

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training & Development

ESA Filework Guidelines (For Health Care Professionals)

MED-ESAFWG~001

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1 June 2012

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Foreword

This document has been produced as part of a training programme for Health Care Professionals approved by the Department for Work and Pensions Chief Medical Adviser to carry out benefit assessment work.

All Health Care Professionals undertaking medical assessments must be registered medical or nursing practitioners, or physiotherapists who in addition, have undergone training in disability assessment medicine and specific training in the relevant benefit areas. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

This document must be read with the understanding that, as experienced practitioners and disability analysts, the Health Care Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this training module.

In addition, the document is not a stand-alone document, and forms only a part of the training and written documentation that a Health Care Professional receives. As disability assessment is a practical occupation, much of the guidance also involves verbal information and coaching.

Thus, although the document may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to Health Care Professionals.

Office of the Chief Medical Adviser

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Document control

Superseded documents

Version history

Version	Date	Comments
7 Final	1 June 2012	Signed off by CMMS
7c draft	28 th March 2012	External QA comments HWD & further internal comments incorporated and updates to standards
7b draft	25 th January 2012	Internal QA comments Medical Training & Development incorporated
7a draft	05 January 2012	Schedule 28 Review Medical Training & Development
6 Final	16 th December 2010	Signed off by CMMS

Changes since last version

Key Additions & Clarification

- Addition of new appendices and change in order:
Appendix A: Revised WCA 2011 Support Groups
Appendix B: Revised WCA 2011 LCW Descriptors
Appendix C: ESA 2008 Support Groups
Appendix D: ESA 2008 LCW Descriptors
Appendix E: IB \ PCA Descriptors & Exemption Categories
Appendix F: Prognosis Matrix
Appendix G (Previously appendix A): Glossary of Terms.
- Section 2.3.1 FRR4 details and PV status to list of available MSRS information /evidence.
- Section 2.3.2 after first set of bullet points - reason for recording key clerical points of evidence on MSRS.
- New Sub section 2.4.1 added – information previously in 6.2.4 Medical Knowledge of Condition.
- 2.5.2 Under Potential Review Criteria – emphasis on recording FRR4 electronically except in sensitive cases.
- Section 3 Text box added to reflect Update to Standards 13/2012 and the process for IBR TI cases
- Section 5 subdivided into 2 sections;
5.1 General LCWRA only Referrals & 5.2 Income Related ESA LCWRA Only Referrals (to reflect UTS 38/2011).
- In new Section 5.1 – updated how to handle situation where **new** evidence conflicts with DM decision to treat as LCW.
- In new Section 5.1 - added reference to special support groups.
- Section 6.1 ESA Re-referral Scrutiny- added clarification that full reports may not always be visible.

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- Section 6.1 ESA Re-referral Scrutiny – added clarification of need to satisfy self that LCW threshold was likely to have been met and is still appropriate when ESA 85 not available at re-referral. Added a summary box of key points in re –referral advice.
- Section 6.2.1 MSRS Information – added comment about evidence available from reconsiderations. (UTS14/2001)
- Section 6.2.3 MSRS/ESA 55 information – deleting reference to section 3.3 and adding correct section reference (2.4 Analysis of the Evidence & 2.5 Deferring for FME in ESA Filework).
- Section 6.2.3 Case scenarios updated to make more applicable to 2011 regulations.
- New Section 8.3 The Work Programme added.
- New Section 10.5 Miscellaneous ESA Filework. (Covering aspects of CZ and CN advice referrals).

The following is a list of key deletions made to these guidelines:

- Removal of references to 2008 regulations
Section 1.1 paragraph1; Section 2.1.1 throughout; Section 4.1 paragraph 10; Section 5 throughout.
- Removal of references to the IB Handbook (obsolete)
Section 1.1 last paragraph; Section 7.3.3
- Removal of reference to the ESA Handbook
1.1 final paragraph; 2.1.1 throughout; Section 3; Section 5 throughout.
- Section 11.3 Doctor Approval removed. Users can now refer to
- Removed - Appendix B:Users can refer to the full standalone document on LiveLink (MED-NEURODA~001 Neurological Condition List by Practitioner Type)

Outstanding issues and omissions

Updates to Standards incorporated

Update to Standard 09/2012, 12/2012 &13/2012, incorporated

Issue control

Author: Medical Training and Development Team

Owner and approver: The National Clinical Manager (Performance)

Signature:

Date:

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1. Introduction

1.1 Introduction

The Employment and Support Allowance was introduced in 2008. A process of review of the ESA 2008 regulations was carried out and revised regulations implemented in March 2011. From that period, most claims were assessed under the new regulations. The new assessment is referred to as the Revised Work Capability Assessment (WCA). There was a period of transition lasting 6 months where some claimants will continue to be assessed under the 2008 regulations until these were phased out in September 2011. All referrals are now considered under the 2011 Regulations.

This guideline will refer to filework under the 2011 Regulations. Only where relevant will reference be made to other regulations. (For reference the 2008 regulations functional support group criteria are listed in Appendix C. The 2008 LCW descriptors are listed in Appendices D. Similarly, IB descriptors and exemption categories are listed in Appendix E.)

The purpose of the Employment and Support Allowance (ESA) filework process is to identify those individuals for whom advice on limited capability for work / work related activity can be provided without the need for a face to face examination. There are 4 such categories where the available evidence suggests that the claimant:

1. has severe functional restriction fulfilling criteria for inclusion in the Support Group.
2. meets the criteria for inclusion in the Support Group on other grounds that don't directly measure function (such as terminal illness).
3. fulfils criteria for being treated as having limited capability for work (LCW) where adequate evidence is also available to advise on limited capability for work related activity (LCWRA).
4. continues to meet the threshold of LCW in cases where they have previously been identified as having LCW at a medical examination or those who have previously been accepted to be unfit for work under the PCA regulations where the evidence suggests they are likely to reach the threshold of LCW/LCWRA under the 2011 regulations.

These areas are covered in more detail in the next section (2.1.1)

These Filework Guidelines have been written to support existing and New Entrant Health Care Professionals (HCPs) in their training and in carrying out Filework related to Employment and Support Allowance (ESA). Before HCPs can provide filework advice to Decision Makers, they must be fully approved in ESA examinations, and they must have completed an appropriate approved filework training course and demonstrated competency during this course.

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This document provides guidance for HCPs undertaking all ESA filework activities. It is not intended to provide HCPs with a comprehensive overview of ESA.

HCPs undertaking filework will be expected to be familiar with the content of the Revised WCA Handbook to understand the ethos, structure and fundamental principles of Employment and Support Allowance. Therefore throughout this document, references will be made to guidance in the Revised WCA Handbook. This document will also make reference to Atos Healthcare “Livelink” for accessing the most up to date copies of various forms that may be referred to in this guidance. HCPs are also expected to be familiar with the EBM protocols and should provide advice in keeping with these guidelines. It is expected that all HCPs providing ESA Filework advice will have access to the Revised WCA Handbook, Technical guides, EBM protocols and the LiMA Repository to refer to as required. A Glossary is provided at Appendix G listing some abbreviations used throughout this document.

1.2 Categories of ESA Filework

This document will provide guidance on the various categories of filework. These are:

- The Terminal Illness (TI) **check** (or Special Rules (SR) check).

You will hear the process referred to by both names. For the remainder of this document this process will be referred to as the TI check to avoid confusion. This process requires urgent attention and rapid progression of the claim as **the main purpose of this stage of filework is to identify those with a terminal illness**. Further details of this process can be found in the TI check section of this document.

- **The Pre-Board Check**

This process **aims to identify those with the most serious problems who satisfy criteria for entry into the Support Group**. Some other outcomes are possible at this stage and will be considered in the Pre-board Check section of this document.

- **LCWRA only advice referrals**

This process relates to circumstances where **the DM has already accepted that the client can be treated as having limited capability for work due to specific circumstances** such as pregnancy around date of confinement, Public Health Order, regular treatment, hospital inpatient treatment or special income related circumstances. **The DM will require advice at this stage about whether or not the claimant meets criteria for Support Group inclusion**. Further detail of this process can be found in the section “LCWRA Only Referrals”.

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- **Re-referral scrutiny**

This process relates to claimants who have previously had a face to face examination for ESA. There are a number of different outcomes possible at re-referral scrutiny and these will be considered in the re-referral scrutiny section of this document.

- **IB Re-assessment scrutiny**

This process relates to claimants who have previously been assessed under the Incapacity Benefit Regulations. From March 2011 assessment under the Revised WCA regulations commenced for claimants on Incapacity Benefit. Further detail of this process can be found in the section “IB Reassessment Scrutiny”.

1.3 Objectives

The specific objective for the ESA Filework Guidelines is:

- To ensure that HCPs adopt a nationally agreed framework for providing the ESA filework service, which is common to all business units.

Adherence to the ESA Filework Guidelines will ensure that medical advice is:

- Consistent
- Auditable
- In keeping with the policy requirement.

2. General Principles of ESA Filework

2.1 Purpose of ESA Filework

2.1.1 General Considerations

As part of the Welfare Reform Act 2007, the Department for Work and Pensions introduced Employment and Support Allowance (ESA).

The intention of Employment and Support Allowance is to identify individuals who have:

1. Limited Capability for Work (LCW)

Individuals with **limited capability for work** have a level of disability, defined in the legislation, at which it is unreasonable to require them to work. This may be due to functional restriction or by meeting certain specific criteria, for example undergoing radiotherapy.

Further guidance on criteria for “treat as LCW” and the functional criteria for LCW (2011 Regulations) can be found in the Revised WCA Handbook.

2. Limited Capability for Work Related Activity (LCWRA)

Individuals with Limited Capability for Work Related Activity have a severe level of disability such that it would be unreasonable to require them to work or participate in activities such as training or rehabilitation to help them return to the workplace. Those individuals who have LCWRA are considered to be in the “Support Group”. This may be due to severe functional restriction or by meeting certain specific criteria such as undergoing certain types of chemotherapy or being diagnosed with a terminal illness.

Further guidance on criteria for the Support Group (2011 Regulations) can be found in the Revised WCA Handbook.

The assessment of capability for work and ability to undertake work related activity (LCW/LCWRA status) will be determined by the JobCentre Plus (JCP) Decision Maker (DM). The DM will consider all the available evidence. In some circumstances, the Decision Maker may be able to determine that the claimant can be “treated as having LCW” where specific criteria apply, however in most cases, the DM will refer the case to Atos Healthcare for advice on whether the claimant fulfils criteria to be considered as having Limited Capability for Work and whether they have Limited Capability for Work Related Activity.

LCW and LCWRA status may be established through advice given at the initial filework stage without the need for a face to face medical examination, however in the majority of cases, a face to face examination (LCW/LCWRA medical examination) will be required to assess functional abilities and limitations in areas

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of physical, mental, cognitive and intellectual function. The DM will review advice provided by Atos Healthcare before determining benefit entitlement.

Although most claimants will be seen for an initial referral, there are some whose level of disability is such that it would not be appropriate to require them to attend for an examination. This is usually due to them having very severe illness or disability resulting in inclusion in the Support Group.

In re-referral cases (ESA or IB re-assessment), not all claimants will need a further exam. If there is evidence that the claimant would meet criteria to be considered as having LCW or LCWRA, it may be possible to advise, without the need for a face to face examination, that it is likely that the claimant has LCW or indeed LCWRA.

The initial assessment process is intended to be carried out between weeks 8 and 12 after the first date of claim.

In each type of filework, there are different possible outcomes. Each “type” of filework and the advice that can be given will be considered in greater detail in appropriate sections of this document.

2.2 Overview

The majority of ESA filework is accessed, completed and advice submitted to the Decision Maker electronically via MSRS (Medical Services Referral System) an automated case management and workflow system. The advice is completed on the form ESA85A through the LiMA application and submitted electronically to the Decision Maker. The only exception to this is certain highly sensitive cases, for example, MPs, gender reassignment, VIPs, members of the Royal household or people in witness protection.

In each type of filework advice, the HCP will have to consider the information and evidence available to them, determine whether further evidence is required and then provide and justify their advice to the Decision Maker.

In each case, the advice provided must be objective and impartial, in keeping with the consensus of medical opinion and on the balance of probability.

2.3 Sources of Evidence/ Information

The HCP, when providing advice, must consider all the evidence available.

This may be found in:

1. The MSRS application
2. The ESA 55 jacket

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2.3.1 MSRS Information

Within the MSRS application, all the evidence must be considered in order to provide an opinion. Some examples of evidence that may be available include:

- The claimant's age
- Appointee status
- Certified cause of incapacity
- Previous filework advice outputs (ESA 85As & IB85As)
- Previous LCW/LCWRA examination reports (ESA 85s)
- Previous Personal Capability Assessment reports (IB85s)
- FRR4 details
- UCB status

Claimant Age

The claimant's age must be considered as this may impact upon the likely level of disability caused by their medical problem.

Appointee Status

It is important to check whether or not the claimant has an appointee as this may impact on the requirement to obtain further medical evidence. This may be extremely important in Mental Function problems suggesting that the claimant has a significant level of impairment.

Cause of Incapacity

The cause of incapacity noted on MSRS must be considered. This may be listed as "MED3" or "FRR4". Information noted on MSRS as MED 3 implies that this is information provided by a Healthcare Provider. Information provided as FRR4 details is information that has been provided by the claimant. Further detail may be obtained by referring to the technical guide available on LiveLink

Previous ESA 85As/Previous IB85As

Previous ESA 85As should be considered in every case where they are available as they may provide useful information from previous referrals. IB85As may provide information of relevance when considering whether the person may meet the LCW/LCWRA threshold of the Revised WCA.

Previous ESA 85s

If the case has been referred for re-referral scrutiny, previous ESA 85 reports should be available for review. A well completed, and well justified ESA 85 report will often

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provide the best source of evidence for the scrutinising HCP but care must be taken to review the report with care checking for listed conditions and consistency within the report. More detail will be provided on evaluating the ESA 85 in the section of this handbook looking at “Re-referral Scrutiny”. ***The ESA 85 may have been completed under the 2008 Regulations and care must be taken to consider the application of this report in the context of the 2011 Regulations.***

An ESA 85 may also be available where the claimant has been examined and found to be in the Support Group. These cases will be referred back to Atos Healthcare for a Pre-board check. Although the ESA 85 may not be fully completed, there may still be valuable information in the report.

Previous IB 85s

A person may previously have been assessed under the Incapacity Benefit regulations and then referred under the WCA regulations. Although the descriptors are very different in IB, the report may still contain evidence that suggests they may meet criteria to be considered as LCW/LCWRA in the context of the Revised WCA. (See Appendix E for IB\PCA descriptors.)

FRR4 details

MSRS allows the HCP to record any telephone contact with the GP/ Consultant etc electronically. This information may be of use in many types of Filework and must be carefully considered.

UCB Status

Careful consideration should be given to the reason for UCB status. If this is likely due to the medical condition, this should be taken into consideration in evaluating the evidence and giving advice. The safety of colleagues also needs to be considered. All the UCB documentation must be viewed before calling for exam (MEC or DV). If the UCB documentation is not available on MSRS, the file must be returned to the Administration Section to obtain a full account of the reasons for the UCB status. (Refer to the latest update to standards Issue 12/2012 available on LiveLink. The former PV procedures have are under review and as 19/03/2012 the DWP no longer refer to PV procedures.)

