NHS
Business Services Authority

VDPS Principles of Medical Assessment

1. Introduction

This document outlines the quality standards expected within the Vaccine Damage Payment Scheme (VDPS) medical assessment reports. It also incorporates previous learning that may be useful to consider in the preparation of reports.

The Vaccine Damage Payments Act (VPDA) 1979 states where 'on the balance of probability' it is determined that a person is, or was immediately before their death, severely disabled due to a vaccination against any of the specified diseases, a lump sum payment will be made in accordance with the Act.

When originally passed, the Act defined severe disablement as in excess of 80%. From 16/06/2002, this was changed to being defined as disablement of 60% or more.

The VDPA 1979 provides for payments to be made for disablement as a result of the vaccine itself (actual substance). Claims arising from administrative errors are not covered under the VDPS Act and therefore are not eligible for consideration under the VDPS.

2. Core principles

When conducting a VDPS medical assessment and producing an outcome report there are core principles that should be demonstrated:

- Impartiality, Fairness and objectivity
- Justification for the outcome must be robust and stand up to scrutiny
- Uptodate evidence/information must be considered and comprehensively analysed
- Consideration of hierarchy of evidence/information must be applied consistently
- Approach must be professional, in line with GMC expectations.

3. Medical Assessment

All claims are assessed by the independent medical assessment company with a consistent approach. Each case is considered on its own merits, by an experienced independent medical assessor, all of whom are General Medical Council registered doctors with a licence to practice. Medical assessors will consider clinical research, epidemiological evidence and the current consensus of expert medical opinion' together with a claimant's application and their medical records from their healthcare providers to make a clinical assessment on whether it is more probable than not that the vaccine has caused disablement, and if so, whether that disablement is severe.

Claims for Vaccine Damage payment will be referred to medical assessors for advice on:

1) Causation (Whether any disablement has been caused by the vaccine, on balance of probability)
2) Disablement (Where the vaccine has caused disablement, the level of disablement caused by the vaccine and whether the impact of the disablement may change over time)

General principles

- The independent medical assessor will review the information presented and determine if there is sufficient information available to complete the assessment.
- There may be some cases where it appears all information required to carry out an assessment is not available, such as hospital or GP records have not been provided. Where this is the case, the medical assessor must advise NHSBSA that additional evidence is required. Medical Assessment Supplier must advise NHSBSA what evidence is explicitly missing (eg. type, time period etc). NHSBSA will then request this information.
- There may be occasions where some information may be missing (eg. Part of historical medical records) but a complete and thorough assessment can still be carried out. The medical assessor will record in the report what information has been used to carry out the assessment and what the assessment is based on.
- Clinical diagnosis should normally be accepted without a need to review. Where clinical diagnosis does not exist the described symptoms will be considered. Clinical diagnosis is not required to undertake a VDPS medical assessment.

3.1 Assessing Causation

Determining causation is fundamental to the medical assessment. Causation is determined "**on the balance of probabilities**" and this phrase must be used within the report. Determination of causation requires in depth consideration of multiple factors including temporality, biological plausibility, epidemiology and the individual facts of the case.

The report must be appropriately detailed to robustly justify why causation should be accepted or rejected and sources of evidence must be referenced including where relevant, confirmation of the version of evidence that has been used (e.g. the Green Book, Summary of Yellow Card reporting). This includes listing relevant document numbers of medical evidence from the file and justifying opinions and conclusions with appropriate references.

There must be a clear explanation of scientific and medical issues such that the report can be clearly understood by a non-medical person. Any underlying scientific or medical reasoning and all medical terminology must be clearly explained.

Considerations

3.1.1 Temporal link

The vaccine must predate the onset of the claimed symptoms for a temporal link to be possible and there must be a link in time between the two which is biologically reasonable or within limits defined in published research. The existence of a temporal link does not necessarily imply causation, but it is a prerequisite.

3.1.2 Biological plausibility

For causation to be possible, there must be a scientifically plausible mechanism that would be accepted by the body of medical opinion, to explain how the vaccine has led to the

claimed diagnosis/damage. Research in this field is constantly evolving rather than established/accepted. Sources of research quoted must be independent, current, credible, robust sources of medical evidence with references stated.
A biologically plausible mechanism may support causation but is not sufficient on its own to establish causation.

3.1.3 Triggers

A person may have a predisposition to an illness or disability. Which is manifested for the first time by a triggering event. The trigger does not cause the disease but has 'unmasked it'.

