Introduction to sickness and disability benefits for GPs

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Notes

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Warning! The benefit system changes regularly. This pack was produced for training purposes in February 2002. It provides an introduction to, not a full statement of, the law.

Official guidance from the Department for Work and Pensions (previously the Department of Social Security) is available online at:

www.dss.gov.uk -'information for professionals and advisers' which has various sections, the most useful being: `guides and manuals for medical practitioners'

Introduction to Sickness and Disability Benefits for GPs

INTRODUCTION: WHY BENEFITS MATTER

Why do sickness and disability benefits matter to GPs?
Sickness and disability benefits are paid to millions of people. They provide the entire weekly income for thousands of households. The rules and assessment processes can be complex.

The GP's role in assessment is important. Although not the decision maker, what the GP writes can strongly influence whether benefit is paid to or withdrawn from individual patients.

This training pack provides an outline of the key sickness and disability benefit rules. It gives an overview of the most important conditions of entitlement and assessment procedures. It explains why and how the forms/reports that GPs complete can make a real difference.

OVERVIEW: THE BENEFITS SYSTEM

Who administers the benefits system?
The Department for Work and Pensions (DWP) is responsible for the benefits system. The Acts and Regulations that govern the system are ultimately decided by Parliament.

Day to day administration of the system is devolved to agencies in central and local offices across the country. Structural reforms are currently being introduced so that benefit administration is organised in relation to peoples' prospeEts for work:

- *Jobcentre Plus* administers benefits for most people of working age - it is a combination of local Benefits Agency and Jobcentre officers

  Pensions Agency mainly administers benefits for people over retirement age or too sick/disabled to work - it is a combination of local and central Benefits Agency officers

- *Inland Revenue* administers the 'top up' payments for people in work, Working Families Tax Credit and Disabled Person's Tax Credit

- *local authorities* administer Housing Benefit, Council Tax Benefit and other local sources of help (eg free school meals)

Note: patients are likely to refer to benefit administration agencies by a variety of names. For example: DSS, DHSS, Benefits Agency, Social Security, Jobcentre, dole office.

Introduction to Sickness and Disability Benefits for GPs

What types of benefits are there?
There are various benefits for a range of circumstances which can be categorised into three groups. Tables 1 and 2 explain the three categories and list all benefits, with the benefits most important to chronically sick and disabled people highlighted in bold print. Table 3 outlines the general rules about benefits and paid work.

Table 1: **three categories of benefit**

NON MEANS TESTED, CONTRIBUTORY	NON MEANS TESTED, NON CONTRIBUTORY	MEANS TESTED, NON CONTRIBUTORY
You qualify for these benefits if: you have paid (or been credited with) the right amount of the right type of National Insurance contributions at the right time *and* you satisfy the specific rules for each benefit (It does not matter how much other income or savings you have)	You qualify for these benefits if: you satisfy the specific rules for each benefit (It does not matter how much other income or savings you have nor how many National Insurance contributions you have made)	You qualify for these benefits if: you have sufficiently low income and low capital *and* you satisfy the specific rules for each benefit (It does not matter how many National Insurance contributions you have made)

Note: the same individual or household may be entitled to *more than one benefit at the same time* if they meet the conditions of entitlement to different benefits at the same time.

Table 2: list of all benefits (sickness and disability benefits in bold print)

NON MEANS TESTED, CONTRIBUTORY	NON MEANS TESTED, NON CONTRIBUTORY	MEANS TESTED, NON CONTRIBUTORY
INCAPACITY BENEFIT	**DISABILITY LIVING ALLOWANCE**	**INCOME SUPPORT**
BEREAVEMENT BENEFITS	**ATTENDANCE ALLOWANCE**	**HOUSING BENEFIT**
RETIREMENT PENSION	**INVALID CARE ALLOWANCE**	**COUNCIL TAX BENEFIT**
MATERNITY ALLOWANCE	**INDUSTRIAL INJURIES BENEFITS**	**NHS BENEFITS**
CONTRIBUTION-BASED JOBSEEKERS ALLOWANCE	**STATUTORY SICK PAY**	**DISABLED PERSON'S TAX CREDIT**
	STATUTORY MATERNITY PAY	WORKING FAMILIES TAX CREDIT
	CHILD BENEFIT	INCOME-BASED JOBSEEKERS ALLOWANCE
	GUARDIANS ALLOWANCE	

Note: the same individual or household may be entitled to *more than one benefit at the same time* if they meet the conditions of entitlement to different benefits at the same time.

Table 3: benefits and paid work (general rules)

NON MEANS TESTED, CONTRIBUTORY					
	Incapacity Benefit	**Bereavement Benefits**	**Retirement Pension**	**Maternity Allowance**	**Contributory JSA**
Hours	None allowed – unless 'therapeutic' work (below)	No limit	No limit	None allowed – must be on maternity leave	Under 16 per week allowed
Pay	'Therapeutic' work limit of £66 per week	No limit	No limit	Varies	Limit varies
NON MEANS TESTED, NON CONTRIBUTORY					
	DLA/AA	**Invalid Care Allowance**	**Industrial Injuries Benefit**	**SSP/SMP**	**Child Ben/ Guardian's Allowance**
Hours	No limit	No limit	No limit	None allowed – must be on either sickness or maternity leave	No limit
Pay	No limit	Under £72 per week allowed	No limit	Varies	No limit
MEANS TESTED, NON CONTRIBUTORY					
	Income Support	**Housing/ Council Tax Bens**	**DPTC/ WFTC**	**Health benefits**	**Income based JSA**
Hours	Under 16 per week allowed (under 24 for partners)	No limit	Must work for at least 16 per week	No limit	Under 16 per week allowed (under 24 for partners)
Pay	Varies	Varies	Varies	Varies	Varies

Note: These rules can be complex and often vary according to an individual client's circumstances. We recommend asking an independent advice agency for expert help.

INCAPACITY FOR WORK: THE KEY TEST FOR SICKNESS BENEFITS

Which benefits require incapacity for work as a condition of entitlement?

The most important benefits claimed by patients who are incapable of work are *Incapacity Benefit* and *Income Support.* These benefits can be paid separately or in combination. Many patients also claim *Housing Benefit, Council Tax Benefit* and *health benefits* (eg free prescriptions).

How is incapacity for work assessed?

There are two tests: the 'own occupation' test and the 'personal capability assessment'. An introduction to the tests is given below and more details about the 'personal capability assessment' are included in Appendix 1.

What is the `Own Occupation Test'?

This tests whether the patient is incapable of doing the work which s/he is normally employed to do. It is generally applied during the first 28 weeks of a claim for benefit due to illness unless the patient has no regular employment, in which case the Personal Capability Assessment is applied at the start of the claim.

A self certificate is required for the first seven days and then a medical certificate (Med 3 or Med 5) from the GP. The 'own occupation' test is not usually contentious but the DWP must assess incapacity for each claim made.

What is the `Personal Capability Assessment' (PCA)?,

This tests a patient's capacity to perform a range of functional activities related to work in general. It is objective in that an individual patient's prospects of actually getting, keeping or doing a real job are not considered. Non medical factors such as age, education and past work experience are also not considered.

The test is divided into 18 *activities: 14* physical and 4 mental. Within each activity, a range of *descriptors* set out the limits of a patient's capacity to perform those activities. The descriptors range from 'no problem at all' to 'completely unable' to perform the activity. Each descriptor scores points: the more limited a person's capacity, the more points are scored.