2.3.2 Evidence/Information contained in the ESA 55 Jacket

The amount of information in the ESA 55 will vary in each case. If a case has been referred clerically – for example a sensitive case – there will be no MSRS record and all documents will be held clerically in the ESA55. All information must be considered and evaluated. The information could include:

- Information provided by the claimant on form ESA 50 or ESA 50A
- Further Medical Evidence (FME) on form 113, FRR2, FRR3, or letters from health care professionals involved in the claimant’s treatment
- Notes of telephone contacts from a Healthcare Provider or the claimant on form FRR4

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- Documentation from JCP

Remember that in **non-sensitive cases**, where clerical information is present and used in giving advice, it is very important to record the key points of this evidence \ information in any electronic justification. This allows makes the key features available for future reference. For example, key features such as type of treatment and length of any planned therapy, prominent clinical signs that may be recorded in the 113.

ESA50 /ESA50A Information

The ESA 50 or ESA 50A (where the referral is LCWRA only) is the claimant's form, and provides them with the opportunity to provide details about their medical conditions, functional problems and abilities. An ESA 50 or ESA 50A may not always be present since claimants with Mental Function problems cannot be compelled to complete either form. Where completed, the information must be carefully considered. Within the ESA 50/50A you may find copies of hospital letters, repeat prescription sheets, details of whether or not they are in receipt of DLA etc. ***All this information must be considered.***

Further Medical Evidence (FME)

FME may be present in the file. This may have been requested during the current referral when another HCP felt FME was essential in order to provide advice on the case. In most cases, this will be form 113 sent to the GP or form FRR3 sent to another Health Care Professional. In some cases, where specific information is being sought, form FRR2 may have been sent out to a Healthcare Provider involved in the patient's care. (Copies of forms 113, FRR3 and FRR2 can be found on Livelink). From time to time health care professionals involved in the claimant's care may submit letters containing information about the claimant.

FRR4 – Telephone advice minute

Form FRR4 is a telephone advice minute. Details of conversations must be recorded on this form. This is used to document any communication with the claimant, GP or any Healthcare Provider involved in the claimant's care. In most cases, the electronic version of this form will be used, but clerical forms may be available in sensitive cases or on occasion from a previous referral.

Documentation from JCP

Sometimes, JCP attaches information relevant to a case. This could be where a claimant has failed to attend an allocated appointment. Often this will be due to administrative issues such as the appointment letter arriving late or the claimant having problems with mail delivery, however, at times the claimant will have provided detail that they were unwell or admitted to hospital at the time of the appointment. You should consider whether it may indicate a serious problem or deterioration in their condition, where FME may be appropriate.

2.4 Analysis of the Evidence

When undertaking filework, you must be able to evaluate evidence and weigh up the different types of evidence available to you. There may well be conflicting pieces of evidence on file and your role, as the scrutinising HCP, is to consider each piece of evidence carefully and advise based on the strongest evidence.

When scrutinising filework cases there are 5 fundamental areas of documentary evidence where the HCP has to apply evaluation skills. These are:

1. Medical Knowledge

This is what is learnt through training and experience (the consensus of medical opinion). It is important to recognise that there are limitations to the extent of the usefulness of this element in the evaluation process. It provides a reliable indicator to the HCP about the level of disability that might reasonably be expected but its usefulness may be limited by providing generalised “broad brush” advice which is not directly relevant to an individual.

2. Independent Medical Evidence (IME)

This is information which has been provided by a Healthcare Provider such as the claimant's GP or a member of the Community Mental Health Team. They can be seen to be independent because they are not representing only the customer's perspective. Primarily the information will be factual; it may be derived from the Med 3, 113 or even the ESA50 / 50A.

IME may also be taken from a previous, well completed and justified ESA85.

3. Independent Medical Opinion (IMO)

Within IME on occasions an opinion may be offered (e.g. "unable to work"); the value of such opinions need to be considered in the context in which they are given and may on occasion be overridden by the Disability Analyst HCP. However, it may include useful information about function. It is obtained from a variety of sources, usually a Healthcare Provider who is involved in the management of the claimant's medical condition(s). It can assist the HCP in formulating a more holistic view about the claimant's medical conditions, their interaction, how they respond to treatment and their effect on the individual's function; not only from a medical model, but also from a psychosocial aspect.

4. Medical Information (MI)

This comes from a non-medical source, e.g. the claimant or their representative. It includes details of symptoms, medication, hospital attendance, etc. For example, they may indicate a BMI of 36 or may list their daily peak flows. Normally the information provided does not directly describe functional loss, although on occasions it may do. For example, a claimant may indicate “I had a treadmill test for angina and only managed on the machine for 6 minutes”.

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It may not and does not have to be verified but could be verifiable if we chose to ask for IME. For it to be used effectively it has to be both internally consistent with itself and with the IME and IMO on file. It is important to note that “consistent with” does not mean “supported by”. If the information is consistent, there is no need to doubt or exclude it. In terms of IME, in many cases you will have the Med 3 diagnosis, on MSRS. In most circumstances the evidence will not be strong enough to stand alone. However, in many instances it will indicate the presence of a condition in which there is a possible wide range of disability, from mild to severe.

Where the other aspects of the evidence – both the CPO and MI – support severe restriction, it may well be possible to accept physical incapacity leading to Support Group inclusion without further evidence, even in a first referral. Further medical evidence – such as a 113 – is then not essential. Medical Information and claimant provided opinion will often be present in an ESA 50 and both types of evidence should be considered when forming an opinion on likely level of function.

5. Claimant Provided Opinion (CPO)

This refers to reported symptoms and functional loss and is usually derived from documentation provided by the claimant. It may include opinion from a relative or carer who is representing the claimant. This evidence is therefore not independent.

Remember that the claimant may have understated or overstated their problems.

However, this evidence still forms an important part of the overall evidence that requires evaluation in the Disability Analysis process.

With CPO, additional MI may be provided. For example, a claimant may have detailed in the ESA 50 that they cannot walk more than about 5 metres without getting breathless. They are breathless even on washing and dressing. This would be CPO.

The claimant may indicate they are on home nebulisers 4 times daily for COPD and require home oxygen. They indicate they have been provided with a wheelchair by their Respiratory Consultant for their daughter to push them in outdoors. They have had an Occupational Therapy review and hoists and bathing aids have been installed in the home. They have been provided with a carer by social services to help with bathing as they are too breathless to manage this alone. This would be Medical Fact that would be potentially consistent with the CPO.

The Med 3 information may indicate “severe COPD – oxygen dependent”. This Independent medical evidence would be reasonably consistent with the MF and CPO and a high level of disability could be accepted.

Even in cases where the Med 3 diagnosis suggests Severe Mental Illness or Severe Learning Disability, where the ESA50 indicates a high level of symptoms, treatment and community or hospital support, and this is supported by Medical Fact, you still need consider whether there is sufficient information about function for you to advise Support Group inclusion or acceptance at re-referral scrutiny.

In those instances where the situation is unclear, in order to give robust advice from a position of strength, you may need to consider obtaining further Medical Evidence. Medical evidence including that from the claimant's own GP or other Doctor(s) can be very useful in forming a decision not to call the claimant for examination. The

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best medical evidence in a re-referral case will normally be a good ESA85 report completed at a previous referral during that spell of incapacity for work. Where there is a previous LiMA report you can access this through MSRS.

Sometimes the ESA50 will indicate that DLA is in payment. This information should not be considered to be sufficient to allow you to accept incapacity. You have not had the opportunity to evaluate the evidence used to make the decision. You should use it rather as an indicator of possible severity; it may prompt you to go for further evidence in a case where you would otherwise call for examination.

Rarely the ESA50 may contain information that has not been revealed to, or reported by, the GP. You will have to decide how much weight to place on each item of evidence, given the circumstances of the case under consideration, in order to provide advice in accordance with the guidelines.

2.4.1 Using Medical Knowledge of Condition

In all types of filework, the decision to “call,” “accept” or “request FME” must be based on the evidence available and with a background of knowledge of the medical conditions claimed. All HCPs must provide advice which is evidence based and in keeping with the consensus of medical opinion.

HCPs are referred to the EBM protocols and the LiMA Repository for further guidance.

2.5 Deferring for FME in ESA Filework

Atos Healthcare HCPs are best placed to determine when it is appropriate to request fresh medical evidence from the claimant’s GP or other Healthcare Provider. HCPs must be aware of the issue of consent when requesting FME.

2.5.1 Consent for Further Medical Evidence in ESA

Claims for Employment and Support Allowance (ESA) are made over the telephone. As part of the claims process, a declaration is read to the claimant. They must agree this declaration before the claim is accepted. An audio recording is made of this verbal consent. This will be retained by the Department for Work and Pensions (DWP) as a documentary record of consent for the life of the claim.

As consent will be held in every case, FME can be requested whether or not an ESA declaration has been signed.

FME gathered by telephone

In urgent cases, for example terminally ill (TI) cases, the Health Care Professional may well need to phone the GP or other Healthcare Provider to obtain evidence. From time to time you will be asked to provide evidence that consent is held.

If such a request is made, the HCP should undertake to fax this evidence of consent. Request details of a fax number and then complete form ESAC* and fax this with a cover sheet.

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Once this has been faxed, the HCP should call the Healthcare Provider again. If the Healthcare Provider remains unwilling to divulge clinical details then an ESA 113 should be despatched via MSRS. The HCP should ensure that any fax sent with claimant details is in accordance with the **current** Atos Healthcare security policies.
*Note: The ESAC is available on, and should be accessed from, LiveLink.

You should use this same process where an ESA113 has been issued but the Healthcare Provider calls you to request evidence of consent.

Consent requested by written correspondence

When a request for consent is received by post, the administrator or HCP should access MSRS to establish the current status of the referral.

If the referral has progressed to 'workstack' or beyond, then the request should be disposed of in confidential waste and no further action taken.

If the referral is awaiting the return of the ESA 113, at Pre-board Check, then the request should be passed to a Team Leader. The Team Leader should contact the healthcare provider's location and explain that they have received the request and that they will fax the above consent letter along with a further manual ESA 113. The Team Leader will request that, since significant time has already passed, the completed ESA113 is faxed back as soon as possible.

Once the return fax is received, the process continues as normal for receipt of an ESA 113.

If a return fax is not received or is not completed, the process continues as normal for a non-return of an ESA 113.

2.5.2 Requests for FME

FME should be obtained in those cases where there is a strong probability that such evidence will confirm a level of claimed disability where Support Group criteria may be established or "treat as LCW" may be confirmed. In re-referral cases, FME may confirm that there has been no improvement in the condition resulting in ongoing functional restriction or may even confirm further deterioration such that Support Group advice may be applicable. Where, in the scrutinising practitioner's judgement, there is a clear possibility that an examination may be avoided they should make reasonable attempts to seek further evidence. FME should not be requested simply to confirm that an examination is required or to obtain further information to assist the examining HCP. In all cases, the reason for adjourning for FME must to be clearly documented.

In certain cases, where evidence in addition to the certified diagnosis is not available, it may be appropriate to try to obtain it, for example, by:

- Making a further attempt to obtain evidence from the GP by phone.
- Requesting the completion of an ESA 113 report.

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- Requesting a factual report from the GP, specialist or other Healthcare Provider.
- Contacting the claimant by telephone for further information.

If information from the GP is needed, usually an ESA 113 will be sent. However, there may be occasions when a specific issue needs to be addressed and form FRR2 is more appropriate (e.g. when information about the frequency of epileptic fits is required).

FME should always be requested before calling for examination a claimant who is noted to have an appointee.

Where there is evidence of a previous suicide attempt, suicidal ideation or self harm expressed in the ESA 50/50A, the HCP must request FME.

When you request FME, at the time of initiating the FME request you need to determine whether:

- The case requires further review if FME is not returned
- The case requires examination if FME is not returned

Therefore where FME is not returned only those cases where review is indicated will be submitted for further review. The remaining cases will automatically be submitted for examination.

At the time of calling for FME, if examination on non-return is selected, you must also indicate whether the case is “Dr only” and whether a DV is required. (See Section 10.3 for information on DVs and Appendix G for a list of Dr only conditions).

If and when FME is returned, the case will always be reviewed with this further information.

Potential Review Criteria

Each case must be considered on its individual merits. However, in deciding the appropriate course of action, you may wish to consider the following points:

- Where a claimant is likely to have a terminal illness, a phone call to the GP will almost always be the most appropriate method of obtaining further evidence in the first instance, however, if an ESA 113 is sent and not returned, the case should be reviewed further.
- Where a claimant reports that they are undergoing chemotherapy then the case will benefit from further review.
- Where a claimant is likely to be so distressed by being called for an examination or have such a high level of disability that an examination will only be considered when all evidence gathering has failed, the case should be reviewed further. In particular consider those claimants with major mental health conditions such as

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psychotic illnesses and claimants who, for example, are oxygen dependant, or quadriplegic etc.

This list is not intended to be exhaustive and, as indicated above, you should consider each case on its own individual merits.

If there was no response, or an inadequate response, to an ESA 113 request despatched previously, a second written request from the scrutiny desk is unlikely to meet with success and should not be made. If FME from the GP is considered essential in a case of this type, you should make a telephone call to the GP, although in practice this situation should arise infrequently. Any record of a telephone conversation with the GP or any other Healthcare Provider involved in the claimant's care should be made on form FRR4 (This is usually recorded electronically on MSRS except in sensitive cases where recording is done on the clerical form.).

Examples of cases where it might be appropriate to seek further evidence (when there is insufficient evidence on file) as an alternative to calling the claimant for an examination:

- A first referral where, in the scrutinising practitioner's clinical judgement, there may be a severe medical condition or disability present suggesting inclusion in the Support Group
- Where in a re-referral or IB re-assessment case there appears to be a level of functional disability that would meet the LCW criteria.

Scrutinising practitioners may use their professional judgement to decide when to contact the claimant by telephone for further information, but the following examples may be helpful:

- The claimant appears to be undergoing regular treatment but details and current status are not given.
- The claimant has fits but details of frequency and nature are not given (in re-referral/IB re-assessment cases).
- Contact details of a Healthcare Provider who may be able to supply a report, are not given on the ESA50.

Evidence may be obtained from a Healthcare Provider by using form FRR3 or by a telephone call to the claimant using form FRR4. For example, where there is evidence of a significant and enduring mental health condition, and the claimant reports frequent contact with the Community Mental Health team, the CPN may well be the person best placed to provide information about the claimant's current condition.

If you decide that that an approach to a Healthcare Provider is the appropriate course of action, you should request that form FRR3 is dispatched. You must complete the details of the claimant and the Healthcare Provider, and include all of the relevant questions.

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If you decide that an approach to the claimant is the appropriate course of action, you may telephone the claimant or ask an administrative colleague to make the call.

In either event, form FRR4 must be completed to provide the claimant's details and the nature of the information required from the claimant. When making the telephone call it is essential that you or your administrative colleague establishes the identity of the person to whom they are talking at the outset.

The following script or something very similar must be used:

"I'm Dr/HCP (name)/ (practitioner's name) Medical Services and I would like to speak to Mr Y". No further details should be given until the claimant has been positively identified.

Further evidence of identity should be sought (e.g. date of birth or NINO) to make a positive identification. If you are uncertain that the person speaking is the claimant, you should terminate the call and note this on the form. If the claimant is unavailable, arrangements should be made to call back.