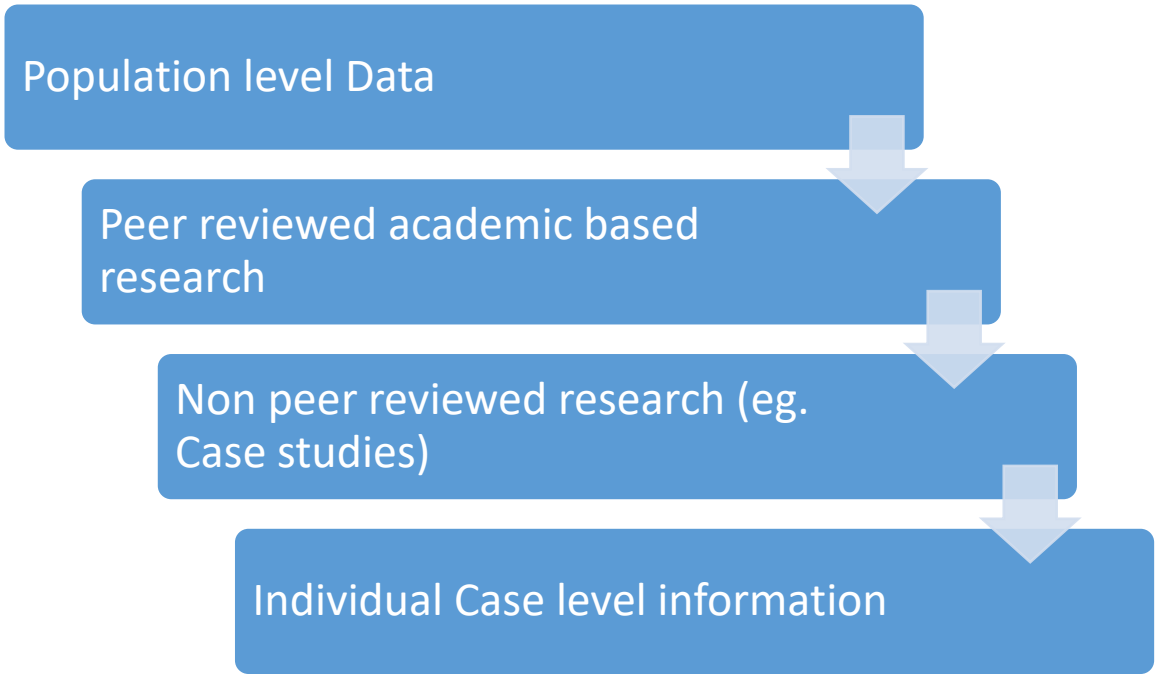
3.1.4 Sources of information available to use to establish or refute causation

All sources of information should be carefully evaluated when deciding "on the balance of probability" whether causation is accepted. Discrepancies must be addressed, and an explanation given for why one piece of evidence has been favoured over another.

3.1.5 Hierarchy of evidence

Evidence can be ranked according to it's relative strength. The stronger the evidence, the more weight it carries and population level data is considered to be the strongest.

Whilst all available evidence needs to be considered the assessor must factor into their advice the weight of any particular evidence especially in cases where evidence may be conflicting. In such cases where evidence is conflicting the assessor will need to explain why they find one evidence source more compelling than another.



3.1.5.1 Population level data

Independent medical assessors use credible resources to support their assessment including, but not limited to:

- Medicines and Healthcare products Regulatory Agency (MHRA) data including Yellow Card information on suspected safety concerns involving a healthcare product. Yellow Card | Making medicines and medical devices safer (mhra.gov.uk) Coronavirus vaccine - summary of Yellow Card reporting - GOV.UK (www.gov.uk)
- Vaccine product information and updates

- The Green Book – A reference material produced by UK Health Security Agency and used by healthcare professionals in the UK. The green book brings together all documents relating to immunisation against infectious diseases. Immunisation against infectious disease: the green book front cover and contents page - GOV.UK (www.gov.uk) Information should be sought from the latest version.
- WHO Causality assessment of an adverse event following immunization https://www.who.int/publications/i/item/9789241516990

3.1.5.2 Absence of population level evidence

Where population level data is not available, advice will be based on the available evidence, giving consideration to the hierarchy of evidence and the individual facts of the case.

Where there has been extensive epidemiological monitoring which has not established a link between a given vaccine and a stated condition, this may suggest a lack of support to establishing a causal link.

3.1.5.3 Peer reviewed academic based research

Wherever possible, high quality peer reviewed research is used to establish causation advice. This ensures that the validity, quality and integrity of the research has been scrutinised by experts in the same field and invalid or poor quality articles are filtered out.
Sources may include:

- Cochrane library
- British medical journal publications
- PubMed
- WHO publications

3.1.5.4 Non peer reviewed research (eg. Case studies)

This information is considered less reliable than peer reviewed information but may be used as an adjunct for advice.
Examples include:

- Non peer reviewed scientific Journal article
- Case studies

3.1.5.5 Individual case level data

The facts established from the file of medical evidence may include:

- Treating clinician opinion on causation. It is important to review the clinical notes to establish if the claimant's treating clinical teams believed there was a causal link between vaccine and damage/diagnosis or not. Occasionally this is documented within the notes. Whilst a clinician's opinion needs to be considered it must be weighed against other evidence
- Yellow card information. If a yellow card was completed by medical personnel, this should be recorded. The completion of a yellow card only suggests a "potential" adverse reaction
- Post mortem documentation
- Coroner's report
- Death certificate

Cases where the decision on causation appears not to align with the population level data (eg. regulatory position, MHRA summaries) the report MUST include robustly justified rationale based on the particular circumstances of the individual case and MUST stand up to scrutiny.

3.8 Further Expertise required

Due to the nature of the case and the availability of scientific evidence the medical assessor may believe further expert opinion is required in order to provide advice on causation. Such a case must be escalated and designated as a 'Complex' case requiring expert opinion. Next steps and timeline will be agreed with the NHSBSA. Once the expert advice has been obtained it must be recorded in the medical assessment report that additional advice has been sought from a named expert. The level of involvement of the expert must be stated in the report and advice given by the expert added to the file.

4. Assessing Disablement

The Vaccine Damage Payment Act 1979 states that a person shall be deemed severely disabled if the disablement is assessed as severe (60% or more). Assessment of the level of disablement is carried out in accordance with Section 103 of the Social Security Contributions and Benefits Act 1992 and Schedule 2 of The Social Security (General Benefit) Regulations 1982 (legislation.gov.uk)

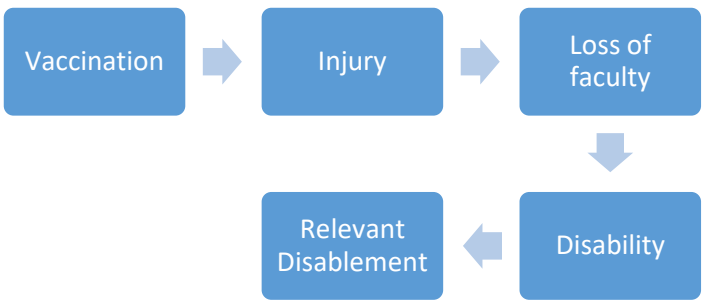
The VDPS Act also states that if a person is assessed to be severely disabled, the question whether his severe disablement results from vaccination against any of the diseases to which the Act applies shall be determined for the purposes of the Act on the balance of probability.