For the physical activities, only one descriptor per activity (the highest scoring) can be counted. For mental activities, each and every descriptor that applies to a patient within the activities can be counted. Incapacity for work is accepted if a person scores enough points to reach an *incapacity threshold.* These are:

- physical activities alone - 15
- mental activities alone- 10
- combined physical/mental activities - 15

For example: physical activities - standing

Only the highest scoring descriptor that accurately reflects the limits of a patient's capacity in the activity 'standing' can be counted. For example, if a patient can only stand unaided for between 10 and 30 minutes before needing to sit down, descriptor 4) d) applies and s/he scores 7 points. On its own, this is not enough to be considered incapable of work but it can be added to other descriptors from other physical and mental activities.

Activity	Descriptors	Points
4. Standing without the support of another person or the use of an aid except a walking stick.	a) Cannot stand unassisted.	15
	b) Cannot stand for more than a minute before needing to sit down.	15
	c) Cannot stand for more than 10 minutes before needing to sit down.	15
	d) Cannot stand for more than 30 minutes before needing to sit down.	7
	e) Cannot stand for more than 10 minutes before needing to move around.	7
	f) Cannot stand for more than 30 minutes before needing to move around.	3
	g) No problem standing.	0

For example: mental activities - interaction with other people

Each and every descriptor that accurately reflects the limits of a patient's capacity in the activity 'interaction with other people' can be counted. For example, if a patient cannot look after her/himself without help and gets irritated by thingsithat would not have bothered her/him before s/he became ill, descriptors 18) a) and d) apply and s/he scores 3 points. On its own, this is not enough to be considered incapable of work but it can be added to other descriptors from other physical and mental activities.

Activity	Descriptors	Points
18. Interaction with other people.	a) Cannot look after him/herself without help from others.	2
	b) Gets upset by ordinary events and it results in disruptive behavioural problems.	2
	c) Mental problems impair ability to communicate with other people.	2
	d) Gets irritated by things that would not have bothered him/her before he became ill.	1
	e) Prefers to be left alone for 6 hours or more each day.	1
	f) Is too frightened to go out alone.	1

Note: there are more complex rules about how to aggregate the total number of points scored for the first two physical activities (walking on level ground and walking up and down stairs) and for combining physical and mental activities. See Appendix 1 for more details.

Examples PICA scores

Please refer to Appendix 1 for full details of activities, descriptors and points

1) Nazir has angina and cannot walk up and down a flight of 12 stairs without holding on and taking a rest and cannot stand without the support of a stick or another person for more than 30 minutes without needing to sit down

This means that the following activities, descriptors and points apply to him:

Activity 2, descriptor c) - 7 points
Activity 4, descriptor d) - 7 points

Total points: 14

Nazir is therefore *capable of work* because he has not reached the incapacity threshold score of 15 for physical activities alone.

2) Maureen has arthritis in her hands and cannot turn a tap or control cooker knobs with one hand. She also has a depressive illness and needs encouragement to get up and dress, does not care about her appearance and living conditions, avoids carrying out routine activities because she believes they will be too tiring or stressful, is unable to cope with changes in her daily routine and is too frightened to go out alone.

This means that the following activities, descriptors and points apply to her:

Activity 7, descriptor f) - 6 points
Activity 16, descriptor a) - 2 points
Activity 16, descriptor d) - 1 point
Activity 17, descriptor c) - 1 point
Activity 17, descriptor d) - 1 point
Activity 18, descriptor f) - 1 points
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physical activity points: 6
mental activity points: 6
Because there are both physical and mental activity scores, and the mental activity score is at least 6, the mental activity score is treated as 9 and added to the actual physical score: 9 + 6

Total points: 15

Maureen is therefore *incapable of work* because she has reached the incapacity threshold score of 15 for combined physical/mental activities.

Note: if Maureen did not have arthritis, she would not have any physical activity score. Therefore she would be *capable of work* because the incapacity threshold score for mental activities alone is 10 and Maureen would only have only scored 6 from mental activities alone.

What is the PCA procedure?
Patients with *physical/sensory* health problems complete a self assessment form. They indicate which activities are limited by selecting the descriptor that most accurately reflects the limits of their capacity to perform those activities. The form also asks about any mental health problems but does not adopt a 'tick box' approach as it does for the physical activities.

Patients with mild/moderate *mental* health problems are assessed at an interview with one of the DWP's own doctors. The same system of allocating descriptors and points to reflect the limits of capacity within the affected activities is used for mental health assessment.

A Med 4 (or Med 6) form from the GP must be submitted along with the self assessment form.

Note: if a patient fails to return the questionnaire or attend a medical examination without good cause, their benefit will generally be withdrawn.

Does everyone have to go through a PCA?
No. Some people are exempt fFom the PCA completely. It is important to supply information about patients who might be exempt (particularly people with severe mental health problems) to prevent them having to undergo the stress of a test unnecessarily (see Appendix 1).

What happens when the self assessment form has been submitted?
A DWP decision maker considers the self assessment and Med 4 forms and makes a provisional assessment of incapacity.

If this indicates capacity for work, a medical examination with a DWP doctor will be arranged and further evidence may be sought from the patient's GP (113113).

If it indicates incapacity for work, further evidence may be sought from the patient's GP (113113) or from other health professionals or the patient may be required to attend a DWP medical examination. In some cases, incapacity for work is accepted without further evidence.

The 113113 `factual report' is a *key document* that GPs are required to complete. It seeks information from the GP about the disabling effects of the patients' condition, in respect of the PCA functional activities, as explained in the above section and in Appendix 1.

What happens at a DWP medical examination?
Many patients are required to attend a medical examination by a DWP doctor. These generally take place at local examination centres but can happen in patients' own homes.

The DWP doctor should have access to the claim form and any GP reports. The DWP doctor completes a form based on the PCA's physical and mental activities and sends a report to the decision maker with advice on the patient's capacity.

Who makes the final decision?
The final decision is made by a DWP decision. maker, not the examining doctor, taking account of all relevant evidence. Notification of the decision is issued in writing to the patient who has the right to challenge this decision within one month.

Common problems and tips about incapacity for work

There are a number of common problems that affect patients and GPs in connection with the assessment of incapacity for work. These are predominantly associated with the PCA.

Failure to return the self assessment form or attend a medical examination: some patients, particularly those with mild/moderate mental health problems or learning disabilities, fail to return the forms or attend examinations. This usually results in withdrawal of benefit and immediate action is needed. Contact the DWP office concerned and refer the patient to an independent advice agency for further help. See Appendix 3.

Varying conditions - 'good' days and 'bad' days: many patients' conditions are not the same every day and their capacity to perform the PCA activities varies over time. Some patients only describe their capacities on 'good' days and underestimate their problems. Others may be tempted to present severe but occasional bouts of incapacity as if these are every day experiences. A better approach is to describe the 'bad' and 'good' days and keep a diary to show the pattern of their varying capacity over a typical period of time and submit this as evidence.

Pain, fatigue, ability to repeat, risk to health: some people may be able to perform the PCA activities but only once or only with pain or subsequent fatigue or by putting their health at further risk. It is important to explain any pain, tiredness, inability to repeat an activity or risk to health that would result from performing the PCA activities. The test must be applied reasonably and these issues are all considerations in the test of 'reasonableness'.