If that is not possible, note this on the form. You will then have to reconsider the file to decide on an appropriate alternative course of action.

Having established the identity of the claimant, you need to explain why the telephone call is being made. The following form of words should be used, dependent upon whether it is the scrutinising practitioner or administrative staff making the call:

"I am one of the doctors/ practitioners providing medical advice to the Department for Work and Pensions" or "I have been asked by one of the doctors/ practitioners who advises the Department for Work and Pensions to obtain further information"

The following form of words is then used: "You have recently completed an ESA50 questionnaire for the Department for Work and Pensions Decision Maker. I wonder if I could ask you some additional questions about your health problems, so that we can decide whether it is necessary to examine you?"

If the claimant agrees, the questions identified by the scrutinising practitioner in the form are asked and the answers are recorded, using the claimant's own words as precisely as possible. The person phoning should always ask if there is anything else that the claimant wishes to say before concluding the call. The person making the call should conclude by reading back what has been documented. The scrutinising practitioner /administrative colleague should advise the claimant that this information will be added as evidence to the file.

If the claimant does not agree to talk on the telephone, the call is terminated and the form completed. If a member of the administrative staff has made the call, the form should be returned to the scrutinising practitioner forthwith.

Under no circumstances should any likely outcome of the claim be indicated. Similarly, no indication should be given as to whether the claimant will or will not be asked to attend for examination.

In all cases, the form must be signed and dated by the person who made the call.

3. The Special Rules Check (TI check)

When a claimant applies for ESA they may state that they are terminally ill. The definition of terminal illness in legislation is:

“That he is suffering from a progressive disease and his death in consequence of that disease can reasonably be expected within 6 months.”

When a claimant is considered to be potentially terminally ill, a referral will be sent to Atos Healthcare for advice.

These referrals must be treated with great urgency.

This referral will be accessed using MSRS. The HCP will access the case and follow a process which has been agreed by the customer. The advice provided to the Decision Maker will be generated using the LiMA application.

The advice given must be current and in keeping with the balance of medical probability with regard to prognosis in the diagnosed condition.

Some TI checks will be submitted with a faxed DS1500, which will be passed to the CSD HCP within an ESA55. In that circumstance, the HCP should consider the TI question based on that evidence. The DS1500 form is used in Disability Living Allowance and Attendance Allowance (See Glossary) to consider applicants for DLA/AA under the Special Rules for the terminally ill. As in ESA, the definition of terminal illness is that life expectancy is likely to be less than 6 months. The DS1500 is completed by a Healthcare Provider involved in the claimant's care. The DS1500 allows the HCP to record medical details of the diagnosis, date of diagnosis, treatment and general condition of the patient.

At times the detail in the DS1500 may not be adequate to confirm TI and a phone call should then be made to the author of the DS1500 for further clarification. The record of the telephone conversation should be recorded on form FRR4.

If no DS1500 is submitted with the claim, the HCP should check whether the claimant has been accepted under the Special Rules provisions for Disability Living Allowance/Attendance Allowance. This information can be accessed by administration colleagues through the “SMART” application. SMART is an IT system used by administration staff. It has a variety of functions including recording data relating to Disability Living Allowance and Attendance Allowance claims. The HCP will complete section A of the SMART TI check pro-forma and pass it to an administration colleague, who will check to determine whether a DLA SR referral has previously been documented on SMART. If the claim has been accepted under DLA SR within the last 6 months, the HCP can consider the claimant as TI for the purposes of ESA. This outcome should be documented on the ESA 85A electronically and sent to the Decision Maker.

If neither of the above applies, the HCP will seek further medical evidence from a Healthcare Provider involved in the medical care of the claimant.

The medical evidence will usually be obtained by telephone contact to the

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claimant's GP, consultant, or other Healthcare Provider involved in the claimant's medical care. Exceptionally, this information will be obtained by a written request for Further Medical Evidence (FME). It should be noted that a claimant who is terminally ill (as defined) will be entitled to the higher rate of benefit while still in the 13 week assessment phase. **Therefore a phone call should be the preferred option to enable prompt establishment of information regarding their medical condition.**

The HCP will review the evidence obtained and provide advice on the body of evidence, indicating whether or not it is likely that the claimant is suffering a terminal illness as defined in the legislation.

If the claimant is considered to be terminally ill (as defined), the HCP will submit that advice to the Decision Maker electronically on form ESA 85A. If the advice is accepted, the claimant will be placed in the Support Group and there will be no requirement for the claimant to complete form ESA 50, to be examined or participate in work related activity.

If the claimant is not considered to be suffering from a terminal illness, the HCP must consider whether or not there is evidence at this stage that they satisfy one of the other Support Group criteria. For example, the GP may confirm that the claimant has breast cancer, with no evidence of metastatic disease, has had surgery and has now commenced IV chemotherapy. In this case Terminal Illness could not be advised; however the claimant fulfils the criteria for inclusion in the Support Group on grounds of receiving chemotherapy. For the special circumstances categories of Support Group inclusion i.e. ("TI," "pregnancy risk", "chemotherapy" and "specific risk"), it is accepted that LCW will also be satisfied. However for those in the severe functional Support Group categories, you must also justify why they meet criteria for LCW.

HCPs should refer to the Revised WCA Handbook for guidance on the Support Group Criteria – both Functional categories and "Special Circumstances". All filework advice must be in keeping with the guidance in the Handbook.

In some circumstances, "treat as LCW" may be confirmed at this stage. For example, the GP may confirm "lumpectomy for breast carcinoma. No evidence of metastatic disease. Now commencing radiotherapy". In this case "treat as LCW" advice could be given. If you indicate "treat as LCW" at this stage, MSRS will issue form ESA 50A to the claimant. On receipt of this the case will then be further reviewed to give advice on LCWRA.

HCPs should refer to the Revised WCA Handbook for guidance on the categories defined in legislation where claimants may be treated as having LCW. All advice must be compliant with the guidance contained in the handbook.

If there is no evidence of Support Group or Treat as LCW being applicable, the case will be processed in the normal manner, i.e. Form ESA50 will be issued and the case will move to Pre-Board Check.

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This process may be summarised as follows:

- Referral for TI check received.
- Check if DS1500 received with claim.
- If DS1500 present advise on TI status if possible. If further detail needed, contact author of DS1500 for further information.
- If no DS1500, check if recent Special Rules claim made.
- If there has been SR claim for DLA, advise on this.
- If no recent SR claim, phone relevant Healthcare Professional involved in claimant's care.
- Remember that even if outcome is not TI, you may have adequate evidence at this stage to advise Support Group inclusion or treat as LCW.

It should be noted that JCP should set a control date for 3 years for TI cases (i.e. the case should not be re-referred for 3 years), however; some cases may be inappropriately re-referred earlier than this. If a referral is received for a claimant where TI was advised less than 3 years ago, the referral should be questioned with the BDC as it is possible the referral was an error.

The Exceptions for IB (Reassessment TI WCA cases

- For IB (Reassessment) TI WCA cases, the referral process is different.
- The cases will be referred via the advice route.
- The HCP will be notified by the scrutiny team leader
- The number of cases is likely to be small.
- The LiMA application will **not** be available to record the reply. The hyperlink will open a free text box within MSRS.
- In these cases once sufficient evidence has been gathered (with the usual urgency for any TI case), the advice as to whether or not the claimant is likely TI must be completed using the free text box on MSRS.
- Unlike other TI referrals where the options of other LCWRA categories or treat as LCW are available, the only two outcomes in the IBR TI cases referred via this route will be TI or not TI.
- The HCP must summarise the evidence underpinning the advice offered and justify the advice.

4. The Pre-Board Check

4.1 The Pre-Board Check

The intention of the Pre-Board Check is to identify those claimants who are the most severely disabled and will be eligible for inclusion in the Support Group (LCWRA). The Pre-Board Check will also identify claimants, for the DM, who satisfy the criteria for “treat as LCW”.

A pre-board check must be completed in all initial claims where the claimant is not terminally ill.

A pre-board check must also be completed in ESA re-referral cases where the claimant has not previously been subject to a face to face examination. IB re-assessment cases will not be subject to Pre Board Check, but will be considered as scrutiny cases.

The case is accessed through the MSRS application and the HCP reviews the information available.

At this stage, many claimants will have completed the ESA 50 (or ESA50A if LCW already established). This information should be looked at carefully along with any other information on file including the Med 3 diagnosis. HCPs should consider whether or not the evidence presented suggests that the claimant fulfils any criteria for inclusion in the Support Group or “treat as LCW”. HCPs can refer to the EBM Key Points for guidance on factors that suggest that severe disability is likely.

In cases where hospital admission is pending, HCPs can recommend ‘Treat as LCW’ if there is firm evidence that the claimant is due to have a major procedure within the next 21 days. HCPs should have firm evidence that the procedure is to be undertaken, clearly state the nature of the anticipated procedure and be sure that it is consistent with the claimant’s medical condition.

It may be possible to advise at this stage based on the evidence in ESA 50 and the Med 3 diagnosis. In cases where there is no evidence that any category of the Support Group applies nor that any of the “treat as LCW” categories apply the advice should be to call.

FME should be requested in cases where there is information suggesting Support Group or “Treat as LCW” criteria are likely to be met. You should adhere to the guidance for requesting FME provided in section 2.5 of these guidelines.

When reviewing a case that has previously been adjourned for Further Medical Evidence you need to decide whether further evidence is still required. When the FME was initially requested, the requesting HCP should have noted whether further review of the case was necessary so in most cases it will be necessary to make a phone call to a GP or other Healthcare Provider to obtain information.

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As before, when justifying your advice for the Severe Functional categories of Support Group, you must also provide reasoning to indicate why the claimant satisfies LCW. This is likely to be clear in cases where the highest descriptor is a Support Group, for example mobilising. (Remember that this is not necessary for the exceptional circumstances categories although you should make it clear to the DM that both LCW and LCWRA criteria are met due to the exceptional circumstances.)

When “treat as LCW” has been identified, the HCP must carefully review the case and provide advice for the DM on whether the LCWRA criteria also apply.

In most cases, it should be possible with the current evidence to advise on whether the criteria for inclusion in Support Group are met. If they are met, full justification should be given for the specific category of Support Group inclusion.

Where there is clear evidence that the claimant does not meet LCWRA criteria, specific justification must be provided to the DM why each Support Group category (both functional and non-functional) does not apply. It is not sufficient to say that no Support Group criteria are met. Your justification may be based on information from the ESA50, FME or on your medical knowledge of the certified cause of incapacity.

In every case, a prognosis must be given. Where Support Group criteria are met, the prognosis given should refer to both LCW and LCWRA. The prognosis given must be logical and in keeping with the consensus of medical opinion. Further detail on prognosis can be found in section 8 of this document.

Certain conditions should only be examined by Registered Medical Practitioners. Some neurological conditions may also be examined by a Registered Nurse trained in neurology or a physiotherapist. A list of these conditions can be found on LiveLink under “Neurological Condition List by Practitioner Type”. The ESA 50 and all other relevant documentation should be closely scrutinised to ensure the case is allocated appropriately.

If the HCP advises that the claimant should be called for an examination, ‘Practitioner Type’ must be selected on MSRS to determine if the examination can be carried out by any healthcare practitioner or whether a medical practitioner is required. As with the current process, where a neurology trained nurse or physiotherapist is required “any” should be selected on MSRS and the ESA55 (case file cover) should be annotated with an “N”.

You need to advise whether the assessment can be carried out at an examination centre (MEC) or whether a home assessment (DV) is required. Further guidance on Domiciliary Visit requests can be found in section 10.3 of this document.

5. LCWRA Only Referrals

5.1 General LCWRA Only Referrals

LCWRA only referrals are generated when the Decision Maker has already established that “treat as LCW” applies.

This may be from information provided by the claimant or from the Med 3 diagnosis where the DM identifies the claimant as being in a “treat as LCW category” These are:

- Infectious disease exclusion by Public Health Order
- Pregnancy around dates of confinement
- Hospital INPATIENT treatment or a day of recovery from such
- Certain regular treatment as defined in the regulations
- (For claimants on Income Related ESA see 5.2.)
- Further detail of each of these categories can be found in the Revised WCA Handbook.

The Decision Maker will require advice from Atos Healthcare about the claimant’s ability to participate in Work Related Activity (LCWRA advice).

The Decision Maker will submit the request for advice, providing information about the “treat as LCW” category and any further detail they have. For example, the DM may indicate they have accepted LCW on the grounds of being a hospital inpatient. They may also then add details of the hospital/consultant in charge of their care. If no such information is included the referral should be returned to JCP for clarification

As soon as the referral is received by AH, MSRS will issue form ESA50A to the claimant. As LCW has already been established within the appropriate period, where the ESA50A is not returned the case needs to continue through the process.

The role of the advising HCP is to review all the information available on file and to decide whether further information is required.

Whenever possible clear advice and justification must be given to the Decision Maker indicating whether or not the claimant meets criteria for LCWRA.

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The HCP must consider the ESA 50A (if returned), the diagnosis provided on the Med 3 as well as any information available on MSRS for example a previous ESA 85. In many cases, there will be a requirement to obtain further information about the claimant's condition. This would normally be by requesting FME. The FME request should be documented on MSRS. . In the event of non-return of FME, you should phone the GP or other Healthcare Provider for further information. The claimant should not be called to examination until all other evidence gathering options have been exhausted.

There are 3 possible outcomes:

1. The evidence suggests LCWRA is applicable. In this case, the ESA 85A should be completed giving advice on the appropriate Support Group category. This should be fully justified.
2. The evidence suggests that LCWRA is not applicable. In this case, the advice should be given to the DM detailing why none of the Support Group categories are applicable. Every category must be clearly justified. These categories include the special circumstances and the functional support groups.
 - Terminal illness
 - Chemotherapy
 - Substantial physical or mental risk
 - Specific pregnancy risk
 - lower limb functions
 - upper limb functions
 - continence
 - eating and drinking/chewing swallowing food
 - communication
 - learning or comprehension
 - awareness of hazard
 - personal action
 - coping with change
 - coping with social engagement
 - appropriateness of behaviour with other people

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In rare circumstances, where no information is available or when level of function cannot be clarified by any other means, it will be necessary for the claimant to be examined in order to provide advice to the DM on LCWRA status; *Examination should only be advised after every possible attempt has been made to provide definitive advice. You should only ever take this action after discussion the case with your team leader or manager.*

Rarely, the situation may arise where the HCP uncovers evidence that conflicts with the LCW decision made by the DM. For example, information may be uncovered to reveal that the claimant is no longer requiring weekly haemodialysis or that they are no longer a hospital inpatient. In these situations review the evidence and consider if Support Group or treat as LCW for another reason is appropriate or, call for exam. Full justification must be given.

5.2 Income Related ESA LCWRA Only Referrals

In addition to the above case types in 5.1, occasionally you may come across clerical referrals for LCWRA only filework advice for a claimant on income related ESA, who is also in education, is entitled to DLA award at any level and is not in receipt of child benefit.

You should treat these referrals as any other LCWRA-only referral with due consideration to all the evidence, seeking FME as appropriate; and fully justify the LCWRA advice.

You would not be expected to identify a claimant satisfies this specific LCWRA-only referral category in any other type of Filework as you would not have the relevant information available to you regarding DLA, child benefit etc.

