

**Health and Benefits  
Division**

## Transformation of the Personal Capability Assessment

Technical Working Group's Phase 2  
Evaluation Report

Commissioned by the Department for  
Work and Pensions

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# Executive summary

In 2006, The Department for Work and Pensions commissioned an independent Technical Working Group to carry out a review of the Personal Capability Assessment (PCA) for assessing limited capability for work.

Following publication in September 2006 of the Technical Working Group's recommendations for amending the physical and mental function assessments, an early, limited evaluation of the revised descriptors and scores was carried out. The recommendations from this early exercise were incorporated into the draft Welfare Reform regulations published in February 2007.

A further and more extensive Phase 2 evaluation has now been completed, using a larger and more representative sample of cases, subjected to both qualitative and quantitative analysis.

The outcome of quantitative analysis suggests that the revised PCA is likely to result in more customers being disallowed benefit than is currently the case. However, this outcome needs to be set against a sample size which, although larger than the Phase 1 sample, is still small in statistical terms. This fact, plus some element of difference between the sample cases and the overall population of customers having a face to face PCA assessment, means that no firm conclusions can be drawn about the overall effect of the revised PCA on disallowance rates for customers who will be claiming the new Employment and Support Allowance.

The Technical Working Group's conclusion from qualitative analysis, comparing the PCA outcome with the Group's assessment of limited capability for work based on using their own expertise, is that once some further consideration has been given to some descriptors and scores; and healthcare professionals applying the revised PCA have received full training and guidance, the revised PCA is a reliable and accurate tool for assessing limited capability for work.

The Government is committed to ongoing evaluation of the revised PCA for the first five years after its introduction.

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# 1 Introduction

1. As part of implementation of the Government's programme for welfare reform, the Department for Work and Pensions commissioned a full review of the Personal Capability Assessment (PCA) process for assessing limited capability for work. The aim of the Department's "Transformation of the PCA Project" has been to:
  - transform the process from a negatively-focused one that only assesses limitation of function, to a positive and forward-looking one that looks at the customer's future aspirations for work and the health-related interventions that might support those aspirations (through the new work-focused health-related assessment)
  - carry out a review of the sources and type of information and evidence gathered to assist the process of assessing limited capability for work (medical certification, further evidence from health care professionals and others, and the customer's self-assessment report)
  - carry out a review of the PCA descriptors and scores, to ensure the PCA remains a fair and accurate tool for assessing limited capability for work, in light of the changes that have taken place since its introduction in 1995 (changes in the prevalence of disabling conditions; in the medical management of conditions; and in the workplace environment)
2. Improving the PCA process involves all the strands of the "Transformation Project" outlined above; and it also involves other, equally important aspects. These include ensuring that health care professionals carrying out the assessment, and the Department's decision makers who determine benefit entitlement, receive appropriate training and guidance in applying the process.
3. This evaluation report only concerns the independent review that has been carried out, of the PCA descriptors and scores. Work is still ongoing on the other strands of the Project.
4. The Department commissioned an independent Technical Working Group to carry out this review, in consultation with a wider consultative group of stakeholders representing the views of disabled people. In a report published in September 2006, the independent Technical Working Group engaged to carry out the review proposed changes to the PCA that would:
  - re-focus the physical function descriptors and scores, to better reflect the activities and functional capability that a reasonable employer would expect of his workforce;
  - expand the mental function assessment to better reflect the problems of people with cognitive and intellectual impairment; and
  - change the scoring system for the mental function assessment to provide greater parity between mental and physical function assessments.

5. The Technical Working Group recommended initial evaluation of the revised assessment to validate the hypothesis that it represents a fair, accurate, and robust assessment of limited capability for work. This exercise was carried out in October 2006, and the result published in February 2007.
6. The Technical Working Group's conclusion from this early, Phase 1 evaluation was that overall they felt the revised assessment will accurately identify those customers with limited capability for work, but that further refinement of the descriptors and scores was necessary. Some areas for improvement were identified and addressed; and some adjustments made, particularly to the mental function activities and descriptors, so the assessment would more accurately reflect limited capability for work. The Group also identified the need to ensure health care professionals carrying out the assessment received appropriate training and guidance in applying it. Draft legislation reflecting the Technical Working Group's recommendations was developed by Departmental officials.
7. The report of the Phase 1 evaluation also recommended further evaluation, based on a larger and more representative sample of cases, to further validate the revised assessment and test the further adjustments that had been made to descriptors and scores.
8. This exercise, Phase 2, evaluation has now been completed. This report describes the outcome, and the further recommendations of the Technical Working Group based on this further evaluation exercise.

