Income Support Impairment component

A guide for determining officers and medical board doctors

States of Jersey

25 June 2015

Contents

Section 1. BACKGROUND

1.0 Introduction

The Care and Mobility Test is an assessment of functions (activities) which are necessary for self-care or being independently mobile. There are 11 physical/sensory activities and one specifically for seizures causing loss of consciousness or altered consciousness. There are 6 mental health/cognitive activities and two additional categories for development and treatment needs for children under 12.

The **physical activities (questions 1-11)** are divided into 3 groups covering:

Lower limb/back function

- Sitting
- Standing
- Rising
- Walking/stairs
- Bending/kneeling

Upper limb/neck function

- Reaching
- Picking up and transferring
- Manual dexterity

Sensory

- Vision
- Hearing
- Speech

Any problem with these activities must be the result of a physical disease (For example, osteoarthritis) or disablement (For example, traumatic loss of a leg). A person with severe anxiety who is only able to sit in a chair for 10 minutes before moving would not be considered under the sitting descriptor, as the difficulty with sitting is due to a mental health problem.

Problems with anxiety would be assessed under the mental health test (questions 13 – 18). If this principle was not applied, it would result in 'double scoring' when assessing the overall effect of a person's functional restrictions and resulting care needs and difficulty getting around.

Separately;

Maintaining control

- Seizures causing loss of consciousness or altered consciousness

The **mental health activities** (questions 13 – 18) cover:

- Management of personal finance
- Maintaining appearance and hygiene
- Management of daily routine
- Awareness of danger and unsafe behaviour
- Getting around outdoors
- Coping with change

1.1 Test Statements

For each of these activities (both physical and mental health), a series of statements (statements) are ranked according to their severity of the functional restrictions. Each descriptor carries a numerical score depending on the severity of the functional restrictions and the amount of help needed with that activity. For example the walking/stairs activity has 6 statements:

(a) *Cannot walk at all.* 15

(b) *Cannot walk more than a few steps and/or up and down one stair without stopping or severe discomfort, even with the support of a handrail*.

15

(c) *Cannot walk more than 50 metres and/or go up and down a flight of stairs without having to stop or feeling severe discomfort.* 9

(d) Cannot walk more than 200 metres without stopping or feeling severe discomfort. 6

(e) Cannot walk more than 400 metres (about 440 yards) without stopping or feeling) severe discomfort. 3

(f) None of the above apply. 0

Statements in *italics* indicate severe limitations of independent mobility outdoors. While some of the activities and statements to which this applies on first thought may not indicate a problem with outdoor mobility (for example 'Does not understand the value of money' in the 'Management of personal finance' activity) the function necessary to perform that descriptor is also necessary for independent outdoor mobility.

The mental health activity 'getting around outdoors' has 5 statements:

1.1.1 Statements

(a) Unable to cope with leaving the house even if accompanied by another person. 20

(b) Unable to cope with leaving the house unless accompanied by another person. 15

(c) Unable to cope with finding way around even in familiar places. 15

(d) Unable to cope with finding way around in unfamiliar places. 10

(e) None of the above apply. 0

Statements in *italics* indicate severe limitations of independent mobility outdoors.

The total test score is the sum of all the points in all the relevant activities. The greater the score the greater the functional restrictions, the greater the resulting help needed and the greater the level of the award. There is a modified test for children age 12 and younger which is covered in the 'Children's' section of this Handbook.

Although we are not directly measuring care needs or difficulty getting around, we do measure the functions necessary. For example, if we consider dressing, the physical abilities required are:

- Bending - to put on lower garments
- Standing
- Sitting - to put on socks
- Rising
- Reaching - to put on jumpers etc
- Manual dexterity - to fasten buttons
- Vision - to select appropriate cloths

From the mental health section:

- Management of finances - to know what to wear
- (the test of planning/cognition)

The following sections give guidance on the general principles of choosing statements, dealing with variable and intermittent conditions, and an explanation of the statements in each activity and examples of daily living activities using that activity.

SECTION 2. MEDICAL ASSESSMENT AND REPORT WRITING

The Medical Assessment

Introduction

The medical assessment process as a whole differs in many respects from the traditional history taking and examination in the general practice and hospital setting. It entails bringing together information gained from observation, questionnaire, medical evidence and examination in order to reach an accurate assessment of the disability of a claimant and so to provide the information and the opinion which the Decision Maker requires. It is a complex procedure, involving careful consideration, structured interviewing, lateral thinking and accurate observation, as well as the application of medical skills. There are four stages in performing the Impairment (Personal Care) Assessment. These are:-

- Reading the documents;
- Interviewing the claimant;
- Examining the claimant and
- Completing the medical report form.

Reading the Documents

In preparation for the interview, you should read carefully the documents in the file. All the medical evidence should be considered. Particular attention must be paid to the claimant's questionnaire.

Interviewing the Claimant

The Nature of the Interview

The interview differs materially from the traditional consultation in medical practice. The aim of the traditional interview is to arrive at a diagnosis and plan future medical management of a patient. In the assessment interview, you are gathering information which will be used to assess the effects of a disability on the claimant in all of the relevant functional areas.

Detailed medical history taking is time-wasting and unnecessary. The essential medical details which impinge on present function are all that is required.

Interview Technique

It is important that the interview is carried out in a friendly, professional and non-confrontational way. If possible, you should meet the claimant and accompany them from the waiting room. This positive initial point of contact will help put the claimant at

ease. From your point of view, it provides an opportunity to observe the claimant outside the examination room, and extends the time spent in contact with them. Most importantly, it initiates the rapport between doctor and claimant which is so essential to an effective interview.

The claimant may be apprehensive, and 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. This is time well spent as it allows the interview to proceed more smoothly and productively thereafter. It is also useful to explain that the clinical examination is not in any way a general "check up", but will be focused on the areas which affect the claimant in their everyday life. This explanation may forestall any criticism that the medical examination was not thorough.

Claimant accompanied by relative, friend, carer.

Claimants will often feel more at ease when accompanied, and indeed this may be a prerequisite to enable them to come to the Examination Centre.

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

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

You will use your own judgement in weighing the companion's evidence. If the companion is too intrusive, then you should point out that the claimant must be allowed to express their view. If this strategy is unsuccessful the companion should be asked to leave.
The actual physical examination is not normally done in the presence of the companion, but strictly with the claimant's consent, and if it appears a reasonable request, then the companion should be allowed to be present.

Recording the Interview

The time of start of examination is when you first make contact with the claimant. The time the examination ends is the time when the claimant leaves you. You should also add the time at which the form was finally completed.

List all the current diagnoses. Ensure that all conditions entered in the claimant’s questionnaire and medical reports are included. Previously unidentified conditions which are revealed during the assessment should also be added.

In many instances the entries will be symptoms rather than exact diagnoses. Your role is to assess disability and for that reason precise diagnoses do not add to the Decision

Maker's understanding of the report. Only be specific if you have good evidence of the diagnosis. If you write "Lumbar disc protrusion" rather than "Low back pain" and it transpires at an appeal that investigations revealed spondylolisthesis then the whole value of the evidence you have provided for the Decision Maker may be undermined.

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 analgesics being taken. This may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. "He takes an average of 12 paracetamol (painkillers) a week, usually over three days" provides a picture for the Decision Maker which will support your description of variability and pain later in the report. It is also useful to comment on the potency of the analgesic.

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

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

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

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

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

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

It is important that details of therapy relating to a mental health problem are recorded. The name of the person providing such treatment should also be recorded.

Clinical History

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

- Brief clinical history (details not already recorded in the 'hospital treatment section.
- Brief details of the claimant's domestic situation, for example; "Lives in a 2-storey house with husband and two children aged 10 and 12".
- A brief outline of the claimant's problems and the functional limitations imposed by them, for example "Variable pain both elbows which the claimant states restricts his/her ability to lift and reach".
- Most important is an outline of how a typical day is spent in the light of the reported limitations.

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.

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

The account of the "Typical day" should be particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and areas likely to be so affected. For example in cases of low back pain, bear in mind activities which involve sitting, rising from sitting, walking, walking up and down stairs, bending and kneeling and standing. These activities are required in personal care tasks and domestic and leisure activities. You should give specific examples of activities, e.g. "says she enjoys watching television sitting in an armchair for 30 minutes at a time". See also the paragraphs in relation to completing the section on activities of daily living.

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

metres in all) but says he has to stop at least twice due to back pain".

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

- Management of personal finance
- Maintaining appearance and hygiene
- Management of daily routine
- Awareness of danger and unsafe behaviour
- Getting around outdoors
- Coping with change

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

Examining the Claimant

Information about appropriate clinical examination is to be found in the sections dealing with individual functional categories.

You should seek 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 doctors should understand that they must not assume consent.

Explicit consent to the examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report.

A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

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

A further important thing to remember when recording your clinical examination findings is to interpret them for the Decision Maker by explaining in plain English the significance of the findings, e.g.

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

Conclusion of the examination

After the interview and examination, the claimant should be invited to ask any questions regarding the procedure. It is appropriate to advise that the Social Security 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.

Questions regarding their treatment should be politely evaded. Most claimants will understand if they are told that without the results of tests, X-rays, etc., it would be impossible to venture an opinion on treatment or management and they should be advised to consult their GP on any medical issue. No criticism of the claimant's medical management, overt or implied, should ever be made.