Where the vaccine has caused disablement, the level of disablement caused by the vaccination and whether the impact of the disablement may change (ie. Increase or decrease) over time must be considered and clearly stated in the report.

Key Principles of Disablement Assessment cover:

- Loss of faculty and disablement
- Multiple contributions to level of disablement
- Offset of existing disablement
- Comparators
- Aids/prostheses
- Future deterioration
- Future improvement

4.1 Loss of faculty and disablement



In Vaccine Damage Payment claims, the claim is made that a vaccination has caused an injury which leads to a loss of faculty. This gives rise to a disability which results in an overall level of disablement.

4.1.1 Loss of faculty (LoF):

This is defined as the restriction in function resulting from the injury and from which disablement results.
This may be a total or partial loss of power or function of an organ/part of body. (For example, loss of muscle and skin right lower limb; loss of functioning brain tissue; loss of skin integrity, disfigurement; reduced confidence, low mood). It is not a disability in itself, but it is a cause (actual or potential) of disability/ies. It can be judged by comparing the individual's condition before the vaccine to their condition after it.

Aids are not considered when determining the loss of faculty.

Following Upper Tier Tribunal Judgements it is required that the loss of faculty is specified when determining the assessment of disablement.

4.1.2 Disablement:

Disability is the inability (total or partial) to perform a normal bodily process as well as a person of the same age and sex, whose physical and mental condition is normal. This reference must be made in the report. Aids are considered.

Disablement is the overall effect of the relevant disabilities on the capacity to perform the normal activities of daily living, or loss of health, strength, power and mental activity to enjoy normal life.
For vaccine damage payment purposes, only disablement caused by vaccination can be taken into account and disablement of 60% or more is said to be severe.

4.2 Multiple contributions to level of disablement

Where causation is accepted, it is essential to consider all conditions/symptoms that are caused or worsened by the effects of the vaccine.

- What is the accepted loss of faculty/faculties? (Any differences between this and that which is stated in the claim form must be explained).
- Is the vaccine the whole cause for this?
- Is there any other cause of the loss of faculty? (There may be multiple causes of loss of faculty/overall level of disablement in an individual. In a severely disabled person, it is possible that only a small part of the disablement may be relevant to the vaccine. Hence any significant Past Medical History must be listed and considered even if unconnected. Any appropriate deductions must be made and this should be used to clearly justify the disablement advice.)

Loss of faculty could be:

Fully Relevant	Vaccine is the only cause
Partially Relevant	Vaccine is part of the cause
Unconnected	Has no causal link to the vaccine

Advice given in VDPS cases must relate to the total relevant disablement and the process by which this has been achieved must be evident in the report.

All partially relevant conditions must be considered and the fully relevant parts of these (i.e. those which have been caused by the vaccine) should be added together to give the total relevant disablement.
E.g. A claimant has pre-existing depression which is worsened by Guillain Barre syndrome (GBS) post AstraZeneca Covid-19 vaccine. The relevant mental health (MH) disablement can be calculated by considering the total disablement from mental impairment and subtracting the pre-existing MH disablement. This would be added to any other disablement resulting from the GBS giving a final net assessment which is fully relevant to the vaccine being assessed.
Consequential injuries/conditions leading to a LoF must also be considered as fully relevant. For example, in a case of Guillain Barre syndrome (GBS) post AstraZeneca Covid-19 vaccine, a fall causing fractured tibia due to poor mobility caused by GBS (and no other cause) would be fully relevant and must be considered in the disablement assessment.

An assessment value should be advised as a percentage or small range of percentages and fully justified with a statement of whether or not the threshold for severe disablement is reached.

4.3 Comparators

Assessment of the level of disablement is carried out, and stated to be, in accordance with Section 103 of the Social Security Contributions & Benefits Act 1992 – Disablement Benefit Legislation. Examples of statutory percentages should be given for comparison.
The assessment must compare the individual to a person of the same age and sex in whom physical and mental condition is normal and this phrase must be stated in the report.

Useful reference materials:

- Schedule 2 of the General Benefit Regulations - The Social Security (General Benefit) Regulations 1982 (legislation.gov.uk)
- Appendix 1 – extract of Non scheduled assessments (IIDB Handbook March 2021)
- Appendix 2 – extract of Mental Health assessment Advice (IIBD Handbook March 2021)
- Appendix 3 – extract of Suggested Levels of Disablement for Respiratory Prescribed Diseases from DWP Respiratory Prescribed Diseases Handbook (May 2021)

Note: Other disablement scales should not be used as they are not equivalent to VDPS

4.4 Aids and Prostheses

These must be considered in assessment of disability and disablement.

The scheduled assessments reflect loss of function and loss of tissue; however, they take into account the use of suitable aids/appliances/prosthesis. Therefore, a person who cannot make use of an appropriate aid/appliance/prosthesis due to reasonable causes may be more functionally disabled and the disablement should reflect this. The scheduled assessments (Schedule 2 of the General Benefits Regulations) serve as a guide and conditions such as pain or unstable joints may result in a greater level of disability and disablement. Detailed justification of any advice given is essential.

