Health and Benefits Division

Transformation of the Personal Capability Assessment

Report of the Physical Function and Mental Health Technical Working Groups

Commissioned by the Department for Work and Pensions

September 2006

DWP Department for Work and Pensions

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EXECUTIVE SUMMARY

As part of implementation of the Government's proposals for welfare reform, the Department for Work and Pensions' Health, Work and Wellbeing Directorate was commissioned to develop proposals for transforming the Personal Capability Assessment (PCA) from an incapacity-based tool for determining entitlement to Incapacity Benefit, to a more positive assessment incorporating assessment of capability and of health related interventions which would contribute to overcoming health-related barriers preventing people with disabilities from engaging in work.

This is the report of the mental and physical function Technical Working Groups which were commissioned to undertake the Transformation of the PCA project, chaired by Dr. Moira Henderson, Head of DWP Health and Benefits Division. Membership of the Working Groups reflected a wide range of expertise in relevant fields. The project was undertaken in close consultation with stakeholder groups directly representing service users.

The remit of the Technical Working Groups was to:

- **Consider the impact of the changing pattern of mental health problems and treatment options on the effectiveness of the mental health component of the PCA assessment**
- **Review the relevance of current mental health descriptors and identify aspects not covered by the current descriptors**
- **Review the physical function descriptors and scores to ensure they remain relevant to today's pattern of disabling conditions and working environment**
- **Make recommendations for a revised PCA assessment which will:**
    - **Ensure those who are currently unfit for work are identified**
    - **Accurately identify those who in spite of their condition are fit to continue work**
    - **For those who are unfit to work, identify interventions that would help to support recovery such that return to work would again become an option**

The remit of the stakeholder consultative groups was to:

- **Represent the views of people with health problems or disabilities**
- **Interact with and advise the Technical Working Groups**
- **Review the processes for gathering information in relation to the PCA, from claimants, their health care team, and other relevant sources**
- **Contribute to development of a new work-focused health-related assessment**

- **Feed in to the Technical Working Groups' report and recommendations to Ministers**

The report focuses on recommendations for revision of the PCA mental and physical function assessments. It proposes a revised assessment which we anticipate will represent a fairer, more accurate, and more robust assessment of the level of a person's functional ability in relation to capability for work.

In particular, it proposes an extensively revised mental function assessment, to address a current gap in assessment of cognitive and intellectual function, in conditions such as learning disability, autistic spectrum disorder, and acquired brain injury. It also proposes a new scoring system for mental function, which addresses a bias in the current PCA against people with mental health problem, as opposed to limitation of physical function.

Review of the physical function assessment has focused on ensuring that the activities assessed and scores allocated accurately reflect the level of functional limitation at which it is unreasonable to require a person to engage in work.

There is still work to be done, to evaluate and refine the proposed new assessment. The report recommends that this should be undertaken in the coming months.

The project has also addressed two major, and still ongoing, strands of work:

- **Review of evidence gathering in relation to the PCA, from claimants, healthcare professionals, and other community and social care professionals involved in supporting them**
- **Development of the work-focused heath-related assessment. This will assess what a person can do, despite their limitations; and what interventions might help to overcome health-related barriers to work**

The report describes the work in hand and recommends that it should continue, and include evaluation of the effectiveness of revised evidence gathering reports

The annexes to the report contain the proposals for the revised PCA; the current PCA for comparison; and a list of the members of the Technical Working Groups and the stakeholder organisations represented

SUMMARY OF RECOMMENDATIONS

(i) **to accept the proposals for revised PCA physical and mental functional assessments**

(ii) **during October 2006, to test and evaluate the revised descriptors and scores, initially to validate the hypothesis that they represent a fairer, more accurate, and more robust assessment of entitlement to benefit on the grounds of limited functional ability.**

(iii) **having validated the hypothesis, to carry out further testing in the early part of 2007, to make any necessary amendments to descriptors or their scores**

(iv) **to carry out qualitative evaluation of the revised mental function assessment with claimants during 2007**

(v) **to develop and pilot a revised IB 50 self-assessment questionnaire during 2007**

(vi) **to complete work in hand reviewing medical evidence gathering, and to pilot the proposed new medical certificates and IB 113 factual reports during 2007**

(vii) **to complete work in hand developing the work-focused health-related assessment, and to pilot the assessment, during 2007**

(viii) **in the longer term, to consider exploring development of a combined physical and mental function PCA**

TRANSFORMATION OF THE PERSONAL CAPABILITY ASSESSMENT

I. INTRODUCTION

1. As part of implementation of the Government's proposals for welfare reform, the Department for Work and Pensions' Health Work and Wellbeing Directorate was commissioned to develop proposals for transforming the Personal Capability Assessment (PCA) from an incapacity-based tool for determining entitlement to Incapacity Benefit, to a more positive assessment, focusing on capability and on the health-related interventions which would contribute to overcoming the barriers preventing people with disabilities from engaging in work.

2. The Transformation of the PCA Project has identified and developed a number of strands of work:

    - Review of the PCA assessment of benefit entitlement
    - Review of evidence-gathering in association with the PCA
    - Development of a new, work-focused health-related assessment

3. Work on the project has been undertaken by a number of technical working groups, comprising healthcare professionals and others with expertise in:

    - a variety of aspects of disability assessment
    - occupational medicine
    - social security legislation
    - application of the PCA assessment
    - development of the original PCA in the early 1990s

4. These technical groups have worked closely with stakeholder consultative groups comprising people with direct experience of disability and/or of provision of support for people with disabilities. There has been some consultation with service users, but this has so far been limited in extent. Members of the consultative groups with particular areas of expertise felt to be lacking in the technical working groups, were co-opted onto these to share their specific skills.

5. This report and the recommendations within it focus on review of the PCA and development of the work-focused health-related assessment. For both these areas, the legislative timetable required that a product be available for the Welfare Reform Bill's passage through Parliament, and for drafting of secondary legislation consequent upon the Bill.

6. There is further work to be done, in testing the recommended revised PCA to validate it as a fairer, more robust, and more accurate assessment of benefit entitlement. Bearing in mind that the face to face medical assessment is only part of the whole PCA process, which is one of gathering the most appropriate evidence from the most appropriate source, there is also further work to be done in the period up to implementation of the new Employment and Support Allowance, to improve evidence-gathering from claimants, their carers, and from healthcare and social care professionals involved in treating them.

II. REVIEW OF THE PERSONAL CAPABILITY ASSESSMENT

Background

7. The Personal Capability Assessment (then known as the All Work Test) was developed in the early 1990s, in preparation for the introduction of Incapacity Benefit in 1995. It was developed in consultation with panels of experts, to provide an objective and impartial assessment of functional limitation, to identify those people entitled to Incapacity Benefit because their level of functional limitation was such that it was unreasonable to expect them to seek work in the open market.

8. The current PCA assesses limitations of physical function relevant to work-related activities in relation to:

- Lower limb function
- Upper limb function
- Sensory functions (vision, speech and hearing)
- Remaining conscious
- Maintaining bowel and urinary continence

9. Each of these areas contains one or more series of descriptors of functional limitation, ranked and scored in order of the severity of their impact on the ability to carry out work-related tasks. The benefit entitlement threshold is set at a score of 15 points, from either a single descriptor, or from a combination of lesser scores. This threshold does not represent the level of functional limitation at which engaging in work is not possible; it represents the level at which it is unreasonable to expect a person to engage in work.