Do not enter into discussions about entitlement to other benefits. If questions about benefits arise during the assessment, then at the end of the assessment, take the claimant to the appropriate Zone where further information can be provided.

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

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

Dealing with Unexpected findings at the examination

Situations arise when doctors carrying out disability assessments may come across information that they feel should be reported to the claimant's General Practitioner. The procedures for the release of unexpected findings to a claimant's General Practitioner is as follows:

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

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

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

When the release of that information is necessary to protect others from risk of death or serious harm;

When the claimant requires urgent medical treatment, but cannot be contacted within a suitably rapid period of time.

When the individual is not competent to give consent.

All doctors are strongly advised to read these guidance notes from the GMC. If any doctor does not have a copy then he/she should contact the GMC at 178 Great Portland St, London W1 W5JE (tel. 020 7580 7642)

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

The nature of the information to be passed to the GP;

The reasons for wanting to disclose this information; and

A request for consent to release of the information.

The doctor should record relevant details of their discussion with the claimant and informed written consent from the claimant should be obtained. The GP should be contacted by telephone or in writing as appropriate.

Completing the Incapacity Report Form

An Overview

It is important when writing Incapacity Reports (currently the S305 report) to bear in mind who will be the recipients. The report will always be seen by a lay Decision Maker and may also be read by members of an Appeal Tribunal and the claimant and their representative.

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

You should also remember that Decision Makers are not medically qualified, and your report must be clear enough for them and other non-medical readers.

The Decision Makers will rely heavily on the report in coming to a decision on entitlement to benefit. The report must provide an objective and fair assessment of the claimant's disabilities in the physical, sensory and mental health areas, as laid out in the Income Support regulations. It must make clear to the Decision Maker what statements you have chosen and why you have chosen them. Your choice must be supported by appropriate medical evidence.

Where your choice of descriptor is different from the claimant's choice, your supporting evidence must give the Decision Maker sufficient information to say why your choice should be accepted, rather than the claimant's.

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

Legible

Consistent and without contradictions

Is clear, concise, relevant and positive

Contains sufficient detail to justify the statements chosen

Explains why the medical opinion may in some circumstances differ from the claimant's own view of their disability

Avoids unnecessary medical terminology

In keeping with a consensus of medical opinion.

Doctors will develop their own style in completing the report. However, the following general guidance is based on practical experience. That part of the report relating to diagnosis, medication, treatment and clinical history can be completed while interviewing the claimant. The remainder should be completed when the claimant has left.

Medical Terminology

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

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

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

Abbreviations

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

Choosing and Justifying Statements; the Overall Approach

The objective of the medical report is for you to provide your opinion of the claimant's level of function in the functional activities and to provide a prognosis.

The choice of the most appropriate descriptor in the functional category area will depend upon:

Consideration of all the medical evidence

The interview with the claimant

The medical examination

Your medical knowledge of the likely effects of the condition.

For each of the physical and sensory areas you must choose only one descriptor, and that should be the descriptor which reflects the claimant's level of functioning most of the time, taking into account such factors as pain, stiffness, response to treatment and variability of symptoms. This ensures that your opinion is not just a "snapshot" of the claimant on the day of examination, but reflects their functional ability over a period of time.

It is essential that you work from the top of the descriptor list and work downwards choosing the first descriptor which applies.

In certain functional areas, the statements 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.

In each Functional Category, you should also indicate whether your descriptor choice AGREES or DISAGREES with the claimant's own choice, which they should have provided in the Questionnaire.

If the claimant has not chosen a descriptor, or the choice is not clear you should tick the 'customer's choice unclear' box. Where several statements have been chosen in one area, you should assume that the claimant has chosen the highest descriptor.

Where the claimant has indicated on the questionnaire that he has "no problem" and you agree, then supportive evidence is not required. Simply tick the "No problem" descriptor and the "Yes" box agreeing with the claimant's choice of descriptor. Otherwise, justification of your choice is needed in every case.

This will be entered in the four boxes provided, and the use of these is discussed elsewhere in this section.

Where the claimant indicates he has a problem and you agree with that descriptor choice, then

all boxes under that functional category require completion, albeit in less detail than where you and the claimant disagree.

Where the claimant indicates he has a problem and you disagree with the descriptor choice, then all boxes under that functional category require completion and discrepancies must be explained. You must fully justify and support your choice of descriptor by giving examples from your clinical history, activities of daily living, observation of the claimant and clinical examination. Your evidence must provide sufficient factual information to lead the Decision Maker to understand and accept your choice.

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 "Walking".

Functional areas on the medical report are linked e.g. sitting, rising and bending and justification for this group of functional areas should be justified in the relevant boxes.

Clinical details can be cross referred to other relevant linked groups.

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

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

There will be occasions when it is necessary to choose a "No Problem" descriptor even though some disability has been identified but it is not severe enough to reach the lower threshold; i.e. the penultimate descriptor. In this circumstance you must make it clear to the Decision Maker that you have carefully considered the limitations which are present by recording all the relevant information.

For example, the claimant may have indicated difficulty with walking, but you have evidence from the typical day that they only experience significant discomfort after walking at a reasonable pace for 20 minutes (i.e. well over 400m)

When completing the Report, you must not:

Alter the wording of the statements: they are defined in the Regulations and cannot be modified.

Alter the claimant's questionnaire in any way.

Use correction fluid. If you make an error, it should be clearly scored out, the correct words substituted and the alteration initialled and dated.

If in the claimant's questionnaire a functional category page is left blank, you must show on the corresponding page of your report that you have discussed the problem with the claimant, and write "The claimant states that there is no problem in this area". If, however, it emerges that the claimant is disabled in this area you should proceed to choose and justify your descriptor in the usual way.

Completion of Functional Category Pages

For each functional category (except where the claimant has ticked "No problem" and you agree with them - see above) you must record the relevant information to explain and justify your choice to the Decision Maker. Information is recorded in terms of:

Features of functional ability relevant to daily living

Behaviour observed during the assessment

Findings at clinical examination

Summary of functional ability:

Highlight and explain any inconsistencies between the claimants' account and the medical evidence.

Address variability repeatability and fatigue.

Clarify medical basis for advising the chosen statements.

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……"

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

Any fluctuations in the medical condition i.e. how the condition changes over time.

The variation of functional ability i.e. how the person's functional ability changes over time and in relation to changes in the underlying medical condition.

Any pain which results from performing the activity.

The ability to repeat the activity.

The ability to perform the activity safely - without substantial risk of harm to self or others.

The doctor's choice of statements 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 statements which apply for the majority of the days. Examining doctors should make it clear in the report to the DM how they arrived at their advice.

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

The above implies that approved doctors 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.

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

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

All activities must be capable of being carried out safely. If a person with vertigo is physically able to bend to touch his knees but in so doing falls over due to giddiness, then he should be considered incapable of performing that activity.

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

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

Breathlessness is an important symptom to take into account, because it is not specifically reflected in any of the statements, but it may contribute significantly to disability in relation to walking and walking up and down stairs. For example, a claimant who experiences significant

dyspnoea on carrying out an activity should be scored as if the activity cannot be undertaken.

You should comment on the consistency of the above factors with the diagnosis and with the stage reached by the disease.

For example, a medical certificate or GP report says the claimant has mechanical back pain and on examination you find no back abnormality.

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

If you decide not to accept the degree of variability, etc, you should say:

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

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 the section on 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 "Rising from Sitting".

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

For example:

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

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

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

Behaviour observed during the assessment

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

coat or picking up a bag during the assessment. Manual dexterity can often be assessed at the same time as buttons and zips are manipulated on coats.

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

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

Further examples of observed behaviour relevant to specific functional areas is given in the section on functional categories.

Clinical findings

Clinical findings are entered next. They should be expressed simply and clearly and in non-technical terms. Ideally, they should be set out in a way which reflects the recommended approach to clinical examination-namely the Musculo-Skeletal Overview. If an abnormality is detected then a more detailed regional examination should be performed. In the report set out the details of any inspection, with particular regard to muscle wasting; the results of palpation and auscultation if appropriate; PEFR where indicated, and the range of movement of joints, expressed as a percentage of normal. Such factors as power and reflexes should be addressed and the degree to which these findings depart from the normal should be explained.

For example:

"Lumbar spine: forward flexion to half normal level; lateral flexion full on R but half normal level on L. Straight leg raise 900 (normal) on R but only 450 on L."

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

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

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

Summary of functional ability

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

Highlight and explain any inconsistencies between the claimant's account of his disability and the medical evidence.

Address the issues of variability, repeatability and fatigue particularly where the claimant suffers from a condition where such factors play an important part.

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 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. If, however, it is unavoidable, it should be entered on the final page of the report.
So you should write down the harmful information clearly identifying it as such only on the final page of the 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."

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. If recorded in a report

such information may not 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.

Section 3. CHOOSING STATEMENTS

3.0 GENERAL PRINCIPLES IN CHOOSING STATEMENTS

1) When considering Activities 1 to 11 only the person's physical or sensory abilities must be taken into account. Activity 12 relates solely to seizures causing loss of consciousness or altered consciousness. When considering activities 13 to 18 only the person's mental and cognitive abilities must be taken into account. Activities 19 and 20 only apply to children under the age of 12 years.

