

# **Guidance to Health Care Professionals Regarding the Assessment of the Degree of Relevant Disablement**

Criteria, Process and Health Care Professional  
Performance

October 2024

# Contents

<b>Version Control</b> .....	8
<b>1 Foreword</b> .....	10
<b>2 Background</b> .....	11
<b>3 Introduction</b> .....	12
<b>4 Assessment Criteria</b> .....	13
4.1 Identifying the Injury .....	13
4.2 Identifying the Damage, Disfigurement, and loss of Physical or Mental Capacity ..	14
4.3 Identifying the Disablement .....	15
4.4 Degree of Relevant Disablement .....	16
4.4.1 Assessment of Scheduled Injuries .....	16
4.4.2 Assessment of Non-scheduled Conditions/Injuries .....	17
4.4.2.1 Non-scheduled Physical Conditions/Injuries .....	18
4.4.2.2 Non-scheduled Psychological Conditions/Injuries .....	18
4.4.3 Composite Assessment .....	19
4.5 Calculating Disablement and Disablement with Other Causes .....	19
4.5.1 Relevance of Loss of Capacity .....	20
4.5.1.1 Fully Relevant Loss of Capacity .....	20
4.5.1.2 Partially Relevant Loss of Capacity .....	20
4.5.2 Combined Effect of Relevant and Non-relevant Injury .....	20
4.5.3 Pre-Existing Injuries/Conditions – “Other(Pre)” .....	21
4.5.3.1 Calculation of Disablement for an Other(Pre) Injury .....	21
4.5.4 Post Injuries/Conditions – “Other(Post)” .....	22
4.5.4.1 Calculation of Disablement for an Other(Post) Injury .....	22
4.5.5 Consequential Injuries/Conditions .....	23
4.5.6 Unconnected Injuries/Conditions .....	24
4.6 Expression of Degree of Disablement .....	24
4.7 Permanence of Disablement .....	24

4.7.1	Appropriate Clinical Management .....	24
4.7.2	Adequate Duration .....	25
4.7.3	Steady or Stable State at Maximum Medical Improvement .....	26
4.7.4	Interim Assessment .....	26
4.7.5	Date of Permanence .....	27
4.7.6	Split Assessments .....	27
<b>5</b>	<b>Assessment Process .....</b>	<b>28</b>
5.1	Assessment Forms .....	28
5.2	Initial Review.....	30
5.2.1	Medical Evidence Considered.....	30
5.2.2	Initial Review Return Form.....	31
5.2.3	Case Risk Assessment .....	31
5.2.3.1	Clinical Risk Rating .....	31
5.2.3.2	Non-clinical Risk Rating .....	32
5.2.3.3	Mitigating Risk .....	32
5.2.4	Assessment Routing .....	32
5.2.5	Prioritisation of Assessments .....	33
5.3	Identification Confirmation.....	33
5.4	Paper-Based Assessment.....	34
5.4.1	Best Endeavours .....	34
5.4.2	Posthumous Assessments.....	35
5.5	Face-to-face, Virtual and Telephone Assessment.....	35
5.5.1	Role of a Companion .....	35
5.5.2	Clinic Assessment .....	36
5.5.3	Home Assessment.....	36
5.5.4	Assessments that are non-face-to-face.....	36
5.5.4.1	Virtual .....	37
5.5.4.2	Telephone.....	37

5.6	Subjective History .....	37
5.6.1	Interview Skills and Questioning Styles.....	37
5.6.2	History of Troubles-Related Incident .....	38
5.6.3	Social and Occupational History .....	38
5.6.4	Activities of Daily Living and Mobility.....	39
5.6.5	Other Medical History .....	39
5.7	Objective Examinations .....	39
5.7.1	Musculoskeletal Examination/Neurological Examination.....	40
5.7.2	Mental State Examination/Cognitive State Examination.....	41
5.7.3	Other Examinations .....	42
5.7.3.1	Amputation Stump Length .....	42
5.7.3.2	Scars and Facial Disfigurement .....	42
5.7.3.3	Vision Test.....	43
5.7.3.4	Conversational Voice Testing .....	43
5.8	Observations.....	43
5.8.1	Specific Considerations for Virtual Assessments .....	44
5.9	Injury, Loss of Capacity, Disablement .....	45
5.10	Effect of the Relevant Damage, Disfigurement or Loss of Capacity .....	46
5.11	Assessment of Degree of Disablement and Permanence .....	47
5.12	Justification .....	48
5.12.1	Balance of Probabilities .....	49
5.12.2	Justification of Percentage Disablement .....	49
5.12.3	Evaluation and Analysis of Evidence .....	50
5.13	Medical Evidence.....	50
5.14	Circumstance Where Assessment Report Cannot be Completed .....	51
5.15	Consent .....	52
5.15.1	Proof of Consent.....	52
5.16	Capacity, Consent and Additional Support Needs.....	52

5.16.1	Overview of the capacity and consent process .....	53
5.16.2	Applicant Types .....	53
5.16.3	Legally Appointed Persons .....	53
5.16.4	Authorised Representatives .....	54
5.16.5	Applicants without assistance .....	54
5.16.6	Role of the Legally Appointed Person .....	55
5.16.7	Power of Attorney/Enduring or Lasting Power of Attorney/Controller/Deputy ..	55
5.17	Data Protection .....	56
5.18	Harmful Information .....	56
5.19	Unexpected Findings .....	57
5.20	Safeguarding .....	57
5.21	Unauthorised Recording .....	57
5.22	Note Taking .....	58
<b>6</b>	<b>Health Care Professional Performance .....</b>	<b>59</b>
6.1	Health Care Professional Standards and Principles .....	59
6.1.1	HCP Minimum Requirements.....	59
6.1.2	HCP Competencies .....	59
6.1.3	Conflict of Interest.....	60
6.2	Training.....	60
6.2.1	Initial Training .....	60
6.2.2	Continuous Professional Development .....	61
6.2.3	Training Needs Analysis .....	61
6.3	Quality Audit .....	62
6.3.1	Quality Audit Types.....	62
6.3.1.1	Approval Audit .....	62
6.3.1.2	Rolling Audit .....	62
6.3.1.3	Performance Audit .....	62
6.3.2	Actions taken following Quality Audit .....	63

6.3.2.1	Case Status for Quality Audit .....	63
6.3.2.2	Amendment of Assessment Reports .....	63
6.3.2.3	Quality Audit Feedback .....	63
6.3.3	Quality Checking Grading .....	63
6.3.3.1	“A” Grade Reports .....	63
6.3.3.2	“B” Grade Reports .....	64
6.3.3.3	“C” Grade Reports .....	64
6.3.4	Quality Audit Criteria .....	64
6.4	Approval .....	64
6.4.1	Maintenance of Approval .....	65
6.4.2	Revocation of Approval .....	65
6.4.3	Absence from Undertaking Clinical Assessment Related Work .....	66
6.5	Complaints .....	66
6.5.1	Serious Complaints .....	66
6.6	Case Reconsideration Advice .....	67
6.7	Case Rework .....	67
<b>7</b>	<b>Appendices .....</b>	<b>68</b>
7.1	Appendix A - Part 1: Schedule 2 to the Social Security (General Benefit) Regulations 1982 .....	68
7.2	Appendix B - Table of Non-Scheduled Injuries .....	72
7.3	Appendix C - Psychological Assessment Framework .....	75
7.4	Appendix D - Assessment Report Form .....	81
7.5	Appendix E - Harmful Information Form .....	91
7.6	Appendix F - Medical Factual Report .....	92
7.7	Appendix G - Initial Review Return Form .....	96
7.8	Appendix H - Case Rework/Reconsideration Advice Request Form .....	98
7.9	Appendix I - Clinical Risk Matrix .....	99
7.10	Appendix J - Identification and Verification of Applicants .....	117
7.11	Appendix K - Normal Ranges of Movement .....	118

7.12	Appendix L - Visual Loss Assessment Scale.....	120
7.13	Appendix M - Hearing Loss Assessment Scales .....	121
7.14	Appendix N - Quality Audit Criteria.....	123
7.15	Appendix O - Applicant Mental Capacity Concern Proforma and Process.....	125
7.16	Appendix P - Acknowledgements and References.....	128
7.17	Appendix Q - Abbreviations Used in this Guide.....	129

## Version Control

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29/06/21	June 2021	1.0	Original Document	Victims' Payments Board
23/08/21	September 2021	1.1	<p>Section 4.3 'examples' reworded</p> <p>MSE (section 5.7.2 headings modified</p> <p>MFR (Appendix F) 'yes/no' questions reworded. 'Priority' tick box added</p>	Victims' Payments Board
02/09/21	September 2021	1.2	Section 5.5 reworded to clarify that F2F routing is not the priority	Victims' Payments Board
04/09/23	September 2023	2.0	<p>Section 5.16 further clarifying capacity</p> <p>MFR (Appendix F) Capacity question added</p> <p>TPDPDS5 (Appendix H) rewording of the description of the reason for request</p> <p>Section 5.2.4 – routing</p> <p>Section 5.5.4.2 clarification</p> <p>Appendix O added</p>	Victims' Payments Board
17/09/2024	Sept 2024	2.1	TPDPS1 updated	Victims' Payments Board





## 1 Foreword

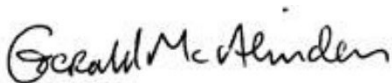
The Troubles in Northern Ireland have caused significant harm, death, divisions within society, and tension between communities for decades. Numerous political agreements have reduced the intensity of the conflict in more recent years however significant societal and political challenges remain.

Reconciliation and understanding between different elements of our community can serve as a vehicle upon which divisions might be eased. Acknowledgement of the physical and psychological harm caused during the Troubles may be one tool by which the resolution of such divisions can progress.

Over several years, countless groups and individuals have tirelessly campaigned for the implementation of a scheme which acknowledges the harm caused by the Troubles. Subsequent to this campaign, the Troubles Permanent Disablement Payment Scheme (TPDPS) was enshrined into law as a mechanism to recognise the implications of living with a disabling condition caused by the Troubles and to acknowledge the harm suffered by individuals who were injured through no fault of their own.

It gives me great pleasure to have progressed this scheme from an act of law into a tangible organisation that will serve the needs of the Victims of the Troubles. To do this, the Victims' Payments Board (VPB) is managing applications to the scheme with administrative support provided by the Department of Justice (DoJ).

Central to the scheme is the assessment, by a suitably qualified Health Care Professional, of relevant disablement; that which has been caused by a Troubles-related incident. I am pleased to publish the clinical guidance that underpins this assessment and would like to thank all individuals and organisations who have contributed to the creation and delivery of the scheme thus far.



Rt Honourable Justice McAlinden

## 2 Background

The Belfast/Good Friday Agreement (1998) recognised the enduring physical and psychological impact of the Troubles on Victims and Survivors and committed never to forget the needs of those who died or were injured, and their families:

*“The tragedies of the past have left a deep and profoundly regrettable legacy of suffering. We must never forget those who have died or been injured, and their families. But we can best honour them through a fresh start, in which we firmly dedicate ourselves to the achievement of reconciliation, tolerance, and mutual trust, and to the protection and vindication of the human rights of all”.*

The 2014 Stormont House Agreement made a commitment to:

*“seek an acceptable way forward on the proposal for a pension for severely physically injured victims in Northern Ireland”.*

Subsequently, the Stormont House Implementation Group was established by the Northern Ireland Executive to oversee the outworking of the Agreement including progressing the pension proposal. A draft consultation paper was developed which included recommendations from a comprehensive advice paper drawn up by the Commission for Victims and Survivors (CVS) in 2014. At an early stage, consideration was given to addressing the pension needs not just of those who were physically injured but also the psychologically injured.

In January 2020 the Victims’ Payments Regulations 2020 (the 2020 Regulations) were published<sup>1</sup>. On 24<sup>th</sup> August 2020 the Northern Ireland Executive Office (TEO) designated the Department of Justice (DoJ) to administer the scheme. The Troubles Permanent Disablement Payment Scheme (TPDPS) opened for applications on 31<sup>st</sup> August 2021 from those living with permanent physical or psychological injury caused by a Troubles-related incident (TRI) and posthumous applications.

The purpose of the scheme is to acknowledge the harm suffered by those injured in the Troubles and promote reconciliation between people in connection with Northern Ireland’s troubled past. Underpinning the delivery of the TPDPS are several principles to which the Victims’ Payment Board (VPB) and all agents of the VPB must have regard. These are:

- a) The need to prioritise, and be responsive to, the needs of Victims of TRIs.
- b) The need to be transparent and to communicate effectively with the public and Victims of TRIs.
- c) The need for the Scheme to be straightforward and simple to navigate.
- d) The need for applications to be determined without delay.
- e) The need for personal data to be handled sensitively.

In addition to these principles, a key concept within the TPDPS is the need to determine the level of permanent disablement caused by a TRI, as assessed by a Health Care Professional (HCP).

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<sup>1</sup> The 2020 Regulations have been amended by The Victims’ Payments Regulations 2020 and The Victims’ Payments Regulations 2023

### **3 Introduction**

The 2020 Regulations establish the TPDPS, a body corporate, to govern the VPB whilst the administrative functions of the VPB are carried out by the Department of Justice (DoJ). As part of their role, the VPB is legislatively required to ensure guidance is issued to HCPs regarding the assessment of the degree of relevant disablement.

This document contains the clinical guidance upon which the determination of percentage disablement and permanence must be considered. It should not replace, but instead is to be read in conjunction with, the 2020 Regulations (as amended). The guidance is part of a wider suite of training materials and resources delivered to HCPs before they complete clinical assessments and it is available to practitioners throughout their career as TPDPS clinical assessors.

The guidance assumes a level of clinical understanding about conditions and injuries, as HCPs should be experienced practitioners, with knowledge of a wide range of diagnoses and their possible disabling ramifications. Therefore, such information is not contained within this guide.

Although the guidance may be of interest to non-clinical readers, it is acknowledged that some of the information may not be readily understood without background medical knowledge and an awareness of disability assessment.

There are three parts to the TPDPS clinical assessment guide. Each section focuses on a different part of the process as noted below:

Section Four – The Assessment Criteria

Section Five – The Assessment Process

Section Six – Health Care Professional Performance

The Assessment Guide provides the HCP with guidance on the various assessment routes and how report forms should be completed. It also provides guidance on practical and procedural matters, as well as the role of HCPs, and quality assurance mechanisms.

## 4 Assessment Criteria

From a clinical perspective, an applicant must have a permanent disablement arising from an injury caused by a TRI, and the level of relevant disablement must be assessed at 14 percent or higher by the HCP in order to be considered by the VPB as clinically eligible for the scheme.

To facilitate the determination of permanence and identify the relevant percentage disablement, there must be a causal link between the TRI, the injury, and the resulting disablement by considering and defining:

1. The injury.
2. If this has resulted in damage, disfigurement, or loss of physical or mental capacity.
3. If this has caused disablement.
4. The overall degree of disablement.
5. The percentage relating to disablement with other causes.
6. The relevant percentage disablement due to TRI.
7. Whether the injury and percentage disablement are determined to be permanent or are likely to change.

This section of the assessment guide will explore each of the above steps in a sequential manner.

### 4.1 Identifying the Injury

Within the 2020 Regulations, the following definitions apply:

*“Disablement” means damage, disfigurement and loss of physical or mental capacity resulting from **injury**, and “disabled” shall be construed accordingly’.*

*“Permanent”, in relation to disablement, means where, following appropriate clinical management of adequate duration, an **injury** has reached a steady or stable state at maximum medical improvement’.*

Although “injury” is not defined in the 2020 Regulations themselves, that term is defined in the enabling legislation (the Northern Ireland (Executive Formation etc) Act 2019), therefore, it has the same meaning as in that Act. Section 10(11) of that Act defines “injury” as “any illness or injury (whether physical or mental)”.

The term diagnosis refers to the identification of an illness or injury following history taking (asking a person for an account of their experiences and the impact of these upon them), an examination (both physical examination and a mental state examination), and testing when relevant.

Diagnostic processes apply specific criteria to symptoms, signs, and medical tests to attribute a specific diagnosis to an illness or injury. Whilst some diagnostic processes comment on function and disability, most do not.

The purpose of the clinical assessment completed by the HCP is not to make a diagnosis but to assess the disablement attributable to the relevant injury.

Some applicants will have been diagnosed with a specific illness or injury prior to their application. Any previous diagnosis will inform the process and will be utilised by the HCP. Sometimes there will be a very clear diagnosis in the medical records, which may have been made by a consultant psychiatrist or a clinical psychologist. On other occasions there will be clear evidence in the records that a person has received support and treatment on the basis of a “working diagnosis”. A working diagnosis is frequently made as part of a treating practitioner’s clinical reasoning process after the practitioner first considers a list of differential or possible diagnoses. After a period of assessment, a working diagnosis is made from this list; the working diagnosis is the option considered most likely to explain a person’s illness or injury when all factors are taken into consideration. If the working diagnosis is relatively certain,

treating practitioners often use this as the basis for treatment. If the outcome of treatment means there is no need for further investigation or another opinion, a working diagnosis is considered to have been successfully applied and utilised. A working diagnosis, therefore, can be considered as evidence of an “injury” in the context of the Scheme.

For the purposes of the Scheme the confirmation of a working diagnosis and treatment thereof must be confirmed in existing medical evidence (that is, it can be clearly confirmed from one or more entries in the medical records) or in writing by a treating practitioner regulated by the General Medical Council (GMC), Nursing and Midwifery Council (NMC), or Health and Care Professions Council (HCPC). Confirmation of a diagnosis may also be given by a registered social worker. International applicants may have their diagnosis or working diagnosis confirmed by a professional with equivalent regulatory status in their country of residence. The assessment provider (AP) is not mandated to confirm the veracity of the regulatory status of the treating practitioner providing evidence of diagnosis or working diagnosis. Any such professional providing this advice should have knowledge or experience in the specific scope of practice under consideration.

It should also be noted that diagnostic procedures, guidelines, criteria, and standards have changed significantly in the period considered within this Scheme (1966-2010). This will result in certain complications when seeking to determine a diagnosis or a working diagnosis. Evidence of a diagnosis or working diagnosis made historically may be provided in support of an application and will be considered appropriately.

It is not within the remit of the HCP completing the disablement assessment to make a diagnosis or working diagnosis and this should never be attempted. Where the AP's HCP cannot formally identify either a diagnosis or working diagnosis within medical evidence submitted with the application or sought by the HCP at the initial review (IR) stage (see section 5.2), further diagnostic assessment by a specialist or consultant may be required. This will be organised by the administrative functions of the VPB when indicated.

## 4.2 Identifying the Damage, Disfigurement, and loss of Physical or Mental Capacity

Within the 2020 Regulations, the following definition applies:

*“Disablement” means **damage, disfigurement and loss of physical or mental capacity** resulting from injury, and “disabled” shall be construed accordingly’.*

Damage, disfigurement, and loss of physical or mental capacity relate to an adverse impact on the function of a specific part of the body, limb or organ resulting from an injury and from which, in turn, there results some disablement. The terms are not in themselves disablement but may cause disablement.

The HCP must first be satisfied that it is more likely than not that the applicant has sustained damage, disfigurement, or a loss of physical or mental capacity due to a TRI before being able to advise on disablement.

Whilst ‘Physical Capacity’ is not defined specifically within the 2020 Regulations, loss of physical capacity is to be considered the localised total or partial loss of function or power in a limb, organ or part of the body and is expressed as such. For example, a right below knee amputation, which would be considered the ‘injury’, would cause impaired right-sided weight bearing, which would be considered the ‘loss of physical capacity’.

For example, a loss of physical capacity may result in/may cause (not exhaustive):

- Reduced spinal movements
- Reduced vision in right eye
- Reduced movements in left wrist

Loss of “Mental capacity” should not be interpreted in line with the Mental Capacity Act (Northern Ireland) 2016. Loss of mental capacity is instead to be considered as loss or impairment of one or more aspects of mental function. For example, Major Depressive Disorder, which would be considered the ‘injury’, may cause lack of motivation which can be considered to amount to a ‘loss of mental capacity’.

Loss of mental capacity may result in/may cause (not exhaustive):

- Reduced insight
- Lowered self-esteem
- Increased anxiety
- Reduced speed of cognitive processing

The *relevant* damage, disfigurement, and loss of physical or mental capacity refers to that resulting from a TRI.

#### 4.3 Identifying the Disablement

Within the 2020 Regulations, the following definition applies:

*“**Disablement**” means damage, disfigurement and loss of physical or mental capacity resulting from injury, and “disabled” shall be construed accordingly’.*

Schedule 2 to the 2020 Regulations provides that:

*“The degree of the **disablement** caused by a relevant incident is assessed by making a comparison between the condition of— (a) the person so disabled, and (b) an average, healthy person of the same age and sex who is not disabled”.*

Disablement, caused by damage, disfigurement, and loss of physical or mental capacity, is the global reduced ability or inability to perform activities of daily living or the loss of health, function and power, and mental capability to enjoy a normal life. The HCP should specify what constitutes the relevant damage, disfigurement, or loss of capacity prior to determining disablement.

Disablement is described within a TPDPS assessment as the impact of an injury on one functional area and, when appropriate, how it relates to a paired organ such as both legs, both arms, or both eyes.

Examples of disablement include (but are not limited to):

- Impaired upper limb function
- Impaired psychological function
- Impaired spinal function
- Impaired lower limb function
- Impaired vision
- Impaired hearing
- Impaired skin function

To do so the HCP must review relevant medical records and where required gather additional information through the assessment process (see section 5) to identify the disablement attributable to a TRI.

#### 4.4 Degree of Relevant Disablement

The assessing HCP must assess the degree of disablement caused by any physical and/or psychological injuries caused by, and therefore relevant to, the TRI which will be expressed as a percentage disablement.

Within the 2020 Regulations, the following definition applies:

***“Degree of relevant disablement” means—***

*(a) the degree of permanent disablement, or*

*(b) in a case where an interim assessment has been made, the degree of disablement of a person during an interim period’.*

Further to the above definition, ‘degree of relevant disablement’ must be that which is a consequence of the accepted TRI/TRIs only.

HCPs must make a comparison between the condition of the applicant and an average, healthy person of the same age and sex who is not disabled to be able to assess disablement. Special circumstances such as loss of earning capacity are not considered in the assessment of disablement.

The 2020 Regulations make reference to Schedule 2 to the Social Security (General Benefit) Regulations 1982 which prescribe certain degrees of disablement for specified injuries as per appendix A. Appendix A details the Schedule of Injuries and the degree of disablement percentage attributed to a number of specified injuries, however, the list is not exhaustive. These conditions are referred to as scheduled injuries (see section 4.4.1).

When assessing the degree of disablement resulting from an injury not specified in Column 1 of Schedule 2 to the Social Security (General Benefit) Regulations 1982, the HCP may appropriately prescribe degrees of disablement set against comparable injuries specified in that Schedule of injuries described in appendix B. Those conditions not included in the schedule of injuries are referred to as non-scheduled injuries (see section 4.4.2).

Where disablement is caused by more than one TRI, a composite assessment of the degree of disablement is to be made by reference to the combined disabling effect of all such incidents (see section 4.4.3).

##### 4.4.1 Assessment of Scheduled Injuries

Some applicants will be assessed as having injuries which are documented in Schedule 2 to the Social Security (General Benefit) Regulations 1982 (see appendix A). This will be an assessment of a ‘scheduled injury’.

Assessments of scheduled injuries reflect loss of capacity and loss of tissue however such assessments also consider the appropriate use of suitable aids, appliances, and prostheses. The scheduled percentages are prescribed on the assumption that the injury had been sustained by a healthy individual without complication. Therefore, a person who is unable to make use of an appropriate aid, appliance, or prosthesis due to reasonable causes may have a greater degree of disablement than that documented. The final percentage disablement should take this into account. The Schedule in appendix A must therefore act as a guide and any complications/circumstances which may result in a greater or lesser degree of disablement must be considered. The 2020 Regulations support this adjustment in percentage score where justifiable by the assessing HCP. Detailed justification of any adjustment made is essential.



For example, two applicants have the same injury of a below knee amputation with a stump length of 10cm. Each have the same loss of capacity due to being unable to weight-bear without the use of a prosthesis.

Applicant 1 has chronic pain at the stump site and is unable to make full use of a prosthesis. The applicant is therefore using a wheelchair or crutches to move around, and the resulting degree of disablement is considerable.

Applicant 2 is an athlete who uses different prostheses for different situations, is able to manage them without assistance and can move around without difficulty when worn however the degree of disablement is comparably less than applicant 1 as this applicant has had function restored by the use of the prosthesis.

The scheduled percentage disablement for this injury is 50% (see appendix A). However, in the example above, the HCP would use their medical judgement to adjust the percentage so that applicant 1 may be allocated a greater percentage disablement and applicant 2 a reduction, if appropriate and justifiable.

#### 4.4.2 Assessment of Non-scheduled Conditions/Injuries

The 2020 Regulations state:

*“For the purpose of assessing the degree of disablement resulting from an injury not specified in Column 1 of Schedule 2 to the Social Security (General Benefit) Regulations 1982, the health care professional may have such regard as the health care professional considers appropriate, to the prescribed degrees of disablement set against injuries specified in that Schedule.”*

For many applicants, the injuries sustained, both physical and psychological, will not be included within Schedule 2 to the Social Security (General Benefit) Regulations 1982 (see appendix A). When advising on the assessment of disablement not covered by the Schedule, the HCP will compare the disablement which they are assessing to disablements of a similar severity which are included in the Schedule (appendix A).