## 2 Methodology

9. As for Phase 1, cases used in Phase 2 evaluation were completed by Atos Healthcare (formerly Atos Origin Medical Services) doctors, experienced in carrying out PCA assessments. Participating doctors were asked to complete both current and revised PCA assessments on 212 customers claiming Incapacity Benefits and scheduled to have a face to face assessment. For Phase 2, the participating doctors were given some brief training and guidance in applying the revised PCA. This is in contrast to Phase 1 evaluation, for which the doctors deliberately received no training or guidance in applying the revised assessment.
10. The cases included a mix of customers, with the aim of providing a sample that was representative of the overall IB population. One of the criticisms of Phase 1 evaluation however, was that it did not include any customers with learning disability. Under IB legislation, many such customers are exempt from having to undergo a PCA face to face assessment, so it is relatively rare for a customer with a learning disability to present at an examination centre. For Phase 2, Atos Healthcare were therefore requested to specifically identify and include customers with learning disability.
11. Of the 212 cases in the sample:
  - 149 had conditions affecting mental function
  - 141 had conditions affecting physical function
  - 78 had conditions affecting both mental and physical function [the figures in the first two bullet points above effectively “double count” these 78 cases by counting them under both physical function and mental function]
12. Of the 149 cases with conditions affecting mental function, 12 had a learning disability. The most common mental function conditions identified, in 101 of the 149 cases, were anxiety and/or depression.

### 2.1 Qualitative evaluation

13. Evaluation was carried out by members of the Technical Working Groups, in a series of workshops held during March and April. Representatives of the PCA Consultative Group of welfare rights and other organisations representing disabled people, who had taken part in the review of the PCA, also participated in the workshops and contributed to discussion. Working in pairs, Technical Working Group members were asked to use their expertise to evaluate whether in their

opinion, and regardless of the points scored in either the current or the revised PCA, the customer had limited capability for work:

- on the grounds of a physical condition
- on the grounds of a mental condition
- or, if neither of the above applied individually, whether a combination of physical and mental conditions resulted in limited capability for work

14. Technical Working Group members were also asked to give their opinion on any issue identified relating to:

- the wording or design of individual descriptors
- overlap between functional activities
- interpretation of the revised PCA by Atos Healthcare doctors

15. All participants discussed their findings in a plenary session after each workshop; the opinions and issues raised were very similar in all five workshops held. Further discussion then took place at a full meeting of the Technical Working Group, at which the issues raised were considered, and recommendations made for addressing them. The recommendations were shared with the PCA Consultative Group at a plenary meeting of this group, attended by representatives of the Technical Working Group.

## 2.2 Quantitative evaluation

16. Quantitative evaluation was carried out by the Department's Operational Research analysts. They were provided with anonymised data on the sample cases relating to:

- age
- gender
- diagnosis (of up to three identified disabling conditions)
- points scored on individual descriptors in both the current and the revised PCA
- the Technical Working Group's opinion on limited capability for work

17. Statistical analysis was carried out to evaluate:

- The outcome of the current and revised PCA in terms of benefit entitlement
- The accuracy of the current and revised PCA in identifying limited capability for work, based on the Technical Working Group opinion
- How representative the sample cases were to the overall population of IB customers undergoing a face to face PCA assessment