2) Only one descriptor is chosen – the highest which applies to the person (work from the top descriptor down choosing the first which applies).

3) The variability of the condition and its disabling effects are also considered (see section on variable and intermittent conditions).

4) Where the person is normally fitted with or normally wears a prosthesis they are assessed as if they were fitted with or wearing that prosthesis.

5) Where the person normally wears or normally uses any aid or appliance or could reasonably be expected to normally wear or normally use any aid or appliance they are assessed as if they were wearing or using that aid or appliance.

6) The person must be capable of performing the activity:

Reliably – to a reasonable standard and in a normal manner. For example, a person who shuffles downstairs on their bottom would not be considered capable of performing in the walking/stairs activity.

Repeatedly – if a person cannot repeat an activity with a reasonable degree of regularity, and certainly if they can only perform the activity once, then they should be considered incapable of performing that activity. The activity does not however have to be capable of being performed continuously.

At a reasonable speed

Without:

Severe pain - activities do not have to be performed without any discomfort or pain. However, if the person cannot perform an activity effectively because of pain they should be considered as incapable of performing that activity. When considering pain take into account factors such as the predictability of onset and the effectiveness of treatment. Pain which starts without

warning and requires analgesia is very different from angina which can be forestalled, or rapidly remedied with appropriate treatment.

Fatigue - This is an abnormal feeling of exhaustion.

Breathlessness - This is an important symptom to take into account because it is not specifically reflected in any of the statements, but it may contribute significantly to disability in such activities as walking. For example, a person who has significant breathlessness carrying out an activity should be considered as if that activity cannot be undertaken.

Safely - without substantial risk of harm to self or others.

5) A person who is able to perform the activity with commonly available equipment and adaptations (such as a walking stick, stair hand-rail or hearing aid) should be considered capable of performing the activity (unless otherwise stated in the descriptor).

3.1 VARIABLE AND INTERMITTENT CONDITIONS

1 Variable conditions are illnesses whose disabling effects vary over a period of time, either on a daily, weekly or monthly basis or at periods throughout the day.

2 When deciding which statements are applicable to a person with such a condition a broad approach is appropriate. In considering whether a person cannot perform an activity the decision maker/doctor should not stray too far from an arithmetical approach. That is, what the person cannot do for the majority of the time. However, the frequency of bad days, the length of the period of bad days and of intervening periods, the severity of the claimant's disablement on both good and bad days and the unpredictability of bad days are relevant when applying the broad approach.

3 A person who suffers from a condition which only causes disablement for 4 or 5 days a month such as migraine cannot be regarded as unable to carry out the prescribed activities for the whole month however severe the disablement on those few days or however unpredictable those attacks may be.

For example:

A person who cannot perform a descriptor on 3 days and would only just be capable of performing that descriptor on the other 4 days of the week could be considered incapable of performing that descriptor all week

A person who suffered from long periods of illness separated by weeks of remission, in which no significant disablement is suffered, might only be considered incapable of performing that descriptor during the actual periods of illness.

Section 4. PHYSICAL/SENSORY ACTIVITIES

(Problems in these activities must be due to a physical disease or disablement)

4.0 Activity 1 - Sitting

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

Statements

(a) Cannot sit without severe discomfort.

(b) Cannot sit without severe discomfort for more than ten minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.

(c) Cannot sit without severe discomfort for more than 30 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.

(d) Cannot sit without severe discomfort for more than 1 hour without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.

(e) None of the above apply.

4.0.1 Scope

This category involves the ability to maintain the position of the trunk without support from the arms of a chair or from another person.

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.

4.0.2 Examples of daily living activities

Consider the claimant's ability in relation to:

Other leisure or social activities, e.g. listening to the radio, using a computer, sitting in a friend's house, pub or restaurant, reading, knitting.

Consider for how long the claimant sits at meal times (which may involve sitting in an upright chair with no arms).

The time spent travelling in cars or buses.

Observed behaviour

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

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

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

4.1 Activity 2 – Standing without the support of another person

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

Statements

(a) Cannot stand unassisted.

(b) Cannot stand for more than 10 minutes before needing to sit down.

(c) Cannot stand for more than 30 minutes before needing to sit down.

(d) None of the above apply.

4.1.1 Scope

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

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

4.1.2 Examples of daily living activities

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.

Observed behaviour

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

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

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

4.2 Activity 3 - Rising from Sitting in an upright chair with a back but no arms without the help of another person.

Statements

(a) Cannot rise from sitting to standing

(b) Cannot rise from sitting to standing without holding on to something

(c) None of the above apply

4.2.1 Scope

This refers to the ability to rise from an upright normal height chair with a back but no arms without the help of another person.

The person may use the seat to push up with the upper limbs but if this is the only way they can rise this is treated as holding onto something and (b) above would apply. (Commissioners decision R (IB) 2/03)

Rising from a specially adapted chair such as a raised or electric 'ejection' chair should not be considered.

4.2.2 Examples of daily living activities

Relevant activities may include:

Getting on and off the toilet unaided;

Getting in and out of a car; and

Getting out of chairs or off the bed.

Observed behaviour

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

4.3 Activity 4 – Walking

Walking is on level ground.

Statements

(a) Cannot walk at all.

(b) Cannot walk more than a few steps and/or up and down one stair without stopping or severe discomfort, even with the support of a handrail.

(c) Cannot walk more than 50 metres and/or go up and down a flight of stairs without having to stop or feeling severe discomfort.

(d) Cannot walk more than 200 metres without stopping or feeling severe discomfort.

(e) Cannot walk more than 400 metres without stopping or feeling severe discomfort.

(f) None of the above apply.

Statements in *italics* indicate severe limitations of independent mobility outdoors.

4.3.1 Scope (walking)

Walking is bipedal locomotion that is movement achieved by bearing weight first on one leg and then the other. Those who rely on a wheelchair or can only swing through on crutches do not fulfil this definition and therefore cannot walk at all.

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

Walking ability may also be restricted by limited exercise tolerance as a result of respiratory or cardiovascular disease resulting in breathlessness or angina, as well as any relevant musculoskeletal problems. If a particular descriptor activity could only be performed by inducing significant breathlessness or distress, a higher descriptor must be chosen.

Walking may also be affected by disturbances of balance due for example to dizziness or vertigo and it is important to ensure that this activity can be undertaken safely.

4.3.2 Examples of daily living activities (walking)

Consider the claimant's ability in relation to:

Mobility around the home

Shopping trips, exercising pets

A person who can easily manage around the house and garden is unlikely to be limited to walking less than 200 metres; a person who can walk around a shopping centre/supermarket is unlikely to be limited to walking less than 400 metres. Most people walk around 800 metres shopping in a large supermarket

4.3.3 Scope (stairs)

Walking up and down a flight of stairs implies that both tasks can be managed, but not necessarily one after the other. The activity may be prevented by severe discomfort, severe breathlessness, lower limb weakness or balance problems.

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

4.3.4 Examples of daily living activities (stairs)

Relevant details include information regarding the home:

Is it a flat or a house with stairs?

Is the bathroom/toilet upstairs?

Does the claimant sleep upstairs or downstairs?

If the home has no stairs, consider how the claimant copes in friends' homes and in shops or other public buildings. Consider how the claimant copes getting on and off public transport.

Observed behaviour

Observe the claimant walking from the waiting area to the examination room, and note the gait, pace and any problem with balance. If appropriate look for evidence of breathlessness as a result of walking. Note the use of any aids e.g. walking stick, and whether the use was appropriate. Record any assistance which was needed from another person.

It is very unlikely that the ability to go up and down stairs will be observed within the examination centre. However, general observations about mobility are relevant; they can be crossed reference to the "walking" category.

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

4.4 Activity 5 - Bending and Kneeling from a standing position

Statements

(a) Cannot bend to touch knees and straighten up again.

(b) Cannot either bend or kneel, or bend and kneel or squat as if to pick up a piece of paper from the floor and straighten up again.

(c) None of the above apply.

4.4.1 Scope

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

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

Descriptor (a) describes just bending whereas descriptor (b) considers the ability by bending, kneeling or a combination of bending and kneeling to get the hands to the floor as if to pick something from the floor. This involves a combination of flexing the lumbar spine, flexing the hip joints, and bending the knees to a squatting position.

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

Also the UK Commissioners have recorded in decision CIB/2945/2000 that where a claimant has problems with balance this should be taken into account when considering the activity of bending and kneeling as this clearly requires the claimant to move from a standing position to perform the various statements and to straighten up. Any ability on the part of the claimant to perform the statements which can only be achieved if they are holding on to something should be discounted. Their ability should be measured by what they can achieve without holding on.

Observed behaviour

Record general mobility. While it is not appropriate to directly observe the claimant undressing/dressing note the time taken and any help requested with certain items of clothing particularly shoes.

Note the claimant's ability to climb on and off the couch.

It may be possible to observe the claimant pick up an item such as a handbag or shopping bag from the floor of the examination room.

4.5 Activity 6 – Reaching

Statements

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

(b) Cannot raise either arm to the head as if to put on a hat.