A guide to the severity of disablement with examples are contained in table 1:

Category	Percentage disablement	Severity of Disablement	Example (from Schedule 2)
0	0%	No disablement	N/A
1	1-10%	Minimal	Guillotine amputation of tip without loss of bone of middle finger
2	11-20%	Mild	Loss of two phalanges of index finger
3	21-30%	Mild-moderate	Loss of thumb
4	31-40%	Moderate	Amputation below knee with stump exceeding 13cm
5	41-50%	Moderately severe	Loss of four fingers of one hand

6	51-60%	Severe	Amputation at knee resulting in end-bearing stump or below knee with stump not exceeding 9 centimetres
7	61-70%	Very severe	Amputation below hip and above knee with stump exceeding 13 centimetres in length measured from tip of great trochanter, or at knee not resulting in end-bearing stump
8	71-80%	Extreme	Amputation through both feet proximal to the metatarso-phalangeal joint
9	81-90%	Very extreme	Amputation through shoulder joint
10	91%+	Total	Absolute deafness

Table 1 – Severity of Disablement of Non-scheduled Injuries

#### 4.4.2.1 Non-scheduled Physical Conditions/Injuries

Whilst not all injuries are included within Schedule 2 to the Social Security (General Benefit) Regulations 1982, the Schedule can be used as a guide to the appropriate assessment of non-scheduled injuries. It is therefore essential that the assessing HCP uses clinical judgement and reasoning to assess the degree of disablement of a non-scheduled injury in comparison with the scheduled injuries. The higher the degree of disablement percentage, the higher the functional disablement expected.

An example where the degree of disablement for a non-scheduled injury is determined:

An applicant experiences a crush injury to one hand resulting in no grip, power or sensation. This would be considered as a non-scheduled injury. However, the schedule indicates that the amputation of one hand would prescribe a 60% degree of disablement. Using this as a “benchmark” and when considering the applicant has no functional use of one hand given loss of grip, power and sensation it could be reasonably considered that this injury would be comparable to the total loss of one hand.

However, take an applicant who experienced a crush injury to one hand resulting in *reduced* grip and power, and no sensation. The percentage degree of disablement would be altered accordingly, and it could *not* be reasonably considered that this would be compared similarly, in percentage terms to the total loss of one hand. It may be that the reduced grip could functionally be similar to the disability from the loss of a thumb and therefore an assessment in the 21-30% range would be appropriate.

This example is intended to demonstrate how the Schedule can be used to maintain a perspective when comparing non-scheduled injuries.

#### 4.4.2.2 Non-scheduled Psychological Conditions/Injuries

It is accepted that higher percentage disablement scores should reflect higher losses in functional ability due to a TRI. This applies to both scheduled and non-scheduled injuries, physical and psychological injuries.

Psychiatric injuries are not contained within Schedule 2 to the Social Security (General Benefit) Regulations 1982 however the Schedule must still be used as a guide to the appropriate assessment of such injuries. It is essential that the assessing HCP uses clinical

judgement and reasoning to assess the degree of disablement of a non-scheduled psychiatric injury in comparison with the scheduled injuries.

Further guidance for clinical assessors is contained within appendix C.

#### 4.4.3 Composite Assessment

The 2020 Regulations state:

*“Where disablement is caused by more than one relevant incident, a **composite assessment** of the degree of disablement is to be made by reference to the combined effect of all such incidents.”*

When considering multiple injuries, caused by multiple TRIs the composite assessment is not necessarily the addition of percentages for the separate injuries but must consider the disabling impact of the combination of injuries. ‘Relevance’ in relation to a composite assessment is considered in the same way as any condition or loss of capacity and is detailed in section 4.5.

For example, the loss of a middle finger (scheduled degree of disablement 12%) sustained in one TRI, and one phalanx of the index finger (9%) sustained in a second TRI would both be considered in the global disability of reduced upper limb function.

The disablement resulting from these injuries would not necessarily be the addition of the separate scheduled assessments (21%). This figure would amount to more than the scheduled degree of disablement for the loss of the two fingers (20%), which is not reasonable when considering the resulting disablement from each injury.

For an applicant who experiences disablement due to post-traumatic stress disorder and depression as a consequence of multiple TRIs, the overall assessment of relevant disablement must take into account the combined effects of the relevant injuries. The disablement associated with depression is not distinct from that caused by PTSD and so the combined functional disablement should be assessed.

It is for the HCP to advise the appropriate assessment of disablement in the circumstances of the case. Each individual case must be considered individually and must be analysed and justified on its own merits.

#### 4.5 Calculating Disablement and Disablement with Other Causes

If global disablement (G) is caused only by the relevant disablement (R) attributable to the TRI/TRIs, then the percentage disablement can be expressed using the formula:

$$G=R$$

Or:

$$\text{Global Disablement} = \text{Relevant Disablement}$$

However, “disablement with other cause” is when disablement is caused by a TRI but also has a cause other than the TRI. Where disablement has more than one cause, the assessment must advise on the proportion of disability due to the TRI (deemed to be relevant) and that related to the other cause or causes (deemed to be non-relevant).

#### 4.5.1 Relevance of Loss of Capacity

The concept of relevance is important as it determines how the loss of capacity will be classed for the global percentage disablement. The relevance of the loss of capacity is explained in the sections below.

##### 4.5.1.1 Fully Relevant Loss of Capacity

A **fully relevant** loss of capacity arises solely from the TRI and resulting injury. Any resulting disablement will be considered fully relevant.

For example, an applicant involved in a bomb explosion who has had a bilateral below knee amputation and no other lower limb medical conditions. Without the TRI, the applicant would not have suffered any loss of capacity and resulting disability. Their reduced lower limb function is therefore considered fully relevant.

##### 4.5.1.2 Partially Relevant Loss of Capacity

A **partially relevant loss of capacity** exists when the TRI and another cause results in disability in the same functional area.

The assessor would need to consider:

*Is there another cause of disability in the same functional areas as that caused by the TRI?*

And if YES then another cause of loss of capacity in the same functional area has been identified. The loss of capacity is therefore only partially relevant because it relates to the effects of the TRI and another condition.

The other cause of loss of capacity could occur before or after the TRI and still result in partially relevant disability.

For example, an applicant who has a considerable problem with their right knee for several years and is known to have right knee osteoarthritis (“other(pre)” condition, see section 4.5.3), who later injures their right knee in a TRI. The disability is ‘reduced lower limb function’ but the loss of capacity that results in that disability is only partially relevant as it is due to both the effects of the TRI and the other pre-existing condition.

Another example would be an applicant who fractured their right humerus in a TRI. After the TRI, they were involved in a road traffic accident and fractured their right wrist. The disability is reduced upper limb function but the loss of capacity that results in that disability, is only partially relevant as it is due to both the effects of the TRI and the other condition which post-dates the TRI (“other(post)” condition, see section 4.5.4).

Disability arising from other causes are considered differently depending on if they pre-exist or post-date the injury sustained during the TRI.

These terms will be further considered in the sections below.

#### 4.5.2 Combined Effect of Relevant and Non-relevant Injury

To calculate the percentage disablement of the relevant injuries and those with other causes, the assessing HCP must first calculate the “global disablement”. The global disablement may be expressed by the following formula:

$$G = R + N + I$$

Or:

$$\text{Global Disablement} = \text{Relevant Disablement} + \text{Non-relevant Disablement} + \text{Interaction}$$

The interaction (I) between the Non-Relevant condition and the TRI is the additional disabling effect of the non-relevant condition on the relevant disability caused by the TRI. It can also be considered the additional disability due to having both conditions at the same time.

Consideration needs to be given to injuries that are in the same organ, limb or part of the body that form a functional area, but not related to the TRI and their disabling effects.

For example, consider a combination of injuries of back pain/left sciatica caused by a TRI and subsequent non-related right ankle fracture; even though the ankle fracture is unrelated to the TRI it will have an effect on lower limb function (such as their ability to walk) and therefore add to overall disability in this functional area.

#### 4.5.3 Pre-Existing Injuries/Conditions – “Other(Pre)”

An “other(pre)” condition is a pre-existing condition and is non-relevant to the TRI but also present at the time of the TRI. An other(pre) condition makes a relevant loss of capacity more disabling than it would otherwise have been.

For example, consider an applicant who experiences a right knee injury in a TRI blast but had a pre-existing left knee osteoarthritis (OA) that was already causing some degree of disability. The overall lower limb disablement for the applicant is a combination of both. However, to calculate the relevant disability an appropriate amount must then be subtracted for the pre-existing disablement resulting from the left knee arthritis. This calculation should reflect the impact of the injury resulting from the TRI and the worsening effect on the disablement caused by the TRI of the other effective cause. This may also be considered the disability caused by the interaction between the effects of the TRI and the pre-existing OA.

The interaction between any injury will be calculated according to the formula in section 4.5.3.1.

If a pre-existing injury/condition is not causing any disablement at the time of the TRI, it is not treated as an other(pre) injury.

For example, an applicant sustained a soft tissue injury to the right knee due to a TRI. However, 3 years prior to the TRI they were treated for ligament damage to the right knee. At that time, they had physiotherapy which was helpful, and the condition fully resolved with no ongoing disability. In this example the ligament damage is not treated as an other(pre) injury.

##### 4.5.3.1 Calculation of Disablement for an Other(Pre) Injury

To calculate the degree of disablement with an “other(pre)” injury, the assessing HCP should complete the following:

$$(G - N) = (R + I)$$

**Where (Global Disablement – Non-relevant Disablement) = (Relevant Disablement + Interaction)**

#### 4.5.4 Post Injuries/Conditions – “Other(Post)”

An “other(post)” injury or condition is a non-relevant injury or condition, not resulting in disablement at the time of the TRI but later contributing to disablement in the same functional area as the injury that was caused by the TRI, and not itself resulting from that TRI. An other(post) condition changes the loss of capacity due to the TRI from fully relevant to partially relevant, as it is another cause of disability in the same functional area.

The 2020 Regulations indicate that greater disablement due to the interaction of a post-injury can only be considered if the net assessment of the relevant disablement amounts to 11% or more. The net assessment refers to the disablement associated with the TRI plus any interaction caused by an other(pre) condition, if one exists. When the threshold of 11% or more is met, the addition is made for the additional disability caused by having both the relevant and non-relevant (in this case other(post)) causes, not the actual disability caused by either of them. This will be calculated according to the process in section 4.5.4.1.

##### 4.5.4.1 Calculation of Disablement for an Other(Post) Injury

To calculate the degree of disablement with an other(post) injury, the assessing HCP should complete the following:

1. The net assessment for an individual functional area should first be calculated. This consists of the disablement associated with the TRI in an individual functional area or, both the TRI and the interactive effect of any other(pre) condition, if one is present.
2. If the net assessment is less **than 11%**, no further addition is required for the interaction between the (other)post condition and the TRI injury.

OR

If the net assessment is **11% or more** for an individual functional area, the assessing HCP should proceed as follows:

- Establish the interactive additional disablement created by the other(post) injury
- Do not add the full effects of the other(post) injury
- Use this small interaction (usually ≤5%) as an addition to the net assessment

The following case example details how an other(post) injury is considered when the net assessment refers to the disablement associated with the TRI only.

Case example				Disablement
<p>For example, an applicant sustained an injury to their right knee due to the TRI. They reached a steady and stable state of disablement until 10 years after the TRI (and 10 years ago) when they injured their left ankle in a road traffic accident. This further increased the level of disablement.</p> <p>The disablement resulting from the TRI in this case is considered as partially relevant as there is another, non-relevant, cause of the disablement (road traffic accident). There was a permanent, further increase in disablement as a result of this, but not related to the TRI, so an interaction must be considered when establishing a final disablement percentage.</p>				Reduced lower limb function
Global assessment of disablement	Net Assessment (Relevant)	Other effective causes	Interaction	Final percentage disablement
40%	20%	10%	2%	22%
(G=R+N+I)	<p>'R'</p> <p>&gt; 11% - a further addition is required for the interaction of the other(post) condition</p>	<p>'N' minimal disablement due to ankle injury, also impairing lower limb function</p>	'I'	Net assessment plus interaction with other(post) injury

Table 2 – Example of Calculation of Disablement with an Other(Post) Injury only

#### 4.5.5 Consequential Injuries/Conditions

Not all post-injuries are unrelated to the TRI. Some injuries may occur as a direct result of the injuries sustained within the TRI. This refers to an injury which post-dates the TRI but would not be present had the TRI not occurred.

For example, a person who suffers a fracture due to the accepted TRI, resulting in damage to the articular surface of the knee joint who then subsequently develops traumatic arthritis in the same joint. An assessing HCP may consider the latter injury only arose due to the disabling effects of the TRI even though the latter injury did not occur immediately at the time of the TRI, it's effects are consequential to it.

Consequential injuries are rare and sometimes only become apparent after a considerable period of time has elapsed following the TRI. As a result, such cases must be supported by clear evidence as to their aetiology in line with balance of probabilities. Where sufficient evidence exists, the injury would not be treated as an unconnected condition but instead as a relevant loss of capacity, which could be considered fully or partially relevant if another cause is identified to affect the same individual functional area.



#### 4.5.6 Unconnected Injuries/Conditions

Unconnected injuries are those that have no effect upon the disablement and the relevant damage, disfigurement, or loss of mental and/or physical capacity caused by the TRI. These should be recorded on the assessment report form as unconnected injuries and will not impact percentage disablement.

Within an unconnected injury or condition, any resulting disablement will not be considered in the calculation of global disablement.

For example, an applicant who suffers PTSD when present at a TRI, 10 years later falls down the stairs and breaks left femur. The applicant has ongoing problems with this injury. However, this latter accident and resulting injury is unconnected to the TRI and injury resulting from the TRI, so the resulting disability is not considered.

#### 4.6 Expression of Degree of Disablement

The assessed degree of disablement must be expressed as a percentage between 0 and 100 where the higher the score, the higher the degree of disablement.

The 2020 Regulations indicate that the percentage must be expressed as a multiple of 10 and to do so the percentage must be rounded to the nearest multiple of 10 with the exception of 14% which must be rounded to 20%. This allows payment to be scheduled accordingly where the percentage has been expressed as 14% or greater.

However, the HCP must record the actual percentage disablement in order that this can be compared for any future assessments of the same applicant (for example in the case of re-assessment or appeal). The assessed percentage disablement must be justified fully by the HCP.

The 'rounding process' should be completed by the VPB as any reference to payment is outside the scope of the assessing HCP.

#### 4.7 Permanence of Disablement

The HCP must advise the Board on all aspects of permanence subject to review of history taking and medical evidence available using clinical rationale and reasoning to justify the decision advised.

The 2020 Regulations state:

*“**permanent**”, in relation to disablement, means where, following appropriate clinical management of adequate duration, an injury has reached a steady or stable state at maximum medical improvement’.*

The components of permanence will be further explained in the sections below.

##### 4.7.1 Appropriate Clinical Management

To determine permanence, it is essential that the assessment identifies if the applicant has received appropriate treatment after which no further improvement can be expected.

The 2020 Regulations state:

*“**permanent**”, in relation to disablement, means where, following **appropriate clinical management** of adequate duration, an injury has reached a steady or stable state at maximum medical improvement’.*



The historical context in which TPDPS exists must be borne in mind when considering what is deemed to be appropriate clinical management. Applicants assessed within the scheme must have sustained an injury on or after 1<sup>st</sup> January 1966 but before 12<sup>th</sup> April 2010. According to the 2020 Regulations, injuries sustained outside these dates may be assessed where a panel has so directed. Medical practice has evolved as the literature that underpins best-practice has developed. What would be considered ‘appropriate clinical management’ currently is therefore very different to what would have considered ‘appropriate clinical management’ in the ‘00s, ‘90s, ‘80s, ‘70s and ‘60s. The assessing HCP should not therefore directly compare the treatment given historically, to that which would be expected in current medical practice.

The HCP must establish whether the clinical management that was received, or sought, was accepted at that time as appropriate by a reasonable body of clinical opinion. If it is determined that appropriate clinical management was not sought, the HCP must consider whether this was due to factors beyond the applicant’s control. Where treatment was refused by the applicant, the HCP must determine if this refusal or declination of treatment was reasonable when considering the individual circumstances of the applicant.

When determining what is considered to be appropriate clinical management, the assessing HCP must consider:

- the nature of the condition/injury
- the nature of the treatment received
- the response to treatment
- the treatment available at the time of onset
- if treatment was not received, the nature of treatment sought or offered
- if treatment was not sought or offered, was this due to being unable to access treatment due to factors beyond applicant’s control
- any underlying reasons why treatment may not be favourable now.

**Further recommendation of treatment is outside the scope of the assessing HCP’s role.**

#### 4.7.2 Adequate Duration

The 2020 Regulations state:

*“permanent”, in relation to disablement, means where, following appropriate clinical management of **adequate duration**, an injury has reached a steady or stable state at maximum medical improvement’.*

To determine permanence, it is essential that the assessment identifies if the applicant has received appropriate treatment of an *adequate duration* after which no further improvement can be expected.

When determining what is considered to be an adequate duration, the assessing HCP must consider:

- the nature of the condition/injury
- the nature of the treatment
- the treatment available at the time of onset
- any good reason as to why treatment was not received for an adequate duration.

#### 4.7.3 Steady or Stable State at Maximum Medical Improvement

The 2020 Regulations state:

*“permanent”, in relation to disablement, means where, following appropriate clinical management of adequate duration, an injury has reached a **steady or stable state at maximum medical improvement**’.*

It is to be expected that a condition or injury may be subject to minor fluctuations and changes over time and with age. Such minor fluctuations may be still considered to be at a steady and stable state.

Maximum medical improvement indicates that no further improvement is likely when considering the balance of probabilities and what is medically reasonable and within the consensus of medical opinion.

When determining what is considered to be a steady or stable state at maximum medical improvement, the assessing HCP must consider:

- The history of the condition
- Any fluctuations or changes to symptoms since the onset
- Any changes to functional impact since the onset
- Any changes to treatment since onset
- Any current or planned treatments.

#### 4.7.4 Interim Assessment

The TPDPS aims to determine the degree of permanent disablement for an applicant without delay. However, where the condition of the applicant does not allow the degree of permanent disablement to be assessed, the HCP must complete an interim assessment. The 2020 Regulations mandate the need for the injury to have reached a steady or stable state, not the level of disablement. Whilst there may be overlap between the two, if the determination of the assessing clinician is that the injury is permanent, but the degree of permanent disablement is not currently predictable, an interim assessment may be made. To do so the HCP must specify the degree of disablement, state the advised interim period and the justification for such decisions to the VPB.

This situation may arise where treatment has not yet begun or is in very early stages, in cases of multiple injuries, where some injuries are settled but others not or in cases with mental health disorders where an adequate course of appropriate treatment has not been received.

The 2020 Regulations state:

*An “**interim assessment**” is an assessment of the degree of permanent disablement of the applicant during the interim period.*

*The “**interim period**” is an assessment of the period of time for which it is reasonable, having regard to the possibility of changes in the applicant’s condition, to assess the degree of disablement of the applicant.*

The interim period is to be a maximum of 2 years before which time the Board must make arrangements for the applicant to be reassessed by an HCP. If at this point the degree of permanent disablement still cannot be assessed the HCP must specify the extended interim period, the interim assessment, and the justification for extension to the Board. The interim period may be extended more than once to a maximum of 4 years.

If, at the end of a 4 year interim period, an HCP considers that the condition of the person still does not allow the degree of permanent disablement to be assessed, the HCP must assess the degree of permanent disablement so far as it is possible and make a report to the Board

of the assessed degree of permanent disablement and the reason for the extension and that assessment.

Example where an interim assessment would be appropriate.

<b>History</b>		
An applicant underwent an amputation below knee with stump exceeding 13 centimetres, following a TRI. The applicant is currently experiencing difficulties with current prosthesis, which the applicant cannot use, including chronic pain. Revision surgery is required which is planned to occur in the next 6 months. According to medical evidence the stump will subsequently measure less than 9 centimetres, with potential for an amputation above knee.		
<b>Interim Assessment of Degree of Disablement</b>	<b>Interim Period</b>	<b>Justification for Interim Period</b>
40%	2 years	The degree of disablement has not yet reached a steady and stable state as evidenced by planned, significant intervention which is likely to significantly impact this degree of disablement. A 2 year interim period is advised to allow for the intervention to take place and the injury to reach a steady and stable state at maximum medical improvement.

Table 3 – Interim Assessment Example

In cases where the applicant is deceased, the assessed degree of disablement is taken to be permanent and therefore an interim assessment does not apply.

#### 4.7.5 Date of Permanence

HCPs should provide advice to the VPB about the date at which the HCP believes the relevant level of disablement had become permanent. This date is unlikely to be exact given the timeframe in which the scheme operates, however it should be expressed in terms of years, and months and be expressed as accurately as is practicable. Advice can be made on the balance of probabilities and will be based on medical evidence and assessment findings where relevant.

#### 4.7.6 Split Assessments

The TPDPS will consider backdated payments to 23/12/2014. If a relevant permanent injury and relevant loss of capacity is caused by a TRI in the period between this date and the date of the assessment, but the level of permanent disablement changes in that period, a 'split assessment' may be considered by the HCP. A split assessment is made where evidence supports retrospective changes in the level of permanent disablement, which is often brought about by medical intervention of some kind.

An example may be where an applicant had their forefoot amputated in 2009 following a TRI. In 2015 there were complications with the stump, and this resulted in below knee amputation. Further complications arose with the stump, resulting in an above knee amputation in 2020. In this example, between the date of 23/12/2014 and the date of the assessment there were different levels of permanent disablement and so this should be advised to the board by the HCP.

## 5 Assessment Process

The assessment provider (AP) must assess the degree of relevant permanent disablement i.e. that which is caused by the accepted TRI, which must be expressed as a percentage. The HCP should do so by considering any evidence provided, carrying out an assessment and/or considering the report of another (assessing) HCP.

To determine percentage disablement, assessors must consider the principles of disability analysis. These principles are as follows:

- Systematic, logical analysis of all available medical evidence
- Understanding and/or taking an applicant's history where face-to-face assessment is required.
- Making and recording factual observations where face-to-face examination is required.
- Conducting relevant examinations and documenting their findings when relevant.
- Justification of clinical opinions and explanation of decision making, considering any identified inconsistencies in evidence.

The assessment process, subjective history, objective examination, and assessment report form (TPDPS1) are structured around these basic principles of disability analysis.

Section 4 of the assessment guide explores the assessment *criteria* which govern the scheme in a sequential manner. However, in Section 5 of the assessment guide, each step of the assessment *process* is explored in detail.

### 5.1 Assessment Forms

Assessment findings must be clearly documented and made available to the VPB on the relevant assessment form. Assessment forms are displayed in the appendices as follows:

Form Title	Form Code	Description	Appendix
Assessment Report Form	TPDPS1	The Assessment Report Form documents all findings from the assessment process from initial review (section 5.1) to justification (section 5.12). This report must record the percentage disablement and justification for such as provided to the VPB.	D
Harmful Information	TPDPS2	This form is used where unexpected findings come to light during the assessment of which the applicant is unaware, and which could have a detrimental effect on the health of the applicant if made aware. Section 5.18 explores this in further detail.	E
Medical Factual Report	TPDPS3	This form is used where evidence is lacking and is required to support the application which includes confirmation of physical diagnosis. Appendix F explores this in further detail.	F

<b>Form Title</b>	<b>Form Code</b>	<b>Description</b>	<b>Appendix</b>
Initial Review Return Form	TPDPS4	This form must be used to document all action taken by the HCP to identify a diagnosis, and a justification as to why the case has been returned at the initial review stage without proceeding to full assessment. Section 5.2.1 explains this further.	G
Case Rework/Reconsideration Advice Request Form	TPDPS5	This form must be used if the Board wishes to return a case to the AP for rework or reconsideration advice. The case will be reviewed by a suitably qualified HCP who will make recommendation on any further action in response to request.	H
Applicant Capacity Proforma Mental Concern	TPDPS6	This form must be used if an HCP suspects a possible mental capacity issue that may impair their ability to consent to the assessment process or manage their property and affairs.	O

Table 4 – Assessment Form Summary

The assessment report form TPDPS1 is set out below:

<b>Section of TPDPS1</b>	<b>Title</b>
1	Initial Review
2	Identification Confirmation
3	Subjective History
4	Objective Examinations
5	Observations
6	Injury, Loss of Capacity, Disablement
7	Effect of the relevant damage, disfigurement, or loss of capacity
8	Assessment of degree of disablement and permanence
9	Justification

Table 5 – Assessment Report Form Sections

The sections of the assessment report form are explored in further detail in the following sections.

## 5.2 Initial Review

The initial review (IR) is the process by which the assessment provider (AP) reviews the application form and all available supporting evidence to consider:

- whether a diagnosis/working diagnosis has been confirmed for all relevant injuries on the application form
- the level of risk posed by the assessment process
- the most appropriate assessment routing
- whether any reasonable adjustments are required to facilitate an assessment

The needs of applicants mandate a flexible approach to delivering assessments for the TPDPS. The assessment process must be applicant centred throughout and ensure applicants do not have to attend unnecessary face-to-face assessments where there is sufficient evidence to determine percentage disablement without formal examination. However, absolute priority must also be given to the accuracy of the assessment reports delivered to the VPB and a face-to-face assessment must be considered where a lack thereof may result in an inaccurate assessment outcome.

Section 1 of the Assessment Report Form TPDPS1 instructs the HCP to document the IR outcome in each sub section as follows:

*1.1 Medical Evidence Considered*

*1.2 Case Risk Assessment*

*1.3 Can determination of permanence and relevant percentage disablement be made without further evidence or examination?*

*1.4 What further evidence is required?*

*1.5 Is this case a posthumous assessment?*

*1.6 Is examination required?*

*1.7 What route of examination is required?*

The following sections of the guide explore each sub-section in detail.

### 5.2.1 Medical Evidence Considered

Section 1.1 of the TPDPS1 refers to “medical evidence considered”. At this stage of the IR, an HCP must determine if there is evidence that diagnosis has been made of the injury/injuries or condition/s claimed by the applicant on their application form. This evidence of diagnosis refers to those injuries or conditions sustained due to a claimed TRI, not other non-relevant health conditions.

A diagnosis is a label given to clinical signs, symptoms and test results and can be made by a suitably qualified health professional. However, providing a diagnosis is outside the remit of the TPDPS HCP. Conditions/injuries and diagnoses or working diagnoses ought to be confirmed in writing by an applicant's GP, or other suitably qualified treating practitioner (see section 4.1) prior to the assessment taking place.