- *No income if fail PCA:* patients who fail their PCA may be left with no income at all. They may want to appeal against the decision but until they claim another benefit they will not be entitled to receive any payments. In most cases, they will have to 'sign on' to claim Jobseekers Allowance. Refer the patient to an independent advice agency for further help. See Appendix 3 for details.

Appealing against incapacity for work decisions: patients who fail their incapacity test may want to appeal against the decision. They must do so within one month of the date on the letter notifying them of the decision. We strongly recommend referral to an independent advice agency for further help as quickly as possible. See Appendix 3 for details.

Working while 'on sick': in general, patients who are incapable of work are not allowed to engage in paid work and receive sickness benefits at the same time. However, 'therapeutic' work (work that helps patients to rehabilitate from or to prevent an illness) and voluntary work is permitted. See next section for details.

PERMITTED WORK WHILE `ON SICK': VOLUNTARY AND THERAPEUTIC

In two circumstances, patients can remain incapable of work while actually doing some work.

Voluntary work

A volunteer is: "a person involved in voluntary work [eg with a charitable or community organisation], other than for a close relative, where the only payment received or due to be paid ... is in respect of any expenses reasonably incurred in connection with that work."

Therapeutic work

Therapeutic work is work done `on *the advice of a doctor'* and which:

- helps to improve, or to prevent or delay deterioration in, the disease or bodily or mental disablement which causes that person's incapacity for work *or*

  be part of a programme of treatment and is done under medical supervision while that person is an in-patient or regularly attending as an out-patient of a hospital or similar institution *or*

- be done while that person is attending an institution which provides sheltered work for disabled people

Note: the written support of a GP and permission from the DWP must be obtained before therapeutic work is undertaken. There is both a weekly earnings limit (£66) and a weekly hours limit (16 hours) for patients doing therapeutic work'., Proposals to reform this rule are currently out for consultation.

DISABILITY BENEFITS: DISABILITY LIVING ALLOWANCE (DLA) AND ATTENDANCE ALLOWANCE (AA)

What are DLA and AA?
They are benefits for disabled people that are intended to help meet the extra costs caused by disabilities but there is no restriction on how patients spend the money. These benefits are concerned with personal care needs and mobility problems.

It does not matter whether the patient has ever made National Insurance contributions, nor how much money they have in savings or other income and they are not required to be incapable of work. Means tested benefits and other help can be paid in addition to DLA/AA.

What are the key differences between DLA and AA?
DLA: is for people aged under 65 when they first claim. It is designed for people with personal care needs and/or mobility problems. It is one benefit made up of two `components': care and mobility. DLA must be claimed before a patient's 65th birthday but it can continue to be paid after their 65th birthday as long as they remain disabled.

A patient can qualify for either one or both of the DLA components at the same time. Both components are claimed using the same form. Each component has different rules and is paid at different rates: the care component has 3 rates, the mobility component has 2 rates. The rate paid depends on the extent of personal care needs or mobility problems.

AA: is for disabled people aged 65 or over when they first claim. It is designed for people with personal care needs only- there is no equivalent to the DLA mobility component. AA is paid at 2 rates according to the extent of personal care needs.

Summary of structure of disability benefits		
	DLA **Aged under 65 when claim**	**AA** **Aged 65+ when claim**
Care Comp	High	High
	Middle	Low
	Low	-
Mob Comp	High	-
	Low	-

What are the disability tests for DLA care component and Attendance Allowance?
The extent of personal care need is measured.against tests of the need for attention, supervision, cooking, help with renal dialysis oir terminal illness. See Appendix 2 for a full statement of the rules.

DLA Care Component and AA – summary of disability tests DLA: aged under 65 when first claim AA: aged 65 or over when first claim		
Rate	**Rule**	**Amount (pw)** 2001/2002
Low rate (DLA Care Comp *only*)	Attention in connection with bodily functions – about an hour in the day *or* (aged 16+) cooking test	£14.65
Middle rate DLA Care Comp and low rate AA	Attention in connection with bodily functions – frequently throughout day or night (not both) *or* Supervision to avoid danger – during day or night (not both) *or* renal dialysis with assistance	£37.00
High rate DLA Care Comp and high rate AA	Attention with bodily functions and/or supervision to avoid danger - both day and night *or* terminal illness	£55.30

What does `attention in connection with bodily functions' mean?
There are *seven questions* that will help you to decide if your patient needs attention in connection with their bodily functions:

1) Is your patient disabled?
This includes all types of disability: physical, sensory, learning, mental.

Example 1): she is profoundly deaf
Example 2): he suffers severe osteo-arthritis in the lower body

2) What primary bodily function/s are partially or totally impaired as a result?
Bodily functions include eating, drinking, breathing, walking, washing, seeing, hearing, un/dressing, reading, walking, sitting, getting in/out of bed, taking medication, etc.

Example 1): hearing and communication are the totally impaired, primary bodily functions
Example 2): getting up from bed or a chair or the bath, un/dressing, using the toilet and walking are all likely to be the partially impaired, primary bodily functions

3) What care is required in connection with those impaired bodily functions in order to overcome or reduce their disabling effects?
The courts say that care "is in connection with the bodily function if it provides a substitute method of providing what the bodily function would provide if it were not ...impaired."

Example 1): a signer can reduce the disabling effects of impaired communication caused by deafness by interpreting from spoken English to Sign Language and vice versa
Example 2): your patient's carer can physically help him to perform the impaired bodily functions - eg help him to get out of bed, dress, use the toilet, etc

4) Is the care required an active service of a close and personal kind?
If t'he care required is not of this nature, it cannot count as 'attention'. Most commonly attention involves physical contact but it can include the spoken word.

Example 1): interpreting and translating between your patient and other people is an active service that is close and personal
Example 2): physically helping your patient to get up, dressed, etc is close, personal and active assistance

5) Is the care given in the presence of your patient?
The carer and disabled person must generally be in each other's presence when the care is given in order to count as 'attention'.

Example 1): interpreting for someone who is deaf generally requires the disabled person and carer to be in each other's presence.
Example 2): the care provided with getting up, dressing, etc necessarily involves the carer and your patient being present at the time the care is given.
Note: however if the carer does the shopping on behalf of your patient (because he cannot get out of the house), this does not count because the carer and disabled person are too distant from each other when the care is given.

6) Is the care `reasonably required'?
The focus must be on need, not what may or may not actually be given. The key test is whether the care is "reasonably required to enable the disabled person (as far as reasonably possible) to live a normal life" and a reasonably normal life includes participation in reasonable social activities.

Example 1): help with communication is a reasonable need in a wide variety of circumstances (including social and leisure activities) on most days of a person's life.
Example 2): the range of bodily functions with which your patient needs assistance are normal activities of daily living and therefore the care is reasonably required.

7) How much care is reasonably required during the day and/or night?
Low: about an hour a day, usually all in one part of the day
Middle: either 'frequently' (= several times) at different points spread across the day or at least twice or for at least 20 minutes at night
High: satisfy both the day and night time attention tests

Example 1): your patient is likely to need help with communication at several points throughout every day but this is less likely to be needed at night.
Example 2): your patient is likely to need physical assistance at several points throughout the day and may also need lengthy or regular assistance at night (eg if he also suffers from continence problems)

What does `supervision to avoid danger' mean?
There are six *questions* to help you decide whether your patient requires supervision to reduce the risk of danger:

1) Is your patient disabled?
This includes all types of disability: physical, sensory, learning, mental.