(c) Cannot raise one arm as if to put something in the top pocket of a coat or jacket but can with the other.

(d) Cannot raise one arm to the head as if to put on a hat but can with the other.

(e) None of the above apply.

4.5.1 Scope

This activity considers a person's ability to reach upwards and outwards, not downwards. It is an evaluation of power, co-ordination and joint mobility in the upper limbs.

It considers only the ability to achieve the described reaching posture and does not measure hand function, i.e. it is not necessary for the person to adjust the hat if he/she can achieve the reaching movement defined in statements (b) and (d) "Cannot raise one arm to head to put on a hat".

"Either arm" in Statements (a) and (b) means disability in **both** arms.

Statements (c) and (d) should only be applied when the person is unable to raise **one** arm (either the Right or the Left) but is capable of raising the **other** arm.

4.5.2 Examples of daily living activities

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.

Reaching up to shelves - putting shopping away.

Household chores such as dusting; hanging laundry on a washing line.

Relevant leisure activities include 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.

4.6 Activity 7 – Lifting and transferring to a distance of 60cm by use of upper body and arms

Statements

(a) Cannot lift and transfer a full glass of 200ml capacity with either arm.

(b) Cannot pick up and pour from a full saucepan or kettle of 1.5 litres with either arm.

(c) Cannot pick up and carry a 2.5 kilogram bag of potatoes with either arm.

(d) Cannot lift and transfer a full glass of 200ml capacity with one arm but can with the other.

(e) None of the above apply.

4.6.1 Scope

Lifting and carrying is a measure of power, co-ordination and joint mobility in the wrists and upper limbs. Activities in other functional areas are excluded from consideration of lifting and transferring ability. Lifting and carrying relate only to the ability to lift and hold an object from table top height in order that it may be carried from A to B.

It is not a measure of the ability to bend or reach, manual dexterity or walk since these activities are considered under other functional categories.

Statements referring to either arm means disability in **both** arm's rather than one or the other. The statements (a), (b) and (c) can only ever be applied when the person is unable to lift and carry with the left arm and right arm. Statement (d) means that the claimant is capable of performing the descriptor with one arm but not with the other.

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

4.6.2 Examples of daily living activities

In order to get a measure of what the person is able to do consider domestic activities such as:

Cooking (lifting and carrying saucepans, crockery).

Shopping (lifting goods out of shopping trolley).

Dealing with laundry.

Observed behaviour

Watch for hand, arm and head gestures. Note the ease (or otherwise) with any coat or jacket that 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.

Where there is a lack of co-operation in carrying out passive neck and shoulder movements then informal observations, coupled with examination of the upper limbs, may allow an estimate of the usual mobility of the shoulder girdle. This may well be confirmed by evidence from the typical day.

4.7 Activity 8 – Manual Dexterity

Statements

(a) Cannot turn the pages of a book with either hand.

(b) Cannot turn a star-headed sink tap with either hand.

(c) Cannot pick up a small object like a coin 2.5 cm or less in diameter with either hand.

(d) Cannot use a spoon with either hand.

(e) Cannot tie a bow in laces or string.

(f) Cannot turn a star-headed sink tap with one hand but can with the other.

(g) Cannot pick up a small object like a coin 2.5 cm in diameter with one hand but can with the other.

(h) None of the above apply.

4.7.1 Scope

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

Descriptor (d) ’cannot use a spoon’ is a test of the person's ability to use a spoon for the purpose for which a spoon is normally used with either the right or the left hand, depending upon which is the dominant hand.

"Either" hand in (a), (b) and (c) means they cannot do the action with their right hand **and** they cannot do it with their left hand.

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

4.7.2 Examples of daily living activities

Consider activities such as:

Writing, e.g. filling in forms.

Coping with buttons, zips, and hooks on clothing.

Cooking (opening jars and bottles) washing and peeling vegetables.

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

Observed behaviour

Preserve the balance of the claimant's privacy with your need to record observed behaviour.

If the claimant has laced shoes and you know they unlaced them then it is reasonable to record they have achieved this even though you have not formally observed it, by stating something like " Although not directly observed, the claimant was noted to have unlaced his shoes whilst undressing for examination and subsequently to have replaced them after the examination had been concluded “. This is especially so if they were able to undress/dress speedily without assistance.

You may have the opportunity to observe how the claimant handles tablet bottles.

4.8 Activity 9 – Vision including visual acuity and visual fields in normal daylight or bright electric light

Statements

(*a*) *Cannot see the shape of furniture.*

(b) Cannot see well enough as if to read 16 point print at a distance more than 20 centimetres.

(c) Cannot see well enough to recognise a friend across the room at a distance of at least 5 metres.

(d) Cannot see well enough to recognise a friend across the road at a distance of at least 15 metres.

(e) None of the above apply.

Statements in *italics* indicate severe limitations of independent mobility outdoors

4.8.1 Scope

This means vision in normal daylight or bright electric light, with glasses or other visual aids, which would normally be worn.

The statements relate to vision only, and not to literacy.

"Recognising a friend" implies the ability to recognise a friend's features, not to recognise them for example from the clothes they are wearing.

This is an example of 16 point print.

Normal vision is taken as visual acuity of 6/6 at a distance of 6 metres from the Snellen chart.

Uniocular vision (vision using one eye) which is 6/ 12 means for this test descriptor (e) applies.

Vision has to be useful vision in the context of a normal environment. A condition causing severe tunnel vision where, despite reasonable visual acuity, an individual cannot read whole sentences or scan a page, causes significant disability. An appropriate descriptor in this situation would be (a) or (b).

4.8.2 Examples of daily living activities

Consider activities such as:

Filling in forms

Reading newspapers or magazines

Helping children with homework or reading bedtime stories

Leisure activities, in particular participatory sports such as snooker or darts; and activities which require good vision such as knitting or sewing

Whether the person drives. The standard of visual acuity required to hold an ordinary driving licence is such that person can read in good daylight with glasses if worn a number plate at a distance of 20.5 metres. This corresponds to 6/10 on a Snellen chart. Any person who holds a driving licence should satisfy the 'no problem with vision' descriptor (e)

Observed behaviour

Ask the claimant how they got to the examination centre and how they found their way about within the centre. Note whether the claimant needed to be accompanied by another person.

Also note any observed ability when dealing with belts and buttons.

4.9 Activity 10 – hearing

Statements

(a) Cannot hear well enough to follow a television/radio programme even with the volume turned up by hearing alone.

(b) Cannot hear well enough to understand someone talking in a loud voice in a quiet room by hearing alone.

(c) Cannot hear well enough to understand someone talking in a normal voice in a quiet room by hearing alone.

(d) None of the above apply.

4.9.1 Scope

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

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

Descriptor (a) is intended for the claimant who cannot hear the sound even when maximum volume is used, implying a very severe degree of hearing loss, which will only apply in exceptional cases e.g. with a binaural hearing threshold above 90db.

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 although modern digital aids can help to overcome their problem.

4.9.2 Examples of daily living activities

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

Observed behaviour

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

Very deaf claimants often fail to respond to their call in the waiting area; bring a companion with them to assist them with communication; or function poorly at the interview requiring you to raise your voice and repeat questions.

4.10 Activity 11 – Speech

Statements

(a) Cannot speak or use language effectively to communicate even with family or close friends.

(b) Strangers cannot understand speech at all.

(c) Strangers have difficulty in understanding speech.

(d) None of the above apply.

4.10.1 Scope

There are 2 key considerations:

Can family or friends (i.e. people who have regular/daily contact) understand the person's speech?

Can strangers understand the person's speech?

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

To people who know them well

To strangers who do not

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

Speech is an extremely complex activity, involving intellectual, neurological and musculo-skeletal components. It may, therefore, be affected by any condition involving these areas. In rare cases, it may be that both psychological and physical factors play a part in the causation of speech difficulties.

Both the psychological and physical factors should be considered using the physical and mental health tests. However, it is essential that only physical factors affecting speech are considered in the physical test and mental health factors in the mental health test to prevent double scoring.

It is occasionally claimed that speech is affected in cases of Chronic Fatigue Syndrome, where the claimant asserts that speech becomes unclear when they are tired. A similar claim may be made by claimants suffering from panic attacks, who describe difficulty in making themselves understood during an episode of acute anxiety. In most cases there is usually no physical cause for this. Careful consideration should be given whether such claimants should be assessed under the Mental Health Assessment.

Some claimants who suffer from breathlessness due to physical causes will describe difficulty with speech. However, in many of these cases, the problem is transitory and only occurs during extra physical effort, like walking quickly or climbing stairs. Therefore, for the majority of the time, they will have normal speech.

4.10.2 Examples of daily living activities

Consider:

The ability to socialise with family and friends

Any difficulties with activities such as shopping, or travelling on public transport

Ability to use a telephone

Observed behaviour

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

4.11 Activity 12 –Seizures causing loss of consciousness or altered consciousness

Statements

(a) *In past 6 months has had 6 or more seizures causing loss of consciousness or altered consciousness and either:*

- *Was awake when the seizure commenced but had no useful warning of seizure,* ***or***
- *Had dangerous post-ictal behaviour.*

(b) *In past 6 months has had 3 or more seizures causing loss of consciousness or altered consciousness and either:*

- *Was awake when the seizure commenced but had no useful warning of seizure,* ***or***
- *Had dangerous post-ictal behaviour.*

(c) *In past 6 months has had 1 or more seizures causing loss of consciousness or altered consciousness and either:*

- *Was awake when the seizure commenced but had no useful warning of seizure,* ***or***
- *Had dangerous post-ictal behaviour.*

(d) None of the above apply.