When an HCP reviews the medical evidence on file at the IR stage of the assessment process, all efforts must be made to identify evidence that supports the diagnosis, diagnoses, or working diagnosis. Where such evidence is lacking, the HCP must engage in an “inquisitive process”. The inquisitive element of the IR process consists of proactive engagement with relevant external HCPs (GPs, specialists etc) to seek evidence of a diagnosis, or working diagnosis. Written medical evidence should support the presence of an injury/condition and treatment thereof in the period between the TRI and application to the scheme.

Where hearing loss is claimed as attributable to a TRI, the HCP should request a pure tone audiogram, to be provided by a suitable supplier, if there is a lack of evidence on file or if medical evidence does not clearly indicate the level of hearing loss due to TRI.

Where no evidence pertaining to diagnosis is available in the initial application or following the above inquisitive process, the TPDPS4 process must be followed. (see appendix G)

### 5.2.2 Initial Review Return Form

If the case is to be returned to the VPB due to insufficient evidence of injury or aetiology, the Initial Review Return Form TPDPS4 (appendix G) must be used to document all action taken by the HCP to assess the injury and give a justification as to why the case has been returned without proceeding to full assessment.

#### *1. What evidence has been reviewed within the initial application pack?*

This may include any evidence on file as well as the application form which lists all injuries and conditions.

#### *2. What actions have been taken to attempt to confirm a formal diagnosis is available out with the initial application?*

This may include written requests and telephone attempts to relevant medical practitioners including the dates, times and number of attempts and any responses received, if any.

#### *3. Justification.*

Clear, succinct justification must be documented to inform the VPB why the case has been returned.

### 5.2.3 Case Risk Assessment

Section 1.2 of the Assessment Report Form TPDPS 1 refers to “case risk assessment”. A risk is the possibility of something occurring, usually associated with a negative outcome. Risk involves uncertainty about the effects/implications of an action on things such as health and wellbeing. During the IR process, a clinical risk assessment (appendix I) should be applied to the profile of each case, considering the risk posed by the assessment process to the applicant. The AP may also assess the risk posed to their staff (non-clinical risk assessment) by the assessment process within each case.

#### 5.2.3.1 Clinical Risk Rating

Clinical risks refer to any risk that the assessment process or assessment route may pose to the applicant when considering diagnosed injury/condition, associated symptoms and/ or treatments.

Examples of clinical risks include but are not limited to:

- severe mental health symptoms such as active psychosis, active suicidal ideation or intent, where the assessment process may negatively affect the applicant's condition.
- severe cognitive restrictions whereby engaging with the assessment process may cause significant distress or confusion.
- treatment such as active chemotherapy where engaging with the assessment process may be harmful to health.



### 5.2.3.2 Non-clinical Risk Rating

Non-clinical risks refer to any risks posed by the individual characteristics of the applicant to the HCP completing the assessment. APs are accountable for compliance with applicable legislation relating to these risks e.g. Health and Safety at Work 1974. The AP will consider and develop policy and process to manage risk to their staff posed by the TPDPS assessment process and should embed the systems and processes they feel are appropriate to fulfil their obligations.

### 5.2.3.3 Mitigating Risk

Risk mitigation refers to the process of planning and/or implementing a method to reduce any identified risk.

Where there is evidence of significant risk, the HCP must first attempt to complete a paper-based assessment (section 5.4). However, where this is not possible the HCP must consider and act to mitigate any risk. There are several methods to mitigate risk which include:

- adhering to the clinical risk matrix (appendix I)
- making a phone call to an appropriate person, which could include the applicant, a health professional or member of their support network listed as a relevant contact, to determine whether support is in place, or required to support the assessment being completed.
- documenting the risk rating on the assessment report form
- completing a safeguarding referral form after escalating a safeguarding risk to an external professional.

### 5.2.4 Assessment Routing

Together with the case risk assessment, sections 1.3 – 1.7 of the Assessment Report Form TPDPS1 relate to assessment routing.

Whilst the IR process determines the most suitable assessment route for each applicant, there should be the facility to challenge this routing if the applicant is concerned about the assessment route selection. The assessment provider must not assume the IR decision is correct if challenged by the applicant. If required, a different HCP should offer a second opinion on the original IR decision if requested by the applicant.

To determine the most appropriate route for assessment the HCP must consider the following steps:

#### **1. Is significant risk identified that cannot be mitigated?**

If yes, a Paper-based Assessment, Virtual or Telephone Assessment must be completed depending on nature of risk.

If no, the HCP must consider the following:

#### **2. Can determination of permanence and relevant percentage disablement be made without further evidence or examination?**

If yes, a Paper Based Assessment (PBA) must be completed

If no, the HCP must consider the following:

#### **3. What further evidence is required?**

**Medical Factual Report**

**Verbal Discussion with professionals involved in applicant's care**

**Verbal Discussion with applicant (not extending to a full assessment)**

**N/A**

**Other**



This depends on the level of detail required and type of detail required. The HCP should contact the most appropriate person involved in the applicant's care. Where possible, the HCP should wait for the return of any further evidence requested before deciding whether a face-to-face assessment is required.

If upon receipt of that evidence step 2 is then satisfied, a Paper Based Assessment (PBA) should be completed.

If upon receipt of evidence step 2 is not satisfied, the HCP must consider the following:

**4. Is this case a posthumous assessment?**

If yes, a PBA must be completed (see 5.4.2)

**5. Is examination required?**

If examinations are required which require physical contact or use of examination equipment by the HCP, a face-to-face assessment in the clinic or home only must be considered

If no, all routes can be considered

**6. What route of examination is required?**

There may be more than one appropriate selection. Where a PBA cannot be facilitated and where neither the case risk assessment nor the need for an in-person examination dictate the assessment route, the following should be considered based on the individual circumstances and needs of the applicant.

- Face-to-face, clinic
- Face-to-face, home
- Virtual via video function
- Where face-to-face or virtual assessment is not possible or practicable telephony function may be considered

The clinical assessor should document their rationale as to why a certain assessment route has been selected on the TPDPS1 in section 1.1.

### 5.2.5 Prioritisation of Assessments

The VPB may prioritise applications with due consideration to:

- whether evidence provided is likely to allow the application to be determined quickly
- the age of each applicant
- the health of each applicant.

The VPB must prioritise applications made by applicants who:

- are terminally ill and disclose that fact to the VPB

The assessment provider must have the facility to expedite cases where the applicant is terminally ill at the request of the VPB.

### 5.3 Identification Confirmation

Section 2 of the assessment report form TPDPS1 refers to identification confirmation. The assessment provider is required to confirm the applicant's identity prior to commencing an assessment. If they are unable to provide sufficient evidence, then the assessment must be terminated. However, the HCP must make all possible attempts to confirm their identity before terminating the assessment.

Acceptable forms of identity include:

- One piece of primary documentary evidence (appendix J), or
- Three pieces of secondary documentary evidence (appendix J), or
- One piece of secondary documentary evidence and the applicant/authorised representative must correctly answer three out of a maximum five security questions, one of which must be a strong question (appendix J) or
- No identification, applicants/authorised representatives must correctly answer three out of a maximum five security questions, one of which must be a strong question (appendix J).

The method of verification must be recorded in section 2 of TPDPS1 as well as name of companion and relationship to applicant, if applicable.

## 5.4 Paper-Based Assessment

Where possible a paper-based assessment (PBA) is completed to avoid any unnecessary face-to-face assessments.

To complete a PBA, there must be sufficient, consistent medical evidence available to complete a full and robust report. The medical evidence should contain relevant information regarding the injury/injuries to include:

- the diagnosis of the injury attributable to any TRI and when the injury was sustained
- the loss of capacity and any resulting disablement
- whether or not the disablement was caused wholly or partly by the TRI
- whether or not the injury has reached a steady or stable state following appropriate clinical management, at maximum medical improvement.

In some cases, there may be small gaps in available information which do not allow the assessing HCP to advise on the degree of permanent disablement. In such cases the assessment provider may attempt to contact relevant external health professionals to clarify this information to gain the required information. This would avoid the need for a full face-to-face assessment.

### 5.4.1 Best Endeavours

There may be occasions where following the initial review, the case is deemed to have inadequate information to complete a paper-based assessment, yet the case risk assessment has deemed a face-to-face, virtual and telephone assessment to be inappropriate. In such circumstances if, despite exhausting all attempts to gain sufficient medical evidence, there remains a paucity of evidence, the case may be completed using “best endeavours”. Determination of permanent disablement in this context should be achieved using the evidence available, clinical knowledge, appropriate and justifiable clinical reasoning and by considering the balance of probabilities. The HCP must state within the report that it is being written using best endeavours, to inform the VPB about the context of the case, and the context in which clinical advice is being provided.

There may be occasions where a clinical assessor may be concerned about an applicant's capacity to consent to the disablement assessment process, consent has not been obtained from a legally appointed person (see 5.15 and 5.16) and as a result, face-to-face, virtual and telephone assessment is deemed to be inappropriate. In the event that following the initial review, the case is deemed to have inadequate information to complete a paper based assessment the HCP must make all reasonable attempts to gain further evidence to complete a paper based assessment, after which the case may be completed using best endeavours if there remains a paucity of evidence.

If, after all attempts to gain further evidence, there is insufficient evidence to determine degree of permanent disablement using best endeavours, this should be discussed with a senior experienced clinician before advising the VPB. In some cases, this may result in the case being returned to the VPB without assessment advice.

#### 5.4.2 Posthumous Assessments

Posthumous assessments apply on the death of an applicant who would have been, before death, entitled to Victims' payments if an application had been made. The HCP must so far as possible, assess the degree of relevant permanent disablement of the deceased before death.

All posthumous applications must be processed via paper-based assessment using medical evidence available. Where medical evidence is lacking in the required detail the HCP requests further medical evidence including confirmation of diagnosis (see section 4.1).

The assessing HCP must ensure the report is written sensitively with respect for any relatives that may read the report. Other considerations include:

- The report should be written in the past tense.
- In cases where the applicant is deceased, the assessed degree of disablement is taken to be permanent and therefore an interim assessment does not apply.

Considering the historic nature of such injuries and therefore the historical nature of any evidence, it is likely that the assessing HCP may be required to employ such report writing techniques as best endeavours, and if appropriate, making contact with a carer/relative to gain an appropriate clinical history to promote the accuracy of posthumous assessments.

### 5.5 Face-to-face, Virtual and Telephone Assessment

If a face-to-face assessment is required, the assessment should be conducted by an HCP at a clinic or in the applicant's home

A face to face or virtual assessment may be required to accurately assess the applicant's permanent disablement. This allows the applicant the opportunity to explain to the HCP how their injury or condition affects them. An assessment by telephone can be used where face-to-face or virtual assessment is not possible or practicable

HCPs should be prepared to adapt their approach to the needs of the applicant, not taking a prescriptive approach and ensuring that applicants are able to convey the disabling impact of their injury in their own words.

#### 5.5.1 Role of a Companion

Applicants have a right to be accompanied to a face-to-face assessment if they so wish. Applicants should be encouraged to bring another person with them to consultations where they would find this helpful. The companion chosen is at the discretion of the applicant which includes or is not limited to, a parent, family member, friend, carer or advocate. On most occasions the applicant is likely to have one, or possibly two, companions. Interactions during assessments should predominantly be between the HCP and the applicant however, the companions may play an active role in assisting applicants to answer questions. HCPs should allow a companion to contribute and should record any evidence they provide.

### 5.5.2 Clinic Assessment

A clinic setting may be deemed appropriate where a paper-based assessment is not possible. Assessments in a clinic environment allow the applicant to be assessed in a safe environment and in person and with the use of an examination plinth.

In some circumstances it will be *necessary* to conduct an assessment in a clinic where the case risk assessment deems this most appropriate (see Initial Review section 5.2) and in circumstances where the assessment cannot be completed as a PBA.

If a face-to-face assessment is required, the HCP must also identify if there is evidence of any difficulties that the applicant may have in attending an assessment and consider any reasonable adjustments which need to be put in place. Reasonable adjustments may include:

- Accessibility for example, the need for a home visit, if clinic assessment inappropriate, ground floor assessment room, accessibility toilet
- Communication support for example, British Sign language, Irish Sign language or another language to include Irish, a loop system for hearing aids, support from a carer
- Gender of assessor where reasonable justification is evidenced by the applicant; appropriate arrangements should be made by the AP in relation to the gender of the assessor.

### 5.5.3 Home Assessment

In some circumstances it will be appropriate to conduct an assessment in the applicant's home (registered address) where the case risk assessment deems this *necessary* (section 5.2) for example if the applicant's health would be significantly negatively impacted by attending a clinic setting and in circumstances where the assessment cannot be completed as a PBA.

As the HCP will be in the applicant's home, additional safety measures should be in place. These include:

- Conducting a dynamic risk assessment to prioritise HCP safety and that of the applicant.
- Ensuring there is a suitable place to sit and to use a laptop.
- Ensuring confidentiality of the applicant can be appropriately maintained.

### 5.5.4 Assessments that are non-face-to-face

Non-face-to-face assessments will take the form of either virtual or telephone call. Such an assessment may be appropriate if:

- the applicant does not require an examination which requires physical contact or use of examination equipment by the HCP including a vision test.

An applicant may request a change of assessment routing to this type of assessment from a clinic or home assessment if the above criteria are met, and the initial review deemed multiple routes (including virtual or telephone) to be appropriate.

Other reasons where a virtual or telephone assessment may be appropriate are if:

- government restrictions do not permit home or clinic assessments such as during the Covid-19 pandemic.
- geographical location does not allow a face-to-face home or clinic assessment.

#### 5.5.4.1 Virtual

It is clear that not all aspects of a full assessment can be completed during a virtual assessment. Some psychological observations can be recorded via a virtual assessment, as well as some parts of a mental state examination, a cognitive state examination, and some aspects of a musculoskeletal/ neurological examination, if safe to do so.

#### 5.5.4.2 Telephone

A telephone assessment must only be conducted where a virtual assessment is not possible. Identification will be verified using the security questions in table 15, appendix J. It is not possible to complete any physical examinations during a telephone assessment and visual observations are not possible, however some elements of mental state or cognitive state examination may be completed as per section 5.8.1, table 9. Therefore, the level of observational detail gained from such an assessment is reduced.

Although the applicant is not visible, the process of history taking and analysis for a face-to-face assessment is followed. The need for a comprehensive history is essential where observations and physical examinations are absent. Any areas which cannot be identified through auditory observations should be explored within the report appropriately using clarifying questions.

### 5.6 Subjective History

The HCP completes the subjective history initially. This consists of the applicant's own account of how their injury/condition and any resulting loss of capacity affects them. During an assessment, the subjective history is taken directly from the applicant either in person, or via virtual/telephone. If a paper-based assessment requires a telephone call to the applicant, this must be recorded in the subjective history. The evidence gathered should be clear and structured to provide a clear picture to the VPB.

HCPs must bear in mind that some applicants may have no or limited insight into their condition, for example applicants with cognitive or developmental impairments. In such cases the HCP must consider if a companion may be better placed to describe their needs. In such cases, the relationship to the applicant and what information has been provided from that person must be clearly documented.

Throughout the assessment, HCPs must evaluate the information gathered to identify any inconsistencies. Inconsistencies may result from an applicant over or under emphasising their disablement and efforts must be made to avoid both through sufficient probing questions.

Each sub section of the subjective history is further described in sections 5.6.2 – 5.6.5.

#### 5.6.1 Interview Skills and Questioning Styles

The HCP must use clear language that is easily understood and should be aware of body language which should be positive – for example, sitting to face applicants at a slight angle, maintaining good non-verbal communication to demonstrate listening. When using computer systems during the assessment, the HCP should look up as frequently as possible from the screen and reaffirm eye contact. The approach should be relaxed, allowing the applicant time whilst encouraging them to talk about themselves and put across the impact of their injury/condition in their own words. The applicant and any companion should be, and feel, fully involved in the process and that the assessment is a two-way process. Summarising and using clarifying questions are useful tools to achieve active listening and to ensure that key pieces of information have been correctly documented.

To ensure the applicant's history is taken effectively, a variety of questioning styles need to be implemented as follows:

- Open questions which necessitate more than a "yes" or "no" answer encourage the applicant to describe how their injury or condition affects them, for example, "Tell me about...", "What do you do when...", "How do you...", "What have you noticed...?", "How does that affect you...?". The HCP should always start with open questions.
- Closed questions which need a specific answer are usually only needed when establishing a fact, such as how often medication is being taken or when an appointment is planned
- Clarifying questions invite the applicant to explain further some aspect of what they have said, for example, "Let me make sure I've understood this correctly, you have difficulty with..." or "just to check, you said you are able to..."
- Extending questions allow the HCP to develop the account the applicant is giving, for example, "So what happens after this..." or "how do you feel once you have completed that?"

These questioning styles all have a role to play when history taking and work to funnel the information for the HCP to record in the most logical way.

#### 5.6.2 History of Troubles-Related Incident

The history of the injury caused by a Troubles-related Incident (TRI) must be explored in this section as below:

- History of the TRI relating to events in the immediate aftermath, the nature of injuries sustained and immediate treatment if applicable. This should not relate to details of events not relevant to the injury/condition.
- Date of diagnosis
- The initial and subsequent treatment, and any current or proposed treatment
- Loss of capacity and how this has changed over time
- Disablement resulting from the injuries sustained with a record of their chronological development
- How these problems are managed for example with aids, appliances or assistance from another person
- Response to any treatment undertaken

If there is more than one injury/condition, these will be explored individually.

#### 5.6.3 Social and Occupational History

This section should include the effects of the damage, disfigurement and loss of physical or mental capacity on how the applicant lives, works and undertakes social and leisure activities. The HCP should explore the following:

- The type of dwelling, number of people in the home, accessibility of the home, adaptations to the home
- If the applicant works or worked at the time of the TRI, what are/were the work duties? Have the duties or hours changed and if so why? Any reasonable adjustments at work? If the applicant does not work, why not?
- Any leisure activities the applicant undertakes with regard to frequency, adaptations and restrictions
- If the applicant drives, exploring frequency, duration, adaptations, restrictions and if not, why not?
- Caring for children/pets



- Housework and shopping
- Exploration of personal relationships, particularly with family and friends. Exploration of interpersonal relationship and how their loss of capacity has affected this, if relevant.

#### 5.6.4 Activities of Daily Living and Mobility

This section includes details of the applicant's activities of daily living (ADL) and mobility including the evolution of such activities. The HCP must explore what the applicant did before the TRI, what they are capable of now, how that has changed and why.

The HCP should gather evidence on:

- Preparing/Eating Food
- Managing medication and treatment
- Washing/Dressing
- Using the toilet
- Communicating with others
- Engaging with others
- Going out – taking into account cognition and psychological elements of planning and following a journey
- Managing money/Budgeting
- Mobility/Walking

If an applicant uses an aid or appliance the HCP must gather information on:

- How this is used
- Why this is used
- Any difficulties with use
- Consideration of whether this is an appropriate aid for the disability

#### 5.6.5 Other Medical History

This includes any injuries/conditions present prior to the TRI and any injuries/conditions which occurred after the TRI.

Each additional injury/condition (with the exception of unconnected injuries) requires a full history to be taken and may follow a structure similar to that described below:

- When was this diagnosed?
- What loss of capacity does the applicant experience?
- How is this managed?
- What is the plan for future treatment?
- Are there any interactions between this condition and the relevant injury?

The global percentage disablement considers these conditions and any interactions (with the exception of unconnected injuries), therefore the history taking needs to be comprehensive. Disablement with other causes can be explored further in section 4.5.

### 5.7 Objective Examinations

HCPs must use examinations relevant to the applicant's condition or injury. Such examinations should be tailored to the individual applicant and vary depending on the nature of the conditions present.

Before starting an examination, the HCP must gain consent to carry out the relevant examination after explaining the procedure in full. If consent has not been provided the HCP

must not carry out an examination and this must be documented. It should be explained to the applicant that the examination is not like one they would have had by a doctor or health professional previously as the purpose of it is not to diagnose or treat. It may be necessary to remove clothing or for the HCP to touch the applicant (for example to measure stump length accurately, to assess sensation or to examine scarring on the body). If the HCP is required to touch the applicant, appropriate consent and infection control measures must be adhered to.

Conducting examinations via a virtual assessment is possible in some circumstances.

The following considerations are required for a musculoskeletal examination/neurological examination:

- Completion of a dynamic risk assessment before, during and after any physical examination
- If there are any risks to the applicant's health identified that cannot be mitigated, the physical examination must not take place and the reason for such must be documented on the TPDPS1
- Standing movements must only be completed in the presence of a companion
- If standing movements are required, the applicant must be advised to hold on to a stable structure for support whilst completing these movements. If the advice is declined this must be documented with the reason if possible.

Examinations that may be included within the assessment include:

Psychological Examinations	Physical Examinations
Mental State Examination Cognitive State Examination	Musculoskeletal examination Neurological examination Stump length Scar measurement Vision test Hearing test

Table 6 – Examinations

### 5.7.1 Musculoskeletal Examination/Neurological Examination

The musculoskeletal (MSK)/neurological examination involves an examination of the relevant part of the body/limb/joint affected by the TRI and can be adapted depending on the presenting condition. Not all elements of an MSK are required in every assessment. The requirement will be dictated by the individual elements of an applicant's condition, medical evidence gathered and history.

Musculoskeletal/neurological examination of a limb may include:

- Shape/alignment
- Swelling
- Deformity
- Tenderness
- Active or passive range of movement (fraction of normal range compared to ranges specified in appendix K)
- Neurology to include (power using the Oxford Scale, muscle wastage, reflexes, sensory changes)



During the examination the HCP should assess the affected side and compare to the unaffected side where possible.

For example, if an applicant has an injury to their right knee only, the range of movement of left (unaffected) lower limbs joints are examined first and compared with the right (affected). This can be measured using fractions of normal range but is not recommended to be expressed as a percentage of the normal ROM at that joint. For example “knee flexion reduced by one half of normal” is preferable to 50% knee flexion, due to the potential for confusion regarding the subsequent assessment of percentage disablement. Normal ranges of movement are detailed in appendix K. If an abnormality is detected in the right knee such as reduced flexion and extension, a more detailed regional examination is performed to assess the shape, alignment, swelling, deformity, tenderness, movement, stability, and neurology (power using the Oxford Scale, tone, wasting, reflexes, sensory changes etc) of that joint or limb.

Part of the neurological examination (reflexes / sensory changes) may be completed using a blunt ended probe where it is a requirement to confirm the relevant loss of capacity to the skin to determine the location of the lesion and mapping it to dermatomal or peripheral nerve distribution. The applicant should be asked if they feel the same on both sides and whether the sensation is dull, sharp or absent and recorded as reduced or absent sensation on the relevant body part.

The assessment provider must advise of the potential need for an examination and the requirement to wear loose clothing to facilitate accurate examinations with minimal disturbance to the applicant.

Some examinations might be carried out with the applicant lying supine. If this is not feasible – for example, if it is a home assessment – the HCP should make a note of the circumstances and carry out the examination to the best of their ability while the applicant is sitting or standing. Where examination is not possible or the applicant does not consent, an explanation should be provided as to why.

### 5.7.2 Mental State Examination/Cognitive State Examination

The Mental State Examination (MSE) and Cognitive State Examination (CSE) are observational tools to support recording the presentation of an applicant seen during an assessment who has a mental/cognitive health injury/condition. The AP must gain consent at the beginning of the assessment to perform an MSE/CSE if such an examination is appropriate.

The 9 areas covered in each are set out in table 7.

<b>MSE</b>	<b>CSE</b>
Appearance	Appearance
Behaviour	Behaviour
Mood	Mood
Thought Content	Working Memory
Perception	Intellect
Cognition	Information Processing
Insight	Central Coherence
Speech	Insight
Suicidal Ideation	Sensory Processing
Self-Harm	

Table 7– Mental and Cognitive State Examinations

Although it is not necessary to be a specialist in mental health or cognitive/developmental conditions to undertake a MSE or CSE, it is necessary to have a clear understanding of the 9 areas covered in each and how these may manifest in applicants with various conditions.

### 5.7.3 Other Examinations

Other examinations may be applicable depending on the condition and must only be completed if relevant to do so.

#### 5.7.3.1 Amputation Stump Length

If a certificate of amputation stump measurement issued by the artificial limb and appliance centre, or detailed medical records containing amputation stump length is not on file, HCPs may observe the stump length according to proximal bony landmarks and document the remaining tissue length as high, medium and low.

#### 5.7.3.2 Scars and Facial Disfigurement

- When examining and documenting scars it is preferable that, where the medical evidence does not allow for a PBA, the HCP examines in person. The following must be documented where the applicant consents to being examined: The precise site, using anatomic landmarks
- The shape and size –measurement of length and width of the scar and calculate the area (e.g. 6x4 centimetres) for all but linear scars
- Surface of the scar – colour, texture, any visible tethering of the surrounding tissue

Scars of differing size, location, orientation and abnormalities can give rise to differing levels of disablement and therefore it is important to document adequate detail during assessment. To ensure accuracy when recording scars, it can be necessary to draw a diagram to describe the exact location, size and orientation.

Facial disfigurement does not commonly cause direct *physical* functional compromise however it should still be considered as part of the disablement assessment. Therefore, it is important to record additional information of the surface contour of the scar for example:

- elevated or depressed on palpation
- abnormal texture (irregular, atrophic, shiny, scaly, etc.)
- hypo or hyperpigmented
- colour of scar compared to unaffected areas of skin with measurement of the area of abnormally pigmented skin.

#### 5.7.3.3 Vision Test

Vision test cards will be available for HCPs to use where relevant to assess an applicant's visual acuity. HCP should record vision in both eyes, both before and after correction. Where appropriate abnormality of eye movements, scarring, cataract, aphakia and field defects should be recorded

If an applicant has an ophthalmology report as part of their medical evidence, or a Certificate of Visual Impairment, it is not necessary to perform a vision test. The percentage disablement scales as a result of the visual loss is referenced in appendix L.