### 3 Results – qualitative evaluation

18. The Technical Working Group identified those cases where the outcome of the revised PCA was at variance with their expert opinion on the customer's limited capability for work.
19. Many of the issues identified related to interpretation and application of the revised PCA by Atos Healthcare doctors. The Group considered that most of these issues could be addressed through appropriate training and guidance, and did not reflect a need to review the descriptors or scores of the revised PCA itself. Examples of these issues were:
- “Standing... even if free to move around”: guidance should explain this does not mean standing absolutely still, but takes into account normal adjusting movements that a person would make, for example while standing in a supermarket checkout queue
  - “Coping with change”: guidance should make clear that this involves the customer's subjective view of their ability to cope with change; and that distinction must be made between planned and unplanned change
  - “Prompting”: guidance should confirm that this means prompting that is required, and not necessarily just prompting that is received, by the customer
20. Specific training needs were identified in relation to:
- consistent assessment of the level of anxiety/depression
  - manifestations of psychotic symptoms in severe mental illness
  - recognising indicators of learning disability and communication difficulties
21. Customers with severe mental illness or severe learning disability are currently exempt from face to face PCA assessment for IB. Atos Healthcare doctors therefore currently have relatively little experience of assessing these conditions. For Employment and Support Allowance (ESA), all customers except those with the most severe level of functional limitation will have a face to face assessment. This is because the Government wishes to ensure that appropriate provisions for support into work are available to all customers who can take part in work-related activity. The Technical Working Group recognised that Atos Healthcare doctors and other health care professionals carrying out the revised PCA for ESA will need specific training in assessing significant mental illness and learning disability.
22. Where the Group identified that the cause of a different outcome between the revised PCA and the Group's opinion on limited capability for work was

attributable to descriptor scores, they recommended that consideration be given to reviewing individual descriptors relating to various functional activities to more accurately reflect limited capability for work:

**Walking:** the Group considered that the walking distance of 30 metres for the 15 point descriptor was too stringent. They recommended that the walking distance for the 15 point descriptor should revert from 30 metres to 50 metres; that there should be a new distance of 100 metres for the 9 point descriptor for this activity; and that the walking distance for the 6 point descriptor should remain at 200 metres

**Reaching:** the Group considered that there was need to reintroduce a descriptor relating to a person's ability to reach upwards, and recommended adding a 6 point descriptor to this effect

**Picking up and moving or transferring:** the Group considered that lifting a 2 litre jug with one hand was possibly beyond the ability of people without any disabling condition, and recommended that the 15 point descriptor be changed from 1 litre jug to 0.5 litre carton; and the 9 point descriptor from a 2 litre jug to a 1 litre carton

23. Where the Group felt that the cause of the different outcome was attributable to the way in which descriptor wording had been interpreted by Atos Healthcare doctors, they recommended that consideration be given to amending the wording of descriptors, to make the policy intent clearer; and that correct interpretation of the activities should also be covered in guidance:

**Continence:** the Group considered that the phrase “full evacuation” (of bladder or bowel) used to reflect the difference between significant incontinence and very minor leakage was being applied too stringently. They recommended considering a change in wording along the lines of “loss of control sufficient to require substantial cleaning or a change in clothing”; and that guidance should ensure clear interpretation of the intention for assessing this activity

**Remaining conscious:** the Group recommended considering modification of the wording of the descriptors, to reflect “useful” warning of an imminent seizure, not just a brief warning which did not allow time to take action to avoid danger as a result of losing consciousness. They recommended consideration should be given to including a phrase along the lines of “sufficient to avoid danger”

**Learning or comprehension in the completion of tasks:** the Group considered that the example of a “simple task” in the 15 point descriptor [“such as the preparation of a hot drink”] was being interpreted too literally in some cases. They recommended consideration be given to amending the wording of

this descriptor, together with provision of suitable examples of such tasks to be included in guidance

**Initiating and sustaining personal action:** the Group identified that customers with depression tended to underscore in the mental function assessment, because inability to initiate or sustain action due to apathy or withdrawal as a result of significant depression is not reflected in the descriptors. They recommended incorporating words along the lines of “due to cognitive problems or emotional state”, to better reflect that this activity applies to mood disorders as well as cognitive disorders. They recommended that guidance should make clear that this applies to mood disorders rather than to mild degrees of anxiety.

The Group also recommended consideration be given to changing “personal action” to something like “daily activities”; and “verbal prompting” to “assistance and encouragement”.

**Coping with social situations:** the Group considered that customers with anxiety were tending to score in several activities, all of which reflected the same functional limitation. The Group considered this was predominantly due to assessing doctors basing the assessment on diagnosis rather than on functional effects, which is a training issue. However they also recommended that consideration be given to changing the wording of the “coping with social situations” activity, to supplement training and guidance.