As this is currently a clerical referral, all the advice needs to be completed clerically. The ESA 86 should be completed with full justification.

Rarely, you may become aware that the claimant is no longer in education or receiving DLA. In these circumstances, you should pass the referral back to the administration team with a note explaining why the claimant is no longer likely to be "Treat as LCW" in this referral sub category. They will then arrange for this referral to be sent back to the DWP.

6. ESA Re-referral Filework

6.1 ESA Re-referral Scrutiny

When a claimant has been accepted as having LCW by the Decision Maker based on a full LCW/LCWRA medical examination (ESA 2008 or 2011 regulations), or following IB re-assessment scrutiny the case will be referred to Atos Healthcare after an appropriate period for further advice. This time period will normally be based on the advice provided by the examining HCP at the time of the assessment.

The possible outcomes at re-referral scrutiny are:

- To accept ongoing LCW
- “Treat as LCW”
- To advise that the Support Group criteria have been met
- To advise that further assessment by face to face examination is required

ESA Cases

For ESA re-referral cases that have not been subject to the IB re-assessment process re-referral scrutiny allows the possibility to “accept” for a further period of time that the person has continuing limited capability for work as long as the following criteria are met:

- The claimant has had a full LCW/LCWRA Medical Examination (completed ESA 85). The full report ESA 85 report may not always be visible, for example if it was completed clerically, however the referral details on MSRS should make it clear that the person has previously been subject to a face to face assessment. You do not have to see the previous case to accept at scrutiny.
- The claimant has scored above threshold (15 points or above) either on Physical or Mental Function descriptors at this assessment and the DM has accepted LCW. (Not “treat as LCW”)

The current available evidence suggests there has been no improvement, or there is evidence of deterioration in their functional capability, and it is likely that they will continue to score over threshold.

The case will be referred back to Atos Healthcare Medical Services and accessed by an appropriately trained HCP.

At this stage, the practitioner will review, through the MSRS application, the ESA 85 from the previous referral, if available, and the current ESA 50, if completed. The HCP must carefully review any ESA 85 completed under the 2008 regulations and consider whether the claimant would continue to be considered

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as LCW under the 2011 regulations.

For example, the descriptors relating to mobility are significantly revised from the 2008 regulations where the main function considered was walking rather than mobilising.

The ESA 85 will usually have been completed electronically using LiMA. Where the previous ESA 85 has been completed clerically, the ESA 85 will not be available at re-referral. **Where the ESA 85 is not available, there must be sufficient evidence that you can satisfy yourself that LCW threshold was likely to have been met and is still appropriate.**

After review of all the evidence, the HCP must make a decision on whether FME is required. The decision on FME should be based on the current evidence available and must only be requested if it is likely to impact on the scrutiny advice.

In cases where the claimant was accepted as satisfying the criteria for Support Group by the Decision Maker either as a result of filework advice or following examination, the case will be re-referred as a Pre-Board Check. **Those previously in the Support Group or “Treat as LCW” cannot be “accepted” as having ongoing LCW.**

Re-referral of IB Re-assessment Cases

In IB reassessment cases the principle remains the same. The evidence available to you may include a previous IB reassessment scrutiny or IB 85. The outcomes are the same as for ESA re-referrals above. There is no requirement for a past IB 85 to be visible to allow ongoing acceptance of the case.

The key for all re-referral cases whether ESA re-referral or IBR scrutiny include:

- Understand that a case that was previously IBR may not have a previous exam report available.
- Remember that a previous report on the system is not mandatory for acceptance for any re-referral scrutiny case.
- Review all the available evidence.
- Advise whether or not the claimant is likely to score above threshold on the 2011 WCA descriptors for acceptance.
- Advise as to the broad areas on which acceptance is based.
- Consider and advise if Support Group or “Treat as LCW” likely to be more appropriate.
- If none of the above outcomes, then call for face to face assessment.

6.2 Scrutiny of Evidence in Re- referral cases

In ESA re-referral filework, the HCP must scrutinise all available evidence. This evidence may be on MSRS or in the ESA 55 jacket.

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6.2.1 MSRS Information

- Within MSRS the HCP should check for any further medical evidence such as Med 3 or FRR4 information to see if there is evidence of a change in the claimed level of functional capability.
- Other information such as appointee status and any “Potentially Violent” information should be considered along with the age of the claimant as this may impact on likely level of disability.
-
- Any previous filework outcomes on ESA 85As should be reviewed as this may provide some detail of previous level of disability.
- Check other evidence including advice offered at reconsideration.
- Any previous ESA 85s should be reviewed.

6.2.2 ESA 55 Information

The re-referral will be initiated electronically by the DM. Therefore clerical papers from previous referrals will not be available.

However there may be useful information within the ESA 55 Jacket, for example the ESA 50. At re-referral, the claimant may have completed a new ESA 50 detailing their current problems. This document can be invaluable in assessing stated problems and comparing this evidence to the previous ESA 85. Details of changes to medication, any new treatment/consultant input etc should be considered. The claimant’s stated abilities and limitations in each functional area should be considered and compared to the level of ability detailed in the ESA 85.

6.2.3 MSRS/ESA 55 information

ESA 85

The previous ESA 85(if available) should be accessed and reviewed on MSRS. This may have been completed under the 2008 or 2011 regulations.

When considering the ESA 85, there are many aspects to consider. These require knowledge of both the 2008 and 2011 descriptors and scoring. (For descriptors and scoring see appendices B and D.) The report must also be reviewed and scrutinised for consistency and appropriate justification in each case.

Scoring at previous LCW/LCWRA examination

In order to be able to consider acceptance, the claimant **must have been** awarded

- 15 points or more on physical descriptors, or

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- 15 points or more in the Mental Function descriptors
- 15 points or more through a combination of physical and mental function descriptors

In some cases, the ESA 85 will suggest a score of less than 15 points. The claimant may have in this case been awarded ESA by the Tribunals service. You will not have sight of the evidence considered by the Tribunals service so in many cases, a further examination may be necessary.

Choosing Descriptors – Physical cases

The descriptors chosen at the LCW/LCWRA examination must be considered with the current ESA 50 and the HCP must be aware of whether 2008 or 2011 regulations were applicable.

The following guidelines for reviewing the evidence must be considered in line with the guidance at section 2.4 - 2.5 of this document.

In cases where the claimant has identified some improvement in one area of function where they were previously awarded scoring descriptors, this may suggest that a further examination is required to assess current level of function. Some examples of possible scenarios where this may occur are listed below:

1. A claimant was awarded 15 points for restriction in walking limited to 50m and 6 points for standing restricted to less than 30 minutes at their previous assessment following a recent fractured femur under the 2008 regulations. In their current ESA 50 they indicate they still have some pain but their walking has now much improved following physiotherapy and they can manage in excess of 200m and can stand for longer than 30 minutes. They also indicate that their analgesia has been reduced from high strength dihydrocodeine to paracetamol. In this case, as long as there was no indication of problems in any other area, the outcome would be to call.
2. A claimant was awarded 15 points at their previous LCW/LCWRA medical examination for weekly seizures. They had only recently been diagnosed with epilepsy and their consultant had been trying various medication regimes with little success to control their condition. Their recent ESA 50 now indicates that they have been tried on new medication and have only had 2 seizures in the last 7 months. They indicate no other problems. Again, in this case there appears to be an improvement in the condition since the last assessment, and the likely outcome would be to call the claimant for examination.
3. A claimant was previously awarded 15 points for bowel incontinence occurring on a monthly basis. At this time, they had poorly controlled ulcerative colitis. Since then, they indicate in the ESA 50 that they have had surgery and a now have a stoma. They indicate they can manage this by themselves and feel their condition has significantly improved. They have no other medical conditions. Again, in this case there is no evidence in the ESA 50 of problems with the stoma, and therefore calling the claimant for further assessment is likely to be appropriate.

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At times the evidence in the ESA 50 may suggest deterioration in the condition or that there is unlikely to have been a significant change since the last assessment. Usually there will be a requirement for supportive “Medical fact” to be documented to allow acceptance of ongoing LCW and at times there may be a requirement for FME. For example:

1. A claimant was awarded 15 points at their previous assessment for monthly bowel incontinence. The report was detailed and consistent. They had poorly controlled Crohn’s disease at the time of the assessment. The claimant has indicated on the ESA 50 that they continue to have loss of full bowel control every 2-3 weeks despite various changes to medication. They have also recently lost a lot of weight and have been prescribed “Build up drinks” by their GP. They have had 3 hospital admissions lasting 10-14 days in the last 6 months due to dehydration and they await further referral to a specialist unit to consider further management options. The claimant has supplied dates of hospital admissions, details of current medication and details of their current consultant and the tertiary referral centre they have been referred to. Again, in this case it may be reasonable to accept the stated level of disability for a further period based on the medical facts presented and knowledge of the diagnosed condition.
2. A claimant was awarded 15 points for visual impairment - cannot see 16 point print at 15cm and has now been referred under the 2011 regulations. They were waiting for bilateral cataract extraction. They have indicated that they feel the operation was not fully successful in one eye and the other eye has not yet been operated on. They indicate they still struggle to see and read and cannot read Braille. They have not supplied any dates of clinic appointments and have not submitted details of a Certificate of Visual Impairment. In this case, ongoing LCW may be possible depending on the extent of visual impairment. However the evidence represents only claimant provided opinion. In this case, further evidence would be required from the GP or consultant to verify the outcome of the surgery on one eye. Further information would be needed about their ability to safely navigate. This may be difficult to obtain from FME and it may be necessary to call the claimant for further assessment if not fully clear with the available information \ evidence.

Choosing Descriptors – Mental Function cases

The descriptors chosen at the LCW/LCWRA examination must be considered with the current ESA 50. The following guidelines for considering the evidence must be considered in line with the guidance at section 2.4 – 2.5 of this document.

In cases where the claimant has identified some improvement in one area of function where they were previously awarded scoring descriptors, this may suggest that a further examination is required to assess current level of function. For example:

1. A claimant was awarded 18 points in Mental Function through descriptors in coping with change, getting about and coping with social interaction. No physical issues were identified. At the previous assessment, they had been recently assaulted and developed panic disorder as a result.

At the time of assessment, they had just been commenced on citalopram and

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were awaiting input from the Community Mental Health team. They have documented in their current ESA 50 that they have been attending anxiety management classes and “feel more like their old self”. They have now recommenced some social activities and can leave the house alone. They indicate no new problems. Their GP is reducing their medication. Again, in this case, a decision to call would be likely as there is evidence of improvement.

2. A claimant was awarded 18 points at their LCW/LCWRA medical examination (6 months ago in areas of initiating and completing personal action, and coping with social engagement. At the time of assessment, they had been discharged from a psychiatric unit 4 months previously with a severe depressive episode. They had fortnightly input from the psychiatrist and twice weekly input from the CPN. At the time of the assessment, the claimant was beginning to feel some improvement. In the current ESA 50, the claimant has indicated that she now sees the psychiatrist every 3 months and CPN on a monthly basis. She feels more motivated and has started some voluntary work 6 hours a week in a local charity shop. In this case, there appears to be evidence of improvement. FME is unlikely to change the outcome and “calling” the claimant for further assessment would seem appropriate.

At times the evidence in the ESA 50 may suggest deterioration in the condition or that there is unlikely to have been a significant change since the last assessment. Usually there will be a requirement for supportive “Medical Fact” to be documented to allow acceptance of ongoing LCW and at times there may be a requirement for FME. For example:

1. A 19 year old claimant scored above threshold at the previous assessment in Mental Function. They had a diagnosis of learning disability and scored in the areas of learning or comprehension and in coping with change. The claimant at the time of assessment was living with their parents who provided significant support. They were due to start a life skills course at college. The report was comprehensive and well justified. The prognosis advice given was “that with input may improve within 18 months”. The current ESA 50 was completed by the claimant’s social worker. They have indicated that his progress at his life skills course has been slow and hampered by increasing levels of anxiety. Social work are now providing some respite care and the claimant has been commenced on citalopram for his anxiety. He is now reluctant to leave the house at all and is now having input on a weekly basis from the CMHT and daily support from social work. Details of the CMHT members have been provided and details of social work support workers are identified. It may be appropriate to obtain FME as the claimant may satisfy Support Group criteria under the 2011 Regulations – e.g. if abilities to cope with change have further deteriorated.
2. A claimant was awarded 18 points in Mental Function through descriptors in coping with change, getting about and coping with social engagement (2011 regulations). No physical issues were identified. The report was consistent, well justified and indicated moderate to severe levels of anxiety. At the time of assessment, they had just been commenced on citalopram. A prognosis of 6 months was given with justification that improvement in the condition would be

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expected with medication which had only just been commenced. In the ESA 50, the claimant still indicates ongoing medication with no change to the dose of citalopram. She indicates she sees her GP every 2 months and is increasingly finding it more difficult to attend due to anxiety. She says she can no longer go outdoors alone and has panic attacks on a frequent basis. She was referred to a counsellor by her GP but she felt too anxious to attend. In this case, there is very little evidence in the way of medical fact. The evidence is mainly claimant opinion, however given that she had significant disability at the last assessment; she may well have ongoing LCW. In this case, it would be reasonable to request FME to attempt to ascertain whether there has been any significant change to her condition to allow acceptance of ongoing LCW or establish whether SG is likely to apply.

7. IB Re-assessment Scrutiny

7.1 Background

In 2010 the Government announced plans to re-assess all current recipients of Incapacity Benefit and those in receipt of Income Support on grounds of incapacity in order to establish their readiness to work.

At that time, 2.5 million people in receipt of IB had nothing in place to support them to re-enter the workplace. The Government felt this was not a desirable situation and announced that Incapacity Benefit claimants will be re-assessed under the revised WCA regulations over a 3 year period commencing 2011.

In re-assessing these individuals, those who are found to have limited capability for work under the Revised WCA regulations will be placed in the work related activity group which will allow them access to the “work programme”.

Those who are capable of work will migrate to JSA/Income Support

The Work Programme will be a single package of support providing personalised help for everyone who finds themselves out of work regardless of the benefit they are claiming.

7.2 IB Re-assessment Scrutiny

The DWP will refer most claimants currently in receipt of Incapacity Benefit to Atos Healthcare for re-assessment under the Revised WCA regulations. Those who will have reached state pensionable age by the end of the process in 2014 will not be referred. The timing of referral of each case will be determined by JCP based on the date that their IB entitlement was due for review

The claimant may be in receipt of Incapacity Benefit as:

1. They have been previously accepted as meeting the threshold of incapacity for the Personal Capability Assessment used in IB following advice from a PCA medical examination
2. They have previously been accepted as meeting the threshold of incapacity for the PCA following filework scrutiny advice
3. They have been considered to be exempt from the PCA process following advice either at scrutiny or examination.

Those on Incapacity Benefit may have been referred many times over the years and the Decision Maker has continued to accept they meet the threshold of incapacity. You may find that there are a number of previous examination and filework outputs to consider.

When the IB re-assessment referral is received the Atos Healthcare HCP will apply the process of IB re-assessment scrutiny. This will allow them to:

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- Accept that they meet the threshold for LCW under the Revised WCA Regulations
- Advise that the Support Group criteria have been met (Revised WCA Regulations)
- Advise that “treat as LCW” criteria have been met (Revised WCA Regulations)
- Advise that further assessment by face to face examination is required to determine their level of disability

The pre-board check process is not applicable to IB re-assessment claims. The Filework HCP can base their advice on any evidence available, for example previous Filework outputs, FME or a previous IB examination.