Example 1): he suffers from mental ill health with unpredictable periods of more severe depression when he cuts and harms himself.
Example 2): she is elderly, frail and unstable on her feet when walking.

2) Is there a risk of substantial danger to your patient or to other people as a result of their disability?
The danger must be serious and reasonably likely to occur but need not actually have happened yet. It does not have to be a frequent risk to be counted - it may only need to occur once to be fatal.

Example 1): he has inflicted small cuts on himself several times and there is a realistic danger that he could cause himself more serious damage if left alone.
Example 2): she is at genuine risk of falling and seriously hurting herself.

3) Is the substantial danger one against which it is reasonably possible to protect your patient or other people at risk?
Supervision is precautionary, monitoring someone's need for help, standing in readiness to intervene when required or after more active intervention. The aim is to reduce, not necessarily eliminate, risk.

Example 1): if his carer stays with your patient and keeps an eye on him, especially watching out for his periods of more severe depression, the carer can effectively reduce the risk of serious self harm.
Example 2): if her carer accompanies your patient when walking, the risk of falling and hurting herself, or of dealing with the consequences of a fall, is effectively reduced

4) Is the risk of substantial danger predictable or not and could the disabled person avoid or deal with the risk without help?
If the risk is totally unpredictable, and the disabled person could not protect him/herself, supervision is likely to be needed. Even if the risk is predictable but the disabled person could not protect him/herself, supervision is also likely to be needed.

Example 1): during his periods of more severe depression, your patient cannot reasonably be expected to protect himself against the substantial danger of self harm without help.
Example 2): it is impossible to predict when the risk of falling will occur and your patient is likely to be too frail to cope with the consequences of a fall without help.

5) Is the supervision `reasonably required'?
The focus must be on need, not what mayor may not actually be given. The test is whether the care is "reasonably required to enable the disabled person (as far as

reasonably possible) to live a normal life" and a reasonably normal life includes participation in reasonable social activities.

Example 1): your patient reasonably requires someone to keep an eye on him, particularly as it is not possible to predict when the periods of more severe depression will occur.
Example 2): your patient could avoid all risk of falling by never attempting to walk but this would be an unreasonable restriction on her ability to lead a 'normal' life.

6) How much supervision, during the day and/or night, is required?
Middle (DLA)/low (AA): daytime supervision must be 'continual', which is less than continuous or non-stop but more than occasional or night time supervision must be by someone who is awake, watching over the disabled person for either 20 minutes in one period or several (shorter) times
High: must satisfy both day and nigh supervision tests

Example 1): your patient is likely to need day and night supervision, depending on the pattern of his depression.
Example 2): your patient is Nikely to need day time supervision and may need night time supervision if there are other problems (eg incontinence).

Is there any difference in the `attention' and supervision' tests for children under 16?
Yes. *A* child's need for supervision must not only meet the above tests but also be 'substantially in excess' of the needs of another child of the same age in good health.

Example: all babies need frequent attention in connection with their bodily functions during the day and night. This test requires evidence of the substantially increased quality and/or quantity of attention needed by a disabled baby.

What is involved in the `cooking test'?
This is a theoretical test for people aged 16 and over. It assesses a disabled person's ability to prepare a cooked main meal for him/herself on a daily basis if given the ingredients.

The meal must be a reasonable one for your culture, freshly made (eg not frozen or microwaved), labour intensive, using a normal cooker and normal kitchen facilities, without help from another person. *All* aspects of preparation (physical and mental) are relevant - eg chopping food, lifting hot pans, using cooking utensils, motivation and strength to cook and ability to do all these things with reasonable safety.

What does `terminal illness' mean?
Terminal illness is defined as suffering from a progressive disease as a result of which death can reasonably be expected in the next six months. This is referred to as claiming under the 'special rules'. It only automatically gives entitlement to the high rate DLA care component or AA - it does not give entitlement to the DLA mobility component. GPs are required to complete a DS 1500 form and return it to the Leeds Disability Benefits Centre. The claim should be dealt with within 14 days.

Note: GPs are sometimes asked to complete a DS1500 by patients who are not terminally ill. This is based on a misunderstanding about the purpose of the DS1500 process.

What are the disability tests for the DLA mobility component?
The extent of mobility problems is measured against the following tests

DLA mobility component – summary of disability tests Aged at least 5 years (low rate) or 3 years (high rate) and under 65 years when first claim		
Rate	**Rule**	**Amount (pw)** 2001/2002
Low rate	Can walk but in order to make use of ability to walk, need supervision/guidance outdoors most of the time due to physical or mental impairment (see below)	£14.65
High rate	Unable to walk *or* virtually unable to walk (see below) *or* both deaf and blind *or* have no legs/feet (all above must be due to physical cause only) *or* severely mentally impaired with severe behavioural problems and get high rate DLA care component	£38.65

What is involved in the low rate mobility component test?
This test assumes an ability to walk but assesses the disabled person's need (due to physical or mental impairment) for guidance or supervision from another person for most of the time, in order to take advantage of their ability to walk on unfamiliar routes outdoors.

For example: a patient suffering from agoraphobia may simply be unable to make use of their physical ability to walk without supervision from another person. Or it might be unreasonable to expect a patient with moderate learning disabilities to make use of their ability to walk without guidance or supervision from another person.

Supervision is precautionary, involving monitoring and readiness to intervene. Guidance involves leading or directing, by word or physical contact, to cope with obstacles in order to set or to reach a destination. The supervision or guidance on unfamiliar routes outdoors must generally enable (or're-enable') the person's walking ability.

For example: if a patient suffers a panic attack and 'freezes', another person may help them to calm down and guide them to their destination.

Is there any difference in the low rate mobility component test for children under 16?
Yes. A child's need for supervision or guidance must not only meet the above tests but also be *'substantially* in excess' of the needs of another child of the same age in good health.

For example: what quantitative and/or qualitative difference is there between a healthy 8 year old child's need for supervision or guidance when walking outdoors on unfamiliar routes, in comparison with an 8 year old child with moderate Down's Syndrome?

What does `virtually unable to walk' mean?
This test ignores the place where your patient lives or works but assesses whether:

- their ability to walk outdoors is so limited, due to a physical (not mental) impairment, that they are virtually unable to walk and considers outdoor walking ability *before the onset of severe discomfort* with regard to:
  - distance
  - speed
  - time
  - manner

- *or* whether the exertion required to walk would constitute a danger to their life or would be likely to lead to a serious deterioration in their health

Notes

- Only a *physical impairment* counts.

  There is no *set limit* of distance, time, etc to qualify for DLA mobility comp.

- *`Severe discomfort' is* very important: the distance, time, etc are measured *before* a person starts to suffer from severe discomfort as a result of walking. Walking further, while experiencing severe discomfort, does not count as part of their ability walk. There is no *definition of severe discomfort* but it may include aching, breathlessness or pain. There is no definition of 'moderate' or 'severe'.

For example: your patient suffers from emphysema causing severe breathlessness on exertion. Although he begins to suffer considerable discomfort after walking about 40 metres, he can walk about 100 metres before having to stop and sit down for a two or three minutes to regain his breath. This means that he is likely only to be able to walk for 40 metres for the purposes of the 'virtually unable to walk' test.