#### 5.7.3.4 Conversational Voice Testing

A Conversational Voice test should be carried out on any applicant who reports hearing loss as a result of a TRI. This is to be considered as part of the evidence available to the HCP regarding the applicant's hearing, and not used as sole evidence. The test is a framework for recording observations rather than an objective test and will involve assessment of hearing at varying volumes and distances to ascertain functional hearing levels. The HCP should record any detectable hearing loss noted during this test and if any hearing aid is used.

If an applicant reports hearing loss and doesn't have an audiogram on file, it is necessary for the AP to refer for this. These results will be interpreted by the HCP completing the disablement assessment as part of the analysis of the clinical findings.

The percentage disablement scales in relation to audiogram results are referenced in appendix M.

### 5.8 Observations

One of the key principles of disablement analysis is observation. Observations are a key aspect of the evidence to identify and analyse the functional ability of the applicant in conjunction with other areas of the assessment.

It is important to balance observations with evidence gathered from other areas of the assessment when justifying percentage disablement. The entirety of the evidence must be analysed to check for consistency/inconsistency and the HCP must consider observations as a constituent part of this wider portfolio of information.

It is essential to acknowledge that observations only give a very small, short window into an applicant's functional ability, care must be taken not to excessively rely on observational findings.

HCPs need to bear in mind the subtle and less visibly apparent nature of some symptoms such as pain or fatigue and how these are more difficult to identify through observation of the applicant. In addition, psychological injuries may not always present overtly and this must be considered.

Observations must be recorded in Section 5 of the assessment report form (TPDPS1). Recording of observations commences when the applicant is met at the assessment centre/is met at their home by the HCP and concludes when the applicant leaves the premises of the assessment, or the HCP leaves the applicant's home.

Recorded observations must be factual, relevant to the applicant, the reported injury, and the reported level of disablement. For example, the applicant may be reporting an injury to their leg which requires the use of elbow crutches. In this instance, the HCP would make observations of movements/actions relating to the reported disablement and relating to how the elbow crutches were used and to mobilising.

Suggested observations to document in the report are:

- Appearance

When recording observations about an applicant's appearance it is important the HCP avoids judgemental comments and remains professional. Appearance can contribute to the HCP's understanding of how a person is functioning.

- Use of upper limbs

This contributes to the HCP's understanding of dexterity and upper limb function.

- Use of lower limbs

This contributes to the HCP's understanding of mobility, or how much movement is achievable in the lower limb. For example, how the person moves from standing to sitting.

- Walking

Descriptions may include:

- Pace
- Distance
- Gait (any limp, shuffle, stride length etc)
- Use of aids/appliances/assistance including appropriateness and provision

#### 5.8.1 Specific Considerations for Virtual Assessments

Tables 8 and 9 show examples of appropriate and inappropriate observations during virtual and telephone assessments including elements of the MSE or CSE that may be included when documenting observations.

Appropriate observations	Inappropriate observations
Audible breathing pattern and rate for applicants with respiratory conditions, if affected	Very subjective observations e.g. 'appeared in pain due to delay when answering'
Elements of the MSE/CSE: Behaviour Central Coherence	Commenting on ability to use telephone/computer if this cannot be observed. Many people have adapted ways of using telephones such as using loudspeaker, headphones and/or having others dial for them.

Appropriate observations	Inappropriate observations
Cognition Information Processing Intellect Insight Thought Disorder Speech Appearance Mood Sensory processing Working memory	
Physical movements	

Table 8 – Appropriateness of Observations in a Virtual Assessment

Appropriate observations	Inappropriate observations
Audible breathing pattern and rate for applicants with respiratory conditions, if affected	Very subjective observations e.g. 'appeared in pain due to delay when answering'
Elements of the MSE/CSE: Behaviour Central Coherence Cognition Information Processing Intellect Insight Thought Disorder Speech Working memory	Direct statements from applicants e.g. 'She said she was in a bad mood' which do not add value to the report  Elements of the MSE/CSE: Appearance Mood Sensory processing  Commenting on ability to use telephone as this cannot be observed. Many people have adapted ways of using telephones such as using loudspeaker, headphones and/or having others dial for them.

Table 9 – Appropriateness of Observations in a Telephone Assessment

## 5.9 Injury, Loss of Capacity, Disablement

The following sections have been taken from the assessment report form TPDPS1 with additional explanatory notes.

The concept of injury, loss of capacity and disablement are explored in section 4.1-4.3

The HCP should document what injury or injuries were sustained due to the TRI with the date of diagnosis.

<b><i>Diagnosis</i></b>	<b><i>Date of Diagnosis</i></b>

If evidence gathered supports the presence of resulting damage, disfigurement, or loss of physical and/or mental capacity further details are required, outlining the specific damage, disfigurement or loss of physical and/or mental capacity (this should be described as the local organ/joint/body part/loss of function).

If disabilities arising from the damage, disfigurement or loss of physical and/or mental capacity (this should be described as the global loss of function of the affected body part/limb) are solely attributable to the TRI this should be documented as an 'F' (fully relevant). If there is another cause mark 'P' (partially relevant).

Relevance of an injury is explored in section 4.5.1.

<b><i>Identified Disability (ID)</i></b>	<b><i>Disability</i></b>	<b><i>F/P</i></b>
<i>ID1</i>		

If any conditions are found to be partially relevant, it is necessary to identify and document the condition which is within the functional area of disablement, with consideration to the evidence contained in sections 1-5 of the assessment report form. Conditions which existed before the TRI should be marked 'other(pre)' and those which arose afterwards should be marked 'other(post)'.  
 Disablement with other causes is explored in section 4.5.

<b><i>ID</i></b>	<b><i>Other Cause</i></b>	<b><i>Other(pre) or Other(post)</i></b>

#### Unconnected Conditions

Conditions identified in section 1 (medical evidence considered) and 3.4 (other medical history) that do not have an impact on the functional area of disablement caused by the relevant damage, disfigurement or loss of mental and/or physical capacity must also be documented.

Unconnected conditions are explored in section 4.5.6.

## 5.10 Effect of the Relevant Damage, Disfigurement or Loss of Capacity

Section 7 of the assessment report form outlines the effect of the relevant damage, disfigurement or loss of capacity

This section of the form is to outline the way in which the disabilities described in 6.3 of the assessment report form, in combination with the conditions outlined in 6.4 of the assessment report form, affect the applicant's activities of daily living such as washing, dressing, walking etc.

### 5.11 Assessment of Degree of Disablement and Permanence

Section 8 of the assessment report form outlines the assessment of degree of disablement and permanence.

#### Considerations for Box A

On the assessment report form, an HCP must only complete 'gross assessment' and 'offset' where an other(pre) condition is noted in 6.4 of the assessment report form.

It is necessary to offset (subtract) the effects of any other(pre) condition from the global disability in the functional area only to the extent to which disablement would have resulted from that condition even if the TRI had not occurred. The residual net assessment therefore includes any addition caused by the interaction between the relevant disability and the other(pre) condition, so do not make any addition in box B of the assessment report form.

The HCP must ignore a disablement arising from any other(post) condition shown in 6.4 at this point. It is necessary to assess only the disablement appropriate for the TRI had any other(post) condition not occurred and record that assessment as net, as shown in Box A below.

#### Box A:

<i>ID</i>	<i>Gross Assessment</i>	<i>Offset (percentage and condition)</i>	<i>Net assessment</i>

#### Considerations for Box B:

If the total net assessment in box A is 11% or more and an other(post) condition has been identified in 6.4 assess in box B the extent to which the presence of the other(post) condition makes any 'P' disability worse (interaction) during the period which is taken into account by the assessment. The disablement of the other(post) condition is not to be assessed.

#### Box B:

<i>ID</i>	<i>Additional Assessment (interaction of other(post) condition)</i>

<i>Are the injuries resulting in disablement, permanent?</i>	
<i>Diagnosis</i>	<i>Permanent?</i>
	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<i>Having regard to the possibility of meaningful change in a Victim's condition, can the degree of permanent disablement be assessed?</i>
--

*Note: small, natural, expected fluctuations in a condition should not constitute meaningful change in a Victim's condition.*

ID1

Yes ☐ No ☐

**8.4 At what degree do you think the disablement resulting from the relevant damage, disfigurement or loss of capacity should be assessed?**

*This should be the NET assessment at box A plus any figure in box B in (section 8.1)*

Numbers..... Words.....

**8.5 if 'no' answered to any IDs in section 8.3, for how long should the above assessment be considered (max 2 years from date of the assessment)?**

Years..... Months..... N/A ☐

**8.6 if 'yes' answered to all IDs in section 8.3, confirm the percentage outlined in 8.4 is final**

Yes ☐ No ☐

## 5.12 Justification

Section 9 of the assessment report form outlines the justification.

*Provide a justification for your advice contained within this assessment report. Ensure to consider all of the evidence available to include medical evidence, assessment findings and examinations. Where evidence is conflicting ensure to describe why one element of the evidence is more convincing than the other. Justification should be in clear, concise language without the use of medical jargon.*

The principles of the 2020 Regulations outline that applications must be determined without delay and therefore the assessing HCP must complete the assessment report as soon as is reasonably practicable. However, whilst timely completion is important, the accuracy of the report must take priority.

The following sections of the assessment guide focus on the aspects of section 9 in the assessment report form which require detailed and thorough justification of advice.



### 5.12.1 Balance of Probabilities

The reasoning and rationale for the advised percentage disablement must be justified on the balance of probabilities. The HCP must be satisfied when considering the balance of probabilities, in line with medical consensus, that it is more likely than not, that the applicant has permanent disablement to the degree advised.

In some cases, there may be sufficient, consistent information to advise on disablement despite small gaps remaining in information that have not been possible to fill through further medical evidence or by contacting relevant external practitioners. It may still be possible, in such circumstances, to advise the VPB about the level of disablement on the balance of probabilities.

In such cases, where the available information is consistent, the HCP must consider whether the use of clinical knowledge of the nature of the condition(s), its severity and likely functional impact in other areas to determine, on the balance of probabilities, in line with medical consensus, the percentage disablement.

### 5.12.2 Justification of Percentage Disablement

Section 9 of the assessment report form requires the assessing HCP to justify percentage disablement using appropriate evidence.

Disability assessment is complex, and the outcome of a disability assessment is reliant and influenced by many factors. For this reason, it is essential that the outcome of any report is fully justified. Written justifications are utilised within disability assessment to allow the assessing HCP to articulate the clinical rationale for any advice given. The justification therefore provides the VPB with a summarised argument based on evidence.

The justification must address all relevant aspects of the following for all injuries/conditions:

- The injury - this includes a brief history of the relevant incident, the diagnosis of the injury and date of diagnosis
- The resultant damage, disfigurement, or loss of physical or mental capacity if any
- The resultant disablement if any
- The degree of relevant disablement
- The percentage relating to disablement with other causes
- Whether the percentage disablement is determined to be permanent or likely to change with consideration to treatment and response to treatment

The assessing HCP must be satisfied that it is more probable than not that the injury has resulted in damage, disfigurement, or loss of physical and/or mental capacity before advising on disablement.

The VPB requires a report that is sufficiently detailed, fully justified and can be understood clearly in non-medical terms.

The justification should be used to:

- appraise evidence gathered at assessment
- appraise medical evidence provided before assessment
- identify and address any inconsistent, contradictory, or conflicting evidence
- explain clinical rationale.

A good justification is one that;

- is written in clear English
- is coherent and comprehensible, ensuring any medical terms or abbreviations are explained

- explains any clinical reasoning based on evidence
- avoids internal contradiction

The below example is used to outline the components of a justification only:

Applicant X is diagnosed with PTSD, as confirmed by a Consultant Psychiatrist, as a result of TRI which occurred in 1982. X was treated in the past briefly for bereavement reaction, from which there was a full recovery therefore an other(pre) offset has not been considered. X describes moderate symptoms of PTSD which is affecting some aspects of X's sleep, social, interpersonal, and occupational functioning. However, X works part-time, sees a couple of friends regularly and spends time with their child over the weekend. This is consistent with the observation and examination findings of moderate functional restrictions. As the bereavement reaction resolved fully with no ongoing restrictions, an assessment of \_% for the moderate disablement would seem appropriate for the X's fully relevant PTSD. The evidence indicates X had various pharmaceutical and psychological treatments in the past and X's condition has plateaued over the years with some fluctuations. X has no further treatment planned. Therefore, a final assessment is appropriate in this case.

### 5.12.3 Evaluation and Analysis of Evidence

The justification should show that the advised percentage disablement is consistent with the clinical findings and other evidence provided in advance of the assessment, and that it is in keeping with the balance of probabilities.

Where there are inconsistencies or contradictions in the evidence the reason for the final outcome must be carefully documented. To do so the HCP should draw attention to the different conclusions and outline the reasons for reaching the decision within the justification.

Evidence used to support the degree of percentage disablement advised can derive from a variety of sources to include:

- medical evidence (see section 5.13 for further details)
- history taking to include history of TRI, social and occupational history, activities of daily living, mobility and other medical history
- examinations such as musculoskeletal examination, neurological examination, mental state examination, cognitive state examination and other examinations.
- informal observations

### 5.13 Medical Evidence

Medical evidence held on file can be provided in several formats which include, but are not limited to, those listed in table 10. The source/author, document type, date of issue, and detail included all impact on how robustly the report is supported by the evidence. The below list is not exhaustive; generally medical evidence may be useful if it pertains to diagnosis, treatment and/or type and severity of functional disablement.

<b>Strong Evidence</b>	<b>Weak Evidence</b>
Medical Factual Report (appendix F) Consultant Letters Hospital Discharge Letters Psychiatric Report (in-patient and out-patient) Psychological therapy report Surgical/Operation Notes Prescription List Audiology Reports Certificate of Visual Impairment (CVI) Physiotherapy Report Occupational Therapy (OT) Report Community Psychiatric Nurse (CPN) Report Social Services Records Care Plans Scan results (X-ray, Ultrasound, MRI) Pain clinic reports/notes Prosthetic clinic notes Reports from other benefits such as IIDB, PIP, WCA, AFCS, War Pension, CIC	Confirmation of Appointment Letters Evidence without a date Evidence without identified source/author Delivery note e.g. OT Equipment Site maps

Table 10 – Sources of Evidence

#### 5.14 Circumstance Where Assessment Report Cannot be Completed

It is not always possible to complete the assessment or indeed, the assessment report as intended for several reasons which include:

- Applicant/legally appointed person (see 5.16.1) failed to attend (FTA)
- Applicant/companion / authorised representative / legally appointed person displays unacceptable behaviour
- Applicant/legally appointed person (see 5.16.1) fails to comply with the assessment process
- Applicant/legally appointed person unable to verify identification
- Applicant is unfit to be examined due to being under the influence of drugs/alcohol, general malaise, acute/severe symptoms of condition, symptoms of Covid-19, or cognitive impairment without legally appointed person.
- Applicant/ legally appointed person withdrew consent to be assessed

In such cases the HCP should mark the case as incomplete with the appropriate accompanying rationale and return to the VPB.

There may be occasions where it is not possible to complete the assessment when the case can be marked as incomplete with the appropriate accompanying rationale and the appointment must be rescheduled, rather than the case returned to the VPB. These include:

- Appropriate provisions have not been made such as adequate accessibility, communication support, required gender or recording capabilities.
- HCP did not attend
- HCP is unfit/unable to continue
- HCP unable to complete due to significant contradicting information

## 5.15 Consent

Explicit, informed consent must be gained from either the applicant or legally appointed person (see section 5.16) prior to an assessment being carried out. If an examination (musculoskeletal/neurological and mental state examination/cognitive state examination) is required, consent needs to be gained separately. This is in line with all health professional codes of conduct as set out by the General Medical Council (GMC), Health and Care Professions Council (HCPC) and Nursing and Midwifery Council (NMC).

The consent box on the assessment report form must be completed to document the receipt of informed consent before submission to VPB.

### 5.15.1 Proof of Consent

Proof of consent given by applicants need not be routinely sent by assessment providers when requesting further evidence.

The 2020 Regulations state that the VPB have power to require any person to provide information for the purpose of assisting with the applicant's claim. The application form contains a declaration whereby the applicant is advised that the VPB may seek additional information to support their claim. The assessment provider will be acting as an agent of the VPB in this regard.

In addition to this, the NHS accepts that consent is an integral part of claims for benefit, and proof of consent is not necessary before information is released by hospitals, trusts and clinics funded by the NHS or local authorities.

The position that proof of consent is not required is supported by the General Medical Council (GMC), which advises that:

*'...you may accept an assurance from an officer of a government department or agency, or a registered health professional acting on their behalf, that the patient or a person properly authorised to act on their behalf has consented'.*

It may be appropriate to obtain further evidence from an alternative source should proof of consent be an issue.

## 5.16 Capacity, Consent and Additional Support Needs

Within the 2020 Regulations, the following statements apply as part of regulation 49:

Where a health care professional, after carrying out an assessment of a person, is satisfied— (a) that the person by reason of mental disorder, is incapable of managing and administering their property and affairs; (b) that any of the powers of the court under Article 98 or 99 of the Mental Health (Northern Ireland) Order 1986 ought to be exercised with respect to the property or affairs of that person; (c) that arrangements in that

behalf have not been made and are not being made, it is the duty of the health care professional to notify the Office of Care and Protection of those matters.

#### 5.16.1 Overview of the capacity and consent process

Applicants with additional support needs (ASN) may have mental, intellectual, or cognitive impairments that affect their ability to engage with the application or assessment process, give informed consent, or manage their property and affairs. Applicants who meet this definition of ASN may range from those who prefer support but retain full mental capacity, to those who do not have mental capacity and therefore require a legally appointed person to manage their affairs. The assessment provider should sensitively manage applicants with ASN if the Scheme identifies an applicant as having such needs at the referral stage, by selecting the most appropriate assessment route and allowing applicants to be supported at assessment as required.

Conversely, the assessment provider should establish a process with the Victims' Payments Board (VPB) to raise concerns about applicants who may have ASN due to a potential impairment in mental capacity that is not already managed by a legally appointed person via the Office of Care and Protection (OCP). Whilst the assessment provider must not complete formal mental capacity evaluations (as these are out of scope for the disablement assessment provider and will be facilitated through the VPB directly) or attempt to diagnose a loss of mental capacity, if clinical suspicions about an applicant's mental capacity to manage their property and affairs are established during disablement assessments, such concerns should be raised to the VPB for their review via the process and proforma outlined in appendix O. Any and all subsequent actions to diagnose a loss of mental capacity and referral to the OCP will be completed by the VPB after the Board has determined that an applicant is entitled to receive victims' payments.

#### 5.16.2 Applicant Types

Within the scheme, there will be 3 types of applicants:

- 1) Those represented by a legally appointed person
- 2) Those represented by an authorised representative
- 3) Those applicants with no representation.

These individual scenarios will be outlined below.

#### 5.16.3 Legally Appointed Persons

Some applicants where ASN applies will have a legally appointed person in place to manage their affairs such as:

- Attorney (appointed on foot of a Power of Attorney or an Enduring Power of Attorney duly registered in the Office of Care and Protection) (NI)
- Controller (NI)
- Official Solicitor (NI)
- Attorney (PoA) or Guardian (E&W)
- Deputy (E&W)
- Tutor (under Scottish law)
- Guardian (under Scottish law)
- Curator bonis or judicial factor (under Scottish law)

A legally appointed person is nominated to act on behalf of the applicant and ensures they are supported throughout the process. Where an applicant has a legally appointed person in place and this is identifiable on the application / DACS form, the assessment provider does not need to inform the VPB about these ASN as the VPB will already be aware.

From a consent perspective, if a legally appointed person exists, an assessment cannot go ahead if the legally appointed person does not accompany the applicant. If they do not attend, the clinical assessor will document the appointment as failed to attend (FTA). In practice, it is likely that there will be a relatively small number of applicants who will have a legally appointed person in place.

#### 5.16.4 Authorised Representatives

Some applicants where ASN applies will have assistance from a family member, a welfare advisor or a legal representative. These people have been appointed by the applicant to deal with the application on the applicant's behalf on foot of a form of authority. Such authorised representatives will be the first point of contact in any communications about the application.

An authorised representative should accompany the applicant to any assessments where possible unless, during the assessment booking stage, it becomes evident that either the applicant wishes to complete the assessment alone or the representative is unable to attend and this would not result in undue distress for the applicant.

If, during the disablement assessment process, a clinical assessor is concerned about the mental capacity to manage property / affairs of an applicant represented by an authorised representative, these cases should be raised back to the VPB via the process and proforma outlined in appendix O. If the assessment provider is made aware of mental capacity concerns by a healthcare professional who provides medical evidence in a case, the VPB should also be made aware of this via the same process.

There may be scenarios where the clinical assessor is satisfied that the applicant, with support from the authorised representative, can give informed consent to the assessment, yet retain concerns about the applicant's mental capacity to manage their property and affairs. In such scenarios the assessment may proceed however the case should also be raised back to the VPB via the process outlined in appendix O.

The authorised representative may contribute to the applicant's responses where appropriate, however the assessment conducted should primarily be between the clinical assessor and the applicant themselves.

#### 5.16.5 Applicants without assistance

Other applicants to the scheme will not have assistance to manage their application or attend assessments. For most cases this will not present any issues of concern for the assessment provider as these applicants will likely have capacity to consent to the assessment process and manage their property / affairs. However, there may be a small proportion of this population who are unable to engage with the process, due to reduced mental capacity or lack of insight and do not have a legally appointed person in place to assist them. Applicants such as these would require additional support from the Scheme. If, during the disablement assessment process, a clinical assessor is concerned about the mental capacity of an applicant to manage their property / affairs or consent to the assessment process, who does not have any assistance, these cases should be raised back to the VPB via the process and proforma outlined in appendix O. If the assessment provider is made aware of mental capacity concerns by a healthcare professional who provides medical evidence in a case, the VPB



should also be made aware of this via the same process. If, during the disablement process, a clinical assessor is concerned about the applicant's capacity to consent to the assessment process, a case may be completed using "best endeavours" as described at 5.4.1.

#### 5.16.6 Role of the Legally Appointed Person

Where a person may be eligible for the Scheme but is deemed incapable of managing their own affairs due to a mental disorder or lack of capacity, the application may be progressed by a person who has the legal authority to do so.

The legally appointed person must:

- Exercise the applicant's rights in respect of their TPDPS application
- Receive and handle any communications and/or payments received
- Report (to VPB) changes in the applicant's circumstances, or changes in the legally appointed person's circumstances such as change of name or address

If a legally appointed person exists, an assessment cannot go ahead if the legally appointed person does not accompany the applicant. If they do not attend, the assessment will document the appointment as failed to attend (FTA).

Legally appointed persons may play an active role in helping to answer questions where the applicant or HCP wishes them to do so. For example, an applicant may lack insight or have a memory impairment which would mean they are unable to give an accurate account of their health condition or impairment, or the applicant may require explanation or reassurance from a legally appointed person during the assessment. It is the HCP's responsibility to decide how much information can be gathered from the applicant and how much from the legally appointed person during the assessment.

A similar role may be fulfilled by an authorised representative, such as a family member, welfare advisor or legal representative. However, this is a voluntary role.

#### 5.16.7 Power of Attorney/Enduring or Lasting Power of Attorney/Controller/Deputy

Where an applicant retains capacity and wants an attorney to act on their behalf, the attorney's details are provided to the Scheme and the appointment letter should be sent to that person only. However, it must be the applicant who attends any assessment. If the applicant attends alone, then the assessment can go ahead if they retain capacity.

An Enduring PoA must be registered at the Office of Care and Protection following confirmation by a suitably qualified medical practitioner that the applicant, by reason of mental disorder, is incapable of managing and administering their property and affairs.

A Lasting PoA (applicable in E&W) must be registered with the Office of Public Guardian whilst the applicant has capacity. Once registered, it remains valid, even if capacity is lost.

If capacity has been lost then the expectation is that the applicant would be accompanied. The attorney should be aware of this and if acting responsibly should not let the applicant attend on their own. The attorney may nominate someone else to accompany the applicant.

In the cases of Enduring/Lasting PoA, the assessment questions are mainly answered by the attorney. However, it may be necessary to carry out an examination on the applicant, in which case the attorney would provide consent but the examination would need to be carried out on the applicant.

Controllership/Deputyship is different to an Enduring PoA/Lasting PoA as it is utilised if the applicant has already lost the capacity to organise an Enduring PoA/Lasting PoA and someone subsequently requests the ability to make decisions on their behalf. If an applicant has a Controller or Deputy and is called to an assessment, the Controller or Deputy must accompany the applicant and play an active role in the assessment.

## 5.17 Data Protection

All personal data must be processed in line with the Data Protection Act 2018 and the United Kingdom General Data Protection Regulation (UKGDPR). The assessment provider has a legal obligation to ensure that any information that is utilised is kept confidential at all times.

Consideration must be taken of the privacy and confidentiality of all applicants and to take account of their legitimate expectations and rights regarding the use of their information. This applies to all types of information (personal data and special categories of personal data) whether held on paper or electronically and whether passed in written form or orally.

The AP has a duty to respect the applicant's confidentiality and ensure that all information is appropriately safeguarded. Personal data shall only be processed fairly, lawfully and as transparent as possible in line with the UKGDPR to ensure that:

- Applicants understand the reason for processing personal information
- Applicant's personal data is only handled in ways that are reasonably expected
- Information is not used in ways that unjustifiably have a negative effect on applicants
- Trust is gained in the way information is handled

All personal identifiable information shall be accessed, stored and disposed of securely. The assessment provider must also ensure that all personal information is always kept secure and protected against unauthorised/unlawful or accidental loss, damage or disclosure.

## 5.18 Harmful Information

There may be times in advance of, during or after the assessment when unexpected findings come to light of which the applicant is unaware, and which could have a detrimental effect on the health of the applicant if made aware. In all assessments and on all forms, the HCP must check for any information which could be seriously harmful to an applicant's health if it were disclosed to them. This is classed as "harmful information" and is the only information that can be withheld from the applicant legally. For example, a poor prognosis that is unknown to the applicant or a diagnosis of a psychotic illness of an applicant who lacks insight into their condition.