4.5 Disablement at the time of assessment

The assessors must indicate in the report whether the level of disablement is currently 60% or more, according to the most up to date available evidence. In some cases, the level of disablement may have reduced since the height of the condition.

Claimants who were at least 60% disabled but have already somewhat recovered and are no longer considered 60% disabled:

Assessors are required to consider all relevant factors when determining whether a person meets the necessary 60% disablement threshold, including the period of time that the person has suffered and may be expected to continue to suffer from the disability. Where a Claimant has already recovered from a disability and the assessor concludes that, on the balance of probabilities, the future prognosis does not lead to the 60% threshold being met, the claim should be rejected. We should continue to assess all claims at the earliest available opportunity once medical records have been collected and assessment capacity is available.

The VDPS assessment of disablement looks over a period of time during which the claimant has suffered and is expected to suffer, based on all of the medical evidence available and not just the disablement on a particular date in time. This means that in some cases, even where there have been serious short term symptoms, over the whole period of assessment it may be that the disablement does not meet the 60% threshold. This means that in some cases, even where there have previously been serious symptoms, over the whole period of assessment it may be that the disablement does not meet the 60% threshold.

4.7 Future Disablement

Future prognosis must be considered during the assessment, and the report must indicate whether the level of disability is likely to reach and remain at or above 60% or not in the future when compared to a person of the same age and sex with normal physical and mental condition.

4.7.1 Future Improvement

If the condition is likely to improve on balance of probabilities, a clear and robust justification for this advice must be given with sources of evidence quoted.

Claimants who are at least 60% disabled but who are expected to recover to the point where they are no longer 60% disabled:

The legislation (and case law resulting from that legislation) requires that the assessments consider the length of time a person has suffered and may be expected to continue to suffer in decisions about whether or not they cross the necessary 60% disablement threshold. Assessors should be looking at the Claimant's future prognosis, on the balance of probabilities, when determining the extent of the disablement. Where a disability is likely to improve after what might be considered a short period of time, 12 months might be considered a "reasonable period" for consideration, this can be factored into a determination of whether the threshold is met for the necessary 60% disablement, although 12 months is not a definitive cut off point per se.

Any unsuccessful claimant who experienced an unexpected or unforeseen deterioration, or failure to recover as anticipated, would be able to request a "reversal" of the outcome of their case under the VDPA – effectively meaning that the case is reassessed.

4.7.2 Future Deterioration

If a condition is likely to deteriorate, this must be stated with appropriate references quoted.

Claimants who are not currently 60% disabled but are likely become 60% disabled in the future (particularly common for children receiving vaccinations):

Claims should be awarded in circumstances where the assessor concludes that the necessary 60% disablement threshold is crossed having taking into account all relevant factors, including the Claimant's future prognosis (across the period of time that the person has suffered and may be expected to continue to suffer from the disability), even if the claimant is not considered 60% disabled at the point of assessment, as per the Court of Appeal judgment in SSWP v FG (John) [2017] EWCA Civ 61.

5. Outcome Report

The standards expected within the VDPS medical assessment reports cover three key Quality Themes.

1) **Presentation and process**
2) **Medical Reasoning**
3) **Professional Issues**

5.1 Presentation and process

- Standard template for the outcome report must be used.
- All required Sections of the outcome report template must be completed correctly.
- Beginning of Part 1 should be completed following the completion of the assessment to indicate either:
    a. Claim is disallowed:
        i. On the balance of probability, causation has not been accepted
        ii. On the balance of probability, causation has been accepted but disablement due to vaccination is less than 60%
    b. Award is to be made:
        i. on the balance of probability, the person named is and likely to remain severely disabled as a result of vaccination.
        ii. on the balance of probability, the person named is not severely disabled currently but is more likely than not to become severely disabled as a result of vaccination.

- The assessor must review all evidence in the file and record the number and type of documents at Section1.
- The report must be appropriately referenced. Where the report contains information from the file, the document numbers must be given. Opinions and conclusions must be justified with appropriate references.
- Reports must be legible and clearly presented with grammar and spell checks applied.
- Reports must be written in plain English with medical jargon and abbreviations avoided or explained such that the report can be read and understood by a non-medical person. Reports will be shared with the claimant.
- The report must confirm that the relevant vaccine or vaccines have been given and the date of administration must be stated. In the case of Covid-19 vaccines, the manufacturer (if known) must be recorded in the report.
- The history from the claimant/claimant's representative must be recorded at Section 2 with the main condition or conditions assessed as part of the medical assessment clearly stated and a comprehensive account given of the nature of the stated claim.

- Responses should be given to all questions raised in the claim and on documentation sent by NHSBSA.
- Presence or absence of significant family history should be recorded at Section 2. 3rd party information should not be included, such mother, grandfather, use the term First degree relative/close family member.
- Comprehensive medical history from the medical evidence should be given in chronological order at Section 2 including in all relevant past medical history. Any significant past medical history that is not relevant to the claim can be listed under a separate heading of Past Medical History at Section 2. If there is no past medical history, this must be documented.
- Ensure consistency throughout the report or thoroughly explain any inconsistencies.
- Presence or absence of symptoms at the time of vaccination, and history of the onset of relevant symptoms must be recorded.
- It is confirmed in the report that the relevant vaccine or vaccines have been given and the date of administration is recorded. In the case of Covid-19 vaccines, the manufacturer is recorded in the report.