10. The current PCA also assesses limitations of mental function in four areas of activity:

- Coping with pressure
- Completion of tasks
- Interaction with other people
- Activities of daily living

11. Descriptors within the mental function areas are not ranked, but scored individually on a “Yes/no” basis. The benefit entitlement threshold for a mental health condition is set at a score of 10 points. There is also provision for scores to be combined and upwardly adjusted in cases where there is both mental and physical functional limitation, but which is insufficient to reach the entitlement threshold in either physical or mental function alone. A mental health score of between 6 and 9 points can be

added to a physical function score of 6 points, and the sum is treated as being equal to 15 points.

The rationale for change

12. To date the PCA remains the best assessment of its type in the world. Indeed, it has been adopted by a number of other countries, and it remains a focus of international interest. However, in the twelve or so years since its development, there have been many changes: in the prevalence of disabling conditions; in advances in medical science resulting in the availability of new and more effective medical interventions; and in the workplace environment. The Disability Discrimination Act, introduced after the PCA had been developed, has influenced the ability of employers to make reasonable adjustments to accommodate people with long term disabilities. It has also raised the expectations of disabled people that adjustments should be made to enable them to work.

13. In 1995 the most common condition resulting in entitlement to Incapacity Benefit was a musculoskeletal condition, predominantly low back pain. With significant improvements in the medical management of low back pain, we now see fewer people with back pain on long term incapacity benefits. However, we are increasingly seeing more people with a mental health problem, the most common being mild to moderate depression or anxiety, which is very amenable to therapeutic interventions. In recent years, there has also been greater awareness and recognition of people who have very significant problems with mental function, such as people with learning disability, and those with autistic spectrum disorders. In the workplace, the nature of tasks employees are required to undertake has changed, as have the skills required and expected by employers. The rapid expansion and increasing sophistication of electronic communication, with the different functional abilities required, is just one example.

14. Ten years' experience of administering the PCA has provided a basis for a critical evaluation of its effectiveness in practice. It is clear from the experience of medical assessors carrying out the test, and from the expert advice of members of the technical working groups, that the process can be improved in a number of ways:

    (i) **It is perceived as very negative: despite its name, the focus throughout is on what a person is unable to do, not what they can do.**

    (ii) **It is solely a test of benefit entitlement, and provides no information about the action needed to support a return to**

work. When the PCA was developed in the early 1990s, the objective was to create an accurate test for assessing a person's entitlement to a long-term sickness benefit. But once on benefit, there was little structured help available to support or encourage a return to work. The Pathways to Work programme has been the first step towards such an approach.

(iii) **Some of the areas of function assessed, particularly in relation to mental health problems, are not felt to be the most relevant in relation to activities needed in order to remain in or return to work.**

(iv) **The scoring system is perceived to be weighted unfairly against mental, as opposed to physical, disabling conditions.** In the physical function assessment, individual descriptors are scored at 15, 10, 9, 8, 7, 6, or 3 points. Mental health descriptors on the other hand score 1 or 2 points. So a person can meet the benefit entitlement threshold on the basis of anything between one and five physical function descriptors. But for the mental health assessment, to meet the 10 point threshold, they must score in a minimum of five mental health descriptors.

(v) **The mental health descriptors are insufficient in respect of the particular needs of people with learning disabilities and other conditions affecting cognitive and intellectual functioning.** For example, assessment of a person's ability to learn and apply understanding does not feature; and there is inadequate assessment of the social and interpersonal skills which can represent a major barrier to work for people with mental health problems, learning disability, or autistic spectrum disorder. Under the current system, a majority of people with significant learning disability or autism are treated as having satisfied the PCA without having to undergo the full process to determine their entitlement to benefit. The Government's stated intention for welfare reform is that everyone should have the right to work, and the right to support and help to enable them to do so. Therefore, for the Employment and Support Allowance reliance will be placed on the PCA to provide a more detailed and accurate assessment of mental function.

(vi) **Some of the physical function descriptors and scores are no longer regarded as being effective discriminators between those who can reasonably be required to undertake work and those who cannot.** When the PCA was devised, it was felt that there should be a level of descriptor score to distinguish between "minimal disability" and "no disability at all", for certain functional areas. Therefore, among the descriptors that make up the six

functional areas relating to lower limb function, there are seven descriptors that score 3 points:

- cannot walk more than 400 metres without stopping or severe discomfort

- cannot walk up and down a flight of 12 stairs without holding on

- can only walk up and down a flight of 12 stairs if he goes sideways or one step at a time

- cannot sit comfortably for more than one hour without having to move from the chair

- cannot stand for more than 30 minutes before needing to move around

- sometimes cannot rise from sitting to standing without holding on to something

- sometimes cannot [either, bend or kneel, or bend and kneel] as if to pick up a piece of paper off the floor and straighten up again

So, in the current PCA, it is possible for a person to meet the benefit entitlement threshold with five descriptors, each scoring 3 points. But even in aggregate, these minimal levels of disability are not considered to add up to an overall level of functional limitation at which it is unreasonable to expect a person to work. Similarly, some of the other descriptors are considered to have been weighted at a level that does not accurately represent the impact of the functional limitation on capability for work.

(vii) **The evidence-gathering process from the claimant (the IB 50 self-assessment questionnaire) needs to be revised and made more user-friendly for people with mental health conditions.** This is discussed in the later section on evidence-gathering.

(viii) **It is important to ensure further evidence is obtained when appropriate, from the most appropriate source, whether the GP, other healthcare professionals, a community worker, or a carer of the claimant.** This is discussed further in the section on evidence-gathering.

(a) REVIEW OF THE MENTAL HEALTH ASSESSMENT

15. Input to this review has come from healthcare professionals with expertise in various areas related to mental illness, cognitive and intellectual function, including expertise in learning disabilities, neurological rehabilitation, and neuropsychology. Input has also come from healthcare professionals with occupational health expertise, who have been able to relate mental health disabilities with the requirements of the workplace; and from a number of voluntary organisations with direct experience of people with mental health conditions and learning disabilities.

16. The deliberations of the mental health technical working group, in consultation with the mental health consultative group, have resulted in the following action:

- review of the areas of mental function that are relevant to the ability to engage in work, taking into account also the abilities and difficulties of people with learning disabilities or other conditions affecting cognitive and intellectual function

- a change from individually-scoring mental function descriptors and a benefit entitlement threshold of 10 points, to groups of ranked descriptors and a benefit entitlement threshold of 15 points

- recognition that the level of support or prompting a person needs, is an indicator of the severity of their functional limitation

Review of areas of mental function

17. The relevant areas of mental, cognitive, or intellectual function that have been identified are:

- learning tasks
- understanding instructions
- memory and concentration
- forward planning
- coping with change
- execution of tasks
- initiation of tasks
- appropriate behaviour with other people
- forming relationships with other people
- ability to communicate appropriately with other people
- emotional resilience
- maintaining appearance and hygiene

- coping with social situations
- panic attacks
- awareness of hazard

Scoring system

18. The mental health descriptors within each of these areas have been developed in a way that parallels the assessment of physical function. Within each area there is a series of descriptors reflecting different levels of functional limitation, each scoring 6, 9 or 15 points, with 15 points representing the benefit entitlement threshold. This system is felt to provide better parity between assessment of physical and of mental function.