7.3 Scrutiny of evidence in IB Re-assessment Cases

In IB re-assessment filework, the HCP must scrutinise all available evidence. This evidence may be on MSRS or in the ESA 55 jacket.

7.3.1 MSRS Information

- Within MSRS the HCP should check for any further medical evidence such as Med 3 or FRR4 information to see if there is evidence of a new diagnosis.
- Other information such as appointee status and any “Potentially Violent” information should be considered along with the age of the claimant as this may impact on likely level of disability.
- Any previous filework outcomes on IB 85As should be reviewed as this may provide some detail of previous level of disability.
- Any previous IB 85s should be reviewed.

7.3.2 ESA 55 Information

The re-referral will be initiated electronically by the DM. *Therefore clerical papers from previous referrals will not be available.*

However there may be useful information within the ESA 55 Jacket, for example the ESA 50. At referral, the claimant may have completed a new ESA 50 detailing their current problems. This document can be invaluable in assessing stated problems and comparing this evidence to any previous information on file. Details of changes to medication, any new treatment/consultant input etc should be considered. The claimant’s stated abilities and limitations in each functional area should be considered and compared to the level of ability detailed in the IB 85 if available.

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At the beginning of the reassessment process JCP will make telephone contact with the claimant to explain the process, and during this conversation they will encourage the claimant to attach any medical evidence that they hold, such as hospital reports, to the ESA 50. It is important that you consider any such evidence

7.3.3 MSRS/ESA 55 information

IB 85

Any previous IB 85s should be accessed and reviewed on MSRS. When considering the IB 85, you need to consider whether the report is consistent and appropriately justified. You need to have knowledge of the IB descriptors and scoring. A list of the IB descriptors can be found in Appendix E.

In order to achieve the threshold for incapacity under the PCA regulations, the claimant **must have been** awarded

- 15 points or more on physical descriptors, or
- 10 points or more in the mental health assessment or
- a combination of 6 or more points on physical descriptors and 6 or more points on the mental health assessment.

You must be aware of the fundamental differences between the descriptors of the Revised WCA and the PCA when considering their advice.

In some cases, the IB 85 will suggest a score below threshold. The claimant may have in this case been awarded IB by the Tribunals Service. You will not have sight of the evidence considered by the Tribunals service so in most cases, a further examination may be necessary unless other evidence is available on file.

Choosing Descriptors – Physical cases

Although the physical descriptors are entirely different in the PCA and the Revised WCA, there is still scope to consider the level of function suggested by the IB descriptors and the IB 85 information. This should be compared against the current ESA 50 looking for any change in the level of disability. If the level of disability was very high in the IB assessment, then the claimant may well reach the threshold for the Revised WCA. However if the level of disability was found to be low at the IB assessment the claimant is unlikely to reach the threshold for the Revised WCA unless further evidence suggests significant deterioration. In cases where the claimant has identified some improvement in one area of function or no change in function where they were previously awarded scoring descriptors, a WCA examination may be required to assess the current level of function. Some examples of possible scenarios where this may occur are listed below:

1. A claimant with a diagnosis of fractured femur following a road traffic accident, was assessed for IB, and found to have significant limitation of function. The MSRS MED3 information states “leg problem”. He was found to have severe restriction of standing, walking, using stairs and bending and kneeling. No other

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physical or mental function problems were identified. His current ESA 50 indicates that he has had further surgery and now walks reasonable distances without crutches. In this case the appropriate advice would be to call for examination.

2. A claimant with a diagnosis of back pain scored a number of “3 point” descriptors in his previous PCA examination – through mild restriction of sitting, standing, walking, stairs, rising from sitting and bending /kneeling. The IB 85 indicates co-codamol for pain with no evidence of specialist input or sciatic symptoms. In his current ESA 50, he indicates that his back pain has not improved at all and he is still as restricted as he was when previously examined. In this case, as the level of functional restriction at the PCA is unlikely to equate to the LCW threshold of the Revised WCA, with no evidence of change, the appropriate outcome would be to call.

At times the evidence in the ESA 50 may suggest deterioration in the condition or that there is unlikely to have been a significant change since the last assessment. Usually there will be a requirement for supportive “Medical fact” to be documented to allow acceptance of LCW/LCWRA under the revised WCA and at times there may be a requirement for FME. For example:

1. A claimant with long standing rheumatoid arthritis (multiple joint involvement) was previously exempt under the PCA criteria for having an active and progressive form of inflammatory polyarthritis. The Med 3 indicates – “severe progressive rheumatoid arthritis – unresponsive to therapy” The previous IB85A indicates a phone call to GP confirmed very limited mobility and severe hand and wrist problems – awaiting immunotherapy. Her current ESA 50 indicates that despite input from a tertiary referral centre with immunotherapy she has become wheelchair bound with severe deformities of the hands and wrists. She has been assessed and is not considered to be safe to operate an electric wheelchair due to the weakness and pain in her hands. In this case the reasonable outcome would be to advise Support Group inclusion because of poor mobility.
2. A claimant has diabetic retinopathy, and was previously found to reach the threshold for incapacity under the PCA regulations. At the time, he was found to be unable to see well enough to read 16 point print at a distance greater than 20 centimetres. In the year leading up to the reassessment of his benefit claim he developed bilateral retinal haemorrhages and was subsequently registered blind. He has attached a certificate of visual impairment with his ESA 50. In his ESA 50 his wife indicates that he has lost his confidence and that he requires assistance from his wife to navigate outdoors as he has no confidence to cross the road safely and even struggles indoors. She also indicated that he cannot read Braille and has help with all written correspondence. In this case it would be appropriate to give advice to the DM to accept the claimant as reaching the threshold for incapacity under the Revised WCA regulations for navigation and even consider Support Group for understanding communication in view of the likely severity of visual impairment

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Choosing Descriptors – Mental Function cases

Unlike the Revised WCA, the Mental Health Assessment in the PCA does not have descriptors, so there is little obvious direct correlation between the two types of assessment. However, other information can be reviewed and related to the WCA descriptors. Where an IB85 exists, the typical day may provide adequate information to allow advice that the threshold of LCW may be met in the Revised WCA. As with physical problems, careful scrutiny of the ESA 50 or other evidence may provide information about possible improvement or deterioration since the claimant was last assessed.

For example;

1. A claimant has been in receipt of Incapacity Benefit on the basis of her learning disability due to Down's syndrome for several years. She is now referred for reassessment under the Revised WCA regulations. On MSRS there is a previously completed IB 85 in which the claimant comfortably achieved the threshold for the PCA on the areas of completion of tasks, coping with pressure and dealing with other people. The IB85 indicates that she lives with her mother and can manage simple tasks. She was subsequently accepted on filework scrutiny on one occasion based on information obtained from the GP at the time. There is a recent MED 3 which confirms that the claimant has Down's syndrome. The ESA 50 and the IB 85 suggest that she would have some difficulty managing daily changes to routine and tends to get lost in unfamiliar locations. The appropriate advice would be to accept under the Revised WCA criteria on a combination of managing change, getting about and learning tasks.
2. Mr C was previously exempt under the PCA due to severe anxiety and panic attacks. The previous IB85A notes indicate "GP confirms true agoraphobia – does not leave house". The current ESA 50 indicates that he no longer sees a CPN and has discontinued propranolol, diazepam and citalopram. He indicates he does not see the GP and that he is doing voluntary work for a local charity. The Med 3 indicates "debility". In this case, as there is evidence of likely improvement in the level of function, the advice should be to call to examination to ascertain current level of function.
3. Ms A was previously exempt from the PCA on the grounds of Severe Mental Illness at examination. The IB85 indicates she had a diagnosis of autism and she did not communicate at all at the assessment. Her mother provided all the history – indicating her daughter has severe communication problems, isolates herself in her room and only communicates as necessary with her parents. She attended a special school and has had input from the National Autistic society. She has severe mood swings with uncontrollable aggressive outbursts which can be difficult to manage. She has never made any friends and has never been employed. The MED 3 indicates severe autism. Her current ESA 50 was completed by her mother indicating social services are now involved and a referral has been made to the psychiatric services to consider medication as her violent outbursts are becoming even more problematic. In this case, Support Group advice would be appropriate – either Social Engagement or Appropriateness of Behaviour.

8. Prognosis

8.1 Overview

As part of the filework process, HCPs are required to give advice on **when a return to work / work related activity** could be considered in all cases in which acceptance, Treat as LCW or Support Group inclusion is advised.

The key messages are:

- For the majority of claimants, provision of ESA should be regarded as a temporary measure, until the claimant has recovered from an illness or adapted to disability (following appropriate interventions if necessary)
- ESA is an active benefit (with Work Focussed Interviews and appropriate interventions) and so prognosis does not only consider when / if a claimant's disability would be expected to improve, but also considers the provision of appropriate interventions or adaptations that could be made.

Note the following:

- Under the LCW/LCWRA medical procedures, approved HCPs are required to give advice on prognosis without reference to the outcome of the decision making process
- When the claimant satisfies the LCW/LCWRA medical examination, the medical advice on prognosis provided by approved HCPs to Job Centre Plus is often used by the Decision Maker to determine when subsequent re-referral to Atos Healthcare is appropriate
- The DWP will wish to refer a claimant for reassessment of LCW/LCWRA at the point where there is a reasonable expectation that their prospects of a return to work have improved. Whether the outcome of the case is inclusion in the Support Group, application of Exceptional Circumstances or advice on a functional condition, the Decision Maker will require a reasonable prognosis for a return to work. In assessing when a return to work may be possible, the approved HCP should provide this advice based upon their assessment of the claimant, their knowledge of the natural progression of the identified medical conditions, and the time they feel a claimant may need to adapt to their condition
- Note that the prognosis is not just about improvement in function. This is obviously one part of the prognosis issue, however; there are conditions that will be permanent with no expectation of functional improvement but this does not mean the claimant will be unable to work. Consideration of reasonable time scales to allow

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possible retraining, support, time to adapt to disability and provision of work place adaptations should allow many claimants, even with significant functional restriction to enter into work.

- For those deemed to be in the terminally ill group there is no requirement to include a prognosis
- If there is more than one relevant functional condition, the HCP should aim to provide an opinion on the likely timescale for return to work, taking account of the effects of all conditions
- If an early improvement is expected, a short prognosis should be given in all cases your opinion on when a return to work could be considered must be fully and comprehensively justified. It is important to consider each case individually and to choose and justify the appropriate time period (3, 6, 12 or 18 months), or to justify why a return to work is unlikely within 2 years or in the longer term.

8.2 How to formulate prognosis advice

Improvement Likely

The main question the HCP must consider is:

When would you expect significant improvement in the disability or in cases where improvement in the level of function is not anticipated, with adaptation/re-training/aids when could a return to work be considered?

The HCP's response will depend on whether the key functional problems will improve and over what timescale:

- With further treatment
- With time
- With the natural progress of the underlying disease
- Or whether adjustments will result in a reasonable expectation of the claimant being engaged in some form of work

The duration of prognosis must be based around the medical knowledge of the condition and consideration of rehabilitation and workplace adaptations. This will determine the duration of prognosis.

It is difficult to give specific guidance as each case must be considered on its own merits. Some cases with the same functional loss may have different prognosis. For example:

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Registration as severely sight impaired. Those who have had a gradual process of visual loss and have continued to work and have now become unemployed are more likely to be able to re-enter the workplace in a shorter time than a person who perhaps through trauma has become severely sight impaired. The person with acute visual loss is likely to need more time to adapt to their condition to allow safe navigation and is likely to need retraining or significant workplace adaptations to re-enter a workplace.

In some cases, functional recovery cannot be expected, for example, where there is complete paraplegia following spinal cord transaction. This, however, does not mean that a long term prognosis is appropriate. With ongoing rehabilitation, perhaps retraining and workplace adaptations, the person may be able to return to work.

In musculoskeletal cases, with advances in medicine and with adaptations in the work place, most cases should have some expectation of recovery of function and with additional support should be able to re-enter the workplace in the short to medium term. Again, this is not an absolute as complex rheumatoid cases with multiple joint involvement may require longer for their medical management of the condition to be optimised and they may need multiple adaptations to allow them to work. Therefore overall, each case must be considered carefully and prognosis advice fully justified to the Decision Maker.

In Mental Function cases, consideration of the diagnosis, current treatment and medication should be considered. Guidance from the EBM Mental Health protocols should be followed. In mild to moderate anxiety and depression, in most cases, with support, a fairly short prognosis would be expected. In more major conditions such as first onset of a psychotic episode, the treatment and recovery time may be more prolonged.

With some conditions, prognosis may be more straightforward, for example where LCW is accepted due to pregnancy around dates of confinement.

Where the claimant is in the Support Group because they are having chemotherapy, prognosis may initially seem fairly straightforward since in most cases the duration of treatment will be known. However, you must also assess a "reasonable recovery period". This may vary from one case to the next. A person who was otherwise fit and well may have a shorter recovery period than a person who has had significant weight loss, post operative complications or complications of chemotherapy. You must base your advice on your medical knowledge and skills as a disability analyst to provide reasonable advice to the DM. Where the advice provided seems to be out with that normally expected clear and comprehensive justification must be given.

The timescales for improvement are:

- 3 months
- 6 months
- 12 months

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- 18 months

Change unlikely:

In some cases the HCP may consider change is unlikely. The timescales for advice in these cases are:

- Within the next 2 years:

If significant change is unlikely within two years but nevertheless there is still some possibility that improvement may occur with time or with further therapy, then the HCP should indicate that a return to work is unlikely for at least 2 years.

For example, you might be considering a claimant with rheumatoid arthritis with a significant degree of functional disability, where you would not expect much improvement within 2 years but where surgery or other treatment in the medium term might change the clinical picture. You might reasonably advise that a return to work is unlikely within 2 years.

Or

A claimant has significant learning difficulties needing significant support on a daily basis; however is attending life skills at college and with some degree of further maturity may functionally improve, a 2 year prognosis may be suitable.

Change unlikely:

- In the longer term:

If in your opinion there is a substantial degree of functional impairment due to a serious medical problem which is chronic or will inevitably deteriorate further, even with optimal treatment/ maximal input and adaptations, you should indicate that a return to work is unlikely for in the longer term.

For example, you might reasonably advise an “in the longer term” prognosis for a claimant with a clearly progressive neurological condition.

Or, in the case of a young adult with a very significant degree of learning disability, who has a disability in a number of functional areas because of cognitive impairment and a requirement for a high level of support, you may feel that all management and support strategies have been exhausted and that further adaptation is unlikely to occur. You might then reasonably advise an “in the longer term” prognosis.

Other factors:

Age:

- This is not a medical cause of incapacity but may indicate the stage of the disease.

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Duration of incapacity:

- It is undesirable to frequently review claimants with a confirmed chronic or progressive disability whose capability is unlikely to improve.

Fluctuating conditions:

- It may be reasonable to give a finite prognosis if the natural history of the condition suggests that the periodicity and duration of exacerbations of the condition will be significant.

Multiple conditions:

- If there is more than one relevant functional problem, your prognosis should be based on the overall functional prognosis.

HCPs should remember the repository and the EBM Protocols. These will be helpful when considering prognosis.

