evidence after an assessment is contained within the document entitled “*Evidence Gathering after a Work Capability Assessment*”.

Appendix 1- The LCWRA Descriptors

	Activity	Support Group
1	Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used	Cannot either (i) Mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) Repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion
2	Transferring from one seated position to another	Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from someone else
3	Reaching	Cannot raise either arm as if to put something in the top pocket of a coat or jacket
4	Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this schedule)	Cannot pick up and move 0.5 litre carton full of liquid
5	Manual dexterity	Cannot either - (a) press a button, such as a telephone keypad or; (b) turn the pages of a book with either hand

	Activity	Support Group
6	Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person	Cannot convey a simple message, such as the presence of a hazard
7	Understanding communication by i) verbal means (such as hearing or lip reading) alone, or ii) non-verbal means (such as reading 16 point print or Braille) alone, or iii) any combination of (i) and (ii), using any aid that is normally, or could reasonably be, used, unaided by another person	Cannot understand a simple message due to sensory impairment, such as the location of a fire escape
8	Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used	At least once a week experiences (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device; sufficient to require the individual to clean themselves and change clothing
9	Learning tasks	Cannot learn how to complete a simple task, such as setting an alarm clock, due to cognitive impairment or mental disorder

	Activity	Support Group
10	Awareness of hazard	<p>Reduced awareness of everyday hazards, due to cognitive impairment or mental disorder, leads to a significant risk of:</p> <p>(i) injury to self or others; or (ii) damage to property or possessions,</p> <p>such that they require supervision for the majority of the time to maintain safety</p>
11	Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks)	Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions
12	Coping with change	Cannot cope with any change, due to cognitive impairment or mental disorder, to the extent that day to day life cannot be managed
13	Coping with social engagement, due to cognitive impairment or mental disorder	Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual
14	Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder	Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace

	Activity	Support Group
15	Conveying food or drink to the mouth	<p>(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else;</p> <p>(b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort;</p> <p>(c) Cannot convey food or drink to the claimant's own mouth without receiving regular prompting given by someone else in the claimant's physical presence; or</p> <p>(d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimant's own mouth without receiving—</p> <ul style="list-style-type: none"> (i) physical assistance from someone else; or (ii) regular prompting given by someone else in the claimant's presence
16	Chewing or swallowing food or drink	<p>(a) Cannot chew or swallow food or drink;</p> <p>(b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort;</p> <p>(c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the claimant's presence; or</p> <p>(d) Owing to a severe disorder of mood or</p>

		behaviour, fails to— (i) chew or swallow food or drink; or (ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence
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Appendix 2– ESA85 & UC85 Clerical Report



ESA85 15.11.pdf



UC85 16.01.pdf

Appendix 3 - ESA85S and UC85S



ESA85S 05.11.pdf



UC85S 13.04.pdf

Appendix 4- ESA85A and UC85A



ESA85A 08.22.pdf



UC85A 08.22.pdf

Appendix 5 – Proof of Identity Forms

- **POID1**; for use in face-to-face assessments.



POID1 0124.docx

- **POID2**; for use in telephone and video assessments – not presently included for reasons of security (copies are available to suppliers).

Appendix 6 – DWP Revised Risk Guidance 2015

Guidance for HCPs on Substantial Risk in Considering Claimants with a Mental Function Problem

This update is for guidance, but your advice should be based on your clinical judgement and consideration of the evidence in each individual case.

This guidance is intended to assist Healthcare Professionals (HCPs) carrying out the Work Capability Assessment (WCA) and replaces previous guidance on the interpretation of substantial risk in the context of regulation 29(2)(b) and regulation 35(2) of the Employment and Support Allowance Regulations 2008 and the UC Regulations 2013 as amended by the UC and Miscellaneous Amendment Regulations 2014.

The guidance makes clear that this provision should only be applied in exceptional circumstances, and that in applying the guidance a two-stage process should be followed:

- Stage one – assess the evidence of risk of suicide or self-harm.
- Stage two – assess whether substantial risk would be triggered by a finding that the claimant is able to seek employment or is able to undertake activity to prepare them to move towards work (bearing in mind that there is good evidence that the right sort of employment is in general good for mental health).

The substantial risk criteria should only be recommended if there is evidence that substantial risk to the mental or physical health of any person, by reason of some specific disease or bodily or mental disablement, would be triggered if the claimant were found not to have limited capability for work or work-related activity.

For further information about the non-functional circumstances in which claimants might be found to have limited capability for work-related activity please read section 2.3.2 of the WCA Handbook.

Background

Following completion of a detailed functional assessment, HCPs are required to provide advice to the decision maker as to whether there would be a substantial risk to the mental or physical health of any person if the claimant is either found fit for work or able to undertake work-related activity. Legislation underpinning this is set out in regulation 29(2) (b) and regulation 35(2) of the Employment and Support Allowance Regulations 2008 and the UC Regulations 2013 as amended by the UC and Miscellaneous Amendment Regulations 2014.