Introduction to Sickness and Disability Benefits for GPs

What is the procedure for assessing DLA and AA claims?

The claim forms for DLA and AA are very long. There are separate DLA forms for children under 16 and for adults under 65 and an AA form for people aged 65 and over. The forms are self assessment questionnaires to be completed by the patient, someone who knows them well and a health professional. The GP is usually asked to make a short statement about the patient's main disabling condition on section 2 of the claim form.

What happens after the claim form has been submitted?

A decision maker in the Regional Disability Benefits Centre in Leeds considers the information supplied on the form using guidance in the DWP's *Disability Handbook*. The *Disability Handbook* outlines the main care needs and mobility problems arising from a range of illnesses and impairments.

In some cases, a decision to award DLA or AA is made purely from the information on the claim form. However it is more common for the DWP to seek further information. Patients are often asked to attend a DWP doctor's medical examination. These can take place in DWP examination centres or in patients' own homes.

GPs are often asked to complete short reports about patients' care needs and/or mobility problems. These reports seek information about the disabling effects of a patient's condition on their daily activities.

Who makes the final decision?

The final decision is made by a DWP decision maker, not the doctor, taking account of all relevant evidence. Notification of the decision is issued in writing to the patient who has the right to challenge this decision within one month.

Common problems and `top tips' about the disability benefit tests

There are a number of common problems that affect patients and GPs in connection with disability benefits.

- *Claim forms:* the claim forms are very long and can deter patients from applying. Failure to complete them properly can lead to refusal. Some people are ashamed to admit the full extent of their care needs and/or mobility problems or do not have the language/literacy skills needed to explain their circumstances accurately on the form. It is particularly important to explain everything and to write as much detail as possible in order to give a true picture of a patient's personal care needs and/or mobility problems.

- *GP factual reports:* the DWP often contacts GPs for additional evidence in a factual report. The questions will vary according to the patient's condition but they are generally seeking more than a clinical diagnosis. If you do not know about the effects of disability on a patient's day to day life, it is important to seek information from someone who does know about their personal care needs and mobility problems. Alternatively, contact the DWP immediately and refer them to a more appropriate health or social care professional.

- *Mental disability:* the disability tests are most easily applied to physical impairments and it can be difficult for people with mental health problems to claim successfully. Evidence from carers, family, friends, psychiatrists, CPNs or other mental health support workers can be crucial in explaining the patient's circumstances

  Varying conditions - `good' days and `bad' days: many patients' conditions are not the same every day and their personal care needs and mobility problems vary over time. Some patients only describe their circumstances on 'good' days. Others may be tempted to present severe but occasional bouts of impairment'as if these are every day experiences. A better approach is to describe the 'bad' and 'good' days and keep a diary to show the pattern of their varying needs and problems over a typical period of time and submit this as evidence.

- *Appealing against disability benefit decisions:* patients who are unhappy with a disability benefit decision have the right to appeal. They must do so within *one month* of the date on the letter notifying the decision. We strongly recommend referral to an independent advice agency for further help as quickly as possible. See Appendix 3 for details.

CONCLUSION: FOUR KEY POINTS

1) Your evidence matters *but... you* do not make the final decision
What you write about a patient's functional capacities, personal care needs and mobility problems should be taken seriously by the DWP decision maker. But it is the DWP decision maker, not a ,doctor, who makes the final decision. They should take into account information from the patient, yourself, other health professionals and their own doctors.

2) Clinical diagnosis matters *but...* not as much as the disabling effects of a condition on a patient's daily living activities
The benefit tests for incapacity for work and DLA/AA are primarily concerned to assess the impact of illness and disability on a patient's daily living activities. Clinical diagnosis and treatment details are important but not as central to the decision whether a patient meets the conditions of entitlement for sickness and disability benefits. Remember:

- Incapacity for work is assessed by a 'functional activity' test
- DLA and AA are awarded according to the extent of personal care needed and/or mobility problems experienced

3) The assessment process tries to get it right *but...* many patients have to go to appeal to get the benefit to which they are entitled
In the past three years, official statistics show that around 50% of appeals against DWP decisions to reduce or disallow sickness and disability benefits have been successful. The chances of success increase dramatically if the patient attends the appeal hearing in person and has a representative to advocate on their behalf.

4) GPs must complete certain forms *but...* the best evidence often results from partnership working with other professionals and agencies
GPs are essential to the assessment process and are required to complete certain forms. However other health and social care professionals may also have relevant information about the disabling effects of a condition on patients' daily living activities. Independent advice agencies can act as advisers and advocates for patients who need help with forms and to challenge DWP decisions.

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APPENDIX 1: INCAPACITY FOR WORK - THE PERSONAL CAPABILITY ASSESSMENT IN DETAIL

What is the `Personal Capability Assessment' (PCA)?
The PCA tests a patient's capacity to perform a range of functional activities related to work in general. It is objective in that an individual patient's prospects of actually getting, keeping or doing a real job are not considered. Non medical factors such as age, education and past work experience are also not considered.

The PCA is divided into 18 activities: 14 physical and 4 mental. Within each activity, a range of descriptors set out the limits of a patient's capacity to perform those activities. The descriptors range from 'no problem at all' to 'completely unable' to perform the activity. The greater a patient's limits the more likely s/he is to be assessed as incapable of work. See below for details of how the test is applied.

Who is exempt from the PCA?
It is important to inform the DWP about any condition that may lead to exemption - they may not already be aware of the patient's condition. Warning! These rules may be subject to change - please check for each patient. There are four groups of exemptions:

1) People treated as incapable of work for any day they are:
   - hospital in-patients
   - under observation because of contact with, or suspicion of being a carrier of, an infectious or contagious disease and have been excluded from work by a certificate of a Medical Officer for Environmental Health
   - receiving specified treatments: plasmapheresis, radiotherapy, parenteral chemotherapy, total parenteral nutrition or weekly renal dialysis
   - pregnant, where there is a risk to health or safety of the mother or baby, or for a period 6 weeks before and 2 weeks after the birth

2) People who are:
   - terminally ill (death can be reasonably expected within six months)
   - receiving the highest rate care component of Disability Living Allowance
   - accepted as 80% disabled for Industrial Injuries Disablement Benefit
   - registered blind

3) People who have one of the following medical conditions:
   - dementia
   - tetraplegia
   - persistent vegetative state
   - paraplegia or uncontrolled involuntary movements or ataxia which effectively make the client paraplegic

4) Where there is medical evidence that the person has one of the following conditions:

- severe learning disabilities (defined as "arrested or incomplete physical development of the brain, or severe damage to the brain, which involves severe impairment of intelligence and social functioning")
- "a severe mental illness involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment"
- a severe and progressive neurological or muscle wasting disease
- an active and progressive form of inflammatory polyarthritis
- a progressive impairment of cardio-respiratory function which severely and persistently limits effort tolerance
- dense paralysis of upper limb, trunk and lower limb on one side
- multiple effects of impairment of function of the brain or nervous system causing severe and irreversible motor, sensory and intellectual deficits
- manifestations of severe and progressive immune deficiency states characterised by severe constitutional disease or opportunistic infections or tumour formation

If exempt, the patient and her/his doctor will be notified and they will not have to provide medical certificates unless the claim is reviewed. If not exempt, s/he will have to undergo the Personal Capability Assessment.