24. As with the recommendations made following the review of the PCA last year, the Technical Working Group recognises that its recommendations are subject to advice from the Department’s lawyers, on precise wording that is appropriate for legislative purposes

25. Other issues identified and discussed, but not requiring consideration of amendments to the revised PCA, were:

- the need to gather appropriate evidence. The Technical Working Group has repeatedly stressed that the process and quality of evidence-gathering, obtaining the right evidence from the most appropriate source, is key to carrying out a quality assessment. A number of pieces of work are taking this forward – review of medical certificates of incapacity; review of IB/ESA 113 factual reports from GPs or other primary health care workers; and review of IB/ESA 50 customer self-assessment questionnaires
- how to assess customers with manifestations of alcohol or substance abuse. The majority view is that, as for any other condition, the assessment should be based not on a diagnosis, but on the functional effects of the condition
- how to take account of hygiene problems resulting from severe self-neglect due to conditions affecting mental function. The majority view was that “maintaining hygiene” should not be a distinct activity, but should be

considered under the activity of “Dealing with other people”. This would be covered in guidance.



## 4 Results – quantitative evaluation

26. The Phase 2 sample of just over 200 cases, while significantly larger than the Phase 1 sample, is still small in statistical terms. Therefore, there is a margin of error in all the quantitative evaluation findings, which needs to be borne in mind in interpreting the likely effects of applying the revised PCA to benefit claims.

### 4.1 Outcome of current and revised PCA in terms of benefit entitlement

27. Comparing the outcome of the current and revised PCA on benefit entitlement, the indication is that once the recommended amendments have been made to descriptors and scores, and appropriate training and guidance have been delivered to the health care professionals carrying out the assessment, the revised PCA is likely to result in more customers being disallowed benefit than is currently the case. The increase in disallowance rate in the sample cases was 12 percentage points; however, the overall effect on ESA benefit customers may differ from that in the sample cases, for reasons discussed below.

28. Applying the current PCA to the 212 cases in the sample, 61% met the benefit entitlement threshold of 15 points and 39% failed to meet the threshold. Applying the revised PCA, once allowance is made for implementation of the recommendations of the Technical Working Group, 49% of customers would meet the benefit entitlement threshold, and 51% would fail to do so.

29. Not all customers claiming IB have a face to face PCA assessment. Around 40% have incapacity for work accepted on the basis of documentary evidence alone. The 60% of customers who have a face to face assessment are those who have more doubtful incapacity for work, or for whom there is no clear documentary evidence of incapacity for work.

30. The disallowance rate of 39% applying the current PCA to the cases in the sample is slightly higher than the average for all initial PCA examinations. This implies that on average, customers in the sample tended to have slightly more doubtful incapacity for work than is typical for customers undergoing IB PCA examinations. Fewer customers in the sample cases were identified at the assessment as being in a PCA exempt category, in comparison to the frequency at which an exempt category is identified in the overall population of IB

customers. This is a further indication that the sample population had slightly more doubtful incapacity

31. For ESA, all customers except those who meet the criteria for the Support Group will have a face to face PCA assessment at the time of their initial claim. With the focus in ESA on work-related activity, it will be important to have an accurate baseline of functional limitation, and a face to face assessment provides a more accurate picture than a decision based on documentary evidence.
32. This suggests that for ESA, more customers undergoing a face to face assessment will have limited capability for work, and will therefore meet the benefit entitlement threshold than is currently the case for IB customers, because we will no longer be accepting limited capability for work on the basis of documentary evidence alone unless the customer is in the support group. Therefore the outcome of the revised PCA for the current population of IB customers undergoing face to face PCA assessment is not necessarily representative of the outcome for ESA customers.

## 4.2 Accuracy of current and revised PCA in identifying limited capability for work

33. The Technical Working Group's opinion on the customer's limited capability for work was compared with the total score from the current and the revised PCA, to identify cases where either the current or the revised PCA had resulted in a false positive outcome (where the PCA identified that a customer **had** limited capability for work, but this was not the Technical Working Group's opinion) or a false negative outcome (where the PCA identified that a customer **did not** have limited capability for work, but this was not the Technical Working Group's opinion)
34. The current PCA resulted in 22 false positive outcomes (16% of the sample) and 2 false negatives (1.5% of the sample) for physical function cases. For mental function cases the figures were 12 false positive outcomes (8% of the sample) and 7 false negative outcomes (5% of the sample).
35. Initial analysis of the current and revised PCA suggested that, based on the Technical Working Group's opinion on the customer's limited capability for work, the revised PCA **reduced** the false positive outcomes but **increased** the false negative outcomes.
36. The cases which had resulted in a false **negative** outcome when the revised PCA was applied were discussed in detail by the Technical Working Group in a plenary session.