Other issues

19. Both the technical working group and the consultative group have highlighted that there are other factors that form an integral part of assessment of a person's mental function, and must be taken into account:

- the "whole person" approach
- the need to consider the person's condition over a period of time
- the need to take into account detrimental effects of medication
- the need for appropriate medical evidence.

20. There is need to consider "the whole person", and to take into account the impact of mental function on physical ability, and vice versa. Healthcare professionals carrying out the PCA are trained always to consider whether there is a mental function element to the person's disabling condition. They are trained to assess mental function whenever it is appropriate, and not just in those people presenting with a mental health condition.

21. The current PCA allows for the concept that the interaction of mental and physical functional limitations results in greater disablement than the level of limitation in either area alone. Therefore in certain circumstances, subthreshold physical and mental scores can be combined, and increased to meet the benefit entitlement threshold.

22. There is no robust evidence base for the "greater disability" concept; and there is some difference of opinion as to whether subthreshold physical and mental scores should be combined and increased in this way, or whether benefit entitlement should be based on whichever aspect, physical or mental, is causing the greatest limitation of functional ability. With the proposed changes to mental function descriptors and scoring system, this approach is perhaps less appropriate. But there is unanimous

agreement that in carrying out the assessment, the “whole person impact” must be taken into consideration.

23. It is a principle of the current PCA that the assessment must not be a “snapshot” of the person on the day on which they happen to undergo the assessment. The assessment must take into account the person’s functional ability over a span of time; and the effect of conditions that fluctuate in severity over time. It will be essential to continue doing so in the revised PCA: and indeed, to pay careful attention to conditions that can cause unpredictable fluctuations over prolonged periods of time.

24. It is similarly a principle of the current PCA assessment, that the effects of symptoms such as pain or fatigue, must be taken into account in assessing a person’s level of function, as must any detrimental effects of medication; and it will be essential to continue doing so in the revised PCA.

25. The need for accurate and informative evidence from the most appropriate source is discussed later in the report, in the section on evidence-gathering.

26. The proposed new mental health assessment is detailed at **Annex A,** with the existing assessment for comparison at **Annex B**. It should be noted that the wording of the proposed descriptors is indicative only at this stage. It is not intended to represent the wording that will be laid down in legislation. The precise wording for legislative purposes will be agreed with the Department’s lawyers. The legislative wording will quantify, as far as possible, the intention behind terms such as “frequently”, “regularly”, or “occasionally”. The “Notes “ alongside the descriptors are for the purposes of this report only, to explain the underlying thinking in more detail. They have no legal status or standing.

(b) REVIEW OF THE PHYSICAL FUNCTION ASSESSMENT

27. Input to this review has come from healthcare professionals with expertise in a range of relevant disciplines, including rheumatology, general practice, neurology, occupational therapy, physiotherapy, and management of chronic pain. Some members of the technical working group had previously been involved in development of the original PCA. Members of the consultative group of stakeholders have been co-opted onto the working group to provide expert advice in certain areas.

28. The deliberations of the physical function technical working group have resulted in the following actions:

- re-focusing the physical functional areas to better reflect the activities felt to be most relevant to capability for work – those activities that an employer might reasonably expect of his workforce.

- Re-focusing descriptors and scores to identify more accurately the overall level of functional limitation at which it is unreasonable to expect a person to engage in work

- Ensuring that assessment of vision includes visual fields (peripheral vision) as well as visual acuity (central vision)

Review of areas of physical function

29. The relevant areas of physical function that have been identified are:

- mobility in a workplace environment (ability to walk, and to negotiate one or two steps)
- ability to remain in one place (ability to sit or stand)
- bending and kneeling, (as if to reach low places)
- manual dexterity (including ability to use a computer keyboard and mouse)
- picking up and moving light objects (at table top level)
- reaching upwards
- ability to communicate by speech
- hearing
- vision
- remaining continent
- remaining conscious

Scoring system

30. The scores for individual descriptors have been revised to more accurately reflect the impact of the limitation of function they represent, on the ability to engage in work. The benefit entitlement threshold remains 15 points. Individual descriptors have been allocated scores of 6, 9, or 15. The rationale for removing the lower limb function descriptors scoring 3 points has been discussed at paragraph 14(vi) above.

31. The proposed new physical function assessment is detailed at **Annex A** with the existing assessment for comparison at **Annex B**. As for the new mental function assessment, the wording of the proposed descriptors is indicative only at this stage; the precise wording will be agreed with the Department's lawyers.

(c) NEXT STEPS IN REVIEW OF THE PERSONAL CAPABILITY ASSESSMENT

32. There is work still to be done, to test the proposed new assessment in a live environment. This will be done by asking Atos Origin Medical Services doctors to complete a PCA on Incapacity Benefit claimants using the current assessment, and at the same time to complete a revised assessment. This will enable us to ensure the proposed new assessment fairly and more accurately identifies those people whose mental or physical functional limitation is such that it is unreasonable to require them to engage in work. Benefit entitlement in claimants taking part in the evaluation will be decided on the basis of the existing PCA, since this is the current test of entitlement to Incapacity Benefit.

33. Early testing of the new concepts, to validate the hypothesis that the revised assessment is a fairer, more accurate, and more robust assessment of benefit entitlement, will take place in October 2006. Following this early evaluation of fairness and accuracy of the revised PCA, we propose to carry out further, similar, comparative tests, to enable us to refine the descriptors and scores if necessary. We propose to involve members of the technical expert groups in these evaluations.

34. Full evaluation of the revised assessment will include piloting and evaluation of the revised forms for evidence gathering. This is discussed in detail later in the report.

35. An important and valuable aspect of testing the revised assessment will be to obtain customer feedback from claimants, particularly those with a mental health condition, undergoing the revised assessment. We propose to involve members of the mental health consultative group in designing this aspect of evaluation.

36. An aspect which has been suggested, but not further developed at this stage, is the concept of a single functional assessment that takes into account both physical and mental function. This proposal has a number of attractions, but would require extensive work to develop, which has not been possible in the timescale. Nevertheless, it remains worth considering as a development for the longer term.

III. REVIEW OF EVIDENCE GATHERING IN ASSOCIATION WITH THE PCA

37. The PCA process is one of gathering relevant evidence, from the most appropriate sources, to enable a comprehensive, robust, and fair assessment of a person's capability for work. Evidence can be, and is, sought from a number of sources: from the claimant, healthcare practitioners, community support workers, or carers who have detailed knowledge of the person's day to day needs. It is crucially important that evidenced is sought from the person best placed to provide it.

38. There are three strands to the review of evidence-gathering:

- review of medical certificates (Med 3 and Med 4) completed by GPs
- review of factual medical reports (IB 113)
- review of the claimant's self-assessment questionnaire (IB 50)

Review of medical certificates

39. Although by no means the only, and not necessarily always the most appropriate, source of evidence in relation to details of functional ability, GPs are in a unique position to play a vital part in their patients' wellbeing in relation to disability and work.

40. In consultation with GPs, the medical Royal Colleges, occupational health physicians, and other stakeholders, we are reviewing the content of the current medical certificates completed by GPs. Current medical certificates, particularly the Med 3 certificate of incapacity for work, frequently contain little more than a diagnosis. We want to develop certificates that will provide more detailed information; but which at the same time do not unduly increase the burden of paperwork on GPs.