How are points scored in the PCA?
The PCA assesses a patient's capacity to perform a number of physical and mental activities. Within each physical and mental activity, a list of `descriptors' sets out the limits of a their capacity to perform the activity. These range from 'no problem at all' to `completely unable'. Each 'descriptor' scores points. The more restricted the capacity, the more points are scored.

To be incapable of work, an *incapacity threshold* score must be reached. This is either:

- 15 points from the physical activities alone or
- 10 points from the mental activities alone or
- 15 points from a combination of physical and mental activities

If a patient has combined physical/mental disabilities, any score below 6 from the mental activities test cannot be aggregated with the physical scores. However any score between 6 and 9 (inclusive) from the mental activities test is automatically treated as a score of 9 and is added to the actual score from physical activities test to give the total score.

In the physical activities test: only the highest scoring descriptor per activity is counted. This applies to all activities except the first two - walking on the flat and walking up stairs. For the two 'walking' activities, points can only be awarded for either walking on the flat or walking up stairs but not both. The highest scoring descriptor is used and added to the total score from all physical activities.

In the mental activities test: points are awarded for each and every descriptor that applies. This means that up to nine points may be awarded for each activity area.

How have the descriptors been interpreted by the courts?
There have been many legal challenges to the DWP's interpretation of the descriptors in particular cases. These challenges have been helpful in clarifying the meaning of some of the descriptors and how to approach broader issues, such as varying conditions and pain.

Varying *conditions:* many patients' capacity to perform the activities vary over time. It is important not describe their capacities only on their 'good' days. On the other hand, it is wrong to present severe but very occasional bouts of incapacity as if these are every day experiences. A better approach is to describe the 'bad' and 'good' days in detail. A diary to show the true picture of a person's variable capacity over a typical period will often be useful evidence. If a condition can go into remission for long periods of time, they may be capable of work during remission but incapable when the illness returns. It all depends on the facts.

Pain and fatigue: some patients may be able to perform the PCA activities but only while suffering pain, nausea, dizziness or subsequent fatigue. It is important to explain any such issues that would result from performing the PCA activities as the test must be applied reasonably and with regard to pain and fatigue.

Ability to repeat activities *and* risks to health: some patients may only be able to perform an activity once and be unable to repeat it or performing the activity may put their health at risk. The PCA must take account of the patients' capacity to repeat activities with reasonable regularity and should not put their health further at risk.

Physical Activities

Activity	Descriptor	Points
1. Walking on level ground with a walking stick or other aid if such aid is normally used.	a) Cannot walk at all.	15
	b) Cannot walk more than a few steps without stopping or severe discomfort.	15
	c) Cannot walk more than 50 metres without stopping or severe discomfort.	15
	d) Cannot walk more than 200 metres without stopping or severe discomfort.	7
	e) Cannot walk more than 400 metres without stopping or severe discomfort.	3
	f) Cannot walk more than 800 metres without stopping or severe discomfort.	0
	g) No walking problem.	0
2. Walking up and down stairs.	a) Cannot walk up and down one stair.	15
	b) Cannot walk up and down a flight of 12 stairs	15
	c) Cannot walk up and down a flight of 12 stairs without holding on and taking rest.	7
	d) Cannot walk up and down a flight of 12 stairs without holding on.	3
	e) Can only walk up and down a flight of 12 stairs if s/he goes sideways or one step at a time.	3
	f) No problem in walking up and down stairs.	0
3. Sitting in an upright chair with a back, but no arms.	a) Cannot sit comfortably.	15
	b) Cannot sit comfortably for more that 10 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.	15
	c) Cannot sit comfortably for more that 30 minutes without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.	7
	d) Cannot sit comfortably for more than 1 hour without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.	3
	e) Cannot sit comfortably for more than 2 hours without having to move from the chair because the degree of discomfort makes it impossible to continue sitting.	0
	f) No problem with sitting.	0

4. Standing without the support of another person or the use of an aid except a walking stick.	a) Cannot stand unassisted.	15
	b) Cannot stand for more than a minute before needing to sit down.	15
	c) Cannot stand for more than 10 minutes before needing to sit down.	15
	d) Cannot stand for more than 30 minutes before needing to sit down.	7
	e) Cannot stand for more than 10 minutes before needing to move around.	7
	f) Cannot stand for more than 30 minutes before needing to move around.	3
	g) No problem standing.	0
5. Rising from sitting in an upright chair with a back but no arms without the help of another person.	a) Cannot rise from sitting to standing.	15
	b) Cannot rise from sitting to standing without holding on to something.	7
	c) Sometimes cannot rise from sitting to standing without holding on to something.	3
	d) No problem with rising from sitting to standing.	0
6. Bending an kneeling	a) Cannot bend to touch his/her knees and straighten up again.	15
	b) Cannot either bend or kneel, or bed and kneel as if to pick up a piece of paper from the floor' and straighten up again.	15
	c) Sometimes cannot either bend or kneel, or bend and kneel as if to pick up a piece of paper form the floor and straighten up again.	3
	d) No problem with bending and kneeling.	0
7. Manual dexterity.	a) Cannot turn the pages of a book with either hand.	15
	b) Cannot turn a sink tap or the control knobs on a cooker with either hand.	15
	c) Cannot pick up a coin which is 2.5 centimetres or less in diameter with either hand.	15
	d) Cannot use a pen or pencil.	15
	e) Cannot tie a bow in laces or string.	10
	f) Cannot turn a sink tap or the control knobs on a cooker with one hand but can with the other.	6
	g) Cannot pick up a coin which is 2.5 centimetres or less in diameter with one hand but can with the other.	6
	h) No problem with manual dexterity.	0

8. Lifting and carrying by use of the upper body and arms (excluding all other -activities specified in Part 1).	a) Cannot pick up a paperback book with either hand.	15
	b) Cannot pick up and carry a 0.5 litre carton of milk with either hand.	15
	c) Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity with either hand.	15
	d) Cannot pick up and carry a 2.5 kilogramme bag of potatoes with either hand.	8
	e) Cannot pick up and carry a 0.5 litre carton of milk with one hand, but can with the other.	6
	f) Cannot pick up and carry a 2.5 kilogramme bag of potatoes with one hand, but can with the other.	0
	g) No problem with lifting and carrying.	0
9. Reaching.	a) Cannot raise either arm as if to put something in the top pocket of a coat or jacket.	15
	b) Cannot raise either arm to his/her head as if to put on a hat.	15
	c) Cannot put either arm behind back as if to put on a coat or jacket.	15
	d) Cannot raise either arm above his/her head as if to reach for something.	15
	e) Cannot raise one arm to his head as if to put on a hat, but can with the other.	6
	f) Cannot raise one arm above his/her head as if to reach for something but can with the other.	0
	g) No problem with reaching.	0
10. Speech.	a) Cannot speak.	15
	b) Speech cannot be understood by family or friends.	15
	c) Speech cannot be understood by strangers.	15
	d) Strangers have great difficulty understanding speech.	10
	e) Strangers have some difficulty understanding speech.	8
	f) No problems with speech.	0
11. Hearing with a hearing aid or other aid if normally worn.	a) Cannot hear sounds at all.	15
	b) Cannot hear well enough to follow a television programme with the volume turned up.	15
	c) Cannot hear well enough to understand someone talking in a loud voice in a quiet room.	15
	d) Cannot hear well enough to understand someone talking in a normal voice in a quiet room.	10
	e) Cannot hear well enough to understand someone talking in a normal voice on a busy street.	8
	f) No problem with hearing.	0