37.7 physical function cases (representing 5% of the sample) had been identified as having false negative outcomes from the revised PCA. Of these, however, the Technical Working Group identified that:

- 1 had been misidentified as having limited capability for work, when the limited capability related only to the customer's usual occupation, not to all work
- 2 were issues relating to training and guidance for doctors applying the revised PCA
- 1 arose because the doctor applying the revised PCA for the evaluation did not have the option of applying the criterion, reflected in draft legislation, that the customer should be treated as having limited capability for work despite not scoring 15 points, on the grounds that there would be a substantial risk to his health if he were found not to have limited capability for work
- **only 3 (2%) were due to issues with interpretation of the revised PCA descriptors**; and the Group had already identified and addressed these issues in its recommendations for consideration of change and/or guidance

38.12 mental function cases (representing 8% of the sample) had been identified as having false negative outcomes from the revised PCA. Of these, the Technical Working Group's findings were that:

- 8 were issues relating to training and guidance for doctors applying the revised PCA
- 1 arose because the doctor applying the revised PCA for the evaluation did not have the option of applying the criterion, reflected in draft legislation, that the customer should be treated as having limited capability for work despite not scoring 15 points, on the grounds that there would be a substantial risk to his health if he were found not to have limited capability for work
- **only 3 (2%) were due to issues with the revised PCA descriptors**; and the Group had already identified and addressed these issues in its recommendations for change (ensuring apathy and withdrawal due to depression are correctly taken into account).

39. Closer scrutiny of the cases which had resulted in a false **positive** outcome identified that **none** of these arose on account of a problem with the revised descriptors or scores.

40. Of the 4 physical function cases (representing 3% of the sample) identified as having false positive outcomes, all 4 were identified as being due to transcription errors in recording the outcome of the evaluation.

41. Of the 6 mental function cases (representing 4% of the sample) identified as having false positive outcomes:

- 2 were identified as being due to transcription errors
- 1 was the subject of a difference of opinion among Technical Working Group members who carried out the evaluation, as to whether the customer had or did not have limited capability for work

- 3 were issues relating to training and guidance for doctors applying the revised PCA

42. In summary therefore, once appropriate steps are taken to ensure correct interpretation of descriptors, and detailed training and guidance are developed for health care professionals applying the test, the revised PCA has the potential to be more accurate than the current test in correctly identifying limited capability for work, significantly reducing both false positive and false negative outcomes when compared with the current PCA.

### 4.3 How representative the sample is of the overall IB population

43. Analysis shows that there were some differences in sample cases compared to the overall IB population, which may have a small impact when considering the outcome of the revised PCA for the overall population. The main differences were that the sample cases tended to:

- be younger than the overall IB population (52% of the sample under the age of 45, compared with 39% in the overall IB population)
- include more customers with mental function problems, or with combined mental and physical function problems; but fewer customers with a primary diagnosis of anxiety/depression
- include slightly fewer customers with back pain;
- include slightly more customers with disorders of hearing or vision
- have a slightly higher overall disallowance rate on the **current** PCA
- include fewer customers who were identified at examination as being in a PCA exempt category [see paragraph 5 above]
- have lower median (average) mental function scores in the **current** PCA
- have a higher disallowance rate based on the **current** PCA mental function descriptors (53% disallowance in the sample, compared to 38% in the overall IB population)

44. In terms of interpreting how the revised PCA is likely to affect the overall population of customers claiming ESA, some of the differences suggest the sample cases may underestimate the benefit disallowance rate resulting from the revised PCA, while other differences may overestimate it. It is not possible therefore to draw any firm conclusions from this exercise, about the overall impact of the revised PCA on benefit allowance rates.

45. The differences are not large; and the comparisons between the sample cases and the overall IB population do not suggest the sample results are significantly biased. So although it is not possible to draw firm conclusions, it is reasonable to continue using the evaluation findings as working assumptions of the impact of the revised PCA on benefit entitlement outcome.

46. The differences between the sample and the overall IB population do not affect the interpretation of how the revised PCA is likely to affect customers with physical function limitations.
  