41. One of the ways of reducing the number of people who are dependent on benefits, is to aim to avoid people coming on to long-term benefits in the first place. A recently published review[1], commissioned by the Department, demonstrates that not only can being out of work be harmful to health, but being in work can have positive benefits for health. Therefore we also want to use medical certification as a prompt to GPs, stimulating them to consider in all cases, whether a certificate of incapacity for work is indeed in their patient's best interests. We want them to consider alternative approaches, in consultation with the person's employer, to identify interventions that might assist the person to remain in work, or to return at the earliest opportunity.

[1] Is Work Good For Your Health and Well-being? Waddell & Burton, 2006

Review of factual medical reports

42. Factual medical reports can be of very great value in the PCA evidence-gathering process, particularly in correctly identifying those people with the most severe levels of functional limitation. Although there will be no exempt category in the new Employment and Support Allowance, it will be important to identify, on the basis of paper evidence, those people whose level of severity of functional limitation places them in the support group. It would clearly not be in anyone's best interests that people with this level of functional limitation should be asked to attend a face to face assessment.

43. Of all claimants, those where there is perhaps most need for appropriate further evidence are those with a condition affecting mental function, who may have great difficulty in accurately and effectively describing how their condition affects them.

44. In reviewing the content of factual reports, we want to ensure that they provide relevant information. The content of the report, ensuring that the information asked for is factual, that the provider will know and be able to provide, is one factor of this strand of the Transformation of the PCA Project. It is equally important to ensure that information is sought, not only from GPs, the traditional source, but also from other carers, healthcare or social care professionals when these are better placed to provide relevant information.

Review of the claimant's self-assessment questionnaire (IB 50)

45. Currently as part of evidence-gathering, claimants who are not treated as automatically having satisfied the PCA (the current "exempt" group) are asked to complete a self-assessment questionnaire, selecting those physical function descriptors that they feel best reflect their level of functional limitation. For people with mental health conditions, the IB 50 currently contains little more than a blank page asking claimants to describe their mental health problems.

46. The mental health technical group identified very early on that this approach is not appropriate for people with a mental health condition; and that a more structured, user-friendly questionnaire would be more appropriate.

47. Because the format of the IB 50 is dependent to a significant degree on the format of the PCA assessment, work has not yet begun on reviewing and revising the IB 50. We propose to begin work on this strand early in 2007, to allow time for development and testing a revised IB 50 well before implementation of the Welfare Reform Bill. We propose that this review should be carried out by members of the mental health technical

working group and consultative group, with further input from service user groups. Input already obtained from some limited service user involvement has produced some valuable insight into symptoms experienced by people with a variety of mental health conditions, and will contribute to the review.

48. Of equal importance in evidence gathering is the information gathered by healthcare professionals carrying out the PCA medical assessment. The revised mental function assessment in particular will need to be underpinned by a review of the way in which evidence is gathered from the claimant at interview. This will lead to development of revised guidance for healthcare professionals carrying out the assessment.

IV. DEVELOPMENT OF THE WORK-FOCUSED HEALTH-RELATED ASSESSMENT

49. The present PCA, other than in Pathways to Work areas, ends with the assessment to determine entitlement to Incapacity Benefit. One of the aims of welfare reform is extension of the PCA beyond entitlement to benefit based on what a person cannot do. It should also assess what a person can do, despite limitations of function; and what health or workplace interventions would help overcome any identified health-related barriers preventing a return to work. Currently in Pathways to Work areas only, a capability report is completed by the doctor carrying out the PCA, to provide information for the Personal Adviser about a claimant's residual functional ability.

50. The new work-focused health-related assessment that is being developed for the Employment and Support Allowance will provide a far more detailed report, which will be available to the Personal Adviser, to private and voluntary sector providers of condition management programmes, and to the person's GP. The new report is being developed by a group comprising occupational health experts, consultative group members, occupational psychologists, and Personal Advisers. There will be scope to pilot the new assessment, most likely in Pathways to Work areas, during 2007.

51. The principle of the assessment is to explore with the claimant, not just their residual functional ability, but their approach and attitude to returning to work. It will explore with them their motivation, their aspirations for returning to work, their self-confidence, and their perceptions about the health-related and psychological barriers facing them in relation to returning to work. It will also provide an opportunity to explore the medical treatment they are currently receiving, and whether, for example, that is causing problems such as detrimental effects of medication. It will identify other interventions that could be considered as part of a condition management programme.

52. The work-focused health-related assessment will be carried out by trained healthcare professionals. The report will be given to the Personal Adviser, who will be responsible for discussing any recommendations with the claimant, and agreeing an action plan. With the claimant's consent, a copy of the report will be sent to their GP, to ensure co-ordinated action in terms of supporting a return to work.

53. The timing of the work-focused health-related assessment (whether it should immediately follow the benefit entitlement assessment, or whether it should be carried out at a subsequent appointment) has been the subject of some concern and difference of opinion. There are advantages

to carrying it out at the same appointment: not least the convenience for the claimant of only having to attend one appointment instead of two. Any perceived conflict of interest could be managed by appropriate explanation of the different nature and purpose of the two assessments. It is normal practice for occupational physicians to consider and discuss limitations in the ability to work, and suitable interventions, at the same interview.

V. CONCLUSION AND RECOMMENDATIONS

54. Much has been achieved in a relatively short space of time. The technical working groups have made recommendations for revised physical and mental functional assessments in the PCA assessment to determine benefit entitlement; and work is well advanced in all other strands of the Transformation of the PCA Project.

55. But there is still much to do, to evaluate the revised PCA assessment, to complete the review of evidence-gathering, and to complete the development of the work-focused health-related assessment. In the longer term, consideration should be given to the feasibility of developing a single assessment incorporating both physical and mental function.

56. Our recommendations therefore are:

(i) to accept the proposals for revised PCA physical and mental functional assessments

(ii) during October 2006, to test and evaluate the revised descriptors and scores, initially to validate the hypothesis that they represent a fairer, more accurate, and more robust assessment of entitlement to benefit on the grounds of limited functional ability.

(iii) having validated the hypothesis, to carry out further testing in the early part of 2007, to make any necessary amendments to descriptors or their scores

(iv) to carry out qualitative evaluation of the revised mental function assessment with claimants during 2007

(v) to develop and pilot a revised IB 50 self-assessment questionnaire during 2007

(vi) to complete work in hand reviewing medical evidence gathering, and to pilot the proposed new medical certificates and Ib 113 factual reports during 2007

(vii) to complete work in hand developing the work-focused health-related assessment, and to pilot the assessment, during 2007

(viii) in the longer term, to consider exploring development of a combined physical and mental function PCA

Annex A – proposed revised PCA benefit entitlement assessment

1. Attached are draft versions of the proposed revised mental and physical function assessments. In reading these, it is important to remember that the wording of descriptors is indicative of the underlying intention. It is not necessarily the wording that will be laid down in legislation. The final wording, which will appear in regulations governing the PCA, will be discussed and agreed with the Department's legal advisers.