Statements in *italics* indicate severe restrictions of independent mobility outdoors.

4.11.1 Scope

This activity considers the risk caused by a loss of consciousness as the result of the person having an seizures causing loss of consciousness or altered consciousness whilst awake. In order to assess this risk the following factors need to be considered:

- Frequency of seizures.
- Type of seizure (needs to be a generalised tonic/clonic fit with loss of consciousness). Petit mal or absence seizures may be included as there may be a period of altered consciousness.
- Whether there is any useful warning – so the person can put themselves away from danger – cooking/crossing road. This is why they must be awake for this to

apply as a person who has a seizure whilst asleep cannot have any warning they are aware of.

- Whether there is a period of dangerous post fit behaviour which would result in injury to self or others.

It is likely that there would be a history of significant injury with the seizures described in the statements and where there is dangerous post fit behaviour.

Most people with seizures causing loss of consciousness or altered consciousness would usually have their seizures well controlled by medication. Where there is some associated pathology e.g. learning difficulties or post head injury more frequent seizures which are more difficult to control may occur.

Any disability due to side effects of medication taken to control seizures needs to be taken into account.

A mental health assessment should be performed if the side effects of medication are sufficient to interfere with cognitive ability or produce other mental disablement.

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 the claim of frequent episodes of lost consciousness.

4.11.2 Examples of daily living activities

Consider:

Whether the person drives – the Licensing Authorities will refuse to issue a licence to anyone who has had a daytime fit in the past year.

Potentially hazardous domestic activities such as cooking

Potentially hazardous self care activities such as bathing

Recreational activities e.g. swimming, contact sports

It should also be noted that this activity considers seizures causing loss of consciousness or altered consciousness which have the following features:

- When awake there were no useful warning of the seizure or
- Dangerous post seizure behaviour

Such a person may have no warning of an impending seizure and so be unable to put themselves in a position of safety. They may also have dangerous post fit behaviour which could result in serious injury to self or others.

This activity recognises the serious consequences of these seizures and the need for help particularly in the post fit period when serious injury may be caused.

Seizures which do not have the above characteristics and faints and blackouts do not result in the serious risk posed by the seizures within the scope of activity 12.

While a person may be confused after a faint or blackout this does not represent the dangerous behaviours considered by activity 12.

Episodes falling within the scope of activity 12

The type of seizures which would fall into activity 12 are Tonic-Clonic seizures.

The seizure event may be preceded by a prodromal period, (which may manifest as a change in mood or behaviour, and during which, the patient feels different), lasting hours or days. This is not part of the seizure itself.

They may or may not then experience an aura, or vague warning, which is itself, part of the seizure and precedes the other manifestations. It may be a strange feeling in the stomach, or a strange smell and can take many forms. In such cases the individual would normally be able to take steps to avoid danger.

The person then goes rigid due to intense sustained muscular contractions and becomes unconscious. This is the tonic phase.

During this phase air is forced out of the lungs causing the individual to cry out or make a strange noise. The bladder also contracts and urinary and faecal incontinence may occur.

The jaw muscles contract and the teeth clench together often with biting of the inside of the lips and the tongue.

If the person is standing they may fall heavily to the ground, and may sustain serious injury.

During the tonic phase breathing ceases and the person may begin to turn a blue colour (central cyanosis).

After a few moments the rigidity is periodically relaxed and the clonic phase begins. This phase is characterized by rhythmic jerking of the muscles causing the whole body to shake (convulse) uncontrollably. Frothing at the mouth often occurs. Breathing returns in the clonic phase but is erratic. This phase may last for a few seconds to several minutes. On average the entire event will last about 3-5 minutes.

The person will then gradually regain consciousness but is often dazed and confused (the post post-ictal state).

The patient gradually regains consciousness, but will be confused and disorientated for at least half an hour after regaining consciousness, and may not recover full memory function for some time (hours).

They may also complain of a headache and feel terrible with the desire to lie down and sleep. In some cases the person may remain unresponsive following the seizure. In other cases they may become aggressive with disturbed and exhibit dangerous behaviour. This post-ictal state may persist for several hours, or up to days, following the seizure.

Afterwards the person often has sore and aching muscles due to the intense contractions, and a sore tender tongue, which often has been severely bitten.

Such seizures where the person gets no warning to put themselves in a place of safety or if they exhibit dangerous post-ictal behaviour which needs a person to supervise them to prevent injury will need to be constantly supervised (depending on the frequency of the fits).

Syncope

Prior to a vasovagal faint the individual often experiences feelings of nausea, lethargy, dizziness, coldness with a cold sweat breaking out before losing consciousness.

The individual may yawn uncontrollably with a vacant expression and marked pallor of the face and extremities.

In those who have recurrent fainting there can be a brief period of pre-syncopal anxiety that can give warning of an impending attack.

Vasovagal fainting usually occurs while the person is standing but can happen when seated.

When fainting is associated with cardiac arrhythmia it is not so influenced by posture and can happen while seated. As a result the person either sinks to the ground or falls forward.

The period of unconsciousness is usually brief, lasting less than one minute. It is sometimes accompanied by what appears to be a brief convulsion that is due to anoxia (lack of oxygen) of the brain stem and not a true seizure.

The victim usually reverts to normal consciousness very quickly and shows none of the after-effects of confusion, disorientation or automatic behaviour normally seen after for example an epileptic seizure. They may continue to look pale and feel ‘shaky’ for 10-15 minutes following the episode.

With these episodes although there may be loss of consciousness, the risk of any serious injury is not great as the person often knows it is going to happen, can in some cases take avoiding action to prevent the faint (sit or lie down) and quickly comes round and is quickly able to resume activities. There is usually no need for supervision.

Reliably, repeatedly and at a reasonable speed

All activities must be capable of being performed reliably repeatedly and at a reasonable speed. For example if a person was prone to syncope then they may be considered incapable of going up and down stairs. The DO would need to assess the risk:

- Looking at the frequency of the syncope
- Looking at any predisposing factors e.g. the syncope on the stairs could be avoided if they only occurred after a hot bath.
- Whether the person had sufficient warning so they could sit on a stair
- Whether there is a history of falling down stairs.

Section 5. MENTAL/COGNITIVE HEALTH TEST

(Problems in these activities must be due to a mental health disease or disablement)

When to apply the Mental Health Assessment

You must complete a mental health assessment for all cases where the claimant is suffering from a specific mental/cognitive illness or disablement. In addition the mental health assessment should be applied to a claimant:

- Taking any medication which impairs cognitive function to a degree which causes mental disablement
- Who has an alcohol/drug dependency problem which has resulted in mental illness or disablement
- Who has certain physical or sensory disabilities which have produced mental disablement by impairing cognition and/or mental function e.g. tinnitus
- Who has mild/moderate learning disability
- Where a previously unidentified mild or moderate mental health illness or disability is discovered during medical assessment

The mental health assessment should **not** be applied where:

- The normal emotional response to a claimant's physical condition leads to the claimant being `fed up' with the condition. The mental health assessment should only be applied where there is an **abnormal** psychological response to a physical condition, **which significantly affects or adds to the overall disablement.**
- The claimant indicated either during the interview or on the questionnaire that they have a mental health problem but in your opinion there is no clinical evidence of this. **You must be able to fully justify this opinion**, and to explain to the *Decision Maker* your reasons for not applying the mental health assessment.

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

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

- There is no recent history of a specific mental illness having been diagnosed or treated; and

There is no medical evidence before me, nor any clinical findings of mental disease or disablement."

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

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

How to apply the Mental Health Assessment

The mental health assessment is designed to give a composite picture of a person's mental and social abilities in relation to everyday activities.

The Mental Health activities are completed on the basis of the claimant's responses during the interview, your assessment of the mental health condition and your knowledge of the likely effects of the condition.

Only the effects of the claimant's mental disease or disablement must be taken into account in completing the assessment. Do not justify your response with reasons due to physical causes. Literacy, visual acuity, lifting and carrying ability are frequent sources of confusion and should be discounted.

Claimants, particularly those with less severe nervous disorders, may present stereotyped symptoms and behaviour reflecting their perception of how they expect others to see them. For a thorough assessment it is necessary to get behind this presentation.

Collecting the claimant from the waiting room provides an opportunity for friendly introductions and an initial assessment of their behaviour and appearance. Often the claimant will feel more confident and secure when accompanied by a relative or friend. Companions may, with the consent of the claimant, give useful information which contributes to the assessment.

Giving the claimant an opportunity to settle down and allaying fears about the assessment will often allow the interview to progress more fruitfully.

Initially, relevant details of the claimant’s work, social, physical and mental history should be obtained. Record current therapy and the names of therapists (to include general practitioner/psychiatrist, mental health worker).

Asking direct questions, using the mental health statements as a check list, will invariably produce false results (both positive and negative). The key to obtaining the information required is to assess the claimant's mental state by getting relevant information about everyday activities and experiences. You should then ask any additional questions which are needed in order to gain further detail.