Limited Capability for Work

A claimant who does not have limited capability for work as determined in accordance with the limited capability for work assessment is to be **treated as** having limited capability for work if the claimant suffers from some specific disease or bodily or mental disablement and,

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by reasons of such disease or disablement, *there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work. [Emphasis added]*

This does not apply where the risk could be reduced by a significant amount by:

- reasonable adjustments being made in the claimant's workplace; or
- the claimant taking medication to manage the claimant's condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant.

Limited Capability for Work-Related Activity

A claimant who does not have limited capability for work-related activity in accordance with the limited capability for work assessment is to be **treated as** having limited capability for work-related activity if:

- the claimant suffers from some specific disease or bodily or mental disablement; and
- by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work-related activity.

Policy intent

The WCA is a functional assessment and most claimants who are not fit for work or work-related activity should be identified by the functional activities. However, the assessment recognises that there will be small number of claimants who have a high level of function but for whom the decision that they must seek work or undertake work-related activity would be detrimental. This provision should only be applied in exceptional circumstances.

You should note that regulations refer to "substantial risk" to mental or physical health. Substantial risk has been defined as a risk "that cannot sensibly be ignored having regard to the nature and gravity of the feared harm in the particular case"¹. The substantial risk can apply to either the claimant or a third party, for example if there is a risk of injury to another as a result of violent behaviour by the claimant.

The impact of being found fit for work or required to carry out work-related activity

Work and work-related activity (WRA) are very different. If a claimant is found fit for work and chooses to apply for Jobseeker's Allowance, the claimant will usually be expected (subject to relaxations in certain cases) to be available for work, to search for work and to accept suitable employment, which may involve an employer making reasonable adjustments for the claimant as required by the Equality Act.

Work-related activity can involve any of a range of activities supervised by DWP, or a third-party organisation, that assist the claimant to move closer towards the world of work. It is work preparation activity intended to give the claimant the best possible prospects of moving into work at a point when they are able.

¹ IM v Secretary of State for Work and Pensions (ESA), paragraph 65.

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When a claimant is allocated to the work-related activity group a discussion with a DWP adviser usually takes place within 10 days of the WCA. At the discussion (which can be over the phone if appropriate to the claimant's circumstances), the adviser will find out more about the claimant, their aims for the future, their health condition, their current circumstances, and how they can best be supported to start moving closer towards the world of work.

The activity which the claimant is required to undertake could include completing online tasks (such as a self-assessment or a diary of daily activities), telephone or face-to-face discussions with the DWP or Work Programme providers to discuss goals and agree specific activities, taking part in courses to improve skills or confidence, or in some cases continue to engage in activity already taking place (whether arranged themselves or by a third party organisation).

The requirement for work-related activity is different for each individual ESA claimant. Work-related activity must be appropriate and personal to the individual.

Claimants must not be asked by DWP to do anything that is unrealistic or could put their health at risk or be required to undertake work-related activity that includes applying for a job or undertaking work as an employee or otherwise.

If the claimant feels that the work-related activity they have been asked to complete is inappropriate or unreasonable, they can discuss this with the DWP adviser, and if this does not resolve the issue the claimant can request a formal reconsideration.

Stage 1 – assessing risk

You should explore the claimant's mental state during the assessment, including thoughts of self-harm or suicide. Indicators of a high suicidal intent include clear plans, preparation and avoiding possible intervention. Previous suicide attempts are an additional indication. There is no reason to assume that being required to carry out work-related activity will trigger the risk provisions in all cases where claimants experience suicidal thoughts or have self-harmed.

HCPs are not required to undertake a formal psychiatric risk assessment but instead need to consider the risk that could arise as a consequence of an individual being found either fit for work or placed in the work-related activity group. You should base your advice on the balance of probability, consideration of the evidence and clinical judgement in each individual case.

If at any point you consider that the claimant is a significant suicide risk, you must advise the GP if the claimant's clinical team are not already aware (form UE1). You must give specific details of the risk and why you have reached that conclusion. See section 3.1.5 of the WCA Handbook for further information.

Stage 2 – would risk of suicide or self-harm be triggered if the claimant were found not to have limited capability for work or work-related activity

There is a strong evidence base showing that the right sort of employment is generally good for physical and mental health and well-being. "When their health condition permits, sick and disabled people (particularly those with 'common health problems') should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:

- is therapeutic;
- helps to promote recovery and rehabilitation;
- leads to better health outcomes;
- minimises the harmful physical, mental and social effects of long-term sickness absence;
- reduces the risk of long-term incapacity;
- promotes full participation in society, independence and human rights;
- reduces poverty; and
- improves quality of life and well-being.”²

So, you should not assume that recommending that a claimant is fit for work or for work-related activity will trigger substantial risk to physical or mental health.