2. The Welfare Reform Bill prescribes that regulations "shall define the assessment by reference to the extent to which a person who has some specific disease or bodily or mental disablement is capable or incapable of performing such activities as may be prescribed" [2]

3. In the context of mental function the final wording of descriptors will reflect where appropriate that inability to carry out an activity may also be related to failure to do so because of a severe disorder of mood or behaviour – in other words, the person can physically carry out the activity, but is prevented from doing so by a severe disorder of mental function.

4. The notes alongside the proposed descriptors are to provide some explanation of the concepts. They have no legal standing or status. They are not representative of the comprehensive guidance that will be needed for decision makers, and for healthcare professionals carrying out the assessments.

5. In particular, guidance to decision makers and to healthcare professionals carrying out the PCA will indicate factors to be taken into account in determining whether a particular function can be carried out, for example:

    - the person must be able to reliably repeat or sustain the activity – ie being able to carry it out just once is insufficient

    - the effects of pain, fatigue, or distress involved in carrying out the activity must be taken into account

    - any detrimental effects of medication must be taken into account

6. The PCA will be carried out by healthcare professionals, trained to the standard specified by the Department, and approved on behalf of the Secretary of State to carry out such assessments. Continuing approval will be subject to the healthcare professional sustaining an acceptable standard of work

[2] Welfare Reform Bill 2006, Clause 8, subsection 2(b)

Annex A: Mental, cognitive, and intellectual function assessment

1. Learning tasks

Descriptors	Notes
Has significant difficulty learning a simple new task, or remembering a simple new task that has been learned **(15)** Has some difficulty learning a simple new task, or remembering a simple new task that has been learned **(9)** Has difficulty learning a moderately complex new task, or remembering a moderately complex new task that has been learned **(6)** None of the above apply **(0)**	This activity, which reflects ability to learn, is intended to be relevant to learning disability of whatever cause, including the result of acquired brain injury

2. Understanding instructions

Descriptors	Notes
Frequently has difficulty in understanding and carrying out simple instructions **(15)** Occasionally has difficulty in understanding and carrying out simple instructions **(9)** Has difficulty in understanding and carrying out moderately complex instructions without some support **(6)** None of the above apply **(0)**	This activity is distinct from "learning" above. "Learning" assesses the ability to learn and retain information; while "understanding" is about comprehension of information. It is intended to reflect learning disability, and also difficulties in understanding language, such as may occur in people with brain injury or other neurological conditions. The term "support" implies a greater level of support than a reasonable employer would be expected to provide to any person in employment

3. Memory and concentration

Descriptors	Notes
Very frequently forgets or loses concentration to a degree that cannot be self-managed **(15)** Frequently forgets or loses concentration to a degree that cannot be self-managed **(9)** Frequently forgets or loses concentration, but able to self-manage these lapses with pre-planning **(6)** None of the above apply **(0)**	This activity is intended to be relevant to lapses in memory or concentration due to fatigue, anxiety, depression, delusions, hallucinations, memory loss, brain injury or other condition causing neurological impairment. It also reflects difficulties with memory or concentration that result from detrimental effects of medication, such as drowsiness or sedation.

4. Forward planning

Descriptors	Notes
Cannot get to a specified place or appointment on time without daily prompting or support **(15)** Cannot get to a specified place or appointment on time, without prompting or support more than once a week, but less than daily **(9)** **C**annot get to a specified place or appointment on time without some prompting or support over a period of time **(6)** None of the above apply **(0)**	This activity is intended to reflect reliability of thinking, in a person's ability to plan and organise the activities needed for reliable timekeeping (such as getting up on time). This would include thinking which is affected by detrimental effects of medication. It is also intended to reflect inability to travel without support from another person, as a result of disorientation; or of agoraphobia causing fear of travelling unaccompanied by another person

5. Coping with change

Descriptors	Notes
Cannot cope with very minor changes in routine even if pre-planned **(15)** Cannot cope with pre-planned changes in routine **(9)** Cannot cope with small unplanned changes in routine **(6)** None of the above apply **(0)**	This activity reflects flexibility sufficient to cope with changes in normal routine. It is intended to reflect difficulties that may be encountered by people with severe learning disability, autistic spectrum disorder, brain injury, or psychotic illness

6. Execution of tasks

Descriptors	Notes
Takes twice as long as would reasonably be expected to perform and accurately complete a task **(15)** Takes up to twice as long as would reasonably be expected to perform and accurately complete a task **(9)** Takes half as long again as would reasonably be expected to perform and accurately complete a task **(6)** None of the above apply **(0)**	This activity reflects the ability to carry out a task within a reasonable time. It is intended to reflect difficulties that may be encountered by people with obsessive compulsive disorder, learning disability, or brain injury. It is also intended to reflect the impact on carrying out a task of psychotic or dissociative states such as experiencing hallucinations or delusions. It may be compounded by the effects of medication.

7. Initiation of tasks

Descriptors	Notes
Has significant difficulty in initiating and sustaining personal action (planning, or organisation, or problem solving, or prioritising, or switching tasks) without support by frequent external prompts**(15)** Has moderate difficulty in sustaining, personal action (planning, or organisation, or problem solving, or prioritising, or switching tasks) without support by regular external prompts**(9)** Has some difficulty in sustaining personal action (planning, or organisation, or problem solving, or prioritising, or switching tasks) without support by intermittent external prompts **(6)** None of the above apply **(0)**	This activity reflects the ability to sustain action without need for external prompting. It is intended to reflect difficulties that may be encountered by people with conditions such as depressive illness that result in apathy, or abnormal levels of fatigue, or abnormal levels of anxiety. It is also common in some people with schizophrenia. It may be compounded by the effects of medication.

8. Appropriate behaviour with other people

Descriptors	Notes
Has unpredictable outbursts of irritable, aggressive, disinhibited, or bizarre behaviour sufficient to frequently cause disruption **(15)** Has unpredictable outbursts of irritable, aggressive, disinhibited, or bizarre behaviour sufficient to sometimes cause disruption **(9)** Has unpredictable outbursts of irritable, aggressive, disinhibited, or bizarre behaviour sufficient to occasionally cause disruption **(6)** None of the above apply **(0)**	This activity is intended to reflect difficulties in social behaviour which might be encountered by people with psychotic or other conditions such as brain injury that result in lack of insight. It is also intended to reflect the difficulties people with autistic spectrum disorder may have in social behaviour. It is intended to reflect the effects of episodic relapsing conditions such as some types of psychotic illness, as well as conditions resulting in consistently abnormal behaviour

9. Forming relationships with other people

Descriptors	Notes
Is unaware of impact of, or is unable to control, own behaviour to the extent that has difficulty maintaining relationships with others even for brief periods; or frequently causes distress to others **(15)** Is unaware of impact of, or is unable to control, own behaviour to the extent that has difficulty maintaining relationships with others for a prolonged period; or regularly causes distress to others **(9)** Is unaware of impact of, or is unable to control, own behaviour to the extent that occasionally has difficulty maintaining relationships with others; or occasionally causes distress to others **(6)** None of the above apply **(0)**	This activity is intended to reflect difficulties in social behaviour that may be encountered by people with a variety of conditions, including autistic spectrum disorder, psychotic illness, and brain injury