The use of open questions is crucial when dealing with mental health problems. Examples include:

- What do you think is wrong with you?
- How have things changed for you?
- How do you pass the time?
- Tell me about your social activities
- What stops you from doing things?
- How do you think work would alter things for you?

Attitudes and beliefs should be explored in order to uncover genuine fears distress.

It is always better to ask "how" questions rather than "why" and to flesh out the answer with clarifying questions such as "Could you give me an example of that?" This process helps the individual to give concrete examples and also gives an opportunity to answer the specific questions that are used as statements.

However, in certain areas one or two of the questions are of a factual nature and in these instances direct questions may be unavoidable.

For example, "Have there been any mishaps or accidents in the last three months?" You should not merely accept the answer when choosing this descriptor if your examination and knowledge of the mental condition/illness indicate that there is no medical reason for the mishaps. While interviewing the claimant you should assess and record the relevant parameters of a Mental State examination. These are:

- Appearance
- Behaviour
- Speech
- Mood
- Abnormal thoughts
- Abnormal perceptions
- Intellect and cognition
- Evidence of addiction
- Insight.

5.0 Activity 13 – Management of personal finance

Statements

(a) Does not understand the value of money.

(b) Cannot budget for daily or weekly needs.

(c) Cannot budget for irregular bills.

(d) None of the above apply.

Statements in *italics* indicate severe restrictions of independent mobility outdoors.

5.0.1 Scope

This activity considers cognitive and conceptual problems arising as a result of a mental disease or disablement. It is a theoretical test which uses budgeting as a proxy to assess these functions. The person does not actually have to perform the descriptor but must have the capacity to be able to perform the descriptor if required to do so.

Examples of daily living activities

Consider tasks which require planning and awareness/recognition

Paying bills and ensuring has sufficient funds to pay

Shopping – ability to get required items and ability to stay within budget

Planning a route

Planning everyday tasks – doctors/dentist visits, hairdresser etc.

5.1 Activity 14 – Maintaining appearance and hygiene

Statements

(a) Unable to maintain normal appearance and hygiene without daily prompting/supervision from another person.

(b) Unable to maintain normal appearance and hygiene without weekly prompting/supervision from another person.

(c) None of the above apply

5.1.1 Scope

This refers to the ability to recognise the need for washing, shaving, grooming and attending to menstrual hygiene without the need to be reminded. It does not cover the physical ability to perform these tasks. These are considered in the physical test, activities 1 to 12.

Prompting does not mean simply reminding to undertake appearance and hygiene tasks. Many without a mental health problem particularly children and adolescents may need telling to go and clean their teeth etc. In order to satisfy this activity the prompting needs to be throughout that particular activity e.g. cleaning teeth. A person would need to be prompted to clean their teeth, put toothpaste on the brush and then clean their teeth to an adequate standard.

Supervision means 'watching over' during the task to ensure the task is completed without danger to the individual and/or to a reasonable standard

> *Note added 20/7/21: following Appeal Tribunal Outcome [2019]TRS009: The Independent Tribunal has directed that the definition of 'supervision' used in the legislation must be strictly adhered to. The Regulations state "prompting/supervision" and not direct supervision, and therefore the explanatory text used above will be deemed to be invalid by the Tribunal. It is likely that the legislation will be amended in future to more closely match this explanatory text, whereupon this note will be removed.*

By normal we mean reasonable.

Descriptor (a) refers to people who need reminding to undertake tasks to maintain hygiene/appearance each day. Such people may not wash, shave or comb hair without prompting and may be unaware or unconcerned about their appearance.

5.1.2 Examples of activities of daily living

Consider the person's reported appearance and reports of self neglect. Lack of awareness of need to undertake activities of person hygiene may also be associated with little awareness of need to maintain adequate cleanliness of house and poor nutrition.

5.2 Activity 15 – Management of daily routine

Statements

(a) Does not rise without prompting and the 24 hour cycle constantly out of phase.

(b) Needs daily prompting regarding rising from **and** retiring to bed.

(c) Needs daily prompting to ensure rising from or retiring to bed.

(d) Needs intermittent prompting to ensure rising from or retiring to bed.

(e) None of the above apply.

5.2.1 Scope

This activity considers a person's ability to recognise the time of day and take appropriate action regarding going to bed and rising. Any problems in this area must be due to a mental disease or disablement.

Prompting does not mean simply reminding to get up or go to bed. Many without a mental health problem particularly children and adolescents may need telling it is time for bed or they need to get up for school but they will be aware of the time of day and that really they need to get up or go to bed.

Some will make a choice of going to bed late in the early hours of the morning and not get up until late however they will know the time of day and make this choice knowingly.

In order to satisfy this activity the prompting needs to be repeated several times and the need for the prompting must be due to the person not recognising the need to go to bed or rise as they do not recognise the time of day as a result of a mental disease or disablement.

Note added 20/7/21: following Appeal Tribunal Outcome [2019]TRS009: The Independent Tribunal has directed that the definition of 'prompting used in the legislation must be strictly adhered to. The Regulations state "prompting/supervision" and not "prompting several times", and therefore the explanatory text used above will be deemed to be invalid by the Tribunal. It is likely that the legislation will be amended in future to more closely match this explanatory text, whereupon this note will be removed.

Descriptor (a) applies to those who have no concept of time and do not undertake activities appropriate to the time of day for this reason.

5.2.2 Examples of daily living activities

Consider:

The time the person rises and goes to bed if help is unavailable

Other activities with appropriate daily times such as meals

5.3 Activity 16 – Awareness of dangers and consequences of unsafe behaviour

Statements

(a) Is totally unaware of common dangers or consequences of behaviour.

(b) Needs to be instructed at least on a daily basis about common dangers or about the consequences of behaviour.

(c) Is generally aware of common dangers and behaviour is acceptable but only in a familiar structured environment.

(d) None of the above apply.

Statements in *italics* indicate severe restrictions of independent mobility outdoors.

5.3.1 Scope

This activity considers three areas:

- A person's ability to appreciate and take action to avoid dangers within the home and outdoors.

- Whether a person exhibits unsafe behaviour or dangerous behaviour to an extent that they need supervision in order to prevent injury to self or others or perform illegal acts.

- Whether the awareness of danger or unsafe behaviour occurs at any time or only in environments which are unstructured or unfamiliar.

Common dangers could include dealing with electrical and gas appliances and awareness of traffic dangers.

Unsafe behaviour may include physical violence, verbal aggression or unsafe behaviour.

5.3.2 Examples of daily living activities

Consider whether the person:

Prepares cooked meals themselves

Is able to go out alone (assuming can find their way around)

Any reported incidents of violent, abusive or disinhibited behaviour

5.4 Activity 17 – Getting around outdoors

Statements

(a) Unable to cope with leaving the house even if accompanied by another person.

(b) *Unable to cope with leaving the house unless accompanied by another person.*

(c) Unable to cope in finding their way around even in familiar places.

(d) Unable to find their way around in unfamiliar places (but can in familiar places).

(e) None of the above apply.

Statements in *italics* indicate severe restrictions of independent mobility outdoors.

5.4.1 Scope

This considers a person's ability to:

- Leave the house

- not even if accompanied
- if accompanied by another person

- Find their way around outdoors independently
  -in familiar places

  -in unfamiliar places

This activity does not consider any supervision which is required as the person is unaware of dangers or to prevent unsafe behaviour. This has already been considered in activity 16 – 'awareness of danger and unsafe behaviour.'

Unable to cope means that the person cannot do the activity.

Descriptor (a) – unable to leave the house even if accompanied would apply rarely and likely only in cases of extreme agoraphobia. This descriptor does not reflect a severe restriction of mobility outdoors as the person does not go out. An award of mobility is therefore not appropriate to this descriptor. The higher functional restrictions of people who satisfy this descriptor when compared with those who satisfy descriptor (b) - only go out if accompanied, is reflected in a higher score.

5.4.2 Examples of daily living activities

Consider the person's ability to:

Go shopping attend doctor/dentist appointments independently

Find their way to the local shops/park etc

Undertake long journeys using public transport independently

The ability to drive

5.5 Activity 18 – Coping with change

Statements

(a) Pre-planned changes in daily routine results in disruptive or unsafe behaviour.

(b) Unplanned changes in routine results in disruptive or unsafe behaviour.

(c) None of the above apply.

5.5.1 Scope

This activity considers a person's ability to cope with change:

- Whether or not it is planned.
- Whether the change is minor or very minor.

By 'coping' we mean the ability to accept change without it resulting in disturbed behaviour (e.g. disruptive).

A very minor change is one which would not normally be considered important e.g. having lunch half an hour earlier.

This activity would mainly apply to those with learning difficulties or autistic spectrum disorder.

5.5.2 Examples of daily living activities

Consider:

Ability to attend appointments

If there is a rigid daily routine

Section 6. CHILDREN'S TEST

(Applies to children age 12 and under)

6.0 BACKGROUND

The children's test applies to claimants aged under 12. The principles of the test are identical to the adult test using some activities and statements. This test must consider the problems a disabled child has with the activities and statements over and above a child without a disability. Children age 12 and above are considered able to perform all the activities and statements in the adult test.