In such circumstances, the HCP must complete TPDPS2 (appendix E) by completing the following:

- Identify where harmful information has been identified within the assessment process
- Omit any information within the TPDPS1 that is considered harmful and replace with a non-specific statement that does not disclose the harmful information
- Do not refer to the TPDPS2, within the TPDPS1
- Write the relevant heading and subsequent information in TPDPS2, where harmful information has been removed from the TPDPS1.



### 5.19 Unexpected Findings

There may be occasions when the HCP is made aware of information that should be reported to a suitable person responsible for the applicant's care. For example, if it is identified that the applicant has a significant undiagnosed medical condition. This is usually the applicant's GP.

The HCP has a duty to maintain the confidentiality of the information obtained during the assessment. Therefore, the HCP must seek consent to inform the GP of the unexpected finding from the applicant explaining what information will be shared and why.

If the applicant agrees, the HCP should complete and send the relevant referral form to the applicant's GP as soon as is reasonably practicable. If the unexpected finding is of a life-threatening nature, the HCP must seek the applicant's consent to telephone the GP and/or call an ambulance if appropriate. If required to make such a telephone call this must be followed up with a written notification to the GP as soon as possible.

If the HCP has sought consent but the applicant has declined consent, the HCP must use their clinical judgement as to whether the situation is sufficiently serious to warrant breaking confidentiality to contact emergency services or the GP without the applicant's consent. The HCP should act within their professional standards guidelines and be able to justify their actions.

### 5.20 Safeguarding

There may be occasions whereby an HCP is made aware of allegations or evidence to suggest a safeguarding referral may be required. For example, an applicant may express they are subject to abuse or being neglected. The AP must apply a safeguarding approach to protect the needs of anyone they encounter within the assessment process and engage with relevant external authorities such as the police, Health and Social Care Trusts or their safeguarding teams when indicated.

Safeguarding procedures intended for the use by all organisations working with, or providing services to, adults across all sectors in Northern Ireland are set out in the Health and Social Care Board's Adult Safeguarding Operational Procedures (2016). A similar approach is to be taken if there is a safeguarding concern relating to children and young people.

Jurisdictions outside Northern Ireland will have their own policies and procedures for the safeguarding of children and vulnerable adults, and it is important that these are adhered to.

### 5.21 Unauthorised Recording

If the HCP suspects that the applicant/authorised representative is covertly recording the assessment, the applicant/ authorised representative must be asked to stop recording. If the applicant/ authorised representative declines, the assessment must be terminated, and the case should be returned to the VPB with the reason.

If the HCP suspects that a *companion* is covertly recording the assessment, the companion must be asked to stop recording. If the companion declines, the applicant would be given the options:

- Continue with the assessment without the companion
- Terminate the assessment, and the case would be returned to the VPB with the reason given.

There is no statutory obligation for the assessment provider to provide audio recording.

## 5.22 Note Taking

Applicants and companions attending an assessment are entitled to take notes during the assessment for their own purposes. The applicant or companion may keep the notes and are not required to provide a copy of their notes to the HCP, although the HCP may record that notes were taken. The notes taken are not an official record of the process and are for the applicant or companion's own purposes.

## 6 Health Care Professional Performance

The assessment provider (AP) must adhere to certain processes and standards, to ensure health care professionals (HCPs) carrying out assessments meet the required standards.

Sections 4 and 5 of the assessment guide explore the assessment criteria and process which govern the scheme in a sequential manner. However, Section 6 of the assessment guide explores each aspect of health care professional performance in detail to include:

- health care professional standards and principles
- training
- quality audit
- approval
- complaints
- case reconsideration advice
- case rework

### 6.1 Health Care Professional Standards and Principles

The standards and principles to which the HCP must conform relate to conduct, performance and ethics as set out by their relevant governing body and also contained within this guide. It is the responsibility of the HCP to adhere to these standards.

#### 6.1.1 HCP Minimum Requirements

The minimum requirements of an HCP carrying out assessments under the TPDPS are:

- To be a fully registered medical practitioner, a psychologist, a registered nurse, an occupational therapist, a physiotherapist, a social worker or fully registered with a regulatory body established by an Order in Council under section 60 of the Health Act 1999 a member of such other profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
- Have at least 2 years post full registration experience (this refers to either UK registration or equivalent overseas registration for non-UK HPs)
- No restrictions on practice unless related to a disability
- Have experience and training in disability assessment medicine
- Have undertaken other such training that the Victims' Payments Board (VPB) considers appropriate
- Have passed a Counter Terrorist Check (CTC) employment screening

#### 6.1.2 HCP Competencies

Before they are approved to carry out assessments, APs must be able to demonstrate that HCPs:

- Have appropriate clinical knowledge and understanding of the likely impact of a wide range of conditions, injuries and disabilities associated with Troubles-related incidents
- Have appropriate interpersonal skills to ensure suitable and sensitive interaction with applicants with particular regard to the context of Troubles-related incidents and issues specific to degree of disablement
- Have appropriate assessment skills relating to both psychological and physical injuries

- Have appropriate written skills to document a clear, focused history, accurate observations, and examinations findings and adequately justified assessments reports

### 6.1.3 Conflict of Interest

A conflict of interest in the context of TPDPS arises where an HCP has a personal interest which might influence, or be perceived to influence, that HCP's judgement in carrying out their duties as determined by their role.

When a reasonable, fair-minded, and informed observer would conclude that there is a real possibility that an HCP is or could be biased due to a personal interest then there is a conflict of interest.

An HCP should not take part in any case if they are or may be directly linked to the applicant as follows:

- A past or present interest that could reasonably be thought to influence judgement as an HCP
- Where there have been previous interactions with the applicant, either personal or professional such as an employer, a relative, an HCP regularly attending treatment etc.
- When, during assessment of a case an HCP finds that there is a conflict of interest, action on the case must cease and another suitably qualified individual must complete the assessment.

Knowing the individual would not necessarily be considered a conflict of interest.

## 6.2 Training

All HCPs must undergo training delivered by the AP and based on this guidance, ensure competencies for their role are met. This training must cover clinical and non-clinical processes to enable HCPs to carry out their role.

This guide should not be used as a stand-alone document but should form part of a suite of training materials and written guidance that the HCP should successfully complete. As disability assessment is a practical occupation, the guidance and clinical development will also involve practical learning through training and clinical support.

### 6.2.1 Initial Training

Initial training should give HCPs a foundation of understanding for the role. The training programme should include, but not be limited to, the following knowledge and skills, ensuring HCPs have:

- An understanding of the 2020 Regulations
- An understanding of the values, principles and ethos which underpin the TPDPS
- An understanding of the context of the Troubles and are trauma-aware with a good understanding of handling applicant's sensitive information.
- An understanding of the challenges faced and needs of people living with permanent disablement caused by a Troubles- related incident, including the risk of re-traumatisation
- An understanding of, and an ability to perform the role of an HCP in order to assess applicants with varied health conditions or disabilities.
- The ability to undertake examinations appropriate for the applicant (mental/cognitive state and physical examinations).
- An understanding of how these conditions or disabilities affect either their mental or physical capacity/disablement.

- An understanding of the importance of customer service and equal opportunities and any relevant policies and procedures.
- An ability to deal with potential clinical or operational risk
- An ability to competently use relevant IT systems

Training programmes should involve both theoretical and simulated assessments (including initial review (IR), paper-based assessments (PBA), face-to-face assessments and quality audit) to ensure that HCPs can meet the competence and knowledge requirements.

Following classroom-based training, HCPs must undergo a written and practical assessment to ensure that the required level of competence has been achieved.

Once all elements of classroom-based training are completed and the AP is satisfied that the HCP meets the competence and knowledge requirements at this stage, the HCPs are able to carry out assessments without supervision but are subject to 100% audit until full approval is granted (see section 6.3.1.1).

### 6.2.2 Continuous Professional Development

The AP should develop, deliver, and evaluate a programme of refresher training and continuous professional development (CPD) for all HCPs involved in TPDPS assessments.

Training modules relevant to the TPDPS should be developed, delivered, and evaluated to ensure clinical skills are up to date and HCPs can meet any changing demands of the service as required. Ongoing training also supports HCPs completing assessments with their individual regulatory requirements.

The AP should undertake regular training needs analysis (section 6.2.3) at organisational level to identify areas of training needs together with priorities for implementation. Training plans should be tailored to the needs of the HCP to support CPD which should take the form of both self-directed and targeted learning based on business and/or individual need.

APs must evaluate the effectiveness of their training and CPD programmes and make changes where applicable.

### 6.2.3 Training Needs Analysis

Training needs analysis (TNA) is a process that the AP should carry out to determine training requirements, to enable their HCPs to complete their job as effectively as possible. TNA should also be used as a tool to facilitate, develop, and improve clinical quality. This must be underpinned by data analysis.

There are 3 key steps involved in training needs analysis:

#### **Step 1: Identify skill sets**

The first stage is to identify the skill sets that HCPs require to carry out TPDPS assessments competently through initial training.

#### **Step 2: Evaluate the skills of staff**

The second stage is to evaluate HCP current skill levels in relation to the skills laid out in the first stage of this process. This allows identification of HCPs who are meeting expectations, and those who require further training to meet the expected skill level through ongoing support, evaluation, and audit.

#### **Step 3: Highlight the skills gap**

Once the skills are evaluated, these can be compared to the competencies set out in step 1. If there is a gap between the two, training can be used to close this gap and ensure the HCP is at the expected level through CPD and refresher training.

These steps should be carried out regularly by the AP to assure the quality of HCPs, their assessments, and subsequent reports, are being maintained.

## 6.3 Quality Audit

Quality audit is the mechanism by which an experienced HCP, with appropriate knowledge and skills, reviews an assessment report to ensure the required quality standard has been met. The auditor provides feedback on the quality of the case to the assessing HCP. It is essential that assessment reports are subject to quality audit to assist with monitoring, quality improvement and maintenance of clinical competence.

Clinical audit within TPDPS is required for the following reasons:

- To provide assurance to the VPB on clinical quality and consistency between HCPs
- To support management and development of individual clinicians
- To continually improve the quality of clinical service
- To drive individual and business wide quality improvement via TNA where audit themes identify areas for development
- To support revalidation processes for clinical regulatory bodies
- To ensure each assessing HCP has met the required standards before being granted approval
- To ensure each assessment report that has been audited meets requirements before being submitted to the VPB.

### 6.3.1 Quality Audit Types

Quality audit should take place throughout the careers of HCPs involved in TPDPS. The following are types of clinical audit applicable within the scheme:

- Approval audit
- Rolling audit
- Performance audit

These audit types are further explored in the sections below.

#### 6.3.1.1 Approval Audit

After initial training, HCPs are subject to “approval audit”. This is applied to 100% of assessment reports written until the required quality and competence standards are consistency achieved. The purpose is to ensure that assessment reports completed by inexperienced HCPs are acceptable and accurate before submission to the VPB and to ensure feedback relating to necessary improvements is received for learning and development.

#### 6.3.1.2 Rolling Audit

Once HCPs have met the requirements and been granted approval, and therefore no longer subject to approval audit, assessment reports written are instead subject to “rolling audit”. Rolling audit involves a random sample of reports which are selected for every HCP conducting assessments on a monthly basis to ensure they continue to meet the required quality standard. The quality outcomes of rolling audit provide information for the analysis of training needs on both an individual basis and a broader scale, as outlined in section 6.2.3.

#### 6.3.1.3 Performance Audit

In any instances where there are concerns about an approved HCP via rolling audit, case reconsideration advice, case rework and complaints the AP may decide to audit a higher volume of their work to ensure the required quality standards are met. The duration of performance auditing is at the discretion of the AP and may be initiated on request from the VPB. Corrective action should take place by the AP if necessary.

For roles such as clinical audit where an HCP is not completing assessments on a monthly basis, when an assessment is carried out and a report submitted this will be audited.

### 6.3.2 Actions taken following Quality Audit

Following a quality audit there are several possible actions to be taken as a result which include but are not limited to:

- The assessment provider holding the assessment report submission to VPB until the assessment report is deemed to meet the required standards by quality audit
- An HCP correcting the assessment report
- Quality audit providing feedback to the assessing HCP

The following sections explore these actions further.

#### 6.3.2.1 Case Status for Quality Audit

Quality audit should be carried out on cases before being submitted to the VPB. Quality audit may also be completed on cases returned to the AP by the VPB.

In cases where corrections are required, the assessment provider should hold the assessment report until all corrections have been made and have been deemed acceptable by quality audit, before submitting the VPB.

Quality audit of cases should be prioritised in order of the age of the case to avoid any undue delay for the VPB and for the applicant, where possible. The VPB may also have a function to prioritise cases and this should be taken into account by the AP.

#### 6.3.2.2 Amendment of Assessment Reports

Where assessments have been graded as requiring amendment, remedial action should be taken before the case is submitted to VPB. Where possible, this activity should be taken by the HCP who carried out the assessment. This also allows the HCP to act upon feedback to promote professional development. If the original HCP is not available for reasons such as long-term sickness, an alternative suitably qualified HCP may complete the amendments, if appropriate. Any amendments to the report should be clear, identifiable, and made in line with clinical professional standards and principles, these should be checked by the auditor. Amendments cannot be made to existing history taking, observations or examinations following initial submission.

#### 6.3.2.3 Quality Audit Feedback

Quality audit should serve as a function to promote learning and development. Feedback should be constructive, clear, and reasonable. Feedback should offer both positive reinforcement of good quality aspects of the report and corrective advice where the quality standard has not been met. The assessment provider should keep a record of all quality audit including any iterations of audited assessment reports.

### 6.3.3 Quality Checking Grading

Each assessment report can be attributed one of three grades: A, B or C. The meaning of these grades is outlined below.

#### 6.3.3.1 “A” Grade Reports

“A” grade assessment reports are considered as meeting the set requirements and do not require amendment. To be considered an “A” grade report the assessment report must satisfy the quality audit criteria as set out in appendix N and therefore the assessment report is deemed to be of good clinical quality, the assessment of disablement is accurate, well justified and in line with a consensus of medical opinion and balance of probabilities. Minor errors are acceptable where they do not materially impact the usability of the advice given to the VPB. If feedback is required to the author, this feedback would be minimal and provided to support future learning.



### 6.3.3.2 “B” Grade Reports

Within a “B” grade assessment report, the advice contained therein is appropriate and can be used by the VPB however there are areas that are lacking in detail which could have been completed more comprehensively. Detailed feedback is needed to the original HCP and the report may need to be amended if clearer, more robust advice is required.

### 6.3.3.3 “C” Grade Reports

“C” grade assessment reports do not meet the set requirements and therefore require amendment; Changes should not be made to the objective information such as history, observation or examinations, but amendments may be required to presentation, process or justification and reasoning as outlined in appendix N. Either the report advice is incorrect whereby the rounding process applied to the percentage disablement by the VPB would result in an inaccurate material outcome for the applicant, or where the assessment is based on insufficient detail (medical evidence, history taking, observations, examination findings). There may also be a major procedural error (level of assessment, incorrect consideration of other(pre), other(post), or unrelated conditions). Such errors must either jeopardise the accuracy of the rounded percentage disablement (rounding completed by the VPB), or risk significant harm to the applicant (such as the inclusion of harmful information).

### 6.3.4 Quality Audit Criteria

Each assessment report form (TPDPS1) should be quality audited with consideration of specific criteria. The four key areas of audit are considered as follows:

- Presentation
- Process
- Assessment
- Reasoning

The main components of each of these key areas are outlined in appendix N.

## 6.4 Approval

This is granted once the HCP achieves the required standard of assessment reports and demonstrates application of the required professional standards, principles, and competencies.

To achieve the above the assessment provider must provide the HCPs with an opportunity to undertake adequate initial training which should include a competency-based assessment, supervision from an appropriate experienced HCP and finally, approval related quality checking.

With regard to being granted the final step of the approval process, the HCP must be able to demonstrate an ability to consistently apply the competence standards. To do so the HCP must produce five consecutive “A” graded assessment reports in chronological order as deemed so by the approval audit process.

The approval process applies to:

- all newly recruited HCPs
- any HCPs who have not completed clinical TPDPS related activities, due to being absent from work (section 6.4.3)

There are four stages in the initial approval process:

- Stage 1. Training. This should involve all newly recruited HCPs undergoing and successfully completing a training programme.



- Stage 2. Assessment of Competence. Once Stage 1 is complete, the AP should carry out an assessment of whether the trainee HCP meets the required competence and knowledge standards. This should include written elements e.g. face-to-face assessment reports and paper-based assessments and practical elements e.g. initial review and when assessing further evidence should be requested.
- Stage 3. Clinical supervision. Once Stage 2 has been successfully completed by the trainee HCP, provisional approval to carry out assessments will be provided – both paper-based assessments and face-to-face assessments. The assessment provider should keep evidence to demonstrate that the HCP meets the required competence standards. The number of assessments, level and type of supervision provided is at the discretion of the assessment provider.
- Stage 4. Approval Audit. Once Stage 3 has been successfully completed by the trainee HCP, they will be able to carry out assessments without supervision but subject to 100% audit until full approval is achieved. To achieve full approval the HCP must achieve 5 consecutive “A” graded assessment reports in chronological order as determined by quality audit (see section 6.3.3. regarding audit grading).

Approval for an HCP must be confirmed by the Secretary of the VPB on behalf of the President. This will, in turn, be based on the recommendation of the provider who must produce evidence that the HCP has demonstrated that they meet the required standards.

#### 6.4.1 Maintenance of Approval

Maintenance of approval is dependent upon the HCP:

- Undertaking clinical work relating to TPDPS.
- Continuing to satisfy the required quality standards which can be monitored via quality audit records, training records, complaints etc.
- Keeping up to date with mandatory training
- Maintaining full clinical registration without regulatory sanctions

If an HCP is unable to fulfil the above then approval may be revoked however the assessment provider should provide support to the HCP to fulfil the above requirements, where possible. If the HCP is unable to fulfil the above requirements due to prolonged absence, the assessment provider must complete the actions described in section 6.4.3.

#### 6.4.2 Revocation of Approval

It is possible to revoke approval at any time where there is concern that an HCP may no longer satisfy the competencies required for the role.

The AP should keep a record to support the approval and revocation requirements and maintain a database detailing approval/revocation of approval and the reasons for revocation, if applicable.

Assessment providers must consider whether the circumstances surrounding any revocation of approval warrant them informing the HCP’s professional body.

Revocation of an HCP’s approval should routinely be sought for several reasons which include but are not limited to:

- change of job role no longer requiring approval
- termination of contract
- resignation
- absence from work for more than 6 months
- deceased

When an HCP permanently leaves or changes role to a non-clinical role, the AP should revoke their approval, stating the date of their final assessment.

#### 6.4.3 Absence from Undertaking Clinical Assessment Related Work

If an HCP has a prolonged interruption from undertaking clinical assessment related work due to absence for any reason, the following measures apply to approval status:

Up to 3 months absence:

- no action, resumption of normal duties relevant to role expected.

3-6 months absence:

- HCP should be required to attend refresher training (length and content of training should be at the AP's discretion) and should be subject to performance audit.

6-12 months absence:

- HCP should be required to attend refresher training and undergo approval audit achieving 5 consecutive "A" grade reports.

More than 12 months absence:

- HCP should be required to attend a full initial training programme and undergo approval audit achieving 5 consecutive "A" grade reports.

### 6.5 Complaints

A complaint can be described as an expression of dissatisfaction about the services provided. Complaints can be made by an applicant or their representative. Equally complaints can come from members of the public who are not part of the TPDPS assessment process. Complaints can be made verbally (in person or via telephone) or in written form. The assessment provider must have a process in place to manage complaints effectively.

#### 6.5.1 Serious Complaints

Any complaint in which there is an allegation of professional malpractice against an HCP is termed a "serious complaint". This includes, but is not limited to:

- serious breaches of professional conduct
- inappropriately intimate examinations
- assault during the course of an assessment
- injury during the course of assessment
- abuse relating to any protected characteristic under the Equality Act 2010
- theft
- fraud
- criminal activity
- failure to explore clinical findings of a serious nature e.g. risk of suicide

The assessment provider must manage "serious complaints" appropriately and in a manner differing to the overall complaints processes by inclusion of escalation routes to senior staff.

If a serious complaint is made against an HCP, the VPB should be informed as soon as is reasonably practicable and kept abreast of the outcome. The assessment provider may consider (depending on the allegations) commencement of a disciplinary process, suspension of the HCP from carrying out any assessments which may include revocation of approval (see section 6.4.2) until any investigations into the complaint have been completed. If a serious

complaint is upheld, the assessment provider may consider liaising with the relevant professional body (General Medical Council, Nursing and Midwifery Council, Health Care Professions Council etc.).

## 6.6 Case Reconsideration Advice

There may be circumstances whereby an assessment report has been finalised and submitted to the VPB however new information comes to light that may change the outcome of the assessment for example the submission of further evidence. The assessment provider must have a process in place (see appendix H) where it is possible for the case to be returned to the AP for advice. To provide advice, a suitably qualified HCP should review the assessment report and any new evidence, and make a recommendation as to whether any new information/evidence impacts the original assessment of permanence and percentage disablement, or if there is a requirement for a re-assessment

## 6.7 Case Rework

If the VPB considers that an assessment report is not meeting the set requirement the report may be returned to the provider for rework. The VPB must provide rationale for the rework and present any evidence or identify objective deficiencies within the report to qualify for a rework (see appendix H). Only reports considered to be a “C” grade can be escalated as a rework.

The action to be taken in relation to rework will vary on a case-by-case basis. Wherever possible, cases should be discussed with the original HCP or referred back to them for further action to be taken. There must be a process in place where the AP should provide feedback to HCPs whose reports require rework.

In some cases, it may be necessary for an additional assessment to be carried out, either with the original HCP or a different HCP. The impact of this on applicants should be considered when making the decision to carry out a repeat assessment. Where possible, this should be avoided so as not to place extra burdens on applicants. However, priority must be given to the quality of the advice to the VPB.

There must also be a process in place to challenge the reason why the VPB has returned a case to the AP for rework if the AP considers the request inappropriate and the report in question meets the required standards. The final decision on whether the case requires rework rests with the VPB.

## 7 Appendices

### 7.1 Appendix A - Part 1: Schedule 2 to the Social Security (General Benefit) Regulations 1982

Description of Injury	Degree of Disablement (%)
1. Loss of both hands or amputation at higher sites	100
2. Loss of a hand and a foot	100
3. Double amputation through leg or thigh, or amputation through leg or thigh on one side and loss of other foot	100
4. Loss of sight to such an extent as to render the claimant unable to perform any work for which eyesight is essential	100
5. Very severe facial disfiguration	100
6. Absolute deafness	100
7. Forequarter or hindquarter amputation	100
<i>Amputation cases—upper limbs (either arm)</i>	
8. Amputation through shoulder joint	90
9. Amputation below shoulder with stump less than 20.5 centimetres from tip of acromion	80
10. Amputation from 20.5 centimetres from tip of acromion to less than 11.5 centimetres below tip of olecranon	70
11. Loss of a hand or of the thumb and four fingers of one hand or amputation from 11.5 centimetres below tip of olecranon	60
12. Loss of thumb	30
13. Loss of thumb and its metacarpal bone	40
14. Loss of four fingers of one hand	50
15. Loss of three fingers of one hand	30
16. Loss of two fingers of one hand	20
17. Loss of terminal phalanx of thumb	20

**Description of Injury****Degree of  
Disablement (%)***Amputation cases—lower limbs*

18. Amputation of both feet resulting in end-bearing stumps	90
19. Amputation through both feet proximal to the metatarso-phalangeal joint	80
20. Loss of all toes of both feet through the metatarso-phalangeal joint	40
21. Loss of all toes of both feet proximal to the proximal inter-phalangeal joint	30
22. Loss of all toes of both feet distal to the proximal inter-phalangeal joint	20
23. Amputation at hip	90
24. Amputation below hip with stump not exceeding 13 centimetres in length measured from tip of great trochanter	80
25. Amputation below hip and above knee with stump exceeding 13 centimetres in length measured from tip of great trochanter, or at knee not resulting in end-bearing stump	70
26. Amputation at knee resulting in end-bearing stump or below knee with stump not exceeding 9 centimetres	60
27. Amputation below knee with stump exceeding 9 centimetres but not exceeding 13 centimetres	50
28. Amputation below knee with stump exceeding 13 centimetres	40
29. Amputation of one foot resulting in end-bearing stump	30
30. Amputation through one foot proximal to the metatarso-phalangeal joint	30
31. Loss of all toes of one foot through the metatarso-phalangeal joint	20

*Other injuries*

32. Loss of one eye, without complications, the other being normal	40
33. Loss of vision of one eye, without complications or disfigurement of eyeball, the other being normal	30

*Loss of:**A. Fingers of right or left hand*

**Description of Injury****Degree of  
Disablement (%)**

Index finger—

34. Whole 14

35. Two phalanges 11

36. One phalanx 9

37. Guillotine amputation of tip without loss of bone 5

Middle finger—

38. Whole 12

39. Two phalanges 9

40. One phalanx 7

41. Guillotine amputation of tip without loss of bone 4

Ring or little finger—

42. Whole 7

43. Two phalanges 6

44. One phalanx 5

45. Guillotine amputation of tip without loss of bone 2

*B. Toes of right or left foot*

Great toe—

46. Through metatarso-phalangeal joint 14

47. Part, with some loss of bone 3

Any other toe—

48. Through metatarso-phalangeal joint 3

49. Part, with some loss of bone 1

Two toes of one foot, excluding great toe—

<b>Description of Injury</b>	<b>Degree of Disablement (%)</b>
50. Through metatarso-phalangeal joint	5
51. Part, with some loss of bone	2
Three toes of one foot, excluding great toe—	
52. Through metatarso-phalangeal joint	6
53. Part, with some loss of bone	3
Four toes of one foot, excluding great toe—	
54. Through metatarso-phalangeal joint	9
55. Part, with some loss of bone	3

## 7.2 Appendix B - Table of Non-Scheduled Injuries

The following tables are taken from rulings on percentage disablement at appeal for Industrial Injuries Disablement Benefit which is also linked to the Social Security (General Benefit) Regulations 1982.