10. Ability to communicate appropriately with other people

Descriptors	Notes
Frequently misinterprets or is extremely sensitive to verbal or non-verbal communication to the extent of causing significant distress to either party **(15)** Regularly misinterprets or is extremely sensitive to verbal or non-verbal communication to the extent of causing significant distress to either party **(9)** Occasionally misinterprets or is extremely sensitive to verbal or non-verbal communication to the extent of causing significant distress to either	This activity is intended to reflect difficulties that may be encountered by people with a range of disorders including psychotic illness, autistic spectrum disorder and other conditions, which affect understanding and applying social norms of communication

party **(6)** None of the above apply **(0)**	

11. Emotional resilience

Descriptors	Notes
Has a completely disproportionate reaction to minor events or to criticism to the extent that leaves the room, has a violent outburst, or threatens self-harm **(15)** Has a poor reaction to minor events or criticism, resulting in demonstrable upset and withdrawal **(9)** Shows some disproportionate reaction to minor events or to criticism, but occasional and not extreme **(6)** None of the above apply **(0)**	This activity is intended to reflect difficulties that may be encountered by people with autistic spectrum disorder and other conditions in coping with minor adverse events that would not normally be expected to cause a significant reaction

12. Maintaining appearance and hygiene

Descriptors	Notes
Unable to maintain appearance and hygiene without regular help from others **(15)** Unable to maintain appearance and hygiene without regular prompting from others **(9)** Unable to maintain appearance and hygiene without occasional prompting from others**(6)** None of the above apply **(0)**	This activity is intended to apply to people with mental or cognitive limitation of function. It is intended to reflect difficulties that may be encountered, for example, by people with learning disability, or conditions such as extreme apathy arising from depression. It includes detrimental effects of medication. It is not intended to apply to people who require assistance with hygiene due to a condition that limits physical functional ability, which is reflected as part of upper limb function

13. Coping with social situations

Descriptors	Notes
Is unable to visit new places, or engage in social contact, or express own views because of an overwhelming anxiety **(15)** Avoids visiting new places, or engaging in social contact, or expressing own views because of a consistently high level of anxiety **(9)** Avoids visiting new places, or engaging in social contact, or expressing own views because of a moderate level of anxiety **(6)** None of the above apply **(0)**	This activity is intended to reflect lack of self- confidence in social situations that is greater in its nature and its functional effects than mere shyness or reticence such as any person might experience from time to time

14. Panic attacks

Descriptors	Notes
Normal activities are disrupted by overwhelming fear and anxiety, or panic attacks, more than once a week **(15)** Normal activities are disrupted by overwhelming fear and anxiety, or panic attacks, once a week but not more**(9)** Normal activities are disrupted by overwhelming fear and anxiety, or panic attacks, once a month **(6)** None of the above apply **(0)**	This activity is intended to reflect levels of fear and anxiety that are more than fleeting moments of anxiety such as any person might experience from time to time. It is intended to reflect levels of fear and anxiety that are severe enough to disrupt normal activity.

15. Awareness of hazard

Descriptors	Notes
Reduced self-awareness, or forgetfulness, or lapses in concentration, have led to frequent instances of injury or damage from common hazards **(15)** Reduced self-awareness, or forgetfulness or lapses in concentration, have led to some instances of injury or damage from common hazards **(9)** Some risk from common hazards arising from reduced self-awareness, or forgetfulness or lapses in concentration, as evidenced by incidents of near-injury or damage **(6)** None of the above apply **(0)**	This activity is intended to reflect risks from common hazards that may be encountered by people with reduced awareness of danger through learning difficulties, or conditions affecting concentration, including detrimental effects of medication; or from brain injury or other neurological conditions affecting self-awareness

Annex A: Physical functional assessment

1. Walking, with a walking stick or other aid if such aid is normally used

Descriptors	Notes
Cannot walk more than 30 metres on level ground without repeatedly stopping or severe discomfort **(15)** Cannot walk up or down two steps even with the support of a handrail **(15)** Cannot walk more than 50 metres on level ground without stopping or severe discomfort **(9)** Cannot walk more than 200 metres on level ground without stopping or severe discomfort **(6)** None of the above apply **(0)**	This activity relates to lower limb function. It is intended to reflect the level of mobility that a person would need to have in order to be able to move reasonably within and around an indoor environment. It is not intended to take into account transport to or from that environment

2. Standing in one place, unassisted by another person, or sitting in a chair with a high back and arms

Descriptors	Notes
Cannot stand for more than 10 minutes, even if free to move around, before needing to sit down **(15)** Cannot sit for more than 10 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting **(15)** Cannot rise to standing from sitting in an upright chair without physical assistance from another person**(15)** Cannot move between one seated position and another seated position located next to one another without physical assistance from another person **(15)**	This activity relates to lower limb and back function. It is intended to reflect the need to be able to remain in one place, either sitting or standing. When standing, a person would not be expected to need to stand absolutely still, but would have freedom to move around or shift position whilst standing. Moving between adjacent seated positions is intended to reflect a wheelchair user who is unable to transfer, without help, from the wheelchair.

Cannot stand for more than 30 minutes, even if free to move around, before needing to sit down **(6)** Cannot sit for more than 30 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting **(6)** None of the above apply **(0)**	

3. Bending and kneeling

Descriptors	**Notes**
Cannot bend to touch knees and straighten up again **(15)** Cannot bend or kneel, or bend and kneel, or squat, as if to pick a light object from a low shelf, and straighten up again without the help of another person **(9)** Cannot bend or kneel, or bend and kneel, or squat, as if to pick a light object off the floor, and straighten up again without the help of another person **(6)** None of the above apply **(0)**	This activity relates to lower limb and back function. It is intended to reflect ability to reach a low level such as a low shelf, or the floor, using supports such as furniture if needed, but without dependence on another person for support to straighten up again. "As if to pick up an object" does not include the ability to manipulate the object or the ability to lift weights (these activities are covered in other areas relating to upper limb function)

4. Reaching

Descriptors	**Notes**
Cannot raise either arm as if to put something in the top pocket of a coat or jacket **(15)** Cannot raise either arm to top of head as if to put on a hat **(9)** Neither of the above applies **(0)**	This activity relates to shoulder and/or elbow function. It is intended to reflect the ability to raise the upper limbs to a level above waist level

5. Picking up and moving or transferring to a distance of 60 cm. at table-top level

Descriptors	Notes
Cannot pick up and move a one litre plastic jug full of liquid with either hand **(15)** Cannot pick up and move a two litre plastic jug full of liquid with either hand **(9)** Cannot pick up and move a light but bulky object requiring use of both hands together **(6)** None of the above apply **(0)**	This activity relates to upper limb power. It is intended to reflect the ability to pick up and transfer articles at waist level, ie at a level that requires neither bending down and lifting, nor reaching upwards (these activities are covered by other areas). It does not include the ability to carry out any activity other than picking up and transferring, ie it does not include ability to pour from a carton or jug

6. Manual dexterity

Descriptors	Notes
Cannot turn the pages of a book with either hand **(15)** Cannot turn a “star-headed” sink tap with either hand **(15)** Cannot pick up a £1 coin or equivalent with either hand **(15)** Cannot use a pen or pencil **(9)** Cannot use a conventional keyboard or mouse **(9)** Cannot do up/undo small buttons eg shirt or blouse buttons **(9)** Cannot turn a “star-headed” sink tap with one hand but can with the other **(6)** Cannot pick up a £1 coin or equivalent with one hand, but can with the other **(6)**	This activity relates to hand function. It is intended to reflect the level of ability to manipulate objects that a person would need in order to carry out work-related tasks. As with the current PCA, ability to use a pen or pencil is intended to reflect the ability to use a pen or pencil in order to make a purposive mark. It does not reflect a person’s level of literacy. The same concept applies to use of a computer keyboard. The use of the term “with either hand” is intended to take account of function in the dominant hand