The children's test is divided into 6 age ranges:

- Less than 1 year
- 1 year to under 3 years
- 3 years to under 5 years
- 5 years to under 8 years
- 8 years to under 12 years

The children's test considers the same activities as the adult test. For some activities a child without a disability of a certain age would be unable to perform the activity due to normal development. For similar reasons some statements within an activity will not apply to children of certain age ranges. Therefore for each age range some activities and statements will not be considered where a 'normal' child **in that** age range cannot undertake that activity/descriptor. These are shown in **appendix one** (please use part 2 statement less scores)

Using Activity 4, walking as an example the activity would not apply to children less than one year as the majority of children without a disability do not walk. In the age group of 1 to under 3 years most children without a disability can walk a few steps but would be unable to walk 50 metres.

Activity 12, the 'remaining conscious' activity has been amended, altering the statements to better reflect children's problems in this area.

The statements which reflect severe problems with outdoor mobility remain the same as the adult test where these are applicable to a child.

There are two extra activities which are specific to children aged under 12:

- **Activity 19 - Need for the help of another person as stipulated by a health care professional to ensure that developmental milestones are achieved as fully as possible.**

- **Activity 20 - Need for help from another person as stipulated by a health care professional due to a medical condition.**

These are intended to cover the additional needs a child with a disability may have when compared with a child of a similar age. While some adults will need help with medication the problems are covered in the activities, for example problems with manual dexterity or planning. All children even if they had no problems in the other activities would need help in taking medication. For example, a child aged 6 with diabetes would be capable of performing all the relevant activities and statements for that age but would need help with insulin injections and blood sugar monitoring. An adult with diabetes would have functional restrictions covered in the other activities if he could not manage his diabetes independently.

Activities 19 and 20 scope

Activities 19 and 20 are similar but there is a subtle difference most easily explained by giving some examples:

- a child with severe deafness would attend a speech therapist in order to achieve communication milestones. The parent would be likely to be given some exercises to do at homes. This would fall in activity 19

- a child with diabetes would need help with monitoring condition, giving and adjusting doses of insulin and giving treatment for hypoglycaemic attacks. This would fall in activity 20

- a child with cerebral palsy may have prescribed exercises to do at home in order to develop mobility milestones. Although it could be argued that this is treating the illness the illness is unchanged by this therapy and its purpose is to maximise mobility milestones. This would fall in activity 19

- the parents of a child with cystic fibrosis have been instructed by the physiotherapist to do regular chest physiotherapy. The purpose of this is to try and minimise lung damage caused by the disease and prevent chest infections. This would fall under activity 20 as it is part of the management of the disease rather than maximising milestone development

When considering activities 19 and 20 it is important to decide:

- whether the treatment has been prescribed by a health care professional and if yes

- is the purpose of the treatment mainly to maximise achievement of milestones (activity 19) or treat the underlying medical condition or its complications (activity 20)

6.1 Activity 4 – Walking

ONLY APPLIES TO CLAIMANTS AGED 3 AND OVER

WALKING AND STAIRS – walking on level ground and/or walking up and down stairs (12 steps)

Statements

a) *Cannot walk at all.*

b) *Cannot walk more than a few steps on level ground and/or up and down one stair without having to stop or feeling severe discomfort, even with the support of a handrail.*

c) *Cannot walk more than 50 metres on level ground and/or walk up and down a flight of 12 stairs without having to stop or feeling severe discomfort.*

d) Cannot walk more than 200 metres on level ground without having to stop or feeling severe discomfort.

e) Cannot walk more than 400 metres on level ground without having to stop or feeling severe discomfort.

f) None of the above.

Statements in italics indicate severe limitations of independent mobility outdoors for children aged above three.

6.2 Activity 12 (children under 12) – Seizures causing loss of consciousness or altered consciousness

Statements

(a) At least once a week in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure.

(b) At least once a month in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure.

(c) At least once every 2 months in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure.

(d) None of the above apply.

6.2.1 Scope

This activity differs from the adult activity in that it does not consider whether there is any useful warning or dangerous post fit activity, otherwise it is the same.

6.3 Activity 19 – Need for the help of another person as stipulated by a health care professional to ensure that developmental milestones are achieved as fully as possible

Adult input prescribed by a health care professional to ensure developmental milestones are achieved as fully as possible.

Statements

(a) Requires help throughout his or her waking hours.

(b) Requires help on a daily basis.

(c) None of the above apply.

6.3.1 Scope

This concerns the extra adult help a child with a disability may need in connection with:

- Achieving milestones.
- Developing gross motor and manipulation skills.
- Developing social behaviour.

The help may be for example speech, physiotherapy or play therapy but must be part of treatment prescribed by a health care professional.

Help needed with dressing, feeding and bathing should not be considered as the functions required for these activities are included in other statements.

6.4 Activity 20 – Need for help from another person as stipulated by a health care professional due to a medical condition

Help prescribed by a health care professional with management of medical conditions.

Statements

a) Requires help with a medical therapeutic procedure, monitoring of the condition or the administering of medication at least 3 times a day.

b) Requires help with a medical therapeutic procedure at least once a day.

c) Requires help with a medical therapeutic procedure at least twice a week.

d) Requires help with monitoring the condition or the administering of medication at least twice a day.

e) None of the above apply.

6.4.1 Scope

This covers the help adults give a child in connection with his or her treatment. The treatment must be prescribed by a doctor or other health care professional

Treatment includes:

- giving medication
- monitoring the condition e.g. blood sugars

Therapeutic procedures includes:

- physiotherapy.

Section 7. GLOSSARY OF TERMS

GLOSSARY OF TERMS

Continuous	This does not mean continual i.e. without a break. It means that it has broad periods with some breaks in between
Frequent	More than two
Permanent	Long term
Repeated	More than once
Substantial	Not insignificant

APPENDIX

Schedule 2 Income Support (Jersey) Regulations 2007

SCHEDULE 2

(Schedule 1, paragraph 6(2))

PART 1:

Statements in respect of personal care element of impairment component

Directions

(1) A statement in respect of any of the activities numbered 1 to 12B in the table shall be selected having regard only to the member of the household's physical and sensory abilities.

(1A) Where a member of a household is normally fitted with or normally wears a prosthesis, he or she shall be assessed as if he or she was fitted with or wearing that prosthesis.

(1B) Where a member of a household normally wears or normally uses any aid or appliance, or could reasonably be expected to normally wear or normally use any aid or appliance, he or she shall be assessed as if he or she was wearing or using that aid or appliance.".

(2) A statement in respect of any of the activities numbered 13 to 18 in the table shall be selected having regard only to the member of the household's mental and cognitive abilities.

1 STATEMENT	**2** SCORE	**3** Age below which statement does not apply	**4** Age at which statement ceases to apply
1 Sitting in an upright chair with a back but no arms			
a) cannot sit without severe discomfort	15	3 years	None
b) cannot sit without severe discomfort for more than 10 minutes	15	3 years	None
c) cannot sit without severe discomfort for more than 30 minutes	6	3 years	None
d) cannot sit without severe discomfort for more than 1 hour	3	3 years	None
e) none of the above	0	3 years	None
2 Standing without the support of another person			
a) cannot stand without that support	15	3 years	None
b) cannot stand for more than 10 minutes without that support	15	3 years	None

c) cannot stand for more than 30 minutes without that support	6	3 years	None
d) none of the above	0	3 years	None
3 Rising from sitting in an upright chair with a back but no arms without assistance			
a) cannot rise from sitting to standing without the support of another person	15	3 years	None
b) cannot rise without holding on to something	6	3 years	None
c) neither of the above	0	3 years	None
4 Walking			
a) cannot walk at all	15	3 years	None
b) cannot walk more than a few steps on level ground and/or up and down one stair without having to stop or feeling severe discomfort, even with the support of a handrail	15	3 years	None
c) cannot walk more than 50 metres on level ground and/or walk up and down a flight of 12 stairs without having to stop or feeling severe discomfort	9	3 years	None
d) cannot walk more than 200 metres on level ground without having to stop or feeling severe discomfort	6	3 years	None
e) cannot walk more than 400 metres on level ground without having to stop or feeling severe discomfort	3	3 years	None
f) none of the above	0	3 years	None
5 Bending or kneeling from a standing position			
a) cannot bend to touch knees and straighten up again	15	3 years	None
b) cannot either bend or kneel, or bend and kneel or squat as if to pick up a piece of paper off the floor and straighten up again	15	3 years	None
c) neither of the above	0	3 years	None
6 Reaching			
a) cannot raise either arm as if to put something in the breast pocket of a jacket	15	1 year	None
b) cannot raise either arm as if to put on a hat	15	1 year	None
c) can only raise one arm as if to put	9	1 year	None