The table must not be rigidly applied in TPDPs and must act only as a guide for reference.

The below percentages do not hold statutory significance in all cases. It is useful as a framework for similar injuries but is not exhaustive of all possible injuries/conditions or resulting disablement. Each applicant's disablement must be assessed on an individual basis and justified appropriately.

Condition/Injury	Clinical Reasoning	Percentage Disablement
Aphakia and pseudophakia	<p>Aphakia - the lens is surgically removed, and the patient is given thick pebble cataract spectacles or contact lenses to correct the visual acuity.</p> <p>Pseudophakia - in the majority of cases treatment gives rise to pseudophakia. The damaged lens is removed and a plastic intraocular lens is inserted.</p> <p>Spectacle lenses produce a reduced visual field and there is considerable distortion.</p> <p>Contact lenses can be inconvenient, require a degree of manual dexterity and can be difficult to manage particularly if near vision is considerably reduced. Intraocular lenses provide a fixed focus and loss of accommodation.</p> <p>To assess % of disablement for this condition: Determine the best corrected visual acuity for each eye separately</p> <p>Assess visual disablement according to the "Reduction of Vision: Compensation Rates" (appendix L)</p> <p>Add the appropriate figure from appendix L to figures stated in this chart for each affected eye</p> <p><b>Note:</b> there may be supplementary issues, which may lead to a higher assessment such as, cosmetic disfigurement of the eye. The applicant must be compared with a normal person of their own age. Insufficiency of accommodation in a young person would be more disabling than that in a person in the age group in which presbyopia is a normal feature.</p>	<p><i>Unilateral Aphakia</i> Spectacle lenses 9% Contact lenses 6%</p> <p><i>Bilateral Aphakia</i> Spectacle lenses 22% Contact lenses 16%</p> <p><i>Pseudophakia</i> Unilateral 3% Bilateral 8%</p>
Loss of taste or loss of smell		1-20%
Loss of pinna of ear		20%
Amputation of breast (female)		20-30% (dependant on age)



Complete pneumonectomy	The given percentage disablement assumes no respiratory disablement, cosmetic effect only. If respiratory disablement has arisen, this needs to be taken into account.	6-14%
Thoracoplasty		6-20%
Lobectomy		6-14%
Lingulectomy		6-14%
Splenectomy	Removal of the spleen may lower natural resistance to certain organisms and removal of the spleen also involves loss of tissue.	2-5%
Orchidectomy	The removal/loss of a testicle involves tissue loss and loss of reserve useful function which constitutes a mild to severe permanent loss of faculty.	Unilateral 2-5% Bilateral 50 – 100% (dependant on age)
Oophrectomy	The removal/loss of an ovary involves tissue loss and loss of reserve useful function which constitutes a mild to severe permanent loss of faculty.	Unilateral 2-5% Bilateral 50 – 100% (dependant on age)
Nephrectomy	Loss of kidney results in a loss of faculty. The extent of disablement resulting from that loss of faculty is for the medical authorities to give advice on and in this respect regard must be had to the loss of reserve useful function and consideration as to whether the remaining kidney is functioning normally.	Unilateral 5-10%
Partial gastrectomy		6-14%
Colostomy		30%+
Ileostomy		50%+
Loss of glans penis		20-50% (dependant on age)
Loss of penis		70-100% (dependant on age)
Urethral stricture		1-20%
Impotence (depending on age)		6-50%
Sterility		6-50% (male and female)
Hernia – inguinal or scrotal reducible and well controlled		Single 1-5% Bilateral 6-14%
Drop wrist - complete		30%
Ankylosed Joints: In assessing the disablement resulting from the complete fixation of joints, consideration needs to be given to the position in which the joint is fixed. Below are listed the usual optimum positions for ankylosed joints.		
Ankylosed Joint: Shoulder (at optimum position)	Arm abducted to about 20 degrees with the elbow slightly in front of the body and with free movements of the shoulder girdle.	40%

Ankylosed Joint: Elbow (at optimum position)	The angle between humerus and forearm should be rather more than a right angle, at about 110 degrees. The forearm should be supinated, so that the palm is slightly upwards.	40%
Ankylosed Joint: Wrist (at optimum position)	In the neutral position, that is in line with the forearm and with slight or no loss of pronation and supination.	30%
Ankylosed Joint: Hip (at optimum position)	Thigh flexed 10 degrees with a slight abduction and slight external rotation.	60%
Ankylosed Joint: Knee (at optimum position)	In 5 degrees of flexion	30%
Ankylosed Joint: Ankle (at optimum position)	5-10 degrees plantar flexion of the foot	20%
Loss of patella		6-14%
Complete foot drop		30%

Table 11 – Non-Scheduled Injuries

### 7.3 Appendix C - Psychological Assessment Framework

Unlike many physical injuries, psychiatric conditions are not often the result of a single factor or incident. Causation is commonly multifactorial. It is thus important to carefully assess each individual applicant's case to determine causation and relevance as well as permanence. Specific consideration must be made of the applicant's history, their mental state and the nature of each condition claimed for within the application.

Schedule 2 to the Social Security (General Benefit) Regulations 1982 does not contain prescribed degrees of disablement for psychiatric conditions; instead the injuries contained therein are either physical or sensory in nature. The following psychological assessment framework is devised to provide guidance for the assessing HCPs and to promote consistency between assessors. It is a generic rather than a diagnosis-specific guidance document and each applicant must be treated as an individual.

The framework has been developed with specific consideration of Schedule 2 to the 1982 Regulations, the Global Assessment of Functioning (GAF) scale, Industrial Injuries Disablement Benefit (IIDB) psychiatric descriptors, the Department for Veterans Affairs (USA scheme) descriptors, and specialist clinical knowledge of conflict / trauma related diagnoses.

It is important to note that the decision as to whether an applicant meets diagnostic criteria will not be taken by HCPs.

How to use the framework:

- It has eleven sections, each of which has a descriptive anchor point.
- The anchor points combine symptoms and function and involves an assessment of the impact of symptoms on social, relationship and occupational functioning.
- Assessments should be based on all relevant evidence. It is designed to provide an overall (global) measure and rates psychological, social, and occupational functioning, covering the range from positive mental health to severe psychopathology.
- Each anchor point also contains a note to the assessor regarding the potential impact of, and necessity for, various treatments (social, psychological and pharmacological) as this may often assist in reaching a final determination of the degree of disablement.
- The written anchor points are designed to act as a guide only. An applicant does not need to have all or any of the specific examples of signs and symptoms and deficits in functioning listed at each anchor point to be considered at that anchor point.

Further training in relation to the specifics of the assessment of psychiatric conditions within the scheme should be developed and delivered by the AP.

**The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.**

Category	Indicative Percentage Disablement	Indicative Severity of Disablement	Description The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.	Notes on treatment
0	0%	No disablement	<p>No mental illness symptoms evident.</p> <p>Good functioning in all relationships and social environments excepting what might be seen as everyday concerns or problems. Interested in a wide range of activities.</p> <p>Good functioning in occupational environments (or no evidence that he/she would not be effective in an occupational environment if not currently employed).</p> <p>Ability to perform self-care tasks not impaired.</p>	Does not appear to require continuous psychological or pharmacological treatments to maintain this state.
1	1-10%	Minimal	<p>Mental health symptoms may be evident but are very mild or intermittent (e.g., very mild anxiety or very mild depression of mood).</p> <p>Functions well in social environments and in interpersonal relationships excepting some minimal difficulties.</p> <p>Minimal impairment of functioning in occupational environments is evident.</p> <p>Ability to perform self-care tasks minimally impaired.</p>	Does not appear to require continuous psychological or pharmacological treatments to maintain this state.
2	11-20%	Mild	<p>Mild mental health symptoms are evident (e.g., mild anxiety, tension, irritability, insomnia, depressed or flat mood, symptoms consistent with PTSD).</p> <p>Has meaningful interpersonal relationships and friends but may have some difficulties in relationships. Interests may be limited.</p> <p>Symptoms may be associated with mild impairment in ability to function in an occupational environment even when suited to skill level, educational attainments, and work experience. Modest changes to the occupational environment may be required.</p> <p>Symptoms may be easily exacerbated by psychosocial stressors. May attempt to control day to day activities to limit provocation of mild symptoms. If any exacerbation occurs it is transient and self-limiting.</p> <p>Ability to perform self-care tasks mildly impaired.</p>	May require continuous or intermittent psychological or pharmacological treatments to maintain this state.

Category	Indicative Percentage Disablement	Indicative Severity of Disablement	Description The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.	Notes on treatment
3	21-30%	Mild-moderate	<p>Mild-moderate mental health symptoms are evident (e.g., depressed mood, flat affect, occasional panic attacks, symptoms indicative of PTSD).</p> <p>Has some meaningful interpersonal relationships and friends but experiences difficulties in relationships with peers or co-workers. Interests outside of work and in hobbies are limited.</p> <p>Symptoms may be easily exacerbated by psychosocial stressors. May attempt to control day to day activities to limit provocation of mild symptoms. If any exacerbation occurs it may persist for some time.</p> <p>Mild-moderate impairment in ability to function in an occupational environment even when suited to skill level, educational attainments, and work experience. Occasional decrease in work efficiency or intermittent periods of inability to perform occupational tasks. Significant changes to the occupational environment may be required.</p> <p>Ability to perform self-care tasks mild-moderately impaired.</p>	May require continuous or intermittent psychological or pharmacological treatments to maintain this state.
4	31-40%	Moderate	<p>Moderate symptoms are evident (e.g., low mood, anxiety, symptoms consistent with PTSD, delusions or hallucinations which are not fixed, obsessional rituals, other symptoms of major psychiatric illness).</p> <p>Moderate difficulties in functioning in social environments (e.g. has limited number of friends, may avoid outings and gatherings).</p> <p>Decision making usually competent and effective.</p> <p>Moderate impairment in occupational functioning with occasional decrease in work efficiency or intermittent periods of inability to perform occupational tasks or intermittent absences from work. Significant changes to the occupational environment may be required.</p> <p>Ability to perform self-care tasks moderately impaired.</p>	May require continuous or intermittent psychological or pharmacological treatments to maintain this state.

Category	Indicative Percentage Disablement	Indicative Severity of Disablement	Description The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.	Notes on treatment
5	41-50%	Moderately severe	<p>Moderately severe symptoms are evident (e.g., low mood, anxiety, symptoms of persistent PTSD, delusions or hallucinations which are not fixed, obsessional rituals, other symptoms of major psychiatric illness).</p> <p>Likely to have moderately severe difficulty functioning in many social environments (e.g., has few friends, may avoid outings and gatherings). Few, if any, hobbies or leisure activities.</p> <p>Decision making intermittently competent and effective.</p> <p>Likely to have moderately severe difficulty functioning in occupational environments. Remunerative work may be possible with supervision, or frequently absent from work.</p> <p>Ability to perform self-care tasks moderately severely impaired.</p>	Treatments may be of some benefit only: partial treatment responsiveness.
6	51-60%	Severe	<p>Severe symptoms are evident (e.g., persistent, and severe low mood or anxiety, symptoms of severe and persistent PTSD, delusions or hallucinations which may be fixed, obsessional rituals, other symptoms of major psychiatric illness).</p> <p>Likely to have severe difficulty functioning in many social areas (e.g., socially isolated, seldom leaves home, no social outlets).</p> <p>Likely to have severe difficulty functioning in occupational environments. Remunerative work likely to be possible only in a supportive and supervised environment.</p> <p>Decision making intermittently competent and effective.</p> <p>Ability to perform self-care tasks severely impaired.</p>	Treatments may be of very limited benefit only: partial treatment responsiveness.

Category	Indicative Percentage Disablement	Indicative Severity of Disablement	Description The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.	Notes on treatment
7	61-70%	Very severe	<p>Very severe symptoms are evident (e.g., symptoms of persistent PTSD, delusions or hallucinations, obsessional rituals, other symptoms of major psychiatric illness). May have suicidal preoccupations.</p> <p>Very severe impairment of social functioning present (e.g., problems relating to others, frequent distancing from others or open hostility). Frequent periods of little or no enjoyment of life.</p> <p>Very severe impairment of occupational functioning present. Likely to have very severe difficulty functioning in occupational environments. Remunerative work likely to be possible only in a highly structured supportive and supervised environment.</p> <p>Very severe impairment of communication or judgement. Behaviour considerably influenced by symptoms. Decision making ineffective.</p> <p>Ability to perform self-care tasks very severely impaired.</p>	Treatments such may be of limited benefit: limited treatment responsiveness.
8	71-80%	Extreme	<p>Extreme symptoms are evident (e.g., symptoms of persistent PTSD, delusions or hallucinations, obsessional rituals, other symptoms of major psychiatric illness).</p> <p>May have suicidal preoccupations and persistent intent.</p> <p>Extreme impairment of social functioning present (e.g., symptoms interfere with family life, sense of well-being and day to day life). Problems relating to others. Frequent periods of little or no enjoyment of life. Frequent distancing from others or open hostility.</p> <p>Extreme impairment of occupational functioning present (e.g., cannot keep a job, stays in bed all day).</p> <p>Extreme impairment of communication or judgement. Behaviour considerably influenced by symptoms. Decision making ineffective.</p> <p>Ability to perform self-care tasks extremely impaired.</p>	Treatments may be of limited benefit: limited treatment responsiveness.

Category	Indicative Percentage Disablement	Indicative Severity of Disablement	Description The framework is to be used when assessing global disability (not that specifically attributable to a TRI) and does not consider disablement with other causes due to other(pre) and other(post) conditions.	Notes on treatment
9	81-90%	Very extreme	<p>Very extreme mental health problems are evident (e.g., symptoms of very severe and persistent PTSD, delusions or hallucinations, very severe obsessional rituals, other symptoms of major psychiatric illness).</p> <p>Significant danger of hurting self-suicidal preoccupation or suicide attempts with clear expectation of death.</p> <p>Very extreme impairment of social functioning present (e.g., symptoms interfere with family life, sense of well-being and day to day life). May require supported accommodation.</p> <p>Very extreme impairment of occupational functioning present (e.g., cannot keep a job, stays in bed all day).</p> <p>Very extreme impairment of communication or judgement. Behaviour considerably influenced by symptoms. Decision making ineffective.</p> <p>Ability to perform self-care tasks very extremely impaired-persistent inability to care for personal hygiene.</p>	All treatment options may have been exhausted and may not have been successful (including psychotropic medications, other physical treatments such as ECT and psychotherapy): may be entirely treatment resistant.
10	91% +	Total	<p>Totally incapacitating mental health problems (eg persistent delusions or hallucinations, grossly inappropriate behaviour, persistent danger of severely hurting self with a clear expectation of death, persistent despair and cynicism, persistent danger to others; communication grossly impaired and may be mute or largely incoherent).</p> <p>Total/complete impairment of social and occupational functioning present and likely to require continuous hospitalisation or supported accommodation.</p> <p>Ability to perform self-care tasks completely/totally impaired-persistent inability to care for personal hygiene.</p>	All treatment options have been exhausted and have been unsuccessful (including psychotropic medications, other physical treatments such as ECT and psychotherapy): entirely treatment resistant.

Table 12 - Psychological Assessment Scales



## 7.4 Appendix D - Assessment Report Form

### **Section 1:**

#### **Initial Review (IR)**

##### **1.1 Medical Evidence Considered:**

(list date, title, summary)

Have the injury / injuries reported in the TPDPS application form been confirmed within medical evidence either before or following an inquisitive process?

Yes ☐ No ☐

If 'no' please document this on a TPDPS4 assessment form and do not submit the TPDPS1.

##### **1.2 Case Risk Assessment**

(Review risk matrices)

Clinical Risk Rating:

Non-Clinical Risk Rating:

##### **1.3 Can determination of permanence and relevant percentage disablement be made without further evidence or examination?**

Yes ☐ No ☐

Rationale:

##### **1.4 What further evidence is required?**

Medical Factual Report ☐ Verbal Discussion with professionals involved in applicant's care  
☐

Verbal Discussion with applicant (not extending to a full assessment) ☐ N/A ☐ Other ☐  
Specify:

**1.5 Is this case a posthumous assessment?**

Yes ☐ No ☐

**1.6 Is examination required?**

Yes ☐ No ☐

**1.7 What route of examination is required?**

F2Fhome ☐ F2F clinic ☐ Virtual ☐ telephony ☐ N/A ☐

## **Section 2:**

### **Identification Confirmation and Consent**

Identification confirmed? Yes ☐ No ☐ N/A ☐

Document used:

Reference Number:

Companion name (if applicable):

Relationship to applicant:

Informed consent gained to proceed with assessment? Yes ☐ No ☐

## **Section 3:**

### **Subjective History**

3.1 History of Troubles-related Incident

3.2 Social and Occupational History

3.3 Activities of Daily living and Mobility

3.4 Other Medical history

## **Section 4:**

### **Objective Examinations**

Has informed consent been gained to complete objective examinations? Yes ☐ No ☐

4.1 Musculoskeletal / Neurological

4.2 Mental State Examination / Cognitive State Examination

4.3 Other

## **Section 5:**

### **Observations**

Informal Observations
-----------------------

## **Section 6:**

### **Injury, Loss of Capacity, Disablement**

6.1 What injury or Injuries were sustained due to the TRI?	
<b>Diagnosis</b>	<b>Date of Diagnosis</b>
<b>6.2 Does evidence support the presence of relevant damage, disfigurement, or loss of physical and/or mental capacity?</b>  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> if 'no' go to section 9  <b>If 'yes', give details and describe below, outlining the relevant damage, disfigurement or loss of physical and/or mental capacity (this should be described as the local organ / joint / body part / loss of function)</b>	

Also specify from what date the relevant damage, disfigurement, or loss of physical and / or mental capacity was present:

**6.3 Identify the disabilities arising from the relevant damage, disfigurement or loss of physical and/or mental capacity (this should be described as the global loss of function of the affected body part / limb). If the disability results from the relevant loss of capacity mark 'F', however if there is another cause mark 'P'**

Identified Disability (ID)	Disability	F/P
ID1		
ID2		
ID3		
ID4		

**6.4 If you have marked any ID's as 'P' mark the ID below, identify the condition which is the 'other cause' of disablement, with consideration to the evidence contained in sections 1-5. Conditions which existed BEFORE the TRI should be marked 'other(pre)' and those which arose afterwards should be marked 'other(post)'.**

ID	Other Cause	Other(pre) or other(post)

### **6.5 Unconnected Conditions**

List below any conditions identified in sections 1 and 3.4 that do not have an impact on the disablement caused by the relevant damage, disfigurement, or loss of mental and / or physical capacity

## **Section 7:**

### **Effect of the relevant damage, disfigurement or loss of capacity**

7.1 Outline the way in which the disabilities described in 6.3, in combination with the conditions outlined in 6.4 affect the Victim's activities of daily living such as washing, dressing, walking

## **Section 8:**

### **Assessment of degree of disablement and permanence**

8.1 Percentage disablement:

Instructions:

Only input in 'gross assessment' and 'offset' when an other(Pre) condition is noted in 6.4

Offset (subtract) the effects of any other(pre) condition from the global disability in the functional area only to the extent to which disablement would have resulted from that condition even if the TRI had not occurred. The residual NET assessment will therefore include any addition for the resultant greater disablement so do not make any addition in box B below.

Ignore any disablement arising from any other(post) condition shown in 6.4. Assess only the disablement appropriate for the TRI had any other(post) condition not occurred and record that assessment as NET in box A below.

**Box A:**

ID	Gross Assessment	Offset (percentage and condition)	Net assessment

If the total NET assessment in box A is 11% or more and an other(post) condition has been identified in 6.4 assess in box B the extent to which the presence of the other(post) condition makes any 'P' disability worse (interaction) during the period which will be taken into account by the assessment. Do not assess the other(post) condition itself.

Do not make any addition in box B for any other(pre) condition shown in 6.4

**Box B:**



ID	Additional Assessment (interaction of other(post) condition)
<b>8.2 Are the injuries resulting in disablement, outlined in 6.1, permanent?</b>	
Diagnosis	Permanent?
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>8.3 Having regard to the possibility of meaningful change in a Victim's condition, can the degree of permanent disablement be assessed?</b>	
<p><b>Note: small, natural, expected fluctuations in a condition should not constitute meaningful change in a Victim's condition.</b></p>	
<b>ID1</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ID2</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ID3</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ID4</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**8.4 At what degree do you think the disablement resulting from the relevant damage, disfigurement or loss of capacity should be assessed?**

**This should be the NET assessment at box A plus any figure in box B in (section 8.1)**

ID	Disability	Injuries Included	Physical or Psychological	Assessment %

**Numbers..... Words.....**

**8.5 if 'no' answered to any IDs in section 8.3, for how long should the above assessment be considered (max 2 years from date of the assessment)?**

**Years..... Months..... N/A ☐**

**8.6 if 'yes' answered to all IDs in section 8.3, confirm the percentage outlined in 8.4 is final**

**Yes ☐ No ☐**

## **Section 9:**

### **Justification**

Signed

\_\_\_\_\_

Assessor's Name

\_\_\_\_\_

Professional Designation

\_\_\_\_\_

Date

## 7.5 Appendix E - Harmful Information Form

### Harmful Information – TPDPS2

In all assessments and on all forms, the Health Care Professional should check their advice for any information which could be seriously harmful to the applicant's health if it were disclosed. This is called "harmful information" and is the only information that can be withheld from the applicant legally.

An example of harmful information is as follows: a poor prognosis that is unknown to the applicant or a diagnosis of a psychotic illness in an applicant who lacks insight into their condition.

### Instruction on use

- 1) This form should be used where harmful information has been identified within the assessment process.
- 2) Omit any information within the TPDPS1 that is considered harmful and replace with a non-specific statement that does not disclose the harmful information.
- 3) Within the TPDPS1, do not refer to the TPDPS2.

In those sections where harmful information has been removed from the TPDPS1, write the relevant heading and subsequent information in this form (TPDPS2).

Clinician signature.....

Clinician name.....

Date.....

## 7.6 Appendix F - Medical Factual Report

Name

Address 1

Address 2

Address 3

Postcode

VPB Assessment Services

PO Box 607

Darlington

DL1 9ED

T: 0300 200 7808

E: vpb@justice-ni.gov.uk

DD Month XXXX

### **Troubles Permanent Disablement Payment Scheme**

#### **Medical Factual Report**

To whom it may concern,

**Case Ref: VPBXXXX**

We have been advised by an applicant to the Troubles Permanent Disablement Payment Scheme (TPDPS or "the Scheme") that they are one of your patients. The purpose of this letter is to seek medical information to support their application.

Should this form be completed and returned within six (6) weeks of the date of this letter, a fee of £100 will be paid by the Victims' Payments Board.

Clinically, the Scheme aims to assess the level of permanent disablement attributable to a Troubles-related incident (TRI). The expression of disablement is made on a percentage scale; the assessment of which is completed by the Capita Disability Assessment Team.

An essential component of this process is the provision and analysis of medical evidence. Under Regulation 29 of the Victims' Payments Regulations 2020<sup>2</sup>, the Victims' Payments Board may request any additional information to assist them in the assessment of an application to the Scheme. This Regulation also obliges you (the recipient of such a request) to provide the requested information that is

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<sup>2</sup> [The Victims' Payments Regulations 2020](#)

in your control, and in terms of compliance with data protection law, you can be assured that Article 6(1)(c) of the UK GDPR<sup>3</sup> provides you with the lawful basis to disclose this information to the Board.

The attached Medical Factual Report (MFR) is regarded as a notice issued under Regulation 29 for these purposes. Completion of this MFR will facilitate the assessment provider to process your patient's application in a manner which is as efficient and accurate as possible.

I would be grateful if you could only provide factual information available within the medical record held by your organisation, or directly observed or objectively tested by you clinically.

The form prompts the provision of additional medical reports where relevant, that may be within the records held by your organisation. The following list is not exhaustive, however, gives examples of documents that may be useful to the assessment provider. Please note – this form is used to send to all primary and secondary care providers; it is acknowledged that some of the below noted documents may not be held by your organisation.

Consultant Letters	Physiotherapy Reports
Hospital Discharge Letters	Occupational Therapy (OT) Reports
Psychiatric Reports (in-patient and out-patient)	Community Psychiatric Nurse (CPN) Reports
Surgical/Operation Notes	Social Services Records
Prescription Lists	Care Plans
Audiology Reports	Scan results (X-ray, Ultrasound, MRI)
Certificate of Visual Impairment (CVI)	Pain clinic reports/notes
Prosthetic clinic notes	

Please do not submit original documents as it will not be possible to return these.

Where the space available for comment is insufficient, please use the final page for additional information.

A form to arrange remuneration for completion of the form is also attached. You should complete this and return it along with the completed MFR in order that the payment can be processed by the Victims' Payments Board.

Please return the completed form along with accompanying medical evidence in the envelope provided.

Thank you in advance for assisting with the provision of medical evidence on behalf of your patient and their application to the TPDPS.

Yours faithfully,

Capita Disability Assessment Team (for the Victims' Payments Board)

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<sup>3</sup> [UK General Data Processing Regulation](#)

### Medical Factual Report

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

VPB Ref No \_\_\_\_\_

Priority Case ☐

**As part of their application to TPDPS your patient has advised they are suffering from the following condition(s).**

1. Can you confirm that your patient is suffering from the claimed conditions? (if possible – please confirm the date of diagnosis or date of working diagnosis)

**If possible, please provide any supporting medical reports. Note – such records may support the formulation of a working and/or final diagnosis.**

2. Please confirm who made this/these diagnosis/diagnoses and their profession.  
(where possible, please be specific with the level of seniority/grade of the diagnosing clinician)

**If possible, please provide any supporting medical reports**

3. If available, please provide evidence as to the aetiology of this/these diagnosis/diagnoses?

**If possible, please provide any supporting medical reports**

4. Please list all other conditions which may affect your patient's functional ability in relation to activities of daily living, mobility, or social and occupational functioning. Please include the dates of diagnosis where possible.