2a) Recommending that a claimant is fit for work

If you conclude that finding a claimant fit for work would trigger risk of suicide or self-harm, then you need to consider whether there are factors that would mitigate the risk if the claimant were found fit for work.

- Is the risk that would arise to physical or mental health substantial?
- Have you considered the benefits of employment weighed against any potential risks? Remember that there is good evidence that people in work have better health outcomes and are at lower risk of suicide.
- Could the risk be significantly reduced by any reasonable workplace adjustments or prescribed medication?

It should be noted that a claimant’s normal anxiety or concern about their ability to cope with the demands of work or a return to work does not constitute a substantial risk.

If you consider that there would be a substantial risk to the mental or physical health of the claimant or another person as a result of a finding that the claimant was fit for work despite potential workplace adjustments or prescribed medication (i.e. that regulation 29(2)(b) applies) you should advise the Decision Maker accordingly, providing robust justification for your advice. You will then need to consider whether there would be a substantial risk if the claimant were found fit for work-related activity.

2b) Recommending that a claimant is fit for work-related activity

The HCP cannot know exactly what activities the claimant will be asked to carry out. However, the flexibility in the DWP approach, tailoring work-related activity to each claimant’s circumstances and health condition, and the requirement that claimants must not be asked to do anything that could put their health at risk, make it unlikely that many claimants will be at substantial risk if required to carry out work-related activity.

In exceptional circumstances, however, you may consider that a claimant is in such a

² Taken from: “Is Work Good for Your Health and Wellbeing”, Waddell & Burton:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

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vulnerable situation that a finding that they can undertake work-related activity might give rise to a substantial risk to their or another person's mental or physical health. Such exceptional circumstances might, though will not necessarily, include:

- current crisis or home treatment team intervention.
- currently sectioned or recently discharged from a section of the Mental Health Act and the Mental Health (Care & Treatment) (Scotland) Act 2003.
- psychotic illness considered vulnerable to relapse.
- a history of violent behaviour as a result of a mental health condition that resulted in recent injury to a third party.

The above examples are for illustrative purposes. Some claimants in the above categories might not be placed at substantial risk by a finding that they can undertake work-related activity. Likewise, there may be claimants who do not fit into the above examples who you conclude would be placed at substantial risk by a finding that they can undertake work-related activity.

As when considering the risks of a finding that a person is fit for work, you should take into account that there is good evidence that unemployed people are at greater risk of suicide and that long term unemployment carries the greatest risk. While, as outlined above, work is different from work-related activity it is important to remember that work-related activity is a vital tool in supporting disabled people and people with health conditions, including mental health conditions, to move closer to the labour market.

If you consider that there would be a substantial risk to the claimant's or another person's mental or physical health if they were placed in the work-related activity group (i.e. that regulation 35(2) applies) you should advise the Decision Maker accordingly, providing robust justification for your advice.

Appendix 7 – DWP Information on Limited Capability for Work within ESA and UC

When the DWP Decision Maker receives the HCP's advice they make a decision on whether the claimant has Limited Capability for Work (LCW), or Limited Capability for Work and Work-Related Activity (LCW and LCWRA).

The requirements placed on claimants differ depending on whether the claimant is found to have LCW or LCW and LCWRA.

LCW and LCWRA

Claimants on ESA will be placed in the **Support Group**. Claimants on Universal Credit will be allocated to the No Work Related Requirements Group. Claimants are not set any requirements, so do not need to meet with a work coach or undertake any work-related activity. They can volunteer for certain work-related support at any point during their claim and participation remains voluntary.

LCW

Claimants on ESA will be placed in the **Work-Related Activity Group** and may be required to attend work-focused interviews and undertake work-related activity. Claimants on UC will be allocated to the Work Preparation Group, participating in regular meetings with their work coach and undertaking work preparation activity.

Broadly, with claimants in these groups, the purpose is to improve their capability or readiness for work, with a view to helping their prospects of moving into work in the future. **They are not expected to search for jobs or apply for a job.**

Work-Focused Interviews

Work-focused interviews are carried out by work coaches at the Jobcentre. The aim is to identify the help and support claimants need to overcome barriers and move them into a position where they would be better placed to get back to work at some point in the future.

For ESA claimants, work coaches use this interview to assess the claimant's prospects for obtaining work in the future and to identify work-related activity (WRA) which is suitable for that claimant. There are no requirements for the number of interviews a claimant must attend. For UC claimants, they are likely to have already been engaging with their work coach, particularly if they made their claim before a Work Capability Assessment. Therefore, the work coach will continue to support their progress in preparing for an eventual move into work, when they are able to.

Work-Related Activity for ESA claimants

WRA can be one or more defined activities that help move ESA claimants closer to a position where they may be ready to search for and take up work in the future. WRA will be different for each individual claimant as it must be appropriate and reasonable, taking into account their circumstances. ESA claimants cannot be required to search for or apply for jobs. Furthermore, they cannot be required to receive medical treatment.