5.2 Medical Reasoning

Causation

- Causation advice is given on the balance of probability, and this is stated in the report.
- Advice is adequately justified. This requires that the author of a report gives a clear explanation of the reasons for giving certain advice and the underlying evidence by which they were guided.
- There is a clear explanation of medical issues such that the report can be clearly understood by a non-medical person. Any underlying medical reasoning and all medical terms are clearly explained first time mentioned in report.
- The report is appropriately detailed with adequate information to give robustly justified advice on causation.
- Comprehensive medical reasoning is documented to support the advice on causation and is in keeping with the consensus of informed medical opinion.
- References used are stated and are independent, current, credible, robust sources of medical evidence.
- Discrepancies are addressed, and an explanation given for why one piece of evidence has been favoured over another.

Disablement

- Where there is disablement caused by the vaccine, the loss of faculty and the disability is specified in the report.
- Disablement is compared to a person of the same age and sex in whom physical and mental health is normal.
- Disablement advised is stated as being in accordance with Schedule 2 of The Social Security (General Benefit) Regulations 1982, with examples of statutory percentages given for comparison, including an example of a disablement equivalent to 60%.

- Where causation has been accepted, all relevant disablement (i.e. disablement caused by the vaccine) is considered. This may include impaired function of several different parts of the body and may require an addition for any relevant deterioration of mental health. This process is evident in the report.
- Any pre-existing disablement of the same body functions is taken into account and any necessary deductions explained, giving a final net assessment which is fully relevant to the vaccine being assessed.
- An assessment value is advised as a percentage or small range of percentages and fully justified.
- A statement of whether or not the threshold for severe disablement is reached is included in the report.
- Consideration of the future disablement is recorded and advice given regarding whether or not the 60% threshold is likely to be met in future.
- Where causation is not accepted, disablement advice in Section 7 is not required.

5.3. Professional Issues

- No confidential third-party information is included in the report.
- The report contains evidence that the author has used adequate information (including the medical file and other credible sources) to produce well justified advice.
- Any concerns that are identified during the assessment should be reported to NHSBSA. This may include, but not limited to, sensitive information, safeguarding concerns or where incorrect patient records have been included within the claimant's records from healthcare providers.

6. Peer Review

Every VDPS Outcome report will be peer reviewed by experienced VDPS medical assessors. The peer reviewer will exercise professional curiosity and ensure all aspects of the report and referenced materials are considered to ensure the assessment is fair, objective, comprehensive and accurate. The peer reviewer will ensure all information is accurate and consistent throughout the whole report and every reference is relevant and credible.
Once the review is complete the peer reviewer will be in the position to sign off the report and professionally agree to the full content.

7. Audit

A selection of reports will be audited by NHSBSA and measured against the principles and standards expressed in this document.

An Integrated Quality Assurance (IQA) form will be completed by NHSBSA with feedback given where required. The feedback will clearly indicate any issues requiring further attention and whether any amendments to the report are needed. These issues should be raised with the original author and any other practitioners involved in the peer review of the report. Relevant amendments should be made by the author and checked by the peer reviewer before the report is returned to NHSBSA with all amendments clearly indicated.

The report will be graded as follows:

Acceptable -	Essential requirements are met to the extent that the product fully conforms to NHSBSA Quality Standards.
Minor issues -	Essential requirements are adequately satisfied. However, specified improvements would enhance the quality and understanding of the report.
Significant issues -	Essential requirements are not met to the extent that the product fails to meet the NHSBSA Quality Standard and may negatively impact the credibility of service.

8. Request for Reversal

If the claimant considers the determination to be incorrect (in terms of causation, or level of current or future disablement), they can request that the decision is reviewed**.** The claimant must provide an explanation of why they believe the original decision to be wrong and further medical evidence must be provided.
Such cases will be referred to medical assessors for consideration of whether the new information constitutes 'fresh evidence' and therefore is sufficient to warrant a formal review of the case.
If so, the medical assessor must consider causation and disablement in light of the new evidence and decide whether the advice and/or outcome of the original assessment is affected. An objective and comprehensive report must be provided on the appropriate VAD82 form.
If the new information does not constitute fresh evidence, the reasons for this must be explained on the appropriate form.

9. Appeals

Where an initial claim for Vaccine Damage Payment has been rejected (on grounds of causation or disablement) and following the reversal review the outcome remains unchanged, claimants have the right to an appeal of the disallowance of their claim, by a First-tier Tribunal (Ft-T) under Section 4 of the Act.
Disablement must be considered for all cases going to appeal irrespective of whether causation has been accepted.
The Tribunal is comprised of a legally qualified chairman and 1 or 2 medical members.
There is no time limit imposed for making such an appeal request under Section 4 of the Act.
Section 3A of the Act allows a decision made by a Ft-T to be reviewed by the Secretary of State or to be taken to the Upper Tribunal.
A judicial review on a point of law can be carried out in the Administrative Court (part of the High Court).

Appeals may require additional input from the assessor to clarify factual aspects of their report and support responses to appellant questions.

Appendix 1 – Non scheduled assessments

An extract from 'IIB Handbook 1 for Health Care Professionals The Principles of Assessment v 13, March 2021'

(Note: Not all information may be directly applicable to Vaccine Damage assessment.)

Limb amputation cases

Assessment

The prescribed degrees of disablement set out in the Schedule relate to stabilised degrees of disablement. The HM Courts and Tribunals Service generally give a scheduled assessment where the claimant has a healed stump, has been fitted with an artificial limb, and has had a reasonable amount of time to get used to it. Where this is not the case, a provisional assessment at a higher rate than the scheduled assessment should normally be given.

Non Scheduled Assessments

The following information refers to guidance on levels of assessments commonly used by the HM Courts and Tribunals Service for ankyloses in the optimum positions. These are often referred to as the Non Scheduled Assessments. While the Non Scheduled Assessments do not carry the full authority of legislation, they are useful benchmarks for use by an HCP when considering a non-scheduled injury.