(See Appendix F for a Prognosis Matrix)

8.3 The Work Programme

The Work Programme is a major new payment for results welfare to work programme launched throughout Great Britain in June 2011. It replaces previous programmes such as the New Deals, Employment Zones and Flexible New Deal. It is delivered by a range of private and voluntary sector organisations providing support for people who are at long-term risk of unemployment. It represents a significant investment by the Government and its partners in seeking to help millions of people into lasting jobs.

The design of the Work Programme seeks to address weaknesses of previous programmes, and brings together and simplifies the range of contracted provision and support. The programme supports a wide range of participants, from those who are at risk of long-term unemployment, to others with limited capability for work and who may have been out of work for several years.

Individuals can access the Work Programme at different times dependent on a number of characteristics. These include: the type of benefit they are receiving, their age, their distance from the labour market and, for individuals placed in the Work-related Activity Group (WRAG) of ESA, their WCA prognosis. Some will be required to attend the Work Programme, whilst others will be able to volunteer with the agreement of their Jobcentre Plus adviser. Whilst not on the Work Programme claimants will be supported by Jobcentre Plus.

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Individuals who are placed in the WRAG and given a 3 or 6 month prognosis will be required to join the Work Programme. These individuals will be expected to recover or adapt to their condition within a relatively short period of time, so they will be provided with immediate support to help them back to work. They will be reassessed respectively at the 3 or 6 month point and if found fit for work can claim Jobseekers Allowance and continue to receive support through the Work Programme. This will place them in the best possible position to return to work once they are well enough to do so. Individuals placed in the WRAG and given a prognosis of greater than 6 months will not be required to join the Work Programme. They will be able to access the Work Programme on a voluntary basis or receive support through Jobcentre Plus.

Once on the Work Programme, claimants will be expected to stay on the programme for two years. During this time, some people's circumstances and the nature of their participation in the programme may change. If, for example, they are found to be in the Support Group at reassessment, then they will no longer be mandated to remain in the Work Programme, but could still access the support on a voluntary basis.

Work Programme providers are able to require participants in the WRAG to undertake work related activity. However, this activity must always be reasonable given the claimant's circumstances. ESA claimants cannot be required to look for, apply or undertake work, nor undergo medical treatment.

Claimants in the WRAG who are not on the Work Programme will be expected to prepare for a return to work with support from Jobcentre Plus, undertaking work-related activity as required by their adviser.

9. Justification

You are required to explain and justify any advice that is given at the filework stage.

The purpose of the justification of advice is to

- Fully explain the advice given when advising acceptance including justification why LCWRA is not met when advising LCW only

and

- Explain prognosis advice

In cases where the advice given is to accept, the purpose of including a justification in all cases is:

- To provide the Decision Maker with a brief summary of the reasons why you consider the evidence to be sufficiently clear to allow you to advise on the level of disability without the need for an examination
- To explain medical reasoning:
 - For subsequent audit purposes

and

- To inform another filework HCP who considers the case when it is next referred

You may also wish to explain your reasoning if

- The opinion appears to be out of keeping with the ESA Filework Guidelines

or

- There is a need to highlight important issues for the attention of the examining HCP

Justification must:

- Be specific to the case under consideration
 - Refer to the certified cause of incapacity and to any other relevant conditions
 - Be succinct and in line with the IQAS quality standards

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Justification for every Filework Outcome must be recorded. Justification is recorded as either:

- a LiMA phrase (with use of free text box as appropriate.)

or

- Free text

Both these can be entered into the Justification box. LiMA will provide a selection of justifications from which to choose or you can create an individual response using free text. ***You must provide enough detail to explain your opinion if the advice given seems to be contrary to any of the principles set out in the ESA Filework Guidelines.*** You need to justify and explain the reasoning not only to the Decision Maker but to a medical auditor.

Advice should:

- Not include embarrassing information
- Not mention the ESA Filework Guidelines in the justification

10. Miscellaneous

10.1 Harmful Information

Any information that is identified as harmful to the claimant can be indicated to the Decision Maker by entering it into the 'Harmful Information' box. Any information entered here will only be printed out onto the harmful information part of the ESA85A. This may be of particular importance in TI cases.

10.2 Unexpected Findings

On rare occasions, you may identify information suggesting the claimant may have an undiagnosed illness, or information may be revealed in the ESA 50 that the GP may not be aware of e.g. suicidal ideation. You must consider this information carefully and follow the guidance provided by your professional body about breach of confidentiality.

You should refer to the Revised WCA Handbook for further information and should consult with a senior colleague before disclosing information to a third party.

10.3 Domiciliary visits

Not all benefit assessments are conducted at an examination centre. Sometimes a claimant indicates that they are unfit to travel to or to attend the MEC and then a domiciliary visit (DV) may be necessary.

Examination at a MEC is the most desirable option, as the conditions there are most suitable for an assessment, in terms of Health and Safety and providing a suitable environment to conduct a comprehensive examination. However, it is recognised that, at times, the examination needs to be conducted in the claimant's home.

It is impossible to provide specific guidance that covers all eventualities, but the following guidance should be considered when assessing a request for a DV.

- Does the claimant have a medical condition that precludes them from travelling to the MEC?
- Has there been medical verification of the severity of the condition that precludes them from attending for examination in the MEC?
- Are there health and safety implications for a DV? e.g. the claimant or their representative has UCB status identified

When considering these factors, you must ensure that there is medical confirmation of the condition providing the reason why the claimant cannot travel on the grounds of health. The request for a DV may come from a GP or other health care professional involved in the claimant's care. When assessing this request you should consider:

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- Whether the request is based on medical fact rather than opinion e.g. “My patient has severe agoraphobia and cannot leave the house” rather than “I feel my patient would benefit from an assessment at home” or “My patient tells me they are unable to travel to the examination centre”
- Does the request relate to the claimant’s medical problems rather than social circumstances at home?
- Does the information leading to the DV request suggest a severe level of disability where Support Group advice may now be applicable?

In each case the evidence should be reviewed. At times it may be necessary to seek further clarification from the author of the report to clarify the medical facts.

Information that may help support a DV request may be:

- Diagnosis suggesting significant disability that may make travel extremely difficult – e.g. incomplete quadriplegia where LCWRA status cannot be established to allow Support Group inclusion without further assessment
- Evidence that the claimant receives home visits or telephone consultations with their GP
- Evidence that the claimant has home visits from the psychiatrist/CMHT

The HCP may also consider whether other options may be acceptable- for example if travelling on public transport is the issue, could a taxi be considered?

There are some circumstances where a DV may be authorised without the need for FME. This may be due to practical or health and safety issues. For example if the local MSC had no ground floor examination rooms and the claimant is a wheelchair user, a DV could be authorised. Each case must be considered carefully by the HCP taking into account all the information available and health and safety issues.

In many cases, the HCP may wish to consult with an experienced colleague when considering whether a DV is appropriate.

10.4 Practitioner type

In all cases where examination is required, you must advise on “practitioner type”. All information in the current ESA 50 and the previous documents including the ESA 85/IB 85 must be scrutinised to ensure that no condition is present that requires examination by a medical practitioner or a practitioner trained in neurological assessment.

A list of conditions suitable for assessment by neurology trained nurses and physiotherapists and those suitable for assessment only by a registered medical practitioner is available on LiveLink under “Neurological Condition List by

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Practitioner Type”.

10.5 Miscellaneous ESA filework

From time to time the DM may send other types of filework referrals for advice. The vast majority of these are done electronically. A clerical ESA 55 may be available, but the advice request and response is usually given via MSRS. These are usually dealt with by an experienced practitioner at CSD. As the advice offered will be available online (MSRS), HCP s doing re-referral filework may also access this as evidence.

Occasionally, the DM may submit a referral with a query concerning the diagnosed cause of incapacity. The DM may need clarification as to what class of incapacity is appropriate based on the IRG. The filework HCP should review the information submitted and provide a response to the DM making it clear which IRG diagnosis is clinically equivalent. The IRG is available on LiveLink.

For example;

DM query

Retinopathy. Not on IRG, please advise on equivalent category.

HCP response

Thanks for this referral. Retinopathy is an eye condition. Please consider using IRG number 0788 (Eye, condition, disease or injury).

These referrals may also include advice cases following receipt of new evidence or information by the DM after examination was done. The DM may seek clarification of a specific issue prior to making a decision. This is separate from rework. The majority of cases are reconsiderations with or without an appeal after the decision has been made. The DM would usually have specific questions concerning the impact of the new evidence or information on the original examination advice. The role of the filework HCP is to evaluate all the available evidence, highlight the evidence that underpins the advice offered, and give appropriate advice in response to the question (s) raised. The replies should be in keeping with the consensus of medical opinion.

The HCP can advise the DM in a number of ways:

- Interpreting and explaining medical terminology in claim packs and medical reports. This can include the nature of diagnoses, the use of medication, the interpretation of clinical examination findings, the significance of special investigations and the nature of surgical or other treatments.
- Giving advice of a general nature to the DM on the likely restrictions and sequelae arising from specific physical or mental health conditions.
- Identifying and explaining limitations, inconsistencies or contradictions in

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the evidence, and advising whether further evidence is likely to be useful.

- Advising on response to treatment and prognosis of the disabling condition (s).
- Advising on prognosis in relation to descriptor choices.

For example;

Case 1

A 55-year-old woman with multiple medical problems including Angina, Arthritis and Chronic Fatigue Syndrome states in her ESA50 that she cannot walk more than 100 metres because of fatigue, painful joints and back pain. She reports she has problems with prolonged sitting/standing and climbing stairs.

She uses paracetamol and ibuprofen gel as analgesia. She appears not to be attending any hospital specialist or clinic currently.

She has been assessed by a HCP who documents that she lives alone, apart from a pet cat, in a house with stairs, where the toilet and bedroom is upstairs. She sleeps well, rising without difficulty. She has a shower, standing in the bath without difficulty for 15 minutes. She climbs into the bath using a stool. She cooks her own meals and does all her own housework including vacuuming and changing bed, but says everything takes her ages. She feeds and cares for the cat. She enjoys watching TV including all the soaps the news and occasionally films. She reads a good deal, mainly religious texts. She is involved with her local church; she visits weekly for counselling, and attends services every Sunday, which she never misses. She has been attending yoga classes weekly for the last year. Six weeks ago, she started to attend swimming classes at the local pool with her friend from the yoga class. Initially she found it very tiring but now spends 20 minutes in the pool doing a few laps and stretches with her friend. She visits her mother once a week and also sees friends from church. She says she is too stiff and sore to garden any more, which she used to enjoy. She drives her own manual car and travelled 20 minutes to examination centre without difficulty. No significant variability reported throughout the week or during the day.

Findings at exam include:

Performed neck exam slowly but all movements at the neck were in the normal range. She reported pain on moving the shoulders and declined further upper limb examination due to reported discomfort. Started straight leg raise on the left leg but stopped after about 20 degrees and reported legs heavy and felt discomfort in thighs. Declined squat and rise as reported too weak and would be painful. When asked to perform other lower limb examination of hips, knees and ankle, declined due to reported pain and discomfort.

Sat up on couch with outstretched legs.

Blood pressure (sitting) 126/ 74. Not breathless at examination.

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Informal Observations:

Sat without obvious discomfort for 40 minutes in upright chair with knees and hips bent to about 90 degrees.

Rose from chair using arms of chair to push self up.

Bent to pull step out from under examination couch, as well as to pick up handbag from floor.

Used both hands to get medication and spectacles from the handbag. Reached up to head with both hands to put on spectacles.

Got on the couch swinging both legs onto it without obvious difficulty. Used the step to get on couch. Walked about 20 metres to the examination room with walking stick and slight limp. Noted to walk around examination room without stick.

The advice following assessment was that none apply for all the physical descriptors including: mobilise, sit/stand, picking up and moving, reaching, manual dexterity.

Following disallowance of ESA she submitted a report from a DLA assessment, carried out 3 weeks after the WCA assessment.

In it she claimed that she could walk only 50 – 75 yards due to pain, breathlessness, poor balance and co-ordination and that she dresses and bathes slowly, and manages stairs with an effort. She does not report urinary or faecal incontinence at all.

At assessment she was noted to walk using a stick and with a waddling gait and stooped posture. She was able to demonstrate 30 degrees of SLR, restricted by back and hip pain. She demonstrated spinal flexion to touch knees.

In this case the EMP offered the opinion that she could only walk 50 metres, very slowly, before stopping and that she would benefit from support from another person on uneven ground or hills. The EMP reported she is worse in the afternoons when she is more fatigued, and that she was at increased risk of falls.

Model DM submission

WCA examination carried out on 01st November, zero points awarded for physical descriptors. Has now appealed stating should be in mobilising Support Group.

“The descriptors on which I would welcome your advice are....

1. Mobility.....

With her appeal she has enclosed a copy of DLA report dated 22nd November (three weeks after the WCA assessment). She was awarded HR mobility and LR care for life.

In the WCA assessment the HCP has advised that she should be able to mobilise more than 200m and advised none apply for the mobilising descriptor. The EMP

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has advised that her mobility is severely restricted and that she would be able to walk no more than 50m. I would be grateful if you could advise which of the 2 reports appear consistent in this area with her medical history.

In order for me to carry out reconsideration I would appreciate any comments you are able to make on the 2 contemporaneous reports.

Model HCP response

Thank you for this referral. This 55 yr old lady was assessed separately by 2 approved Disability Analysts over a 21-day period, and as you have indicated, there is marked inconsistency between the 2 reports.

Summary

In the WCA report, the HCP has taken a detailed history, identifying that the principle restrictions reported are due to back pain and fatigue. However, the activities of daily living reveal that she is able to manage quite an active lifestyle. She drives a car, attends yoga and now goes to the pool every week. She does all of her own housework. This suggests reasonable upper and lower limb function. Formal clinical examination was limited by the claimant's reported pain, discomfort and weakness. However, detailed observations made by the HCP demonstrate a far greater degree of functional ability than formal clinical findings suggest, and that would be more in keeping with her typical day history.

In the DLA report, the examining doctor has taken a far less detailed history, documenting only what the claimant reported directly and focussing on what she reports she cannot do. The formal clinical findings appear more complete, and seem to demonstrate substantial restriction of back and hip function. However, in this report the examiner has failed to document any informal observations to validate the formally demonstrated findings.

Medical Advice

The main disabling conditions are back and hip pain, and CFS. Given the level of analgesia taken, the level of specialist involvement and the activities reported, severe disability seems unlikely. Since the detailed history of activities and the documented informal observations in the WCA report seem to support a level of mobility well in excess of that identified in the DLA report, the WCA seems to be the more sustainable opinion.

Case 2

A 19 year old lady with learning difficulties who attended the examination alone. The ESA 50 was completed by the social worker and had indicated problems by ticking "it varies" with all mental function descriptors except appropriateness of behaviour (no problem). She reports that the claimant can be shy and does not always speak up. Now living in supported accommodation and attends a Life Skills course at

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College.

At assessment, the claimant stated she came to the centre alone and got the bus there. The supported house is only 5 minutes away. She reported that she usually manages to wash and dress herself alone every day and cooks meals. She does not like doing housework, but has to do tidying duties in the house. The support workers always encourage them to do the tidying up. She indicated that she likes to go to the shop alone for things to eat and to get sweets. She goes to the supermarket with the support worker and two of the other residents. The support worker drives them there. Gets picked up by the college bus and attends a Life Skills course 4 days a week. She likes to be with her other friends from college and they chat and play games on the computer most afternoons. On Thursdays she goes to a charity shop where she helps with unpacking items. There is a nice lady at the shop who looks after her there and stays with her whole day. She wants to work in the shop at the counter with the customers and use the computer at the counter to sell items.