Agreeing Work-Related Activity

Work Coaches have the freedom to determine, in consultation with the claimant, what WRA is appropriate and reasonable. The claimant's circumstances must be taken into account; including physical or mental health and any learning or cognitive issues, as failure to undertake WRA can result in a sanction applied to the claimant's benefit. The claimant's circumstances are explored at their first work-focused interview, which usually takes place within ten days of the WCA decision.

WRA agreed with the claimant must be appropriate, personal to the customer and aimed at improving access to opportunities in the labour market. Claimants must not be asked to undertake anything that is unrealistic or could put their health at risk.

Examples of work-related activity

The circumstances of each ESA claimant are different and WRA that is suitable for one claimant may not be suitable for others.

WRA can take place in various settings and locations, including in the claimant's own home. This will be determined by various factors, including the nature of the WRA, and the claimant's individual circumstances, including the nature and severity of their health conditions.

A list of examples of the range of most and least demanding types of WRA appears in the Appendix to this DWP Decision Makers Guide Memo (01/18):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/680482/m-01-18.pdf

Examples may include:

- Meetings by telephone such as a telephone review with work coach to discuss barriers, goals, and make referrals.
- Completing tasks online such as setting up an e-mail account, researching support available on the internet to help them towards their goals or completing e-learning as agreed with a work coach.
- Attendance at a Jobcentre or Work Programme provider premises to take part in a skills & experience review or individual mentoring support.
- Group sessions such as referral to external specialist intervention partners for confidence building and motivation workshops.
- Attending a basic skills course in English, Maths or IT.
- Attending a work placement at a community hub/café/other placement of community benefit".

For a specific claimant, WRA could look like this:

- The claimant identifies that a skills need is the main barrier preventing them moving closer to the labour market, when they are able to do so would be referred to the appropriate skills provision.

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- Where a claimant has a health condition that prevents them returning to their previous line of work, the work coach and claimant may agree that a short training course and/or skills check would enable the claimant to identify a different field of work they could do, when they are able to do so.

WRA can also take a less formal shape and/or be less demanding, which might be appropriate for people with more severe mental health or developmental disorders. This could include things like:

- Preparing or updating their CV.
- Leaving the house once a week, gradually increasing until they are leaving the house every day.
- Researching local public transport routes with a view to getting used to travelling within their local area.
- Keeping a diary of their day-to-day activities.
- Making a list of hobbies and things that they enjoy/used to enjoy doing.
- Improving their digital/IT skills by setting up an e-mail account.

If the Claimant feels the WRA is inappropriate or unreasonable

If the claimant feels that the work-related activity, they have been asked to complete is inappropriate or unreasonable, they can discuss their concerns with the Work Coach or Work programme Provider and ask for it to be reconsidered.

Work preparation requirements for UC claimants

Much of the activity undertaken by UC claimants will be similar in nature to the work-related activity expected of ESA claimants in the WRAG.

So, for UC, work preparation activity includes things like:

- (a) attending skills assessment.
- (b) improving personal presentation.
- (c) participating in training.
- (d) participating in an employment programme.
- (e) undertaking work experience or a work placement.
- (f) developing a business plan.
- (g) any other action that makes it more likely that the claimant will move into work in the future.

The work coach will seek to build a relationship with the claimant, understanding their individual circumstances and health or other limitations. They will discuss what actions it

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would be reasonable for the claimant to undertake, with these being recorded in the Claimant Commitment. These actions will be kept under regular review to ensure any requirements remain reasonable and appropriate, with the work coach assisting the claimant in meeting these through coaching, support and encouragement.

Appendix 8 – DWP Severe Conditions Criteria

Criteria:

1. **One** of the following Functional Support Group (LCWRA) criteria must be met:

- Mobilising 50m.
- Transfer independently.
- Reaching.
- Picking up and/or moving.
- Manual dexterity.
- Making yourself understood.
- Understanding communication.
- Weekly incontinence.
- Learning tasks.
- Awareness of hazards.
- Personal actions.
- Coping with change.
- Engaging socially.
- Appropriateness of behaviour.
- Unable to eat/drink/chew/swallow/convey food or drink.

2. If **one** of the above criteria is met, **all four** of the following criteria must also be met:

Criterion	Description	Examples of conditions that might meet the criteria	Examples of conditions that might <u>not</u> meet the criteria
The level of function would always meet LCWRA.	The level of function would always meet LCWRA criteria.	Motor Neurone Disease (MND), severe and progressive forms of Multiple Sclerosis, Parkinson's, All dementias, All chromosomal conditions, Huntington's, severe irreversible cardiorespiratory failure, severe acquired brain injury ...this list is not exhaustive	Conditions which might be severe at times, but recovery of function might be present for substantial periods, such as recently diagnosed relapsing non-progressive forms of Multiple Sclerosis or some people with less severe mental health conditions with periods of reasonable function.