5. Please detail all current and previous treatment for the conditions stated at the top of this form.

**Where possible, please provide treatment records, discharge summaries, care plans etc**

6. Are there any planned changes to their current treatment? If so, please detail what is planned and for what reason?

**If relevant, please list when this treatment is likely to finish**

7. Is / are the condition/s noted in section 1 chronic in nature? (If available, does evidence suggest the condition/s has / have reached a steady or stable state at maximum medical improvement?)

In your opinion and from your knowledge of this applicant, is it likely that the person, by reason of mental disorder, is incapable of managing and administering their property and affairs?

Yes ☐ No ☐ Don't Know ☐

Does the patient have a history of threatening or violent behaviour?

Yes ☐ No ☐ Don't Know ☐

Could the patient travel to an assessment centre by public transport or taxi?

Yes ☐ No ☐ Don't Know ☐

**Please provide detail if 'yes' answered to either of the above:**

Additional Information:

Signed: \_\_\_\_\_

Name (Please Print)\_\_\_\_\_

Date: \_\_\_\_\_

Profession\_\_\_\_\_

## 7.7 Appendix G - Initial Review Return Form

### **Initial Review (IR) Return form (TPDPS4)**

At the initial review (IR) stage of the disablement assessment, a health care professional (HCP) must determine if a diagnosis has been made of the condition/s claimed by the applicant in their application form. See section 4.1 of the TPDPS assessment guide for details on what constitutes an acceptable diagnosis within TPDPS.

Providing a diagnosis is outside the remit of disablement assessment HCPs. Where diagnosis of the claimed conditions is not clear within available medical evidence or if aetiology of a condition is not identifiable on the balance of probabilities, diagnosis and opinion must be sought by a consultant medical practitioner out with the disablement assessment process.

When an HCP reviews the medical evidence on file at the IR stage of the assessment process, all efforts must be made to identify evidence that supports the claimed diagnosis. Where such evidence is lacking, the HCP must proactively engage with relevant treating practitioner (GPs, specialists etc) to see if evidence of a formal diagnosis is available even if it was not provided in the initial application. The TPDPS3 form may be used for this purpose.

Where insufficient evidence is available in the initial application or following the above inquisitive process, the case must be returned to the VPB without full assessment of permanence and percentage disablement.

This form (TPDPS4) must be used to document all action taken by the HCP to identify a diagnosis, and a justification as to why the case has been returned without proceeding to full assessment.

Name..... TPDPS case reference .....

1. Document what evidence has been reviewed within the initial application pack?
2. What actions have been taken to attempt to confirm a formal diagnosis is available out with the initial application? E.g. Written FME request from GP/Psychiatrist/Psychologist, telephone call etc
3. Justification for returning the case without completing a full assessment.

HCP name.....

Date.....



Section 4 is used by the Victims' Payments Board (VPB) when returning a case to the assessment provider after the diagnostic process has been completed.

4. Please document the action taken to arrange a diagnosis for this applicant.

Please attach any associated diagnostic medical report.

VPB actionee.....

Date.....

## 7.8 Appendix H - Case Rework/Reconsideration Advice Request Form

### Troubles Permanent Disablement Payment Scheme Case Rework/Reconsideration Advice Request Form – TPDPS5

<b>Section 1 – Case Details</b>	
Rework or Reconsideration Advice	
Case Reference	
Date of Assessment	
Date Request Received	
<b>Section 2 – Reason for Request</b>	
<i>Brief outline of the reason for request, including any evidence or any identified objective deficiencies within the report</i>	
<b>Section 3 – Response to Request</b>	
Accepted (Yes/No)	
<i>Brief outline of response to request, including any evidence and any changes to be made</i>	
Reviewer	
Date	

# Initial Review Guide Supplement

## Clinical Risk Matrix

<b>Sections of the Matrix</b>
What is a risk? Examples of risk
Routing options
Mitigation of risk
Risk decision tree
Clinical risk considerations Agoraphobia
Autistic Spectrum Disorder Behavioural conditions
Dementia Dependency - Alcohol/Drugs
Epilepsy Haemophilia/Haemarthopathy
Learning Disability
Malignancy Musculoskeletal
Multiple Sclerosis (MS)
Myalgic Encephalopathy (ME) Fibromyalgia and Chronic Fatigue Syndrome (CFS)
Psychological injuries
Neurology
Respiratory disease Sensory conditions

## Clinical Risk Matrix

The clinical risk matrix is in place to ensure risk is identified at the initial review (IR) stage to ensure a supportive applicant journey, free from exacerbation of any current symptoms through the process.

It is the Assessment Provider's (AP) responsibility to gather the applicant's information and support them through the process. The health care provider (HCP) must have the individual in mind when making any decision and ensure any rationale is clear, and that the HCP has referred to any, and all appropriate sections of this document. Failure to do so will result in the requirement for feedback and reflective practice, as the HCP's actions could impact the applicant's journey and/or their wellbeing.

## What is a risk?

A risk is the possibility of something occurring, usually associated with a negative outcome. Risk involves uncertainty about the effects/implications of an action on things such as health and wellbeing.

In the context of IR, when considering risk, the HCP is exploring any indication of unwanted harm to the applicant's health and/or wellbeing if an incorrect route were to be selected.

## Examples of risk

The below is **not** an exhaustive list and considers a range of symptoms that can put an applicant at risk of harm – the HCP should use this guidance, and clinical judgement to support consideration of other risks which may not be highlighted here. Where there is limited information available, caution should be exercised in consideration of risk to select the route least likely to cause harm.

- Panic/distress - which could be exacerbated by communicating with others, or leaving the house
- Sensory overload - where change, and/or increased stimulus can cause severe distress
- Aggression and or Violence - towards selves and/or others, which can include self-harming behaviours
- Risk of self-harm or suicidal ideation
- Disorientation and/or impaired sequencing - where structure is important and changes to this can impair function
- Dependency - where additional stress may cause increased usage
- Severe and uncontrolled seizures and/or fits
- Poor insight
- Spontaneous bleeding - which may be caused by activity
- Reduced immune system which could be caused by active treatment or an ongoing condition

- Impaired respiratory function with severe shortness of breath
- Visual restriction with no independent management in place
- Poorly controlled pain
- Significant fatigue
- Falls caused by an impairment of balance
- Recurrent hospital admissions for treatment
- Intensive support from others (family and/or community services including care) suggesting high levels of care need
- Disengagement from services
- Unstable and highly symptomatic condition(s)
- A movement disorder which makes activities difficult
- Profound Deafness

#### Routing options

There are 5 routing options available:

- Paper based assessment (PBA)
- Face-to-face Clinic
- Face-to-face Home
- Virtual
- Telephone (this only as exception when virtual not possible)

Where significant risk is identified that cannot be mitigated, the HCP must first attempt to complete a PBA. If a PBA cannot be completed due to inability to gather sufficient information, the HCP should use this guide to help consideration of the alternative options.

When making a routing decision the HCP needs to only select an option which is appropriate for that individual based on consideration of the risks identified. See section 3 for further information on decision making.

### Mitigation of Risk

Risk mitigation refers to the process of planning and/or implementing a method(s) to reduce any identified risk(s).

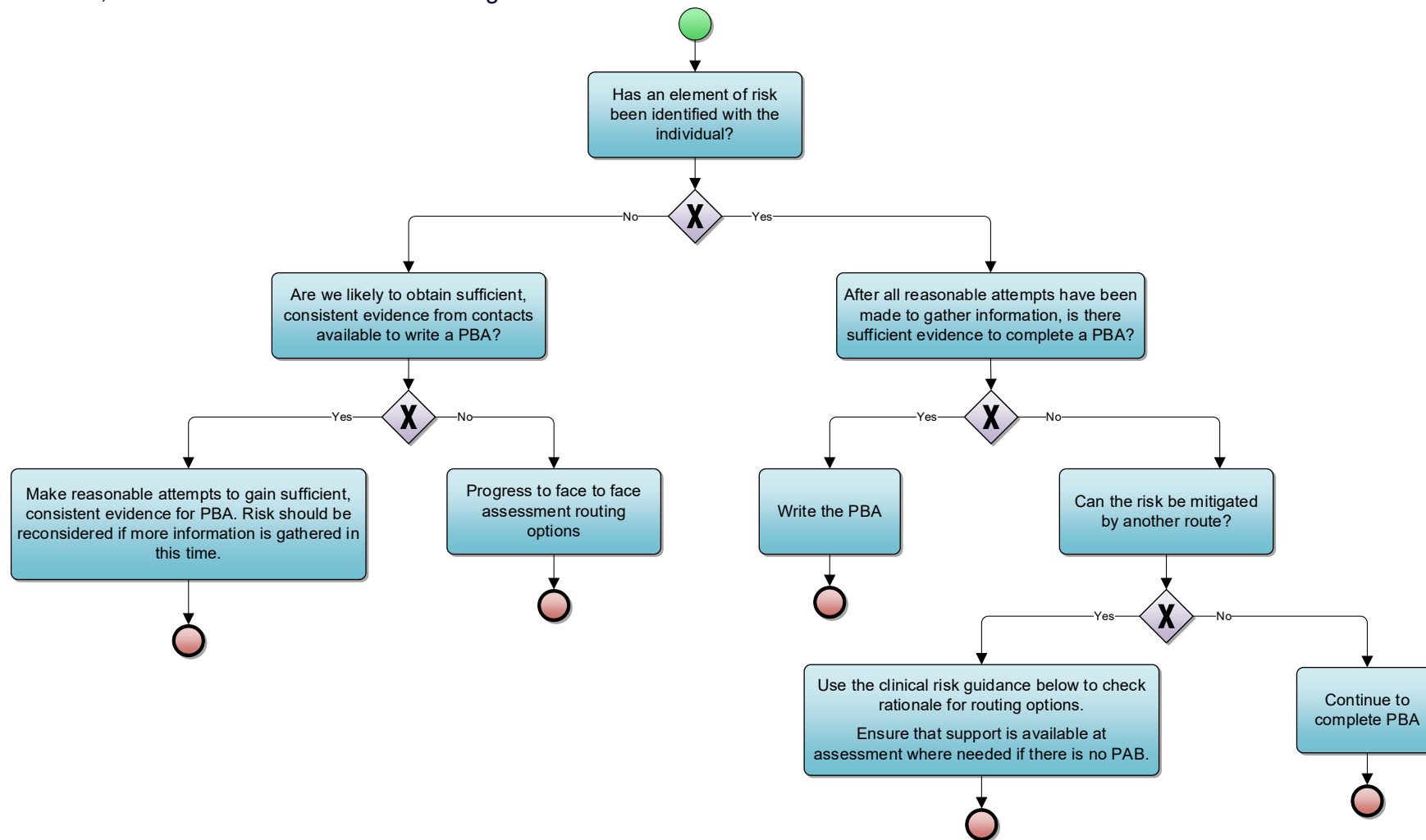
Where a PBA cannot be completed and risk has been identified, the HCP must consider, and act to mitigate the risk(s). This could be done in several ways, a few options to consider are (but not limited to):

- Using section 3 of this document to consider which route carries the lowest risk of harm to the applicant
- Making a phone call to the most appropriate person, which could include the applicant, a treating health care professional (HCP) or member of the support network which is listed as a relevant contact to determine whether support is in place, or required to support the assessment being completed
- Providing details of concerns in written form to inform colleagues of any risk.
- Follow the safeguarding process after escalating a risk to a professional involved in the applicant's care and listed as a contact.

As consideration points are reviewed within the relevant areas of section 3, the HCP must ensure to consider how different routes may impact the applicant's journey in line with the reported condition(s), and whether this would reduce the risk to the applicant to avoid harm occurring. Where concerns are raised about decision making, the HCP should seek support

## Risk Decision Tree

In ALL cases, use this decision tree before moving forward with actions.



*The information contained in this material is for general information only, it is not a replacement of the 2020 Regulations but is a supplementary guidance to be used alongside it*



## Clinical Risk Considerations

Below considerations for several conditions which present elements of risk are listed. Under each route option several potential conditions/disability presentations which may be listed or reported in the evidence are available. Not all presentations need to be present to support consideration of that option. The HCP must consider all the available routes, and whether risk can be mitigated when justifying the choice.

The HCP will need to only select a route option if that is appropriate for that applicant.

**The HCP will only use the below to support consideration of risk mitigation after following appropriate steps in the risk decision tree.**

Clinic	Home	Virtual/Telephone	PBA only
<b>Agoraphobia</b>	<b>This could include someone who expresses concerns of extreme anxiety about leaving their property and this does not need to be a formally diagnosed condition, such applicants will not be appropriately sent to clinic.</b>		
This option must be excluded as the risk of distress cannot be mitigated.	<p>Whilst evidence supports difficulties leaving the home there is no evidence that others coming into the home causes any distress.</p> <p>No violence or outbursts.</p> <p>Evidence confirms no support is required, or support will be available during home assessment.</p>	<p>Evidence suggests difficulty not only leaving the home, but also others coming into their home.</p> <p>Historic risk of self-harm not directly linked to engaging with others or paranoia.</p> <p>The applicant may/may not have risk of violence and aggression but still suggests insight and an ability to participate in an assessment either alone or with support.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<p>Other associated conditions listed where evidence suggests:</p> <ul style="list-style-type: none"> <li>• The applicant also experiences significant difficulty speaking/engaging with others,</li> <li>• Active or risk of suicidal ideation/intent and/or self-harm which may be linked to engaging with others</li> <li>• Have poor insight,</li> <li>• Are highly symptomatic</li> <li>• Requiring high levels of support from carers, health professionals, family.</li> </ul>

Clinic	Home	Virtual/Telephone	PBA only
<b>Autistic Spectrum Disorder</b>			
Where suggested symptoms are mild, attendance at mainstream school or work with no adaptations, no evidence of sensory overload or difficulties with social interaction.	Whilst evidence supports difficulties leaving the home there is no evidence that others coming into the home causes any distress. No violence or outbursts.	Evidence suggests others coming into their home may cause distress but are able to take part in appointments with/without support. The applicant may have unpredictable behaviour and verbal outbursts but still suggests insight and an ability to participate in an assessment either alone or with support.	Evidence to suggest severe symptoms such as: <ul style="list-style-type: none"> <li>• difficulties processing information,</li> <li>• poor social skills,</li> <li>• repetitive behaviour,</li> <li>• becoming overwhelmed by stimulus causing meltdowns' or high levels of distress</li> <li>• difficulties dealing with any change of routine.</li> <li>• unpredictable/challenging behaviour,</li> <li>• delayed speech development, non-responsiveness to others.</li> </ul>
<b>Behavioural conditions</b>	<b>This could include conditions such as conduct disorder and ADHD</b>		
Evidence suggests condition is stable with occasional inattentiveness, hyperactivity. Evidence should also suggest ability to leave the home and access the community without distress with/without the support of another.	Whilst evidence supports difficulties leaving the home there is no evidence that others coming into the home causes any distress. No violence or outbursts.	Evidence suggests others coming into their home can be disruptive. The applicant may/may not have presence of inattentiveness, hyperactivity and impulsiveness leading to challenging behaviour but still suggests insight and an ability to participate in an assessment either alone or with support. Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant has confirmed they can participate in an assessment and will	Other associated conditions listed where evidence suggests the applicant also experiences: <ul style="list-style-type: none"> <li>• significant difficulty speaking to others,</li> <li>• risk of suicide/self-harm,</li> <li>• poor insight,</li> <li>• highly symptomatic</li> <li>• high levels of support from others.</li> </ul>

Clinic	Home	Virtual/Telephone	PBA only
		have support, either through the already available evidence or evidence obtained through relevant phone calls.	
<b>Dementia</b>	<b>This should cover the full range of conditions which come under this umbrella including some of the following Alzheimer's, Vascular, Lewy body, Frontotemporal and mixed and others appropriately linked. Appropriate support should be in place for face-to-face home or clinic assessment.</b>		
Evidence suggests condition is newly diagnosed or under investigation with symptoms such as very mild short-term memory problems, occasional confusion and some reduced concentration but still able to function, mostly independently. Evidence should also suggest ability to leave the home and access the community without distress with/without the support of another.	Whilst evidence supports difficulties leaving the home there is no evidence that others coming into the home causes any distress. No violence or outbursts.	Evidence suggests others coming into their home can be disruptive. They may have personality changes and behavioural problems where this may include outbursts of aggression and/or violence but still suggests insight and an ability to participate in an assessment either alone or with support. Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.	Other associated conditions listed where evidence suggests the applicant also experiences: <ul style="list-style-type: none"> <li>significant difficulty speaking to others,</li> <li>poor insight,</li> <li>highly symptomatic with significant slowness of thought, mood, personality and behavioural changes, poor balance and mobility, severe memory problems, inability to follow sequences</li> <li>requirement of high levels of support from others.</li> </ul>
<b>Dependency – Alcohol/Drugs</b>			
Evidence suggests condition is stable with some previous dependency which is non-impacting. Evidence should also suggest ability to leave the home and access the community without distress with/without the support of another.	Evidence suggests previous dependency which is non-impacting currently and no indication of behavioural issues.	Evidence suggests current dependency with/or without input from dependency services. The applicant may have risk of violence and aggression. Could have high levels of restriction, similar to those reported in the PBA	Other associated conditions listed where evidence suggests the applicant also experiences: <ul style="list-style-type: none"> <li>heavy substance dependency and very unstable symptom management.</li> <li>difficulty engaging with others,</li> </ul>

The information contained in this material is for general information only, it is not a replacement of the 2020 Regulations but is a supplementary guidance to be used alongside it

Clinic	Home	Virtual/Telephone	PBA only
		only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.	<ul style="list-style-type: none"> <li>• risk of suicide/self-harm,</li> <li>• poor insight, with/or without disengagement from services</li> <li>• highly symptomatic</li> <li>• Requirement of high levels of support from others to manage needs.</li> </ul>
<b>Epilepsy</b>	<b>Including undiagnosed seizures</b>		
<p>Evidence suggests condition is stable, or evidence of low-level seizures with an aura.</p> <p>Evidence should also suggest ability to leave the home, access the community and, attend social events, school or work.</p> <p>Only use this option if evidence supports well controlled with no active seizures for prolonged period and no risk of being unconscious.</p>	<p>Whilst evidence supports difficulties leaving the home due to frequent or infrequent seizures which may result in muscle spasms or absence, with or without an aura.</p> <p>No violence or aggressive outbursts.</p>	<p>Evidence suggests post ictal confusion which can result in personality changes and behavioural problems where this may include outbursts of aggression and/or violence.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<p>Evidence may indicate:</p> <ul style="list-style-type: none"> <li>• Presence of an unstable condition with unpredictable, frequent seizures which may result in muscle spasms, prolonged absence, incontinence and/or prolonged confusion post the same.</li> <li>• The applicant does or does not experience an aura or have minimal time to respond to their warning.</li> </ul>
	<p>They may have frequent input from neurologists, specialist nurses, and or family/carers and likely to have multiple medications.</p> <p>Condition may be unstable in nature and have similar to that of PBA only but must be clear that someone can be with them for support in case of incident occurring due to risk of seizure being triggered by stress of assessment.</p>		
<b>Haemophilia/Haemarthropathy</b>	<p><b>In all cases of reported moderate to severe Haemophilia/Haemarthropathy, the below steps should be followed unless there is enough information to write a PBR</b></p> <ol style="list-style-type: none"> <li>1. Request for FE from the Haemophilia Treatment Centre</li> <li>2. Use and exhaust <u>ALL</u> contacts.</li> <li>3. Attempt a PBA.</li> </ol>		

Clinic	Home	Virtual/Telephone	PBA only
	<b>4. <u>ONLY</u> when evidence is not forthcoming, or consent has not been given should another assessment route be considered</b>		
Only to be selected in cases where insufficient evidence to complete a PBA and alternative routings not possible. Only to be selected in cases where risk of spontaneous bleeding is minimal.	Diagnosis of condition but symptoms and restrictions experienced are suggestive to be less severe in nature due to no indication of recent or current bleeds/or increased risk of spontaneous bleeding. No violence or outbursts.	Evidence may support recent or recurrent injury and/or bleeds, which may suggest others coming into the home may not be suitable to reduce any safety risks to them.  Evidence suggests potential outbursts of aggression and/or violence but still suggests insight and an ability to participate in an assessment either alone or with support.  Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.	Evidence may indicate: <ul style="list-style-type: none"> <li>Severe symptoms and high levels of functional restrictions with severe pain, mobility restrictions and high risks re: bleeding.</li> <li>The applicant may spend significant periods of time in bed, may have recent hospital admissions and likely to have significant specialist medical input.</li> </ul>
<b>Learning Disability</b>	<b>This should include Down's Syndrome, Fragile X Syndrome. If support is suggested to be required for any of the below options, the HCP should ensure this can be in place for the appointment releasing.</b>		
Where suggested symptoms are mild, attendance at mainstream stream school or work with no adaptations, no evidence of sensory overload or difficulties with social interaction.	Whilst evidence supports difficulties leaving the home, delayed development, dyspraxia, low levels of concentration, underdeveloped social skills, and support from others is required.  There is no evidence that others coming into the home causes any distress.  No violence or outbursts.	Evidence suggests others coming into their home may cause distress.  The applicant may have unpredictable behaviour and/or verbal outbursts but evidence still suggests insight and an ability to participate in an assessment either alone or with support.  Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear they	May potentially have input from social services or Community Team Learning Disability services <ul style="list-style-type: none"> <li>Severe degree of learning disability, delayed development</li> <li>Significant assistance with daily activities,</li> <li>Hypotonia, the presence of cardiac or bowel conditions and sensory impairment.</li> </ul>

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Clinic	Home	Virtual/Telephone	PBA only
		have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.	<ul style="list-style-type: none"> <li>Difficulties dealing with any change of routine and causing severe distress</li> <li>unpredictable/challenging behaviour,</li> <li>non-responsiveness to others.</li> </ul>
<b>Malignancy</b>	<p>In cases where there is <b>ACTIVE TREATMENT</b> (includes chemotherapy and radiotherapy) the below actions should be followed before considering alternative routing options.</p> <ol style="list-style-type: none"> <li>1. Attempt to complete a PBA where medical contacts are available.</li> <li>2. Use and exhaust ALL contacts.</li> <li>3. If evidence is not forthcoming, then virtual or telephone option should be selected.</li> </ol>		
<p>Evidence suggests condition is stable with no ongoing active treatment at the time of assessment.</p> <p>Presence of intermittent fatigue, disrupted sleep and peripheral numbness, with minimal functional restriction.</p> <p>The applicant is able to attend appointments, may potentially have resumed employment/college or attend social events.</p>	<p>Whilst evidence may or may not support current treatment, evidence will support difficulties leaving the home due to intermittent or persistent symptoms of things like fatigue, and/or pain – however these will not be extreme in nature. See alternative options for higher levels of symptom presentation.</p> <p>However, there is <u>no</u> evidence that others coming into the home causes any distress or put their immune system at risk.</p>	<p>Evidence suggests difficulty not only leaving the home, but also others coming into their home due to having a lower immune system from current or recent treatment.</p> <p>Other co-morbidities, potentially under investigation, and the information notes aggression and behavioural problems.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<ul style="list-style-type: none"> <li>High level of restriction and active treatment.</li> <li>Symptoms which include severe fatigue, nausea and vomiting, hair loss and significant pain, nerve damage/numbness,</li> <li>Likely to spend the majority of time in bed or resting.</li> <li>Significant input from specialist and likely support/assistance with the majority of personal care needs frequently.</li> <li>The applicant may be in Hospital or hospice care.</li> </ul>
<b>Musculoskeletal</b>	<b>This will include conditions such as arthritis, back pain, joint conditions, fractures</b>		
<p>Evidence suggests condition is stable, or things like pain are well controlled. Whilst there may be some pain, discomfort, stiffness and/or restricted</p>	<p>Whilst evidence may or may not support current treatment, evidence will support difficulties leaving the home due to intermittent or persistent</p>	<p>Evidence suggests behavioural problems where this may include outbursts of aggression and/or violence.</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p>

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Clinic	Home	Virtual/Telephone	PBA only
<p>mobility this is manageable, and suggestion is ability to complete most activities without assistance.</p> <p>May use aids to move around.</p> <p>Evidence should also suggest ability to leave the home, access the community, may have ability to drive a car, attend social events, school or work.</p>	<p>symptoms of things like fatigue, and/or pain which may be more poorly controlled.</p> <p>No violence or outbursts.</p>	<p>The individual may be on medication with side effects or due to other comorbidities, be at risk of others entering the home due to a lowered immune system.</p>	<p>Evidence may indicate:</p> <ul style="list-style-type: none"> <li>Severe pain which is poorly controlled</li> <li>Major difficulty leaving the house</li> <li>Regular input from Specialists such as Specialist Nurses, Physiotherapy/Occupational Therapy, Consultants or pain clinic attendance, OR discharged due to inability to support with any other options</li> <li>Excessive fatigue</li> <li>Requirement for assistance required in order to complete activities of daily living with supportive evidence to confirm this.</li> </ul>
<b>Multiple Sclerosis (MS)</b>	<b>This should include considerations of all types of MS including relapsing, primary progressive and second progressive.</b>		
<p>Evidence suggests condition is stable or has infrequent relapses. Symptoms like pain are relatively well controlled. Whilst there may be some pain, discomfort, stiffness and/or restricted mobility this is manageable, and suggestion is ability to complete most activities without assistance.</p> <p>May use aids to move around</p> <p>Evidence should also suggest ability to leave the home, access the community,</p>	<p>Evidence will support symptomatic condition with likely presentation of pain, balance issues, fatigue and numbness in the limbs which causes difficulties leaving the home. However, these will not be extreme in nature. See alternative options for higher levels of symptom presentation.</p> <p>No violence or outbursts.</p>	<p>Evidence suggests behavioural problems where this may include outbursts of aggression and/or violence.</p> <p>The individual may be on medication with side effects or due to other comorbidities, be at risk of others entering the home due to a lowered immune system.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column however it will be clear the</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p> <ul style="list-style-type: none"> <li>Evidence may indicate Symptoms likely to be severely impacting exercise tolerance and mobility, balance and co-ordination issues, weak grip, blurred vision, fatigue, slurred speech, bladder and/or bowel incontinence,</li> </ul>