Exam Findings

Alert at exam. Dressed casually in clean clothing. Smiled a lot during the exam. Appeared friendly and gave answers to all questions with no prompting. Was fiddling fingers throughout the exam. Knew the day of week and the city but did not remember the exact date. Was unable to make change £1-75 p. Able to register 3 items but only able to recall 2 after 5 minutes and three attempts. Adequate concentration. Not anxious.

The advice following assessment was none apply for all the mental health descriptors.

Following disallowance of ESA, the social worker sent a letter seeking reconsideration. She also sent a supporting letter from the learning disability nurse at the college. In the letter the social worker stated that the claimant tends to overstate her abilities and although very proud of living away from elderly parents now, she receives lots of support at the house. The support workers are currently teaching "dressing skills" at the home and at the college as the claimant continues to be unreliable when performing all the activities on her. The social worker indicates that the claimant still often "gets it wrong" for example choosing summer clothes on a cold winter day. She likes colourful clothing preferring orange and green and would not want to change clothes at times when wearing these colours. Every few days she has to be reminded to get washed and dressed appropriately and although she makes snacks in the kitchen she has difficulties with doing simple meals as cannot tell when things are cooked properly and has also set the pans on fire. She now knows not to use cooker unless the support and activity workers are in the kitchen. The support worker also prompts the residents to clean up the house. The claimant is only able to go to the local shops as she has had travel training for this route which is less than 200 metres from the house. She is unable to go to the supermarket just over 1 kilometre away as she gets lost and would cry and get very upset. She was only able to come to the MEC alone as she was prepared for the journey over the 4 weeks prior to the assessment and it is only 5 stops from the home. The support worker actually shadowed her for a few practice trips.

The letter from the learning disability nurse stated that the claimant is now practising

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lots of life skills but is slow at taking up activities. The nurse is concerned that the claimant may have overstated her ability as she tends to give the answers she thinks the person wants to hear and is somewhat vulnerable. All computing activity is supervised and the programme that the claimant plays games on is set up and loaded for her to use with her classmate. When the system had a glitch a few weeks ago, the programme stopped working and she became extremely distressed as she could not reload the game. The activity worker calmed the situation and reloaded the programme which just required clicking on one icon. A part of the college activities involves planning travel training, however; despite this the claimant found it difficult to manage the trip from the house to the college which is 15 minutes away by bus. She became upset when the bus was crowded and felt really lost when the bus got past the usual supermarket. The shop work is part of the supported work in a charity shop the college uses as part of the Life Skills programme. All the claimant's activities there are supervised and she has the main task of packing away two sets of items on the stock shelves. Recently, when the colour of the packaging of the items was changed she became very upset and had to be calmed down. She had to leave the shop for the remainder of the day.

DM submission

WCA exam carried out on 04th January. No points advised for initiating personal action, going out and coping with change. The social worker letter and the letter from the nurse are casting some doubt now. Kindly advise if this new information is likely to alter the advice. I have already reconsidered the learning tasks and coping with change descriptors. The other descriptors I am concerned about are personal action and going out.

Model HCP response

Thanks for your referral.

The WCA report has provided some information on the activities undertaken. However, the claimant seems to be somewhat vulnerable and overstated her abilities. Given the additional information from the social worker and the nurse about reliability of information given at exam, there are some issues with the descriptors in question. The reliability in personal activities such as dressing appears to be under assessed in this case as frequent prompting is a feature. She appears to only manage very familiar routes and managed to come to the MEC which is close to the house after travel training and preparation. The difficulties with travel are further supported by the letter from the nurse.

Advice

The main disabling condition is learning disability. The claimant is attending a Life Skills course at College. The additional information suggests that although participates in dressing activities this is with frequent prompting. Although able to travel to very familiar locations with travel training, she is unable to manage unfamiliar locations unaccompanied.

You may wish to consider IA(c) and GA(c).

11. Medical Quality

11.1 Audit

Prior to approval, all filework is audited. Subsequent filework may be subject to audit at anytime. The quality of medical advice provided by approved HCPs on ESA filework will be assessed against defined quality standards. Further details are available.

It is important to note that sufficient justification for the advice given must be provided by the filework HCP in all cases where the advice is not to call the claimant for examination or request FME.

The quality of the medical advice on ESA filework will be reviewed on the basis of the evidence which was available to the HCP at the time the advice was provided.

In general terms, advice must be:

- In keeping with the consensus of medical opinion on the expected level of disability from the underlying medical condition(s) present

and

- Justified in a manner which a decision maker will understand and will withstand medical peer review.

11.2 Amending filework reports

If a case has been audited and the HCP wishes to make amendments to a report, this can be done through MSRS. The HCP can make any necessary amendments to the report, review the details carefully, and then complete the case. Please refer to the LiMA ESA Filework technical guide for specific instructions about audit amendment if required.

Appendix A - Revised WCA 2011 Support Group Functional Categories

<i>Activity</i>	<i>Descriptors</i>
1. Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be used.	Cannot either: (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion.
2. Transferring from one seated position to another.	Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.
3. Reaching.	Cannot raise either arm as if to put something in the top pocket of a coat or jacket.
4. Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this Schedule).	Cannot pick up and move 0.5 litre carton full of liquid.
5. Manual dexterity.	Cannot either - (a) press a button, such as a telephone keypad or; (b) turn the pages of a book with either hand.
6. Making self understood through speaking, writing, typing, or other means normally used.	Cannot convey a simple message, such as the presence of a hazard.
7. Understanding communication by hearing, lip reading, reading 16 point print or using any aid if reasonably used.	Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.
8. Absence or loss of control over extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the presence of any aids or adaptations normally used.	At least once a week experiences (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device; sufficient to require the individual to clean themselves and change clothing

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<i>Activity</i>	<i>Descriptors</i>
9. Learning tasks.	Cannot learn how to complete a simple task, such as setting an alarm clock, due to cognitive impairment or mental disorder.
10. Awareness of hazard.	Reduced awareness of everyday hazards, due to cognitive impairment or mental disorder, leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions, such that they require supervision for the majority of the time to maintain safety.
11. Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks).	Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions.
12. Coping with change	Cannot cope with any change, due to cognitive impairment or mental disorder, to the extent that day to day life cannot be managed.
13. Coping with social engagement, due to cognitive impairment or mental disorder	Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.
14. Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder	Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.
15. Conveying food or drink to the mouth.	(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else; (b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort; (c) Cannot convey food or drink to the claimant's own mouth without receiving regular prompting given by someone else in the claimant's physical presence; or (d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimant's own mouth without receiving— (i) physical assistance from someone else; or (ii) regular prompting given by someone else in the claimant's presence.
16. Chewing or swallowing food or drink.	(a) Cannot chew or swallow food or drink; (b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort; (c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the

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Activity

Descriptors

- claimant's presence; or
(d) Owing to a severe disorder of mood or behaviour, fails to—
- (i) chew or swallow food or drink; or
(ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence.

Support Group Criteria – Special Circumstances

The following is a list of the other circumstances that may result in a claimant being treated as having limited capability for work-related activity:

1. "The claimant is terminally ill"
2. "Where the claimant is a woman, she is pregnant and there is a serious risk of damage to her health or to the health of her unborn child if she does not refrain from work-related activity".
3. "A claimant who does not have limited activity for work related activity as determined in accordance with regulation 34 (1)" (Support Group Descriptors) "is to be treated as having limited capability for work related activity if -
 - (a) The claimant "suffers from some specific disease or bodily or mental disablement and;
 - (b) by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found not to have limited capability for work-related activity";
4. The claimant is receiving treatment by way of intravenous, intraperitoneal, or intrathecal, chemotherapy or recovering from that treatment or is likely to receive such treatment within 6 months of the date of the determination of capability for work will be treated as having limited capability for work related activity

Appendix B - Revised WCA 2011 LCW Descriptors

Physical Function Descriptors

<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
1. Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be used	Wa	Cannot either (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion.	15
	Wb	Cannot mount or descend two steps unaided by another person even with the support of a handrail.	9
	Wc	Cannot either (i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion.	9
	Wd	Cannot either (i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or (ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion.	6
	We	None of the above apply.	0
2. Standing and sitting	Sa	Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.	15
	Sb	Cannot, for the majority of the time, remain at a work station, either: (i) standing unassisted by another person (even if free to move around) or;	9

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
	(ii) sitting (even in an adjustable chair) for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion.	
	Sc Cannot, for the majority of the time, remain at a work station, either: (i) standing unassisted by another person (even if free to move around) or; (ii) sitting (even in an adjustable chair) for more than an hour before needing to move away in order to avoid significant discomfort or exhaustion.	6
	Sd None of the above apply	0
3. Reaching	Ra Cannot raise either arm as if to put something in the top pocket of a coat or jacket.	15
	Rb Cannot raise either arm to top of head as if to put on a hat.	9
	Rc Cannot raise either arm above head height as if to reach for something.	6
	Rd None of the above apply.	0
4. Picking up and moving or transferring by the use of the upper body and arms	Pa Cannot pick up and move a 0.5 litre carton full of liquid.	15
	Pb Cannot pick up and move a one litre carton full of liquid.	9
	Pc Cannot transfer a light but bulky object such as an empty cardboard box.	6
	Pd None of the above apply.	0
5. Manual dexterity	Ma Cannot either: (i) press a button, such as a telephone keypad or (ii) turn the pages of a book with either hand.	15
	Mb Cannot pick up a £1 coin or equivalent with either hand.	15
	Mc Cannot use a pen or pencil to make a meaningful mark.	9
	Md Cannot use a suitable keyboard or mouse.	9

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<i>Activity</i>	<i>Descriptors</i>		<i>Points</i>
	Me	None of the above apply.	0
6. Making self understood through speaking, writing, typing, or other means normally used; unaided by another person	SPa	Cannot convey a simple message, such as the presence of a hazard.	15
	SPb	Has significant difficulty conveying a simple message to strangers.	15
	SPc	Has some difficulty conveying a simple message to strangers.	6
	SPd	None of the above apply.	0
7. Understanding communication by both verbal means (such as hearing or lip reading) and non-verbal means (such as reading 16 point print) using any aid it is reasonable to expect them to use; unaided by another person	Ha	Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.	15
	Hb	Has significant difficulty understanding a simple message from a stranger due to sensory impairment.	15
	Hc	Has some difficulty understanding a simple message from a stranger due to sensory impairment.	6
	Hd	None of the above apply.	0
8. Navigation and maintaining safety, using a guide dog or other aid if normally used	Va	Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment.	15
	Vb	Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment.	15
	Vc	Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment.	9
	Vd	None of the above apply.	0
9. Absence or loss of control leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting) despite the	Ca	At least once a month experiences (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device;	15

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
10. Consciousness during waking moments		sufficient to require the individual to clean themselves and change clothing.	
	Cb	At risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly.	6
	Cc	None of the above apply.	0
	Fa	At least once a week, has an involuntary episode of lost or altered consciousness, resulting in significantly disrupted awareness or concentration.	15
	Fb	At least once a month, has an involuntary episode of lost or altered consciousness, resulting in significantly disrupted awareness or concentration.	6

Mental Function Descriptors

<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
11. Learning tasks	LTa	Cannot learn how to complete a simple task, such as setting an alarm clock.	15
	LTb	Cannot learn anything beyond a simple task, such as setting an alarm clock.	9
	LTc	Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes.	6
	LTd	None of the above apply.	0
12. Awareness of everyday hazards (such as boiling water or sharp objects)	AHa	Reduced awareness of everyday hazards leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions, such that they require supervision for the majority of the time to maintain safety.	15
	AHb	Reduced awareness of everyday hazards leads to a significant risk of (i) injury to self or others; or (ii) damage to property or possessions, such that they frequently require supervision to maintain safety.	9

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
	AHc Reduced awareness of everyday hazards leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions, such that they occasionally require supervision to maintain safety.	6
	AHd None of the above apply.	0
13. Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks)	IAa Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions.	15
	IAb Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time.	9
	IAc Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions.	6
	IAd None of the above apply.	0
14. Coping with change	CCa Cannot cope with any change to the extent that day to day life cannot be managed.	15
	CCb Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.	9
	CCc Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.	6
	CCd None of the above apply.	0
15. Getting about	GAa Cannot get to any specified place with which the claimant is familiar.	15
	GAb Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person.	9
	GAc Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person.	6
	GAe None of the above apply.	0

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
16. Coping with social engagement due to cognitive impairment or mental disorder	CSa Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.	15
	CSb Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual.	9
	CSc Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual.	6
	CSd None of the above apply.	0
17. Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder	IBa Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	15
	IBb Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	15
	IBc Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	9
	IBd None of the above apply.	0

Appendix C - ESA 2008 Functional Support Group Categories

<i>Activity</i>	<i>Descriptors</i>
1. Walking or moving on level ground.	Cannot— (a) walk (with a walking stick or other aid if such aid is normally used); (b) move (with the aid of crutches if crutches are normally used); or (c) manually propel his wheelchair; more than 30 metres without repeatedly stopping, experiencing breathlessness or severe discomfort.
2. Rising from sitting and transferring from one seated position to another.	Cannot complete both of the following— (a) rise to standing from sitting in an upright chair without receiving physical assistance from someone else; and (b) move between one seated position and another seated position located next to one another without receiving physical assistance from someone else
3. Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this Schedule).	Cannot pick up and move 0.5 litre carton full of liquid with either hand.
4. Reaching.	Cannot raise either arm as if to put something in the top pocket of a coat or jacket.
5. Manual dexterity.	Cannot— (a) turn a “star-headed” sink tap with either hand; or (b) pick up a £1 coin or equivalent with either hand.
6. Continence— (a) Continence other than enuresis (bed wetting) where claimant does not have an artificial stoma or urinary collecting device	(a) Has no voluntary control over the evacuation of the bowel; (b) Has no voluntary control over the voiding of bladder; (c) At least once a week, loses control of bowels so that the claimant cannot control the full evacuation of the bowel; (d) At least once a week loses control of bladder so that the claimant cannot control the full voiding of the bladder; (e) At least once a week fails to control full evacuation of the bowel, owing to a severe disorder of mood or behaviour; or (f) At least once a week fails to control full voiding of the bladder, owing to a severe disorder of mood or behaviour.