Lifelong condition, once diagnosed	The condition will always be present. Some lifelong conditions are present from birth, but others will develop or be acquired later in life.		Conditions which might be cured by transplant/surgery/treatments or conditions which might resolve. This should be based on currently available treatment on the NHS and not on the prospect of scientists discovering a cure in the future.
No realistic prospect of recovery of function	Advice on this should be based on currently available treatment and not on the prospect of scientists discovering a cure in the future.	As per criterion 1.	A person within the first 12 months following a significant stroke who may recover function during rehabilitation, so whilst the condition is lifelong, function might improve.
Unambiguous condition	They have been through relevant clinical investigation and a recognised medical diagnosis has been made.		Non-specific symptoms not formally diagnosed or still undergoing investigation.

For further details, please refer to the Self-Directed Learning Document: Revised New Entrant Training WCA Telephone Assessment Learning Journey – DWP Severe Conditions

Appendix 9 - Document History

Superseded documents

Version history

Version	Date	Comments
2 draft	22nd July 2024	General review, plus update for FAS and re-numbering to version 2 for DWP document control
21a draft	31 st May 2024	General review, plus update for FAS
20 Final	10 th October 2023	Signed off by DWP
20b draft	26 th September 2023	Updated post DWP review
20a draft	16 th May 2023	Routine review & update
19 Final	20 th December 2022	Signed off by DWP
19a draft	19 th December 2022	Activity 15 – Scope reworded for greater clarity
18 Final	21 st September 2022	Signed off by DWP
17 Final	16 th MAY 2022	Signed off by DWP
17c draft	16 th May 2023	Further DWP updates re SR terminology
17b draft	13th May 2022	Updated with DWP comments
17a Draft	19 th April 2022	General Review and UTS updates
16 Final	8 th December 2021	Signed off by DWP

Changes since last version

General - headers, footers, cover page, observation page

General – typo, layout, style for clarity etc.

Work related activity changed to work-related activity in line with legislation text

DV updated to HC throughout

Section 1.1 – Introduction HAAS replaced by HCP (contextual); domiciliary visit to home consultation; UCB process to KCIS

Section 1.2 – Background to Employment and Support Allowance: rationalised to remove some historical information and focus on current regulations;; text describing regulations prior to 2012 amendments removed: terminology updated

Section 1.3 – Wording with regard to LCW applying when LCWRA criteria apply, moved from section 2.3.1 to section 1.3 – minor change in wording also applied; added text that LCW applies when LCWRA applies

Section 1.4 – The Financial Structure of ESA: content rationalised with less focus on payment details

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Section 1.4.1. Overview of the ESA claim process – assessment modality changed to assessment channel for consistency; note added to indicate most F2F assessments are in the AC, HC an exception; HAAS changed to Supplier; where necessary, added HCP advice for clarity. Wording changed to reflect the fact that claimants can insist that an appointment go ahead despite all declared evidence not being available.

Section 1.4.2 - Universal Credit: content rationalised with less focus on payment details (removed: Claimants determined to have limited capability for work; Claimants determined to have limited capability for work and work-related activity; and bullet points from Additional limitations on the payment of the additional amounts for having LCW or LCWRA)

Section 1.5 - The role of the Health Advisory Assessment Service HCP changed to The Role of the Approved HCP: added employed by the Supplier; added other Condition Specific Champions.

New Section 1.5.1 – New information on audit and overview of audit standard

Section 1.6 – example 3: clarified half of normal range

Section 2.1 – Abbreviation for Special Rules for End of Life (SREL) updated

Section 2.3 – Added text – With regards to face-to-face, video and telephone assessments; wording around tailoring/curtailing an assessment in LCWRA cases altered to be clearer

Section 2.3.1 – Wording with regard to LCW applying when LCWRA criteria apply, moved to section 1.3

Section 2.3.2 - Chemotherapy/Radiotherapy for cancer treatment – preamble historical text removed to focus on current regulations; text on advice at filework amended; text added to clarify recovering from treatment after Upper Tribunal ruling; branding and alphanumeric codes removed from mandatory learning document titles; abbreviations and terminology updated for accuracy regarding SREL

Section 2.3.9 - Wording with regard to LCW applying when LCWRA criteria apply, moved to section 1.3

Section 2.4 - Certain claimants treated as having limited capability for work/ work-related activity: HAAS changed to Supplier; where necessary, added HCP advice for clarity

Section 2.4.1 - Treat as LCW criteria in ESA: HAAS changed to Supplier; where necessary, added HCP advice for clarity; Hospital patients – note added to refer to section 3.8.2.2 for policy on major surgery as a day case

Section 2.5 – Re-referral Scrutiny: HAAS changed to Supplier; where necessary, added HCP for clarity

Section 2.6 - IB Re-assessment Filework – statement regarding ability to apply for income support removed

Sections 2.7 & 2.7.1: HAAS changed to Supplier; where necessary, added HCP for clarity

Section 2.7.2 – The Role of the HAAS Professional changed to The Role of the HCP; HAAS changed to Supplier; where necessary, added approved HCP / HCP advice for clarity; relevant

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textbooks changed to relevant evidence-based resources and websites...