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Clinic	Home	Virtual/Telephone	PBA only
may have ability to drive a car, attend social events, school or work.		applicant have confirmed they can participate in an assessment and/or will have support, either through the already available evidence or evidence obtained through relevant phone calls.	<ul style="list-style-type: none"> <li>Potentially wheelchair bound/hoist dependent</li> <li>Requirement for frequent daily support with activities of daily living. May have active input from various specialist nurses, neurologists, GPs, physiotherapy/Occupational Therapy.</li> <li>A care package may also be in place.</li> </ul>
<b>Myalgic Encephalopathy (ME), Fibromyalgia and Chronic Fatigue Syndrome (CFS)</b>			
<p>Evidence suggests condition is under investigation with no current formal diagnosis, has intermittent symptoms, is well controlled or currently stable.</p> <p>Whilst there may be some pain, discomfort, stiffness and/or restricted mobility this is manageable, and suggestion is ability to complete most activities without assistance.</p> <p>May use aids to move around.</p> <p>Evidence should also suggest ability to leave the home, access the community, may have ability to drive a car, attend social events, school or work.</p>	<p>Evidence will support symptomatic condition with likely presentation of pain, and fatigue in most limbs which causes difficulties leaving the home but does not provide sufficient evidence on variability. However, these will not be extreme in nature. See alternative options for higher levels of symptom presentation.</p> <p>No violence or outbursts.</p>	<p>Evidence suggests behavioural problems where this may include outbursts of aggression and/or violence.</p> <p>The individual may be on medication with side effects or due to other comorbidities, be at risk of others entering the home due to a lowered immune system.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column however it will be clear the applicant have confirmed they can participate in an assessment and/or will have support, either through the evidence or evidenced through relevant phone calls.</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p> <p>Evidence may indicate</p> <ul style="list-style-type: none"> <li>Severe CFS/ME/fibromyalgia and other co-morbidities which impact function severely.</li> <li>Severe restriction in mobility,</li> <li>The inability to complete personal care needs</li> <li>muscle wastage, extreme physical and mental fatigue, with the requirement of assistance regularly.</li> <li>Likely to spend the majority of their day in bed or resting.</li> </ul>

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Clinic	Home	Virtual/Telephone	PBA only
			<ul style="list-style-type: none"> <li>The applicant may require a wheelchair and support to access the community.</li> </ul>
<b>Psychological injuries</b>	<b>Conditions may include: Bipolar affective disorder, PTSD, Psychosis, Schizophrenia or Personality Disorders</b>		
<p>Evidence suggests condition is stable with some variable periods of potential low or high moods (but not to extremes), depression and/or anxiety.</p> <p>Evidence should also suggest ability to leave the home and access the community without distress with/without the support of another.</p>	<p>Whilst evidence supports difficulties leaving the home there is <u>no evidence</u> that others coming into the home causes any distress.</p> <p>Any self-harming behaviour does not suggest threat to their own life or potential harm to others. Ensure no risk to HCP from visiting the applicant's home.</p> <p>No suggestion of violence or aggression, no dependencies, no suggestion of carrying weapons or other impulsive or dangerous behaviour.</p> <p>If there is substance misuse the HCP should consider whether risks could be mitigated with this option for assessors.</p>	<p>Evidence suggests difficulty not only leaving the home, but also others coming into their home.</p> <p>The applicant may have risk of violence and aggression, an active dependency (see dependency), may show impulsive or dangerous behaviours which can be supported by others.</p> <p>Any self-harming behaviour does not suggest threat to life and will not be exacerbated by this option.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<p>Other associated conditions listed where evidence suggests</p> <ul style="list-style-type: none"> <li>Recent OR high number of previous hospitalisation (for suicidal attempt/significant self-harm, sectioning, or another crisis).</li> <li>Intensive support from community-based mental health teams/significant input from a psychiatrist or other mental health practitioner.</li> <li>OR, Intensive support from family members/care package to manage all needs due to extent of condition.</li> <li>OR, Disengagement with services due to condition.</li> <li>Unstable, highly symptomatic,</li> <li>Lack of insight.</li> <li>Suggestion that completion of a face-to-face assessment would trigger deterioration in MH.</li> <li>Risk of aggression/violence towards others which cannot</li> </ul>

Clinic	Home	Virtual/Telephone	PBA only
			be mitigated by virtual or telephone assessment. Risk of harm to themselves due to unstable nature of condition and active self-harming with security measures in place by others.
<b>Neurology</b>	<b>This should include conditions such as Motor Neurone disease, Parkinson's, Stroke, Head injury</b>		
<p>Evidence might suggest condition is under investigation with no current formal diagnosis, has intermittent symptoms, is well controlled or currently stable.</p> <p>Whilst there may be some pain, discomfort, stiffness and/or restricted mobility this is manageable, and suggestion is ability to complete most activities without assistance.</p> <p>May use aids to move around.</p> <p>Evidence should also suggest ability to leave the home, access the community, may have ability to drive a car, attend social events, school or work.</p>	<p>Evidence may support symptomatic condition with likely presentation of symptoms such as limb weakness, imbalance/gait issues, spasm/tremor and potentially slowness of movement which causes difficulties leaving the home. However, these will not be extreme in nature. See alternative options for higher levels of symptom presentation.</p> <p>Whilst may have some speech difficulties suggestion is, the applicant are still intelligible. Where they are not, they can be supported by a PAB.</p> <p>No violence or outbursts.</p>	<p>Evidence might suggest behavioural problems where this may include outbursts of aggression and/or violence.</p> <p>The individual may be on medication with side effects or due to other comorbidities, be at risk of others entering the home due to a lowered immune system.</p> <p>Whilst may have some speech difficulties suggestion is, they are still intelligible. Where they are not, they can be supported by a PAB.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p> <p>Evidence may indicate</p> <ul style="list-style-type: none"> <li>• The presence of severe upper and lower limb weakness, dysphagia, severe tremor/muscle spasms, incontinence, speech slurring and significantly restricted mobility.</li> <li>• Potentially wheelchair bound/hoist dependent.</li> <li>• Evidence of specialist input and a multidisciplinary team approach or discharged as no further treatment options available.</li> </ul>

Clinic	Home	Virtual/Telephone	PBA only
<b>Respiratory disease</b>	<b>This could include conditions such as Chronic Obstructive Pulmonary Disorder, Emphysema, Asthma, Brittle Asthma, Cystic Fibrosis</b>		
<p>Evidence suggests condition is under investigation with no current formal diagnosis, has intermittent symptoms, is well controlled or currently stable.</p> <p>Whilst there may be some breathlessness, generally this is manageable, and suggestion is ability to complete all activities without assistance.</p> <p>May use aids to move around.</p> <p>Evidence should also suggest ability to leave the home, access the community, may have ability to drive a car, attend social events, school or work.</p>	<p>Evidence suggests symptomatic condition with likely presentation of mild breathlessness may also experience fatigue which causes difficulties leaving the home. May use oxygen for ambulation only.</p> <p>No violence or outbursts.</p>	<p>The individual may be on medication with side effects or due to high risk of infections evidenced by recurrent hospital admissions or rescue pack in place, be at risk of others entering the home due to a lowered immune system.</p> <p>Evidence suggests behavioural problems where this may include outbursts of aggression and/or violence.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column however it will be clear the applicant have confirmed they can participate in an assessment and/or will have support, either through the evidence or evidenced through relevant phone calls.</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p> <p>Evidence may indicate</p> <ul style="list-style-type: none"> <li>• Very poor exercise tolerance, severe breathlessness, fatigue, persistent cough,</li> <li>• Frequent chest infections,</li> <li>• Potential cardiac problems</li> <li>• Requirement of oxygen frequently or full time</li> <li>• Applicant is likely to require support with multiple activities of daily living,</li> <li>• Potential physiotherapy and multiple prescribed medications.</li> </ul>
<b>Sensory Conditions</b>	<b>The HCP must indicate if any reasonable adjustments are required such as BSL/ISL interpreters.</b>		
<p>Evidence suggests condition is under investigation with no current formal diagnosis, or applicant has a degree sight impairment in one or both eyes, and/or hearing impairment in one or both ears, requiring the use of visual or hearing aids which are effective.</p>	<p>Evidence will suggest significant difficulties leaving the home but no distress with others coming into their home.</p> <p>The applicant may be unable to use a telephone and require support from another to effectively</p>	<p>Evidence might suggest there is distress with others coming into the home.</p> <p>Evidence might suggest behavioural problems where this may include outbursts of aggression and/or violence but still suggests insight and an ability to participate in the assessment either alone or with support.</p>	<p>Evidence should be well documented or obtainable through appropriate sources.</p> <p>Evidence may indicate:</p> <ul style="list-style-type: none"> <li>• High level of sensory impairment.</li> <li>• Applicant is registered blind, with no vision in both eyes and/or no hearing (hearing aids are</li> </ul>

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<p>Continues to have some functional hearing and/or vision to be mostly independent accessing community.</p> <p>This impairment has been on-going for some time and the applicant is able to attend appointments and social events and may be driving, employed or attending college with/out support but this causes no distress or difficulty.</p> <p>The applicant may use a symbol cane.</p>	<p>communicate, such as having a reliance on lip reading.</p> <p>No violence or outbursts.</p>	<p>The individual may be on medication with side effects or due to other comorbidities, be at risk of others entering the home due to a lowered immune system.</p> <p>Could have high levels of restriction, similar to those reported in the PBA only column but it will be clear the applicant have confirmed they can participate in an assessment and will have support, either through the already available evidence or evidence obtained through relevant phone calls.</p>	<p>ineffective). The applicant may use a red and white banded cane.</p> <ul style="list-style-type: none"> <li>• Other co-morbidities which impact function severely; for example, learning disabilities or cognitive restriction.</li> <li>• Significant input from specialist and likely support/assistance with the majority of personal care needs frequently.</li> </ul>

Table 13 - Clinical Risk Matrix

## 7.10 Appendix J - Identification and Verification of Applicants

Primary Documentation	Secondary Documentation
<p>Official European Community Identification card</p> <p>Certificate of Registration – Workers Registration Scheme Certificate</p> <p>A current passport (British, Irish or overseas passport is acceptable)</p>	<p>Full/Provisional Driving License</p> <p>Electoral Identity Card</p> <p>Senior Citizen bus pass</p> <p>Travel pass with photograph affixed</p> <p>Standard acknowledgement letter (SAL) addressed to applicant</p> <p>Adoption certificate</p> <p>UK Residence permit</p> <p>NIHE rent book</p> <p>Rates Collection Agency documents</p> <p>Life Assurance/Insurance documents</p> <p>Paid fuel/telephone bill in customer's name</p> <p>Marriage certificate</p> <p>Original full/short birth certificate</p> <p>Divorce/annulment papers</p> <p>Certificate/contract of employment in HM forces</p> <p>Certificate/contract of employment under the crown</p> <p>Certificate/contract of employment in the Merchant Navy</p> <p>P714 (tax certificate)</p> <p>Solicitors letter containing identifying information</p> <p>Cheque book</p> <p>Cheque guarantee card</p> <p>Store/credit/Post Office Account card</p> <p>Trade Union membership card</p> <p>Apprenticeship indentures</p> <p>Vehicle registration/motor insurance documents</p> <p>Wage slip, P45 or P60 from current or recent employer</p> <p>Medical card</p> <p>Mortgage repayment documents</p>

Table 14 – Primary and Secondary Evidence Documentation

Strong	Weak
<p>Date of letter issued by TPDPS</p> <p>The applicant's national insurance number</p>	<p>Postcode</p> <p>Mobile Telephone Number</p> <p>Address</p> <p>Date of Birth</p> <p>Home Telephone number</p>

Table 15 – Strong and Weak Identification Questions

## 7.11 Appendix K - Normal Ranges of Movement

The following table is taken from information within the Physiotherapist's Pocket Book, Jonathon Kenyon and Karen Kenyon, 2004 and is to be used as a guide only for normal ranges of movement. This list is not exhaustive and it may be that an HCP is required to research normal ranges of movements where they are not identified below.

Joint	Movement	Maximum Degrees of Movement
Cervical Spine	Flexion	80
	Extension	50
	Lateral Flexion	45
	Rotation	80
Thoracolumbar Spine	Flexion	45
	Extension	25
	Lateral Flexion	30
	Rotation	40
Shoulder	Flexion	165
	Extension	60
	Abduction	170
Shoulder - with Abducted Arm	Internal Rotation	70
	External Rotation	100
Elbow	Flexion	145
	Extension	0
Forearm	Pronation	75
	Supination	80
Wrist	Extension	75
	Flexion	75
	Radial Deviation	20
	Ulnar Deviation	35

Hip	Flexion	120
	Extension	20
	Abduction	40
	Adduction	25
At 90 flexion	Internal Rotation	45
	External Rotation	45
Knee	Flexion	120+
	Extension	0
Ankle	Plantar flexion	55
	Dorsiflexion	15
Great toe	Flexion at metatarsophalangeal (MP) joint	40
	Extension at metatarsophalangeal (MP) joint	65
	Flexion at interphalangeal (IP) joint	60
	Extension at interphalangeal (IP) joint	0

Table 16 – Ranges of Movement

## 7.12 Appendix L - Visual Loss Assessment Scale

This Valuation Table is reproduced from the Report of the 18th International Congress of Ophthalmology (1958).

Please see appendix B for how aphakia and pseudophakia may apply to visual loss, in addition to the below.

Reduction of Vision as expressed in percentages.

		6/6	5/6	6/9	5/9	6/12	6/18	6/24	6/36		6/60	4/60	3/60	
		1-.9	0.8	0.7	0.6	0.5	0.4	0.3	0.2	0.15	0.1	1/15	1/20	-1/20
6/6	1/0.9	0	0	2	3	4	6	9	12	16	20	23	25	27
5/6	0.8	0	0	3	4	5	7	10	14	18	22	24	26	28
6/9	0.7	2	3	4	5	6	8	12	16	20	24	26	28	30
5/9	0.6	3	4	5	6	7	10	14	19	22	26	29	32	35
6/12	0.5	4	5	6	7	8	12	17	22	25	28	32	36	40
6/18	0.4	6	7	8	10	12	16	20	25	28	31	35	40	45
6/24	0.3	9	10	12	14	17	20	25	33	38	42	47	52	60
6/36	0.2	12	14	16	19	22	25	33	47	55	60	67	75	80
	0.15	16	18	20	22	25	28	38	55	63	70	78	83	88
6/60	0.1	20	22	24	26	28	31	42	60	70	80	85	90	95
4/60	1/15	23	24	26	29	32	35	47	67	78	85	92	95	98
3/60	1/20	25	26	28	32	36	40	52	75	83	90	95	98	100
	1/20	27	28	30	35	40	45	60	80	88	95	98	100	100

Table 17 – Percentage of Reduction of Vision

Note: These assessments are for defective vision without special features and are based on the visual defect measured, after correction with glasses only.



## 7.13 Appendix M - Hearing Loss Assessment Scales

The following tables are adapted from a different scheme which is also based on the Social Security (General Benefit) Regulations 1982. The tables must not be rigidly applied and must act only as a guide for reference. Each applicant's needs must be assessed on an individual basis. The Valuation Tables are adapted from the Industrial Injuries Disablement Benefit

<b>Degree of Hearing achieved with both Ears together</b>	
Conversational voice not over 3 metres:	
(a) one ear totally deaf	20%
(b) otherwise	<20%
Conversational voice not over 2 metres	20%
Conversational voice not over 1 metre	40%
Conversational voice not over 30 centimetres	60%
Shout not beyond 1 metre	80%

Table 18 – Functional Hearing Loss Scale

The percentage disablement given above applies to the deafness only report.

The Binaural disablement may be read directly from the following table.

The pure tone hearing levels in the table refer to the average values of the 1, 2, 3 kHz Hearing Loss, measured in Decibels (dB).

1, 2, 3 kHz average	Pure Tone Hearing Loss	Worse Ear								
Pure Tone Hearing Loss	Decibels (dB)	50-53	54-60	61-66	67-72	73-79	80-86	87-95	96-105	106+
Better Ear	50-53	20	22	24	26	28	30	32	34	36
	54-60	22	30	32	34	36	38	40	42	44
	61-66	24	32	40	42	44	46	48	50	52
	67-72	26	34	42	50	52	54	56	58	60
	73-79	28	36	44	52	60	62	64	66	68
	80-86	30	38	46	54	62	70	72	74	76
	87-95	32	40	48	56	64	72	80	82	84
	96-105	34	42	50	58	66	74	82	90	92
	106	36	44	52	60	68	76	84	92	100

Table 19 – Interpretation of Audiology Results and resulting Percentage Disablement

## 7.14 Appendix N - Quality Audit Criteria

	Detail	Code
<b>Presentation</b>		
Clear Presentation	Free from unexplained medical terminology/ abbreviations	P1
	In plain English	P2
	Free from spelling/ grammar/gender errors	P3
	Clearly presented	P4
<b>Process</b>		
Initial Review	Any potential risk has been identified and mitigated, where appropriate	S1
	Assessment routing is appropriate	S2
Assessment process	Medical evidence used in the report accurately documented	S3
	Consistent with defined clinical processes	S4
	Consistent with the 2020 Regulations	S5
	Consistent with professional standards	S6
Non-prescriptive advice	No prescriptive medical/clinical advice that equates to direct healthcare	S7
<b>Assessment</b>		
History taking	Date of TRI documented	A1
	Description of relevant details of nature and severity of TRI documented	A2
	Initial and subsequent treatment documented	A3
	Ongoing, current and/or planned treatment documented	A4
	Response to treatment initially and long term documented	A5
	Symptoms: past and current and how they changed over time documented	A6
	Relevant social and occupational history documented	A7
	Effects on activities of daily living documented and described clearly	A8
	Explore fluctuations of conditions and whether there are permanent effects of injury on disablement	A9
	Other health issues described	A10
Examination and Observation	Appropriate examinations and clinical tests used	A11
	Mental state examination/cognitive state examination accurately and concisely documented, if required	A12
	Musculoskeletal examination/neurological examination accurately and concisely, documented if required	A13

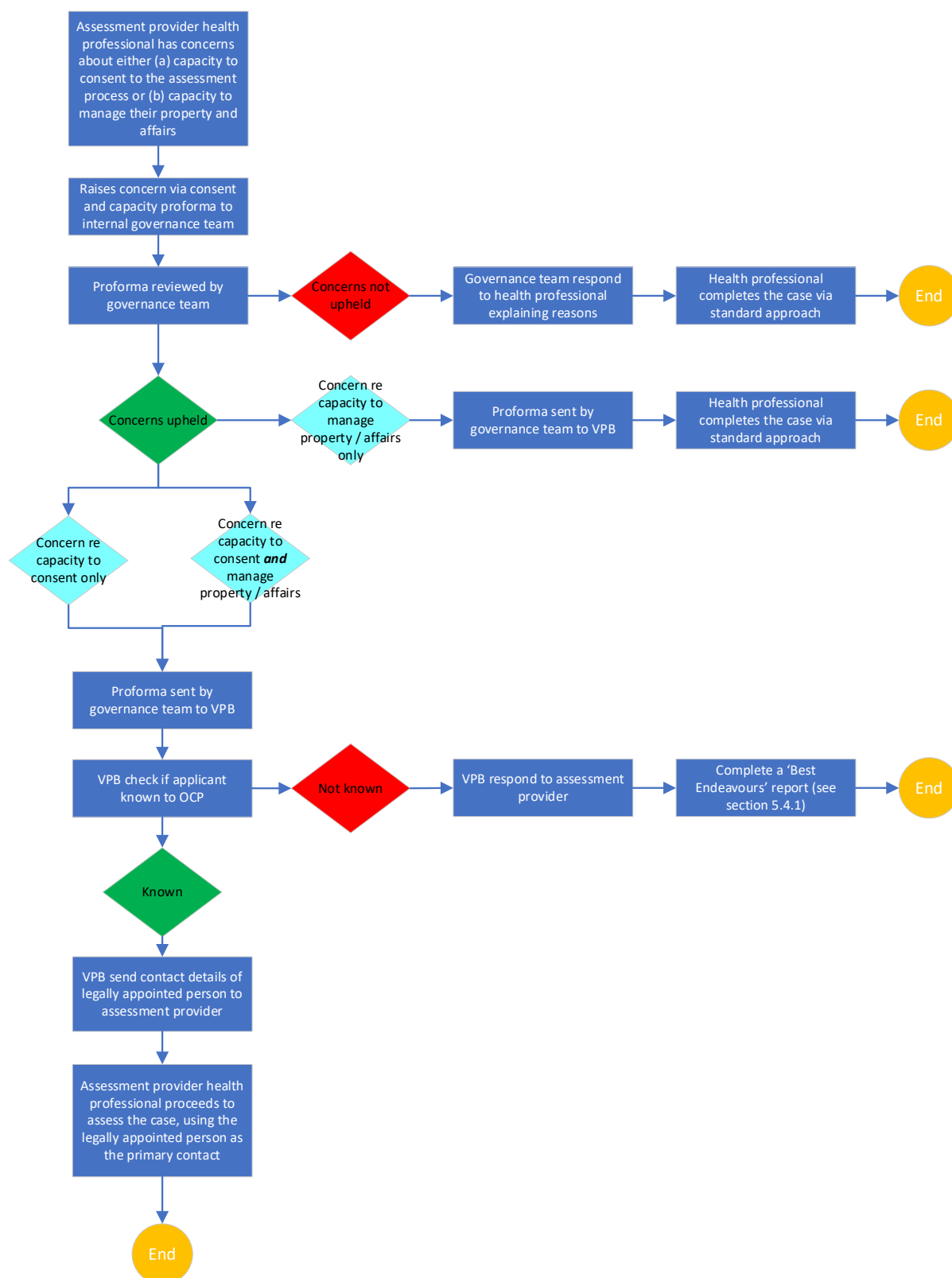
	<b>Detail</b>	<b>Code</b>
	Other examinations and tests clearly documented	A14
	Relevant measurements described and clearly documented	A15
	Appropriate observations documented clearly and professionally	A16
	Documentation is factual, objective, and comparable	A17
<b>Justification and Reasoning</b>		
Clinically logical, demonstrating good rationale	Injury identified and documented specifically including date of diagnosis	J1
	Damage, disfigurement, or loss of physical or mental capacity identified accurately	J2
	Disability identified accurately	J3
	Full/partial relevance assigned accurately	J4
	Other(pre), other(post) assigned accurately, if applicable	J5
	Other(pre), other(post) assessed accurately, if applicable	J6
	Unconnected conditions accurately described	J7
	Disablement accurately described	J8
	Assessed level of percentage disablement can be rounded to the correct multiple of 10	J9
	Date of permanence established	J10
	Interim period appropriate, if applicable	J11
	Medical evidence considered appropriately	J12
	Advice supported by detailed yet concise justification	J13
	Medically reasonable and logical	J14
	Advice in line with balance of probabilities	J15
	Inconsistencies in medical evidence clarified and interpreted where relevant	J16
	Any conflicting information acknowledged, explored, and addressed and any resulting conclusions consistent with the overall evidence	J17
	Clear explanation of any medical issues	J18

Table 20 – Quality Audit Criteria



<ul style="list-style-type: none"> <li>• Not completed (terminated) <input type="checkbox"/></li> <li>• N/A (concern raised at IR stage) <input type="checkbox"/></li> </ul> <p>Action Required (Clinical Governance to complete):</p>	
Clinical Governance reviewer:	
Date of review:	
Date of referral (if sent to VPB)	
Outcome (Victims' Payment Board to complete):	
Date of return (VPB to complete)	
Date of receipt (Capita):	

The TPDPS6 form should be used within the below defined process flow:



## 7.16 Appendix P - Acknowledgements and References

This guide has been written using concepts that support The Industrial Injuries Disablement Benefit (IIDB) of which the technical guidance is accessible via [this link](#). This benefit is underpinned by the same legislation, [The Social Security \(General Benefit\) Regulations 1982](#) and parts of the guide, where relevant are consistent with this.

Where relevant, outputs of historic appeals decisions within IIDB are referenced. These should not be transcribed directly in to TPDPS assessments, however, could be considered within the overall reasoning process adopted by TPDPS clinicians.

The guide quotes directly from the Belfast/Good Friday Agreement of 1998 (accessed [here](#)), the Stormont House Agreement of 2014 (accessed [here](#)) and the Northern Ireland (Executive Formation etc) Act 2019 (accessed [here](#))

The 2020 Regulations referenced in the guide are [The Victims' Payments Regulations 2020](#).

C Mulholland, M Duffy and C Coughlan (2021,) Literature Review: Implementation of Troubles Permanent Disablement Payment Scheme: Rapid Review April 2021, accessed 14/09/2023 (accessed [here](#))



## 7.17 Appendix Q - Abbreviations Used in this Guide

Abbreviation	Unabbreviated Text
AP	Assessment Provider
AS	Additional Support
ASN	Additional Support Needs
DACS	Disablement Assessment Cover Sheet
DoJ	Department of Justice
FME	Further Medical Evidence
FTA	Failed to Attend
F2F	Face-to-Face
GMC	General Medical Council
GP	General Practitioner
HCP	Health Care Professional
ID	Identified Disability
MFR	Medical Factual Report
NRI	Non-related Incident
OCP	Office of Care and Protection
PAB	Personal Acting Body
PBA	Paper-based Assessment
PoA	Power of Attorney
TNA	Training Needs Analysis
TPDPS	Troubles Permanent Disablement Payment Scheme
TRI	Troubles-Related Incident
VPB	Victims' Payments Board or The Board

Table 21 - Abbreviations