Cannot pour from an open 0.5 litre carton of liquid **(6)** None of the above apply **(0)**	

7. Speech

Descriptors	Notes
Cannot speak or use language effectively to communicate **(15)** Speech cannot be understood by strangers **(15)** Strangers have great difficulty understanding speech **(9)** Strangers have some difficulty understanding speech **(6)** None of the above apply **(0)**	This activity relates to ability to communicate through speech. It assumes use of the same language as the person with whom communication is being attempted. The intention is that it would include impediment to communication resulting from a severe stammer, but not impediment from speaking with a local or regional accent. It also includes impediment to communication due to expressive dysphasia (inability to express one's thoughts) resulting from brain injury

8. Hearing with a hearing aid or other aid if normally worn

Descriptors	Notes
Cannot hear a TV set with the volume turned up sufficiently clearly to distinguish words (without looking at the screen) **(15)** Cannot understand somebody talking in a loud voice in a quiet room by hearing alone **(9)** Cannot understand someone talking in a normal voice in a quiet room by hearing alone **(6)** None of the above apply **(0)**	This activity relates to the ability to hear speech sufficiently clearly to be able to follow a conversation. It is not intended to reflect the ability to comprehend speech (this activity is covered by other areas). It is intended to take into account hearing aids if normally worn, but not non-verbal means of communication such as lip reading or use of sign language

9. Vision, including visual acuity and visual fields, in normal daylight or bright electric light, with glasses or other aid to vision if such aid is normally worn

Descriptors	Notes
Cannot see well enough to read 16 point print at a distance of greater than 20 cm **(15)** Cannot see hazards when walking, because of significant reduction of visual fields **(15)** Cannot see well enough to recognise a friend across a room at a distance of at least 5 metres **(9)** Cannot see hazards when walking, because of moderate reduction of visual fields **(6)** Cannot see well enough to recognise a friend across the road at a distance of at least 15 metres **(6)** None of the above apply **(0)**	This activity relates to visual acuity (central vision and focus) and to visual fields (peripheral vision). It is intended to reflect the activity of seeing clearly, without taking literacy into account 16 point print is intended to reflect central vision, but should be enough to allow the person to read a reasonable amount of text at a time, not just individual letters. However it does not include ability to sustain concentration while reading, or literacy "Hazards when walking" may include traffic, obstacles in his path, kerbs

10. Continence (other than enuresis)

Descriptors	Notes
Loses control of bowels so that he cannot control the full evacuation of the bowel, at least once a month **(15)** Loses control of bladder so that he cannot control the full voiding of the bladder, at least once a week **(15)** Loses control of bowels so that he cannot control the full evacuation of	This functional area implies total involuntary voiding of bowel or bladder, not just minor leakage as might occur with minor degrees of stress incontinence. It is not intended to include a properly functioning stoma or urine collecting device from which there is no leakage, but would include major leakage from a stoma or urinary collecting device

the bowel occasionally **(9)** Loses control of bladder so he cannot control the full voiding of the bladder at least once a month **(6)** Risks losing control of bowels or bladder if not able to reach a toilet quickly **(6)** None of the above apply **(0)**	

11. Remaining conscious (without having epileptic or similar seizures)

Descriptors	**Notes**
Has an involuntary episode of lost or altered consciousness, without warning, resulting in significantly disrupted awareness or concentration and consequent potential danger at least once a week **(15)** Has an involuntary episode of lost or altered consciousness, without warning, resulting in significantly disrupted awareness or concentration and consequent potential danger at least once a month **(9)** Has an involuntary episode of lost or altered consciousness, without warning, resulting in significantly disrupted awareness or concentration and consequent potential danger at least twice in six months **(6)** None of the above apply **(0)**	This functional area is intended to reflect altered consciousness which comes on with no warning, so the individual is unable to take action to avoid potential danger. It is intended to include epileptic and similar seizures, and also disrupted awareness due to conditions such as profound and unpredictable hypoglycaemic (low blood sugar) attacks in people with diabetes

Annex B – current PCA mental and physical assessment

Mental health descriptors
Completion of tasks

Descriptor	Points
Cannot answer the telephone and reliably take a message	2
Often sits for hours doing nothing	2
Cannot concentrate to read a magazine article or follow a radio or television programme	1
Cannot use a telephone book or other directory to find a number	1
Mental condition prevents them from undertaking leisure activities previously enjoyed	1
Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration	1
Agitation, confusion or forgetfulness has resulted in potentially dangerous accidents in the three months before the test is applied	1
Concentration can only be sustained by prompting	1

Daily living

Descriptor	Points
Needs encouragement to get up and dress	2
Needs alcohol before midday	2
Is frequently distressed at some time of the day due to fluctuation of mood	1
Does not care about appearance and living conditions	1

Sleep problems interfere with daytime activities	1

Coping with pressure

Descriptor	**Points**
Mental stress was a factor in making them stop work	2
Frequently feels scared or panicky for no apparent reason	2
Avoids carrying out routine activities because convinced they will prove too tiring or stressful	1
Is unable to cope with changes in daily routine	1
Frequently finds there are so many things to do that they give up because of fatigue, apathy or disinterest	1
Is scared or anxious that work would bring back or worsen their illness	1

Interaction with other people

Descriptor	**Points**
Cannot look after themselves without help from others	2
Gets upset by ordinary events and it results in disruptive behavioural problems	2
Mental problems impair ability to communicate with other people	2
Gets irritated by things that would not have bothered them before they became ill	1
Prefers to be left alone for six hours or more each day	1
Is too frightened to go out alone	1

Physical function descriptors

Walking on level ground with a walking stick or other aid if such aid is normally used

Descriptor	Points
Cannot walk at all	15
Cannot walk more than a few steps without stopping or severe discomfort	15
Cannot walk more than 50 metres without stopping or severe discomfort	15
Cannot walk more than 200 metres without stopping or severe discomfort	7
Cannot walk more than 400 metres without stopping or severe discomfort	3
Cannot walk more than 800 metres without stopping or severe discomfort	0
No walking problem	0

Walking up and down stairs

Descriptor	Points
Cannot walk up and down one stair	15
Cannot walk up and down a flight of 12 stairs	15
Cannot walk up and down a flight of 12 stairs without holding on and taking a rest	7
Cannot walk up and down a flight of 12 stairs without holding on	3
Can only walk up and down a flight of 12 stairs if he goes sideways or one step at a time	3
No problem in walking up and down stairs	0

Sitting in an upright chair with a back, but no arms

Descriptor	Points
Cannot sit comfortably	15
Cannot sit comfortably for more than 10 minutes without having to move from the chair [because the degree of discomfort makes it impossible to continue sitting.]	15
Cannot sit comfortably for more than 30 minutes without having to move from the chair [because the degree of discomfort makes it impossible to continue sitting.]	7
Cannot sit comfortably for more than 1 hour without having to move from the chair [because the degree of discomfort makes it impossible to continue sitting.]	3
Cannot sit comfortably for more than 2 hours without having to move from the chair [because the degree of discomfort makes it impossible to continue sitting	0
No problem with sitting	0