Section 3.1 - The Functional Assessment: Introductory text amended to cover assessment channels and protocols further

3.1.1 – Introduction: domiciliary visit changed home consultation

Section 3.1.2 - Reading the Documents: Additional Evidence Brought to Assessment changed to Additional Evidence Presented or Referenced at Assessment, text amended to reflect TA/VA; HAAS changed to Supplier; admin colleagues changed to administration staff

Section 3.1.2 – CHDA changed to supplier, FME changed to medical evidence

Section 3.2.10 – text on mobility and restrictions amended to include more on history, also use of informal observations where possible

Section 3.1.2 – slight re-wording of when and when not to proceed with an assessment where medical evidence is not present and should be

Section 3.1.3 – new text added on reasonable adjustments, reference made to the document DWP: Reasonable Adjustments for Benefit Assessments - Guidance for Healthcare Professionals; text on appointee amended to align with other DWP guidance; ability to bring an alternative person authorised by the appointee removed, mandatory for the appointee to be present at the full WCA (AC or HC F2F/VA/TA); new text on assessments where the appointee is present, but the claimant is not present added to align with other DWP guidance.

Section 3.1.3.2 – Interview Technique: note added about establishing rapport

Section 3.1.3.3 – Claimant accompanied by relative, friend, carer: text on claimant accompanied amended to include VA and TA; note to get consent for presence; clarification of appointee presence

Section 3.1.3.3 – grammar updated

Section 3.1.3.4 – Interpreters: minor amendments

Section 3.1.3.5 – autism spectrum disorder changed to autism

Section 3.1.3.7- Medical diagnosis: minor layout change; minor change to text in penultimate paragraph

Section 3.1.3.7 - penultimate paragraph restructured and amended

Section 3.1.3.7.1 - Non-exploration of conditions that are not causing functional impairment: some text reorganised; additional information added from FAQs compiled for non-exploration of conditions that are not causing functional impairment; text amended including 'unnecessarily spend time on exploration of such conditions that are medically unlikely to cause functional impairment and where the client does not report any functional impairment arising from them; text removed 'CHDA has agreed with the DWP that in some circumstances these conditions do not need to be explored as long as the relevant criteria are met.'

Section 3.1.3.8 – Medication: generic name added to voltarol retard; minor amendments to text about LiMA; 'most' changed to 'many' in relation to people taking as required medications

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Section 3.1.3.9 – Clinical History: bullet point added to remind to follow non-exploration of conditions that are not causing functional impairment; additions to text on loss of consciousness example; note added about following safeguarding policy

Section 3.1.3.10 – Social and occupational history: note added about recording assessment channel used, presence of companion etc., and location of assessment in the clerical reports

Section 3.1.3.12 - LCWRA/Treat as LCW: for functional LCWRA advice and added where relevant and available based on the assessment channel; conditions changed to condition

Section 3.1.4 - Clinical Examination of the Claimant: note added to follow exam protocol for the assessment channel; text on PEFR removed including text on cystic fibrosis, (no longer in exam protocol); 'medical' changed to 'clinical' in reference to professional judgement; the words 'expose or' added to sentence in relation to 'intimate underwear/clothing'

Section 3.1.4.1 - Conclusion of the assessment: minor amendment only

Section 3.1.5 - Dealing with Unexpected findings at the assessment: CHDA document changed to relevant Supplier unexpected findings process guidance; text amended; text on professional body amended, all 3 listed and specific reference made about consent, confidentiality, and disclosure

Section 3.1.6 - Completing the LCW/LCWRA Assessment Report Form: An Overview: text added to include social and occupational history, and typical day recording before claimant leaves; bullet point - consensus of medical opinion changed to in keeping with the medical knowledge of the condition and current medical guidance (based on previous WCA Filework Guidelines changes); the words 'and positive' removed

Section 3.1.7 – Choosing and Justifying Descriptors: The Overall Approach: TI replaced with SREL; as applicable added to exam an observations bullet point; text on questionnaire page entry amended; additional information on free-text in the questionnaire added; 'medical' changed to 'clinical' in reference to HCP knowledge

Section 3.1.9 - Variable and fluctuating conditions: Health Care Professionals changed to Healthcare Professionals / HCPs

Section 3.1.10 – Activities of Daily Living: text on shopping in example amended

Section 3.1.11 – text on observed behaviour amended; additional text on face-to-face observations (AC/HC) added; note on some limitations with TA/VA; additional examples with TA and VA added; exam room changed to assessment room

Section 3.1.12 – Clinical Findings: auscultation, PEFR, reflexes removed; tone added instead of reflexes; PEFR example removed, respiratory rate added

Section 3.1.2 – Wording around elements of a claimant's day to day activities adjusted to note that relevant activities should be enquired about

Section 3.1.3 – Wording adjusted from 2nd to 3rd person in the paragraphs referencing the preference to describe symptoms rather than an unconfirmed diagnosis, wording within the section changed to be gender neutral and a redundant sentence removed.