12. Vision in normal daylight or bright electric light with glasses or other aid to vision if such aid is normally worn.	a) Cannot tell light from dark.	15
	b) Cannot see the shape of furniture in the room	15
	c) Cannot see well enough to read 16 point print at a distance greater than 20 centimetres.	15
	d) Cannot see well enough to recognise a friend across the room at a distance of at least 5 metres.	12
	e) Cannot see well enough to recognise a friend across the road at a distance of at least 15 metres.	8
	f) No problems with vision.	0
13. Continence. (Other than enuresis bed-wetting.)	a) No voluntary control over bowels.	15
	b) No voluntary control over bladder.	15
	c) Loses control of bowels at least once a week.	15
	d) Loses control of bowels at least once a month.	15
	e) Loses control of bowels occasionally.	9
	f) Loses control of bladder at least once a month.	3
	g) Loses control of bladder occasionally.	0
	h) No problem with continence.	0
14. Remaining conscious without having epileptic or similar seizures during waking moments.	a) Has an involuntary episode of lost or altered consciousness once a day.	15
	b) Has an involuntary episode of lost or altered consciousness at least once a week.	15
	c) Has had an involuntary episode of~)ost or altered consciousness at least once a month.	15
	d) 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 s/he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage.	12
	e) Has 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 s/he is incapable of work for the purposes of entitlement to any benefit allowance or advantage.	8
	f) Has had an involuntary episode of lost or altered consciousness once in the 3 years before the day in respect to which it falls to be determined whether s/he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage	0
	g) Has no problems with consciousness	0

Mental Activities

Activity	Descrptor	Points
15. Completion of tasks	a) Cannot answer the telephone and reliably take a message.	2
	b) Often sits for hours doing nothing.	2
	c) Cannot concentrate to read a magazine article or follow a radio or television programme.	1
	d) Cannot use a telephone book or other directory to find a number.	1
	e) Mental condition prevents him/her from undertaking leisure activities previously enjoyed.	1
	f) Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration.	1
	g) Agitation, confusion or forgetfulness has resulted in potentially dangerous accidents in the 3 months before the day in respect to which it falls to be determined whether s/he is incapable of work for the purposes of entitlement to any benefit, allowance or advantage.	1
	h) Concentration can only be sustained by prompting.	1
16. Daily living	a) Needs encouragement to get up apd dress.	2
	b) Needs alcohol before midday.	2
	c) Is frequently distressed at some time of the day due to fluctuation of mood.	1
	d) Does not care about his/her appearance and living conditions.	1
	e) Sleep problems interfere with his/her daytime activities.	1
17. Coping with pressure	a) Mental stress was a factor in making him/her stop work.	2
	b) Frequently feels scared or panicky for no obvious reason.	2
	c) Avoids carrying our routine activities because s/he is convinced they will prove too tiring or stressful.	1
	d) Is unable to cope with changes in daily routine.	1
	e) Frequently finds there are so many things to do that s/he gives up because of fatigue, apathy or disinterest.	1
	f) Is scared or anxious that work would bring back or worsen his/her illness.	1

18. Interaction with other people.	a) Cannot look after him/herself without help from others.	2
	b) Gets upset by ordinary events and it results in disruptive behavioural problems.	2
	c) Mental problems impair ability to communicate with other people.	2
	d) Gets irritated by things that would not have bothered him/her before he became ill.	1
	e) Prefers to be left alone for 6 hours or more each day.	1
	f) Is too frightened to go out alone.	1

APPENDIX 2: DLA AND ATTENDANCE ALLOWANCE - THE DISABILITY TESTS IN DETAIL

DLA Care Component and Attendance Allowance
The patient must suffer from physical and/or mental disability that causes them to:

DLA Care Comp only: low rate:

- require attention in connection with their bodily functions for a significant portion of the day (usually about one hour) or
- (if aged 16 or over) be unable to prepare a cooked main meal for themselves

DLA Care Comp middle rate and AA low rate:

- require attention in connection with their bodily functions frequently throughout the day or
- require attention in connection with your bodily functions repeatedly (twice or more) or for a prolonged period (at least 20 minutes) during the night or
- require supervision to reduce the risk of danger to themselves/others continually (more than occasional but less than non-stop) during the day or

  require supervision from someone who is awake and'yvatching over them to reduce the risk of substantial danger to themselves/others during the night or
- assistance from another person (other than health service staff) when they undergo renal dialysis on a kidney machine at least twice a week

DLA Care Comp high rate and AA high rate:

- satisfy both the daytime and night time attention and/or supervision tests or
- they are terminally ill, suffering from a progressive disease and expected to die in the next six months

Children under 16 years old - extra test
A child's attention or supervision needs must meet the above tests and also be substantially in excess of the normal requirements of another child of the same age in good health

DLA Mobility Component (no equivalent for AA)

Low rate:

- the patient must suffer from a physical *or* mental impairment and, although they can walk, they cannot make use of the ability to walk without supervision or guidance from another person for most of the time when walking on unfamiliar routes outdoors

Extra test for low rate only: children at least 5 and under 16
A child's need for supervision or guidance when walking outdoors must meet the above test *and* there must also be substantially more need for supervision or guidance than for a child of the same age who is in good health

High rate: at least 3

- the patient must suffer from a physical impairment which makes them:
  - unable to walk at all or
  - virtually unable to walk without severe discomfort *or*
  - both deaf and blind *or*
  - have no legs or feet *or*
- they are severely *mentally* impaired, exhibit severe behavioural problems and receive DLA high rate care component

What does `virtually unable to walk' mean?
This test ignores the place where your patient lives or works but assesses whether:

- their ability to walk outdoors is so limited, due to a physical (not mental) impairment, that they are virtually unable to walk and considers outdoor walking ability *before the onset of severe discomfort* with regard to distance, speed, time and manner

- or whether the exertion required to walk would constitute a danger to their life or would be likely to lead to a serious deterioration in their health

What does `severely mentally impaired' with `severe behavioural problems' mean?
This is the *only* reason that a patient with a *mental impairment* can qualify for the high rate mobility component. They must suffer from:

a state of arrested development/incomplete physical development of the brain which results in severe impairment of intelligence and social functioning *and*

- be entitled to highest rate of DLA Care Component *and*

- exhibit disruptive behaviour which is extreme *and*

- this regularly requires another person to intervene and physically restrain them to prevent them causing physical injury to themselves or other people or damage to property *and*

this behaviour is so unpredictable that it requires another person to be present and watching over them whenever they are awake

APPENDIX 3: DWP TELEPHONE NUMBERS

National Benefits Enquiry Line for Disabled People:
0800 882200

Leeds Disability Benefits Centre:
0113 230 9000

National Disability Benefits Centre:
0345123456

Invalid Care Allowance Unit:
01253 856123

Local DWP offices:

Bradford area: 01274 336200

- Keighley area: 01535 617400

APPENDIX 4: INDEPENDENT ADVICE AGENCIES IN BRADFORD DISTRICT

What are independent advice agencies and what can they do to help clients?
Independent advice agencies in Bradford District are almost all voluntary sector organisations. *They are different from the* DWP. They provide advice and advocacy but they cannot award benefits.