something in the breast pocket of a jacket			
d) can only raise one arm as if to put on a hat	6	1 year	None
e) none of the above	0	1 year	None
7 Pouring and picking up and transferring to a distance of 60 cm at table-top level			
a) cannot pick up and transfer a full glass of water of 200 ml capacity with either arm	15	3 years	None
b) cannot pick up and pour from a full saucepan or kettle of 1.5 litre capacity with either arm	15	8 years	None
c) cannot pick up and transfer a 2.5 kg bag of potatoes with either arm	9	8 years	None
d) can only pick up and transfer a full glass of water of 200 ml capacity with one arm	6	3 years	None
e) none of the above	0	3 years	None
8 Manual dexterity			
a) cannot turn the pages of a book with either hand	15	3 years	None
b) cannot turn a star-headed sink tap with either hand	15	3 years	None
c) cannot pick up an object up to 2.5 cm in diameter such as a coin with either hand	15	1 year	None
d) cannot use a spoon with either hand	15	3 years	None
e) cannot tie a bow in laces or string	9	8 years	None
f) can only turn a star-headed sink tap with one hand	6	3 years	None
g) can only pick up an object 2.5 cm in diameter such as a coin with one hand	6	1 year	None
h) none of the above	0	1 year	None
9 Vision, including visual acuity and visual fields, in normal daylight or bright electric light			
a) cannot see the shape of furniture in the room	15	3 years	None
b) cannot see well enough to read 16 point print at a distance of 20 cm	15	3 years	None
c) cannot see well enough to recognise a friend at a distance of 5 metres	9	1 year	None
d) cannot see well enough to recognise a friend at a distance of 15 metres	6	1 year	None

e) none of the above	0	1 year	None
10 Hearing			
a) cannot hear well enough to follow by hearing alone a television or radio programme even with the volume turned up	15	1 year	None
b) cannot hear well enough to understand by hearing alone a person talking in a loud voice in a quiet room	15	1 year	None
c) cannot hear well enough to understand by hearing alone a person talking at a normal level of voice in a quiet room	9	1 year	None
d) none of the above	0	1 year	None
11 Speech			
a) cannot speak or use language effectively to communicate even with close family or friends	15	3 years	None
b) speech cannot be understood by strangers	9	3 years	None
c) speech difficult for strangers to understand	6	3 years	None
d) none of the above	0	3 years	None
12A Seizures causing loss of consciousness or altered consciousness: persons aged 12 and over			
a) in the past 6 months has had 6 or more seizures causing loss of consciousness or altered consciousness and either – (i) was awake when the seizure commenced but had no useful warning of seizure, or (ii) had dangerous post-ictal behaviour	15	12 years	None
b) in the past 6 months has had 3 or more seizures causing loss of consciousness or altered consciousness and either – (i) was awake when the seizure commenced but had no useful warning of seizure, or (ii) had dangerous post-ictal behaviour	9	12 years	None
c) in the past 6 months has had 1 or more seizures causing loss of consciousness or altered consciousness and either – (i) was awake when the seizure commenced but had no useful warning of seizure, or	6	12 years	None

(ii) had dangerous post-ictal behaviour			
d) none of the above	0	12 years	None
12B Seizures causing loss of consciousness or altered consciousness: persons aged under 12			
a) at least once a week in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure	15	1 year	12 years
b) at least once a month in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure	9	1 year	12 years
c) at least once every 2 months in the past 6 months has had a seizure causing loss of consciousness or altered consciousness and was awake at any time during the seizure	6	1 year	12 years
d) none of the above	0	1 year	12 years
13 Management of personal finance			
a) does not understand the value of money	20	8 years	None
b) unable to budget for daily and/or weekly needs	15	8 years	None
c) unable to budget for irregular bills	5	12 years	None
d) none of the above	0	8 years	None
14 Maintaining appearance and hygiene			
a) unable to maintain normal standards of appearance and hygiene without daily prompting/supervision from another person	20	5 years	None
b) unable to maintain normal standards of appearance and hygiene without weekly prompting/supervision from another person	10	5 years	None
c) neither of the above	0	5 years	None
15 Management of daily routine			
a) does not rise from bed without prompting and 24 hour cycle constantly out of phase	20	5 years	None
b) needs daily prompting to ensure rising from and retiring to bed	15	8 years	None
c) needs daily prompting to ensure rising from or retiring to bed	10	8 years	None
d) needs intermittent prompting to ensure rising from or retiring to bed	5	8 years	None

e) none of the above	0	5 years	None
16 Awareness of danger and consequences of behaviour			
a) is totally unaware of common dangers or the potentially harmful consequences of his or her behaviour	20	3 years	None
b) needs to be instructed on at least a daily basis about common dangers or the potentially harmful consequences of his or her behaviour	15	5 years	None
c) is generally aware of common dangers and does not need instructing about the potentially harmful consequences of his or her behaviour, but only when he or she is in a familiar structured environment	10	8 years	None
d) none of the above	0	3 years	None
17 Getting around outdoors			
a) unable to cope with leaving the house even if accompanied by another person	20	5 years	None
b) unable to cope with leaving the house unless accompanied by another person	15	5 years	None
c) unable to cope with finding his or her way around even in familiar places	15	8 years	None
d) unable to cope with finding his or her way around only in unfamiliar places	10	12 years	None
e) none of the above	0	5 years	None
18 Coping with change			
a) pre-planned changes in routine result in disruptive or potentially harmful behaviour	10	3 years	None
b) unplanned changes in routine result in disruptive or potentially harmful behaviour	5	3 years	None
c) neither of the above	0	3 years	None
19 Need for the help of another person as stipulated by a health care professional to ensure that developmental milestones are achieved as fully as possible			
a) requires help throughout his or her waking hours	15	None	12 years
b) requires help on a daily basis	9	None	12 years
c) none of the above	0	None	12 years

20 Need for help from another person as stipulated by a health care professional due to a medical condition			
a) requires help with a medical therapeutic procedure, monitoring of the condition or the administering of medication at least 3 times a day	15	None	12 years
b) requires help with a medical therapeutic procedure at least once a day	9	None	12 years
c) requires help with a medical therapeutic procedure at least twice a week	6	None	12 years
d) requires help with monitoring the condition or the administering of medication at least twice a day	6	None	12 years
e) none of the above	0	None	12 years

Statements in respect of mobility element of impairment component

(Schedule 1, paragraph 7(1))

Directions

(1) A statement in respect of any of the activities numbered 1 to 3 shall be selected having regard only to the member of the household's physical and sensory abilities.

(2) Where a member of a household is normally fitted with or normally wears a prosthesis, he or she shall be assessed as if he or she was fitted with or wearing that prosthesis.

(3) Where a member of a household normally wears or normally uses any aid or appliance, or could reasonably be expected to normally wear or normally use any aid or appliance, he or she shall be assessed as if he or she was wearing or using that aid or appliance.

(4) A statement in respect of any of the activities numbered 4 to 6 shall be selected having regard only to the member of the household's mental and cognitive abilities.

1 Walking

(a) Cannot walk at all.

(b) Cannot walk more than a few steps on level ground and/or up and down one stair without having to stop or feeling severe discomfort, even with the support of a handrail.

(c) Cannot walk more than 50 metres on level ground and/or walk up and down a flight of 12 stairs without having to stop or feeling severe discomfort.

Note: Statement is not relevant in the case of child under the age of 3 years.

2 Vision, including visual acuity and visual fields, in normal daylight or bright electric light

(a) Cannot see the shape of furniture in the room.

(b) Cannot see well enough to read 16 point print at a distance of 20 cm.

(c) Cannot see well enough to recognise a friend at a distance of 5 metres.

Note: Statement is not relevant in the case of child under the age of 3 years.

3 Seizures causing loss of consciousness or altered consciousness

In the past 6 months has had one or more seizures with loss of consciousness or altered consciousness and either –

(a) was awake when the seizure commenced but had no useful warning of the seizure; or

(b) had dangerous post-ictal behaviour.

Note: Statement is not relevant in the case of child under the age of 12 years.

4 Management of personal finance

Does not understand the value of money.

Note: Statement is not relevant in the case of a child under the age of 8 years.

5 Awareness of danger and consequences of behaviour

(a) Is totally unaware of common dangers or the potentially harmful consequences of his or her behaviour.

(b) Needs to be instructed on at least a daily basis about common dangers or the potentially harmful consequences of his or her behaviour.

Note: Statement (b) is not relevant in the case of a child under the age of 5 years.

6 Getting around outdoors

(a) Unable to cope with leaving the house unless accompanied by another person

(b) Unable to find his or her way around even in familiar places.

Note: The statement is not relevant in the case of a child under the age of 8 years

Revision history

Date	Version	Description	Author
23/1/2013	1.1	Additional guidance compiled by Dr R Thomas on the application of Activity 12 for 'Episodes falling within the scope of activity 12, Syncope and Reliably, repeatedly and at reasonable speed' added.	RJ
9/10/2013	1.2	Changes made to activity 12A and 12B epilepsy and to the mobility statement for epilepsy together with clarification of the basis for choosing an activity, following States approval on 8/10/13 of the Income support (Miscellaneous Provisions) (Jersey) Regulations 2013 which came into force from 15/10/2013	RJ
25/6/2015	1.3	Changes made following States approval of the Income Support) (Amendment No.13) (Jersey) Regulations 2015. This changed: Activity 12 from one of epilepsy and unconsciousness to one of seizures causing loss of consciousness or altered consciousness. All tests assessed based on the use of prosthesis or aids where normally worn or fitted or used so references to these removed from the headings of the activities 4, 9 and 10. These changes is effective from 30/6/2015.	RJ