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

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example 2: cardiorespiratory and upper limb impairments added. Added text - Whether the aid/appliance would help the claimant. Why they are not using it. Whether their explanation for not using it is reasonable; 'medical' changed to 'clinical' in reference to HCP training

Section 3.2.2 – Mobilising: text on PEFR amended to reflect no longer a required exam for WCA

Section 3.2.3 – Standing and sitting: scope -text in changed from 10-15 minutes to 15 minutes for clarity, before standing again added to the alternating sitting and standing example; observed behaviour - clarified observation in face-to-face assessment; added notes about VA sitting observations; clinical examination: transaction changed to transection

Section 3.2.5 – Picking up and moving: scope - note added to consider safety, reliability and repeatability with reference to no hands; observed behaviour - general note about F2F and VA observations; examples given for VA

Section 3.2.6 – Manual dexterity: observed behaviour - general note about F2F and VA observations; hands “always inspect”, changed to “where possible inspect...” Examination – “Test grip” changed to “where possible...”

Section 3.2.7 – Navigation and maintaining safety: Scope - text on CVI and copying amended with cross reference to section 4.2.5; observed behaviour: observed behaviour - general note about F2F and VA observations; note to record use of any vision aids. Examination - text on recall for eyesight test simplified; clarified use of vision chart during a face-to-face assessment; note added about visual field testing at TA/VA; note added to use VA exam protocols. ‘White stick’ amended to ‘Long cane’ as an orientation aid for visual impairment; ‘Assistance dog’ changed to ‘guide dog’ in keeping with regulations.

Section 3.2.8 – Making Self Understood: Observed behaviour - text aligned for assessment channels

Section 3.2.9 – Understanding Communication: Scope - text in introductory sentence on Braille and prognosis or re-referral period advice amended for clarity; Details of activities of daily living – bullet point on doorbells amended Observed behaviour - text aligned for assessment channels; Examination - clarified face-to-face; Tinnitus - minor amendments for clarity

Section 3.2.10 – Continence: Scope - added text to cover rising from a chair in informal observations and history taking; Observed behaviour - note about F2F and VA observations

Section 3.2.11 – Consciousness: Scope - text on partial seizures and temporal lobe epilepsy amended to better reflect current classification; migraine: changed to ICHD-3 to reflect current classification; where applicable, migraine with brainstem aura used instead of basilar type migraine; Details of ADL - fits changed to seizures for consistency with accepted terminology

Section 3.3 - Examination of the Musculoskeletal System: General Principles of Examination - note added about exceptions for VA and TA; note added to indicate the description more applicable to F2F assessments; availability of DWP approved examination protocols reinforced; reflexes removed from the list of examinations; Inappropriate signs - note added to indicate reflexes not tested during the WCA but may be encountered in FME; removed voluntary resistance of passive movements (passive movements not encouraged in the WCA); Lumbar Spine - reference to alternative sciatic stretch test removed for consistency.

Section 3.3 - Examination of the Musculoskeletal System – Lower Limb: removed hallux

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plantarflexion and dorsiflexion. Wording around inorganic signs changed in order to be less absolute.

Section 3.4 - Guidance on Specific Conditions (physical) changed to Guidance on Specific Conditions – Physical: text amended, reader changed to HCPs, SDL learning modules, CHDA intranet / portal changed to Supplier systems

Section 3.5 – MSE added as an abbreviation as subsequently used in other text

Section 3.5.1- Introduction: minor amendments for clarity; suicide tendency changed to ideation; “It may be useful practice...” changed to “it is best practice...”

Section 3.5.2 – Learning tasks – Technology and Simple, Moderate or more Complex Tasks: minor amendment only. Wording around anxiety symptoms or anxiety disorders in isolation amended for accuracy.

Section 3.5.3 - Awareness of everyday hazards – Scope: “self-awareness” changed to awareness for simplicity; plus, a minor amendment; further explanation of anxiety disorder

Section 3.5.4 Initiating and completing personal action: Scope: minor amendment. Wording around habitual activities clarified.

Section 3.5.4 – extra note on habitual activities

Section 3.5.6 - Getting About: minor amendments

Section 3.5.7 - Coping with social engagement: Issues to consider - WRA changed to work-related activity; minor amendments. “Skype” removed in favour of a more generic term – “video conferencing app”

Section 3.6 - Guidance on Specific Conditions – Mental Health: text amended, reader changed to HCPs, SDL learning modules, CHDA intranet / portal changed to Supplier systems

Section 3.7 -The Mental State Examination changed to The Mental State Examination (MSE): MSE used in text for consistency

Section 3.8.1 - Life Threatening, Uncontrolled Disease: an up-to-date consensus of medical opinion changed to in keeping with the medical knowledge of the condition and current medical guidance (based on previous signed-off WCA Filework Guidelines changes)

Section 3.8.2 - Background information on Substantial Risk: in conjunction with CHDA removed; “who are receiving ESA and...” changed to “who are deemed capable of work-related activity.”