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:

Shoulders: Arm abducted to about 20 degrees with the elbow slightly in front of the body and with free movements of the shoulder girdle.

Elbow: 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.

Wrist: In the neutral position, that is in line with the forearm and with slight or no loss of pronation and supination

Hip: Thigh flexed 10 degrees with a slight abduction and slight external rotation

Knee: In 5 degrees of flexion

Ankle: 5-10 degrees plantar flexion of the foot

The following table notes the type of assessments for ankyloses, in the optimum positions, which have been given by the HM Courts and Tribunals Service. However, the HCP should advise on the appropriate disablement for the individual claimant, based on functional restriction when compared to a person of same age and sex whose physical and mental condition is normal.

Ankyloses in the Optimum Position	Per Cent
Shoulder	40 %
Elbow	40 %
Wrist	30 %
Hip	60 %
Knee	30 %
Ankle	20 %

Flail joints

Where there is abnormal mobility, the assessment given by the HM Courts and Tribunals Service for the lower limb has normally been at a higher rate that the ankylosed joint. Improved function may sometimes be achieved in both flail and partially ankylosed joints by skilled orthopaedic treatment.

Injuries to hands

In considering injuries to hands, it is the resulting overall loss of ability to do what a person of the same age and sex, whose physical and mental condition is normal, would be able to do which is to be assessed. Where a claimant has sustained two or more injuries, specified separately in the Schedule, disablement is not necessarily an aggregate of specific figures in the Schedule.

To avoid confusion resulting from the use of "first, second and third, etc." when referring to fingers in medical reports, the terminology, "thumb, index, middle, ring and little finger" should always be used.

Disfigurement

In assessing face and scalp injuries, the factor of disfigurement is important.

Hysterical conditions

Where there is no organic explanation for symptoms, the cause may well be a mental loss of faculty. It is for consideration whether such mental loss of faculty is relevant or whether, for instance, it is a conscious or deliberate mental state that is clearly not the result of the relevant Industrial Accident. Where it is an unconscious or uncontrollable functional condition, the question arises as to whether the relevant Industrial Accident is an effective cause of that mental state. However, it may be that the Industrial Accident was merely the occasion upon which the mental state, which was already present or would by the date of the assessment, in the absence of the Industrial Accident, have manifested itself.

Assessments for eye injuries

Items 4, 32 and 33 of the Schedule 2 of the General Benefit Regulations apply to injuries to the eyes. It is important that HCPs record the visual findings for both eyes showing visual

acuity figures both before and after correction. See Section 1 of Handbook for Upper Tribunal Judge's ruling on artificial aids.

Where an Industrial Accident results in an injury to one eye (previously normal) but the vision in the uninjured eye is already impaired, the disablement resulting from the relevant Industrial Accident may be calculated in the following way:

The degree of disablement is assessed taking both eyes together and where applicable subtracting the degree of disablement in both eyes that would have been present in the period under consideration if the relevant Industrial Accident had not occurred. Partial (P) relevance with an offset and an O(Pre) or O(Post) condition may be appropriate.

The Valuation Table (provided overleaf) reproduced from the Report on the 18th International Congress of Ophthalmology (1958) may be of assistance to HCPs considering defective vision.

Valuation Table for Reduction of Vision: Compensation Rates (Figures in percentages) [reproduced from Report of the 18th International Congress of Ophthalmology, 1958]

		6/6 1/0.9	5/6 0.8	6/9 0.7	5/9 0.6	6/12 0.5	6/18 0.4	6/24 0.3	6/36 0.2	- 0.15	6/60 0.1	4/60 1/15	3/60 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

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

The method of assessment of defective vision is based on the Valuation Table referred to above. Any greater disablement arising from interaction with a disability in the eye not involved in the Industrial Accident is automatically included. The following fictitious examples that have regard only to visual acuity and assume no additional features such as pain or disfigurement illustrate this method of calculation.

Example 1: Claimant sustains injury to the right eye (vision normal before Industrial Accident) which results in corrected visual acuity of 6/18. The left eye has no effective corrected vision because of a pre-existing condition.

Impaired vision	"P" relevant
Defective left eye	O(Pre) (other effective cause)
Assessment for both eyes (right 6/18, left Nil)	45%
Assessment for pre-existing defective vision (right 6/6, left Nil)	27%
Net assessment	18% (45% offset 27%)

Example 2: Claimant sustains injury to the right eye that results in corrected visual acuity of 6/24. Prior to the Industrial Accident right and left visual acuities each corrected to 6/12.

Impaired vision	"P" relevant
Defective vision in both eyes	O(Pre) (other effective cause)
Assessment for both eyes (right 6/24, left 6/12)	17%
Assessment for pre-existing Defective vision (right 6/12, left 6/12)	8%
Net assessment	9% (17% - offset 8%)

Aphakia and Pseudophakia

HM Courts and Tribunals Service have normally taken account of the degree of tolerance and sensitivity to the wearing of a contact lens in assessing the degree of disablement.

Industrial injuries involving the eyes may result in aphakia or pseudophakia which may be unilateral and bilateral.

In aphakia there is absence or loss of the natural lens of the eye, for example following surgical removal of the lens in cataract surgery. The individual may be given thick pebble cataract spectacles or contact lenses to correct the visual acuity. In the majority of cases, treatment gives rise to pseudophakia (false lens), where the damaged lens is removed and a plastic intraocular lens is inserted.

All of these treatments have drawbacks. Spectacle lenses produce a reduced visual field and there is considerable distortion. 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.

Note: the following reflects the consensus of opinion of the Ophthalmologist members of the HM Courts and Tribunals Service.