47. For the mental function assessment the differences between the sample and the overall IB population suggest that the revised PCA may result in a slightly greater increase in benefit disallowance than the evaluation indicates. However, once again there are a number of factors that may influence this possible outcome, so it is not possible to draw any firm conclusions from this evaluation. In addition, the recommended amendments to mental function descriptors would tend to increase the benefit allowance rate, by properly taking into account the effects of lack of motivation among people with a depressive illness. Provision of appropriate training for health care professionals applying the PCA will also impact on the outcome

# 5 Discussion

48. This evaluation has built on and extended the early, Phase 1 exercise. It has addressed criticisms raised about the early exercise, by:

- including a larger, more representative sample of cases
- including assessments of people with learning difficulties
- providing some training and guidance for the doctors carrying out the assessments
- more extensively evaluating the outcome of the revised PCA in terms of expert opinion on limited capability for work
- including quantitative as well as qualitative analysis
- ensuring the involvement of members of the PCA Consultative Group

49. Although Phase 2 evaluation also has its limitations, as discussed in this report, the conclusion can be drawn from it that, once further adjustments have been made, the revised PCA is a reliable and accurate tool for assessing limited capability for work. This has been the purpose and aim of the review of the PCA. It is not about making it harder for people to claim benefit. It is about ensuring that those people with limited capability for work are correctly identified. Many activities that score under the current PCA were identified as not amounting to overall limited capability to the extent that it was unreasonable to require people to work; and this has been the basis for review of physical function descriptors. On the other hand, mental function assessment has been rightly extended to better assess people with cognitive and intellectual mental function problems as well as those with mental health problems.

50. The recommendations of the Technical Working Group for adjustments to the revised PCA descriptors and scores will be considered as part of the process for finalising the draft legislation governing descriptors and scores, the final version of which is due in early 2008.

51. The Government is committed to ongoing evaluation of the revised PCA annually for the first five years following its implementation when ESA is introduced.

# 6 Summary of recommendations

## 6.1 Changes to descriptor wording or scores

### **Walking**

15 point descriptor to change to a walking distance of 50 metres, not 30 metres as at present. 9 point descriptor to change to a walking distance of 100 metres; and 6 point descriptor to remain 200 metres

### **Reaching**

A descriptor reflecting difficulty with upward reach to be reinstated

### **Picking up and moving or transferring**

15 point descriptor to change to a 0.5 litre carton, not a 1 litre jug as at present.  
9 point descriptor to change to a 1 litre carton, not a 2 litre jug as at present

### **Continence**

Consideration be given to changed wording and /or guidance for health care professionals applying the assessment, to reflect that incontinence need not be full evacuation of bowel or bladder, but must reflect sufficient loss of control to require a change of clothing or substantial cleaning

### **Remaining conscious**

Wording to change to reflect “useful” warning of impending loss of consciousness, not just “warning” as at present

### **Learning or comprehension**

Consideration be given to wording in relation to “simple tasks”, with specific examples provided in guidance

### **Initiating and sustaining personal action**

Wording to change to reflect difficulty in initiating or sustaining action due to apathy or withdrawal arising from significant depressive illness, together with appropriate guidance for health care professionals applying the assessment

Suggestion that “Personal action” to change to “daily activities” or similar; and “verbal prompting” to change to “assistance and encouragement” or similar

### **Coping with social situations**

Consideration be given to change wording from “precluded because of overwhelming fear and anxiety” to “precluded because of mental state” or similar; and guidance to reinforce that assessment must be based on functional effects, not on diagnosis

## 6.2 Other recommendations

### **Appropriate training and guidance for health care professionals applying the revised PCA**

Incorporating specific training in:

- carrying out consistent mental function assessments
- recognising and assessing manifestations of psychotic symptoms
- recognising and assessing indicators of learning disability
- recognising and assessing communication difficulties

### **The need to gather appropriate evidence**

The process and quality of evidence gathering is seen as key to carrying out a quality assessment

### **Assessment of customers with alcohol/drug abuse problems**

The majority view is that the principle should apply to these people, as to all customers, that assessment is based on the functional effects of the condition, not on the diagnosis

### **Assessment of hygiene problems resulting from conditions affecting mental function**

The majority view was that there should not be a specific activity of maintaining hygiene, but that guidance should ensure it was covered under the activity of “Dealing with other people”