Standing without the support of another person or the use of an aid except a walking stick

Descriptor	Points
Cannot stand unassisted	15
Cannot stand for more than a minute before needing to sit down	15
Cannot stand for more than 10 minutes before needing to sit down	15
Cannot stand for more than 30 minutes before needing to sit down	7
Cannot stand for more than 10 minutes before needing to move around	7

Cannot stand for more than 30 minutes before needing to move around	3
No problem standing	0

Rising from sitting in an upright chair with a back but no arms without the help of another person

Descriptor	Points
Cannot rise from sitting to standing	15
Cannot rise from sitting to standing without holding on to something	7
Sometimes cannot rise from sitting to standing without holding on to something	3
No problem with rising from sitting to standing	0

Bending and kneeling

Descriptor	Points
Cannot bend to touch his knees and straighten up again	15
Cannot [either, bend or kneel, or bend and kneel] as if to pick up a piece of paper from the floor and straighten up again	15
Sometimes cannot [either, bend or kneel, or bend and kneel] as if to pick up a piece of paper from the floor and straighten up again.	3
No problem with bending or kneeling	0

Manual dexterity

Descriptor	Points
Cannot turn the pages of a book with either hand	15

[Cannot turn a sink tap or the control knobs on a cooker with either hand.]	15
Cannot pick up a coin which is 2.5 centimetres or less in diameter with either hand.	15
Cannot use a pen or pencil	15
Cannot tie a bow in laces or string	10
[Cannot turn a sink tap or the control knobs on a cooker with one hand, but can with the other.]	6
Cannot pick up a coin which is 2.5 centimetres or less in diameter with one hand, [but can with the other.]	6
No problem with manual dexterity	0

Lifting and [carrying by the use of the upper body and arms (excluding all other activities specified in Part I of this schedule).]

Descriptor	**Points**
Cannot pick up a paper-back book with either hand	15
Cannot pick up and carry a 0.5 litre carton of milk with either hand	15
Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity with either hand	15
Cannot pick up and carry a 2.5 kilogramme bag of potatoes with either hand	8
Cannot pick up and carry a 0.5 litre carton of milk with one hand, [but can with the other.]	6
Cannot pick up and carry a 2.5 kilogramme bag of potatoes with one hand, [but can with the other.]	0
No problem with lifting and carrying	0

Reaching

Descriptor	Points
Cannot raise either arm [as if] to put something in the top pocket of a coat or jacket	15
Cannot raise either arm to his head [as if] to put on a hat	15
Cannot put either arm behind back [as if] to put on a coat or jacket	15
Cannot raise either arm above his head [as if] to reach for some-thing	15
Cannot raise one arm to his head [as if] to put on a hat, but can with the other	6
Cannot raise one arm above his head [as if] to reach for some-thing, but can with the other	0
No problem with reaching	0

Speech

Descriptor	Points
Cannot speak	15
Speech cannot be understood by family or friends	15
Speech cannot be understood by strangers	15
Strangers have great difficulty understanding speech	10
Strangers have some difficulty understanding speech	8
No problem with speech	0

Hearing with a hearing aid or other aid if normally worn

Descriptor	Points
Cannot hear sounds at all	15
Cannot hear well enough to follow a television programme with the volume turned up	15
Cannot hear well enough to understand someone talking in a loud voice in a quiet room	15
Cannot hear well enough to understand someone talking in a normal voice in a quiet room	10
Cannot hear well enough to understand someone talking in a normal voice on a busy street	8
No problem with hearing	0

Vision in normal daylight or bright electric light with glasses or other aid to vision if such aid is normally worn

Descriptor	Points
Cannot tell light from dark	15
Cannot see the shape of furniture in the room	15
Cannot see well enough to read 16 point print at a distance greater than 20 centimetres	15
Cannot see well enough to recognise a friend across the room [at a distance of at least 5 metres.]	12
Cannot see well enough to recognise a friend across the road [at a distance of at least 15 metres]	8
No problem with vision	0

Continence [other than enuresis (bed wetting).]

Descriptor	Points
No voluntary control over bowels	15
No voluntary control over bladder	15
Loses control of bowels at least once a week	15
Loses control of bowels at least once a month	15
Loses control of bowels occasionally	9
Loses control of bladder at least once a month	3
Loses control of bladder occasionally	0
No problem with continence	0

Remaining conscious [with–out having epileptic or similar seizures during waking moments.]

Descriptor	Points
Has an involuntary episode of lost or altered consciousness at least once a week	15
Has an involuntary episode of lost or altered consciousness at least once a month	15
Has had an involuntary episode of lost or altered consciousness at least twice in the 6 months before the day in respect to which it falls to be determined whether he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage	12
Has had an involuntary episode of lost or altered consciousness once in the 6 months before the day in respect to which it falls to be determined whether he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage	8
Has had an involuntary episode of lost or altered	0

consciousness once in the 3 years before the day in respect to which it falls to be determined whether he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage

Has no problems with consciousness	0

Annex C – working group and consultative group members

Mental Health Technical Working Group

Professor Geoff Shepherd, Director of Service Improvement, Cambridgeshire and Peterborough Mental Health Trust

Dr Jed Boardman, Royal College of Psychiatrists and Sainsbury Centre for Mental Health

Dr Bob Grove, Department of Health and Sainsbury Centre for Mental Health

Miles Rinaldi, Head of Delivery, National Institute for Mental Health in England

Dr Paul Litchfield, Faculty of Occupational Medicine

Sue Godby, College of Occupational Therapists and Unum Provident

Dr Angela Graham, Atos Origin

Dr. Paul Stidolph, Department for Work and Pensions

Mia Rosenblatt, National Autistic Society

Physical Function Technical Working Group

Dr Anthony Clarke, Rheumatologist, Royal National Hospital for Rheumatological Diseases

Anne Johnson, Occupational Therapist, Royal National Hospital for Rheumatological Diseases

Dr David Henderson Slater, Consultant in Neurological Disability/Rehabilitation Medicine, Oxford Centre for Enablement

Anne Spaight, Physiotherapist, and Chair of the Disability Living Allowance Advisory Board

Dr Peter Dewis, Disability Analyst and Customer Care Director, UnumProvident

Dr Angela Graham, Atos Origin Medical Services

Dr Andy Tyerman, Consultant Clinical Neuropsychologist, Vale of Aylesbury NHS Primary Care Trust

Brigid Campbell, Social Security Advisory Committee

Andy Barrick, Royal National Institute for the Blind

Christine Jess, Disability Employment Advisory Council

Mental Health Consultative Group

MIND

MENCAP

Turning Point

SANE

DEAC

The National Autistic Society

Disability Rights Commission

Rethink

Judy Scott Consultancy

RADAR

TUC

Salford Council Welfare Rights Services

Overarching Consultative Group

Leonard Cheshire

Rethink

RNIB

RNID

Macmillan Cancer Support

MENCAP

SSAC

TUC

Disability Alliance

DEAC

SENSE

Arthritis Care

SCOPE

MIND

Citizen's Advice

Disability Rights Commission

Child Poverty Action Group [from August 2006]