Assessment of Disablement in Aphakic and Pseudophakic Eyes

1) Determine the best corrected visual acuity for each eye separately
2) Assess visual disablement according to the “Reduction of Vision: Compensation Rates” table
3) Add the appropriate figure as shown overleaf

Note: there may be additional factors, which may lead to a higher assessment such as, cosmetic disfigurement of the eye. The individual must be compared with a person of same age and sex whose physical and mental condition is normal. Loss 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.

Unilateral Aphakia

Spectacle lenses	9%
Contact lenses	6%

Bilateral Aphakia

Spectacle lenses	22%
Contact lenses	16%

Pseudophakia

Unilateral	3%
Bilateral	8%

Deafness

The scheduled assessment for absolute deafness is 100 per cent. The pages overleaf include, for the information of HCPs, a note of assessments for other degrees of deafness, which have been given in the normal Industrial Accident case by the HM Courts and Tribunals Service. It should be noted that in the case of PD A10 (Occupational Deafness), disablement is assessed using the table of binaural disablement. The binaural table must not be used for the purpose of assessing disablement when the deafness is as a result of an Industrial Accident.

Indicative disablement for non-scheduled assessments given by the HM Courts and Tribunals Service for deafness due to Industrial Accidents only:

Degree of hearing attained with both ears together	
Shout not beyond 1 metre	80 %
Conversational voice not over 30 cms	60 %
Conversational voice not over 1 metre	40 %
Conversational voice not over 2 metres	20 %
Conversational voice not over 3 metres: (a) one ear totally deaf	20 %
(b) otherwise	Less than 20 %

Notes on assessments for deafness

Where the hearing in one ear is normal, complete deafness in the other affects the detection of the direction of sound and decisions of the HM Courts and Tribunals Service indicate a minimum assessment of 20 % is reasonable.

A case in which the right ear heard a conversational voice at 2 metres (6 feet), the left ear a conversational voice at 30 cms (1 foot) and both ears together a conversational voice at 1 metre (3 feet), should therefore be recorded as:

Right	Conversational Voice 2 metres
Left	Conversational Voice 30 cms
Right and Left	Conversational Voice 1 metre
Assessment of disablement	40%

The assessments given above apply to the deafness only. Any additional factors such as vertigo, tinnitus or chronic suppuration may warrant an addition to the assessment of disablement. If so, this should be made clear in the HCP's report.

Assessments involving loss of tissue

Splenectomy

Increasing evidence shows that the removal of the spleen may lower natural resistance to certain organisms and removal of the spleen also involves loss of tissue. HM Courts and Tribunals Service having taken these factors into account have assessed the degree of

disablement resulting from the removal of the spleen at between 2% and 5%.

Orchidectomy

The removal of a testicle involves tissue loss and loss of reserve useful function which constitutes a small permanent loss of faculty. HM Courts and Tribunals Service have assessed the degree of disablement resulting from the removal of a testicle at between 2% and 5%.

Nephrectomy

The Upper Tribunal Judge held in decision R(I)14/66 that where a person loses a kidney then as a matter of law it must necessarily mean that there is 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. Where the other kidney is functioning normally HM Courts and Tribunals Service have assessed the degree of disablement at between 5% and 10 %.

Occupational Deafness (PD A10)

The Binaural disablement table is used in the provision of advice on disablement in PD A10 as indicated below.

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

1, 2 , 3 kHz average	Pure Tone HL	**WORSE EAR**								
Pure Tone HL	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

Appendix 2 – Assessments of Mental Health Disablement

An extract from 'IIB Handbook 1 for Health Care Professionals The Principles of Assessment v 13, March 2021'

(Note: Not all information may be directly applicable to Vaccine Damage assessment.)

Assessments of Mental Health disablement

Disability from mental health conditions resulting from an Industrial Accident or PD rarely continues indefinitely, so it would be unusual to advise a life award. Assessments below 14% should be to a date final; those above 14% should be provisional, with the expectation of subsequent improvement. What follows is a guide to the assessment of disablement resulting from mental health conditions.

Normal mental health/Virtually no disablement

Good mental/psychological functioning in social and occupational environments. Interested in a wide range of activities. Socially effective in everyday life. No evidence that he/she would not be effective in an occupational environment. No more than everyday problems or concerns – if these provoke symptoms they are mild and fleeting and do not disrupt day-to-day functions.

Minimal Problems

No more than slight impairment of mental functioning in social environments. Has meaningful interpersonal relationships. Minor changes in an environment may be necessary to limit provocation of some mild symptoms (e.g. mild anxiety, depressed mood, mildly anti-social behaviour) which are transient self-limiting or adequately controlled by psychotropic medications, psychotherapy or counselling.

Very Mild Problems

Slight impairment of mental functioning in social environments. Functions reasonably well in an occupational environment suited to present skills, educational attainments and work experience, but modest changes to the occupational environment may be required, such as avoidance of tight deadlines. Clear control of activities to limit provocation of mild symptoms e.g. mild anxiety, irritability, depressed affect and antisocial behaviour, mild insomnia. May have increased alcohol and/or tobacco consumption if claimant is a drinker and/or smoker. Disturbances of appetite or eating disorders may occur. May repeatedly check on trivial matters, e.g. taps are turned off, washing hands several times before meals.

Mild Problems

Mild symptoms e.g. anxiety, occasional panic disorders, depressed or flat mood which are exacerbated by psychosocial stressors. Tense and irritable. Repeatedly checks trivial matters e.g. that taps are turned off, thereby interfering with social and occupational activities. Functions reasonably well in an environment tailored to limit common stressors.

May have some difficulty with attendance at work (e.g. more short-term periods of incapacity than normal). Decision making usually competent. Has some meaningful interpersonal relationships, but has few friends and can have difficult relationships with peers or co-workers. Interests outside of work and in hobbies may wane.