Section 3.8.2 - Guidance on advising on Substantial risk for LCW or LCW/LCWRA: Epipen removed and replaced with generic term, adrenaline auto-injector; for scenario with seizures, clarification amended to remove introductory phrase - The policy intent has been clarified by the Medical Policy Advisers in the DWP...

Section 3.8.2 - Guidance on advising on Substantial risk for LCW or LCW/LCWRA: added new bulleted subheading - Claimants undergoing major surgery with a hospital stay less than 24 hours – added policy on physical risk for major surgery with hospital stay less than 24 hours; added new bulleted subheading - Epilepsy and other physical problems

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Section 3.9 - Personal Summary Statement changed to Personal Summary Statement (PSS)

Section 3.10.1 - LCW/LCWRA - Advice on when work could be considered: District Offices removed, and text amended; HAAS replaced by Supplier; minor amendments to the examples

Section 3.11.1 – Introduction: examining HCP replaced with HCP

Section 3.11.1 – ‘the’ changed to ‘an’

Section 3.11.3 - LCWRA Assessment Process: Text on assessment channel updated for consistency; practitioner replaced with HCP; BSC changed to Supplier; contracted doctor changed to HCP to make more generic and reflect fact that other HCP types (physiotherapist) may be in contact claimants for HC purposes

Section 3.11.3 - LCWRA Assessment Process: text for scenario 2 Box 26 changed for clarity and use of correct terminology (Treat as LCWRA), Eat/Drink changed to LCWRA category for Eating and Drinking; text on level of examination updated with reference to utilising the applicable WCA protocol for the assessment channel; unaided used for Mrs B example; scenario 3 – ...UC equivalent forms replaced with ESA50/ESA50A/UC50/UC50A

Section 4.1.1- Clients Unfit to be seen: Supplier administration...added for consistency; Customer replaced with DWP for clarity

Section 4.1.1.1 - The uncooperative claimant – CSR changed to one of the Supplier AC reception staff members, Site Safety Officer changed to designated officer for safety; text on obtaining UCB process form BSC removed, replaced with general reference to see the DWP Keep Customer Interactions Safe Process Guide.

Section 4.1.2 - Lack of an Interpreter – wording on use of staff member amended

Section 4.1.3 - Audio taping of assessments – subtitle changed to Audio recording of WCA assessments; text amended to align as closely as possible with the relevant PIP guidance.

Section 4.1.3 – fully rewritten

Section 4.1.4 Taking of Notes during an Assessment by Claimant or Companion: text on replacing existing desk aids removed, replaced with text indicating any current desk aids for this purpose should contain the approved text; typo corrected – Dept of Work and Pensions changed to Department for Work and Pensions

Section 4.1.6 - Retention of Notes containing Claimant Details: Text on out of hours work amended and replaced with additional text to authorised homeworking and HC Assessments; note added data must be handled in line with process and policy guidelines

Section 4.2 – information on suicide and self-harm added

Section 4.2.2 – LCW/LCRWA assessment phrase substituted with WCA assessment

Section 4.2.5 - Information brought by the claimant to the assessment or referenced by the claimant at assessment – Text amended to update requirements for copies, use of pre-paid envelopes, process at TA/VA/ HC, and F2F AC appointments

Section 4.2.2.1.1- Medical reports provided by a third party: HAAS changed to Supplier

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Section 4.2.2.1.2 - Medical reports provided by HCPs: HAAS changed to Supplier

Section 4.3 - Identification of Claimants – text amended to reflect VA/TA; Reference to POID amended and ID verification added

Section 4.3 - reference to supplier guidance added; reference to embedded document added

Section 4.4 - Domiciliary visits (DV) Renamed to Home Consultations (HC(s)) and all references to DVs throughout the document renamed accordingly – reference to named modules removed and replaced with generic reference to H&S learning modules; Reference to POID (1 and 2) amended and ID verification added

Section 4.4 - UCB changed to KCIS guidance

Section 4.5 – Information on evidence gathered after assessment included

Appendix 5 – Proof of Identity Forms – New POID (1 and 2) added, old POID1 removed.

Appendix 9 – Created to contain document history

Observation form

Please photocopy this page and use it for any comments and observations on this document, its contents, or layout, or your experience of using it. If you are aware of other standards to which this document should refer, or a better standard, you are requested to indicate this on the form. Your comments will be considered at the next scheduled review.

Name of sender: _____ Date: _____

Location and telephone number: _____

Please return this form to: Supplier