How can you contact an independent advice agency in Bradford District?
A quick guide to independent advice agency telephone numbers in Bradford District is given on the next page.

What are the key characteristics of quality independent advice agencies?
All quality advice agencies share the following characteristics:

- operate strict confidentiality policies
- provide their services free of charge
- are independent of all statutory authorities
- offer impartial and non-judgemental advice
- promote equal opportunities policies and practices
- maintain accurate and updated client case records
- use updated information sources and train their staff in new developments
- monitor the numbers of clients, types of enquiry and levels of advice given
- seek client feedback about their services
- operate a public complaints policy
- *some* agencies are able to offer advice in community languages (please check)

What do independent advises do when they see clients?
There are three stages to giving advice:

- advisers offer clients a supportive, 'listening ear', giving them an opportunity to outline the concerns that have led them to seek help. Advisers help clients to diagnose clients' problems and focus on those with which the adviser is able to help and those for which referral to another agency will be necessary

  advisers then use their experience, local knowledge and up to date information sources to outline possible options for resolving or addressing those problems. These should be the best possible, legal options available. Clients then need time to consider their options and decide which course of action, if any, to choose

- the final stage is to take action to implement the client's chosen option. The degree to which the adviser takes action on behalf of the client will depend on the complexity of the issue, the client's ability at that time to take action for themselves and the resources (primarily time) available to the adviser

QUICK GUIDE TO INDEPENDENT ADVICE AGENCIES' TELEPHONE NUMBERS IN BRADFORD DISTRICT

CITY WIDE OR DISTRICT WIDE

- DIAL Bradford (Disability Information and Advice Line): 01274 594173
  Note: Bradford Social Services/Care Trust also commissions benefits support for users of its adult learning disabilities service

- Bradford Citizens' Advice Bureau (CAB): 01274 390170
  Note: Bradford Social Services/Care Trust also commissions benefits support for users of its mental health services

- Cancer Support: 01274 776688 or 01274 777711
  Note: North PCT commissions an outreach project for lung cancer sufferers

- Social Services Welfare Rights Team: all referrals must be made by a Social Worker and will only be made if clients receive home care or day care services from the Social Services Department

AIREDALE PCT

- Keighley Citizens' Advice Bureau (CAB): 01535 661230

  Note: Airedale PCT also commissions primary health care and mental health outreach services

- Keighley Keyhouse Project: 01535 600890

- Keighley Disabled Peoples Centre: 01535 606700

- Bangladeshi Community Association: 01535 604359

- Otley Citizens Advice Bureau (CAB): 01943 465351

NORTH PCT

- Shipley Citizens' Advice Bureau (CAB): 01274 400138/390170
  Note: North PCT also commissions primary health care and mental health outreach services

- Powerhouse Advice Project (Newlands): 01274 752587

- Windhill Advice Centre: 01274 588831/588842
- Thorpe Edge Advice Centre: 01274 620031
- Ravenscliffe Advice Centre: 01274 630800

SOUTH & WEST PCT

- Holmewood Advice Service (including Bierley and Sutton): 01274 686090
- Royds Disability Advice Service (including Woodside, Delph Hill and Buttershaw Healthy Living Centre): 01274 425305
- South Bradford Community Network (covering Odsal, Queensbury, Wyke, Great Horton and including The Willows, Sunnybank and Ridge Medical Centres): 01274 604796
- Bradford Citizens' Advice BQreau (CAB) - Allerton outreach: 01274 772185/390170
- West Bowling Advice & Training Centre: 01274 392896/733770
- Buttershaw Advice and Social Centre: 01274 674812

CITY PCT: Health Plus scheme

Bradford City PCT contracts with seven local advice agencies to deliver advice services in GP practices and Health Centres across City PCT. Health Plus advisers can help clients with:

- benefits, debt, housing, employment rights and immigration

Services are available to patients registered with the City PCT GP practices that participate in the Health Plus scheme.

All sessions are appointment based and can be arranged via the GP practice reception.

If your GP practice does not participate in the Health Plus scheme or if you would like to know more about the scheme, please contact: Airm Sadiq: 01274 424780.

Disability Living Allowance and Attendance Allowance
Case Studies

Work in groups or four or five. Which of the following people might be entitled to Attendance Allowance or the Care or Mobility Components of DLA? Give reasons for your answers.

1) Salim Malik is 12 years old and has a moderately severe Downs Syndrome. On most days, he needs someone to help him to dress and undress, to use the toilet and at night to change his bedclothes if he wets himself. His mother walks with him to school each day.

2) Melissa Barrett is 60 and recently suffered a stroke. She can walk slowly but is very unsteady on her feet. She cannot manage to do anything with her right arm or hand.

3) Peter McParland is 46 and has schizophrenia. He hears voices which tell him not to get up or wash and sometimes tell him to hurt himself. He has had various spells in hospitals because he often `obeys' the instructions from the voices in his head. He has no physical disabilities.

4) Moira McGrath is 78 and had a road traffic accident last week which has left her unable to walk at all and she now uses a wheelchair.

Incapacity for Work

Work in groups of four or five.

Think about patients aged between 16 and 65 that you have seen (or you know about). Select one patient who suffers from one of the following:

- coronary heart disease
- mental health problems
- cancer

Look at the `personal capability assessment' activities in Appendix 1 of the Training Pack and decide:

1) Which activities would that patient have limited or no capacity to perform (do not try to allocate descriptors and points, just identify the activity areas)

2) Did, or would you have had, enough information in that patient's medical records to identify the descriptor that reflects the limits of their capacity to perform that activity?

3) If not, how would you find out that information?

Introduction to Sickness and Disability Benefits for GPs

Final Quiz

1) If you can perform an activity in the `personal capability assessment', even if you cannot repeat it or performing it causes you pain, you score no points for that activity.
True or false?

2) Is a GP's medical certificate the only evidence needed to prove entitlement to incapacity benefits?

3) You can claim Disability Living Allowance (DLA) and have a full time paid job at the same time.
True or false?

4) Which of the following are conditions of entitlement for the DLA Care Component and Attendance Allowance?
   - Attention in connection with bodily functions
   - Terminal illness from which death can be expected within 6 months
   - Supervision or guidance while walking outdoors in unfamiliar places

5) You cannot claim DLA mobility component if you can walk at all.
True or false?

6) If your patient needed help with a benefit problem, where would you refer them?

- To a local independent advice agency
- To a local Jobcentre or Benefits Agency office
- To Nick Hodgkinson at Heartsmart

PERMITTED WORK WHILE `ON SICK'

Current rules:

- Voluntary work: unpaid, no hours limit

- Therapeutic work: under 16 hours per week, under £66 per week, must have GP and DWP permission in advance

New rules (from April `02):

- Three types of permitted work:

- any work, under 16 hours per week, under £66 per week, for max 26 weeks
- any work, unlimited hours, under £20 per week, for unlimited period
- `supported' work, unlimited hours, under £66 per week, for unlimited period

- Four types of `supported' work:

- Enhanced Care Programme Approach, Mental Health NSF
- Employed by social firms
- In touch with Care Co-ordinator/Employment Development Officer
- Social Services Assessment with ongoing Social Worker support