Disturbances in appetite or eating disorders may occur interfering with social activities.

Insomnia may be a problem.

Mild to Moderate Problem

Moderate symptoms e.g. flat affect, circumstantial speech, occasional panic attacks, mood swings. Very few or no friends. Conflicts with peers and co-workers and some unresolved conflicts but these do not disrupt family and social functioning. Some emotional blocking or tension is evident, but decision is usually competent. Some anti-social behaviour, unexplained absences from work. Few leisure interests and hobbies.

Moderate Problems

Likely to have difficulty functioning in many social and occupational environments, e.g. has no friends. Emotionally labile. Anti-social behaviour, obsessional rituals. Avoids outings and gatherings. Few, if any, hobbies or leisure activities.

Decision making intermittently competent and effective. Remunerative work likely to be possible only in a highly structured supportive and supervised environment. Frequent unexplained absences from work.

Moderately Severe Problems

Behaviour considerably influenced by delusions/hallucinations or serious impairment in communication/judgement. May act grossly inappropriately and may have suicidal preoccupations. Decision making quite ineffective. Problems relating to others. Infrequent periods of enjoyment of life. Frequent distancing from others or open hostility. Serious impairment in judgement/thinking/mood.

Severe Problems

Some danger of hurting self e.g. suicidal preoccupation or suicide attempts without clear expectation of death. Preoccupied with suicidal thoughts. Major impairment in maturation/commitment due to the effects of mental illness manifesting in behaviour such as failure to maintain personal hygiene, failure to care for children. Major impairment of social and occupational functioning, e.g. cannot keep a job, stays in bed all day, anti-social behaviour. Ineffective anger and/or emotional deadness which interfere with family or well being. Day to day life disturbed by delusions or hallucinations or obsessional rituals, other symptoms of major psychiatric illness resulting in substantial impairment of communication or judgement.

Very Severe Problems

Persistent danger of severely hurting self e.g. risk of self harm or suicide with a clear expectation of death (as opposed to cries for help). Despair and cynicism are pervasive. Persistent danger to others e.g. persistent violence, family members in danger. Persistent inability to care for personal hygiene etc. Generally painful interpersonal conflicts. Open hostility evident in relationships and attitudes. No sense of commitment or attachment. Communications grossly impaired, e.g. mute or largely incoherent.

Appendix 3 – Suggested Levels of Disablement for Respiratory Prescribed Diseases

Extract of DWP Respiratory Prescribed Diseases Handbook (May 2021)

The information provided is not binding in any way and carries no prescriptive status for either the RPD HCP or the DM. It is purely advisory and used only in the context of a full and careful disability assessment. There may be instances in which, for very cogent medical reasons, a disablement is advised which does not conform to these bands because of other medical factors relating to the case, including the specific RPD present, any comorbidity, response to management, etc . Each case has to be considered on its own merit.

ASSESSMENT BAND	**HISTORY, MEDICATION, CLINICAL FEATURES, INVESTIGATIONS (These may vary according to specific RPD under consideration and any additional associated features)**
Minimal (1 – 5%)	May have none or few symptoms and/or functional limitations. May have no breathlessness even on exertion. May be on no medication. May have none or early clinical signs. May have early radiological findings. FVC >80% FEV1 >80% Hospital measured predicted gas transfer likely to be within normal range (DLco >70%)
Very mild to mild (6 – 10%)	May have few symptoms and/or functional limitations. May be breathless on prolonged or heavy exertion. May be on no or simple medication. May have none or early clinical signs. Radiological findings present. FVC 70 – 79% FEV1 70 – 79% May have reduced or normal hospital measured predicted gas transfer (DLco 60% to >70%)

Mild to moderate (11 – 30%)	May have some symptoms and/or functional limitations. May be breathless walking uphill or climbing stairs, on hurrying on level ground, or walking on level ground at normal pace for age. May be on regular medication. Clinical signs may be present. Radiological findings present. FVC 60 – 79% FEV1 60 – 79% Reduced or normal hospital measured predicted gas transfer (DLco 60% to >70%)
Moderate to moderately severe (31 – 50%)	Variable level of symptoms and/or functional limitations may be present. May be breathless on walking 100 m at normal or slow pace, or climbing one flight of stairs at normal or slow pace. May be receiving specialist care. Likely to be on regular medication. Clinical signs may be present. Radiological findings present. FVC 50 – 59% FEV1 40 – 59% Reduced hospital measured predicted gas transfer (DLco 40 – 59%) (Remember that 50% rule for COPD might apply in PD D1)
Severe (51 – 80%)	Variable level of symptoms and/or functional limitations may be present. Breathlessness may prevent walking 100 m at slow pace without stopping, climbing one flight of stairs without stopping, or activity outside the home without assistance or supervision. Breathlessness may limit activities to within the home. May be receiving specialist care. Likely to be on regular medication. May be on occasional oxygen. Clinical signs present, which may be advanced. More extensive radiological findings present usually showing more extensive disease. FVC <50% FEV1 <40% Reduced hospital measured predicted gas transfer (DLco <40%) (Remember that 50% rule for COPD might apply in PD D1)
Very severe (81% or more)	Significant symptoms and/or functional limitations may be present. May be able to walk only a few steps because of breathlessness. May be bed and chair bound, and totally dependent on carers because of breathlessness. May be receiving specialist care.

	On regular medication, may consist of multiple drug regimes. May be on occasional or regular oxygen. Clinical signs present, which may be advanced. Extensive radiological findings present. FVC < 50% FEV1 <40% Reduced hospital measured predicted gas transfer (DLco <40%) (Remember that 50% rule for COPD might apply in PD D1)