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<i>Activity</i>	<i>Descriptors</i>
(b) Continence where claimant uses a urinary collecting device, worn for the majority of the time including an indwelling urethral or suprapubic catheter	(a) Is unable to affix, remove or empty the catheter bag or other collecting device without receiving physical assistance from another person; (b) Is unable to affix, remove or empty the catheter bag or other collecting device without causing leakage of contents; (c) Has no voluntary control over bowel evacuation; (d) At least once a week loses control of bowels so that the claimant cannot control the full evacuation of the bowel; or (e) At least once a week fails to control full evacuation of the bowel, owing to a severe disorder of mood or behaviour.
(c) Continence other than enuresis (bed wetting) where claimant has an artificial stoma appliance	(a) Is unable to affix, remove or empty stoma appliance without receiving physical assistance from another person; (b) Is unable to affix, remove or empty stoma appliance without causing leakage of contents; (c) Where the claimant's artificial stoma relates solely to the evacuation of the bowel, has no voluntary control over voiding of bladder; (d) Where the claimant's artificial stoma relates solely to the evacuation of the bowel, at least once a week loses control of the bladder so that the claimant cannot control the full voiding of the bladder; or (e) Where the claimant's artificial stoma relates solely to the evacuation of the bowel, at least once a week, fails to control the full voiding of the bladder, owing to a severe disorder of mood or behaviour.
7. Maintaining personal hygiene	(a) Cannot clean own torso (excluding own back) without receiving physical assistance from someone else; (b) Cannot clean own torso (excluding back) without repeatedly stopping, experiencing breathlessness or severe discomfort; (c) Cannot clean own torso (excluding back) without receiving regular prompting given by someone else in the claimant's presence; or (d) Owing to a severe disorder of mood or behaviour, fails to clean own torso (excluding own back) without receiving— (i) physical assistance from someone else, or (ii) regular prompting given by someone else in the claimant's presence.

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<i>Activity</i>	<i>Descriptors</i>
8. Eating and drinking	
(a) Conveying food or drink to the mouth.	(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else; (b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort; (c) Cannot convey food or drink to the claimant's own his mouth without receiving regular prompting given by someone else in the claimant's physical presence; or (d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimants own mouth without receiving— (i) physical assistance from someone else, or (ii) regular prompting given by someone else in the claimant's presence.
(b) Chewing or swallowing food or drink	(a) Cannot chew or swallow food or drink; (b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort; (c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the claimant's presence; or (d) Owing to a severe disorder of mood or behaviour, fails to— (i) chew or swallow food or drink; or (ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence.
9. Learning or comprehension in the completion of tasks	(a) Cannot learn or understand how to successfully complete a simple task, such as the preparation of a hot drink, at all; (b) Needs to witness a demonstration, given more than once on the same occasion of how to carry out a simple task before the claimant is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a further demonstration of how to complete it; or (c) Fails to do any of the matters referred to in (a) or (b) owing to a severe disorder of mood or behaviour.
10. Personal action	(a) Cannot initiate or sustain any personal action (which involves planning, organisation, problem solving, prioritising or switching tasks); (b) Cannot initiate or sustain personal action without requiring daily verbal prompting given by someone else in the claimant's presence; or

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<i>Activity</i>	<i>Descriptors</i>
11. Communication	<p>(c) Fails to initiate or sustain basic personal action without requiring daily verbal prompting given by someone else in the claimant's presence, owing to a severe disorder of mood or behaviour.</p> <p>(a) none of the following forms of communication can be achieved by the claimant—</p> <ul style="list-style-type: none">(i) speaking (to a standard that may be understood by strangers);(ii) writing (to a standard that may be understood by strangers);(iii) typing (to a standard that may be understood by strangers)(iv) sign language to a standard equivalent to Level 3 British Sign Language; <p>(b) none of the forms of communication referred to in (a) are achieved by the claimant, owing to a severe disorder of mood or behaviour;</p> <p>(c) Misinterprets verbal or non-verbal communication to the extent of causing distress to himself or herself on a daily basis; or</p> <p>(d) Effectively cannot make himself or herself understood to others because of his disassociation from reality owing to a severe disorder of mood or behaviour.</p>

Support Group Criteria – Special Circumstances

The following is a list of the other circumstances that may result in a claimant being treated as having limited capability for work-related activity:

- “The claimant is terminally ill”
- The claimant is a woman, she is pregnant and there is a serious risk of damage to her health or to the health of her unborn child if she does not refrain from work-related activity”.
- “A claimant who does not have limited activity for work related activity as determined in accordance with regulation 34 (1)” (Support Group Descriptors) “is to be treated as having limited capability for work related activity if -
 - The claimant “suffers from some specific disease or bodily or mental disablement and;
 - by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found not to have limited capability for work-related activity”;
- People receiving intravenous, intraperitoneal, or intrathecal, chemotherapy (for whatever reason) will be treated as having limited capability for work related activity (i.e. in the support group), while they are receiving treatment and during a subsequent “period of recovery”.

Appendix D - ESA 2008 LCW Descriptors

Physical Function Descriptors

<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
1. Walking with a walking stick or other aid if such aid is normally used.	Wa	Cannot walk at all.	15
	Wb	Cannot walk more than 50 metres on level ground without repeatedly stopping or severe discomfort.	15
	Wc	Cannot walk up or down two steps even with the support of a handrail.	15
	Wd	Cannot walk more than 100 metres on level ground without stopping or severe discomfort.	9
	We	Cannot walk more than 200 metres on level ground without stopping or severe discomfort.	6
	Wf	None of the above apply.	0
2. Standing and sitting.	Sa	Cannot stand for more than 10 minutes, unassisted by another person, even if free to move around, before needing to sit down.	15
	Sb	Cannot sit in a chair with a high back and no arms for more than 10 minutes before needing to move from the chair because the degree of discomfort experienced makes it impossible to continue sitting.	15
	Sc	Cannot rise to standing from sitting in an upright chair without physical assistance from another person.	15
	Sd	Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.	15
	Se	Cannot stand for more than 30 minutes, even if free to move around, before needing to sit down.	6
	Sf	Cannot sit in a chair with a high back and no arms for more than 30 minutes without needing to move from the chair because the degree of discomfort makes it impossible to continue sitting.	6
	Sg	None of the above apply.	0

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
3. Bending or kneeling.	Ba	Cannot bend to touch knees and straighten up again.	15
	Bb	Cannot bend, kneel or squat, as if to pick a light object, such as a piece of paper, situated 15cm from the floor on a low shelf, and to move it and straighten up again without the help of another person.	9
	Bc	Cannot bend, kneel or squat, as if to pick a light object off the floor and straighten up again without the help of another person.	6
	Bd	None of the above apply.	0
4. Reaching.	Ra	Cannot raise either arm as if to put something in the top pocket of a coat or jacket.	15
	Rb	Cannot put either arm behind back as if to put on a coat or jacket.	15
	Rc	Cannot raise either arm to top of head as if to put on a hat.	9
	Rd	Cannot raise either arm above head height as if to reach for something.	6
	Re	None of the above apply.	0
5. Picking up and moving or transferring by the use of the upper body and arms	Pa	Cannot pick up and move a 0.5 litre carton full of liquid with either hand.	15
	Pb	Cannot pick up and move a one litre carton full of liquid with either hand.	9
	Pc	Cannot pick up and move a light but bulky object such as an empty cardboard box, requiring the use of both hands together.	6
	Pd	None of the above apply.	0
6. Manual dexterity.	Ma	Cannot turn a "star-headed" sink tap with either hand.	15
	Mb	Cannot pick up a £1 coin or equivalent with either hand.	15
	Mc	Cannot turn the pages of a book with either hand.	15
	Md	Cannot physically use a pen or pencil.	9
	Me	Cannot physically use a conventional keyboard or mouse.	9

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
	Mf	Cannot do up / undo small buttons, such as shirt or blouse buttons.	9
	Mg	Cannot turn a "star-headed" sink tap with one hand but can with the other.	6
	Mh	Cannot pick up a £1 coin or equivalent with one hand but can with the other.	6
	Mi	Cannot pour from an open 0.5 litre carton full of liquid.	6
	Mj	None of the above apply.	0
7. Speech.	SPa	Cannot speak at all.	15
	SPb	Speech cannot be understood by strangers.	15
	SPc	Strangers have great difficulty understanding speech.	9
	SPd	Strangers have some difficulty understanding speech.	6
	SPe	None of the above apply.	0
8. Hearing with a hearing aid or other aid if normally worn	Ha	Cannot hear at all.	15
	Hb	Cannot hear well enough to be able to hear someone talking in a loud voice in a quiet room, sufficiently clearly to distinguish the words being spoken.	15
	Hc	Cannot hear someone talking in a normal voice in a quiet room, sufficiently clearly to distinguish the words being spoken.	9
	Hd	Cannot hear someone talking in a loud voice in a busy street, sufficiently clearly to distinguish the words being spoken.	6
	He	None of the above apply.	0
9. Vision including visual acuity and visual fields, in normal daylight or bright electric light, with glasses or other aid to vision if such aid is normally worn.	Va	Cannot see at all.	15
	Vb	Cannot see well enough to read 16 point print at a distance of greater than 20cm.	15

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
	Vc	Has 50% or greater reduction of visual fields.	15
	Vd	Cannot see well enough to recognise a friend at a distance of at least 5 metres.	9
	Ve	Has 25% or more but less than 50% reduction of visual fields.	6
	Vf	Cannot see well enough to recognise a friend at a distance of at least 15 metres.	6
	Vg	None of the above apply.	0
10 (a) Continence other than enuresis (bed wetting) where the person does not have an artificial stoma or urinary collecting device.	Ca	Has no voluntary control of the evacuation of the bowel.	15
	Cb	Has no voluntary control of the voiding of the bladder.	15
	Cc	At least once a month loses control of bowels so that the person cannot control the full evacuation of the bowel.	15
	Cd	At least once a week loses control of bladder so that the person cannot control the full voiding of the bladder.	15
	Ce	Occasionally loses control of bowels so that the person cannot control the full evacuation of the bowel.	9
	Cf	At least once a month loses control of bladder so that the person cannot control the full voiding of the bladder.	6
	Cg	Risks losing control of bowels or bladder so that the person cannot control the full evacuation of the bowel or the full voiding of the bladder if not able to reach a toilet quickly.	6
	Ch	None of the above apply.	0
10(b) Continence where the person uses a urinary collecting device, worn for the majority of the time including an indwelling urethral or suprapubic catheter.	CUa	Is unable to affix, remove or empty the catheter bag or other collecting device without receiving physical assistance from another person.	15

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
	CUb Is unable to affix, remove or empty the catheter bag or other collecting device without causing leakage of contents.	15
	CUc Has no voluntary control over the evacuation of the bowel.	15
	CUd At least once a month loses control of bowels so that the person cannot control the full evacuation of the bowel.	15
	CUE Occasionally loses control of bowels so that the person cannot control the full evacuation of the bowel.	9
	CUf Risks losing control of the bowels so that the person cannot control the full evacuation of the bowel if not able to reach a toilet quickly.	6
	CUg None of the above apply.	0
10(c) Continence other than enuresis (bed wetting) where the person has an artificial stoma.	CBa Is unable to affix, remove or empty stoma appliance without receiving physical assistance from another person.	15
	CBb Is unable to affix, remove or empty stoma appliance without causing leakage of contents.	15
	CBc Where the person's artificial stoma relates solely to the evacuation of the bowel, at least once a week, loses control of bladder so that the person cannot control the full voiding of the bladder.	15
	CBd Where the person's artificial stoma relates solely to the evacuation of the bowel, at least once a month, loses control of bladder so that the person cannot control the full voiding of the bladder.	9
	CBe Where the person's artificial stoma relates solely to the evacuation of the bowel, risks losing control of the bladder so that the person cannot control the full voiding of the bladder if not able to reach a toilet quickly.	6
	CBf None of the above apply.	0
11. Remaining conscious during waking moments.	Fa At least once a week, has an involuntary episode of lost or altered consciousness, resulting in significantly disrupted awareness or concentration.	15
	Fb At least once a month, has an involuntary episode of lost or altered consciousness, resulting in significantly disrupted awareness or concentration.	9

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
	Fc	At least twice in the six months immediately preceding the assessment, has had an involuntary episode of lost or altered consciousness, resulting in significantly disrupted awareness or concentration.	6
	Fd	None of the above apply.	0

Mental Function Descriptors

<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
12. Learning or comprehension in the completion of tasks.	LTa	Cannot learn or understand how to successfully complete a simple task, such as setting an alarm clock, at all.	15
	LTb	Needs to witness a demonstration, given more than once on the same occasion, of how to carry out a simple task before the person is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a further demonstration of how to complete it.	15
	LTc	Needs to witness a demonstration of how to carry out a simple task, before the person is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person.	9
	LTd	Needs to witness a demonstration of how to carry out a moderately complex task, such as the steps involved in operating a washing machine to correctly clean clothes, before the person is able to learn or understand how to complete the task successfully, but would be unable to successfully complete the task the following day without receiving a verbal prompt from another person.	9
	LTe	Needs verbal instructions as to how to carry out a simple task before the person is able to learn or understand how to complete the task successfully, but would be unable, within a period of less than one week, to successfully complete the task without receiving a verbal prompt from another person.	6
	LTf	None of the above apply.	0

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
13. Awareness of hazard.	Aha	Reduced awareness of the risks of everyday hazards (such as boiling water or sharp objects) would lead to daily instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, to such an extent that overall day to day life cannot successfully be managed.	15
	AHb	Reduced awareness of the risks of everyday hazards would lead for the majority of the time to instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, to such an extent that overall day to day life cannot successfully be managed without supervision from another person.	9
	AHc	Reduced awareness of the risks of everyday hazards has led or would lead to frequent instances of or to near-avoidance of: (i) injury to self or others; or (ii) significant damage to property or possessions, but not to such an extent that overall day to day life cannot be managed when such incidents occur.	6
	AHd	None of the above apply	0
14. Memory and concentration.	MCa	On a daily basis, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the person's presence.	15
	MCb	For the majority of the time, forgets or loses concentration to such an extent that overall day to day life cannot be successfully managed without receiving verbal prompting, given by someone else in the claimant's presence.	9
	MCC	Frequently forgets or loses concentration to such an extent that overall day to day life can only be successfully managed with pre-planning, such as making a daily written list of all tasks forming part of daily life that are to be completed.	6
	MCD	None of the above apply.	0
15. Execution of tasks.	ETa	Is unable to successfully complete any everyday task.	15

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<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
	ETb	Takes more than twice the length of time it would take a person without any form of mental disablement, to successfully complete an everyday task with which the claimant is familiar.	15
	ETc	Takes more than one and a half times but no more than twice the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar.	9
	ETd	Takes one and a half times the length of time it would take a person without any form of mental disablement to successfully complete an everyday task with which the claimant is familiar.	6
	ETe	None of the above apply,	0
16. Initiating and sustaining personal action.	IAa	Cannot, due to cognitive impairment or due to a severe disorder of mood or behaviour, initiate or sustain any personal action (which means planning, organisation, problem solving, prioritising or switching tasks).	15
	IAb	Cannot, due to cognitive impairment or due to a severe disorder of mood or behaviour, initiate or sustain personal action without requiring daily verbal prompting given by another person in the person's presence.	15
	IAc	Cannot, due to cognitive impairment or due to a severe disorder of mood or behaviour, initiate or sustain personal action without requiring verbal prompting given by another person in the person's presence for the majority of the time.	9
	IAd	Cannot, due to cognitive impairment or due to a severe disorder of mood or behaviour, initiate or sustain personal action without requiring frequent verbal prompting given by another person in the person's presence.	6
	IAe	None of the above apply.	0
17. Coping with change.	CCa	Cannot cope with very minor, expected changes in routine, to the extent that overall day to day life cannot be managed.	15
	CCb	Cannot cope with expected changes in routine (such as a pre-arranged permanent change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.	9

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
	CCc Cannot cope with minor, unforeseen changes in routine (such as an unexpected change of the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.	6
	CCd None of the above apply.	0
18. Getting about.	GAa Cannot get to any specified place with which the person is, or would be, familiar.	15
	Gab Is unable to get to a specified place with which the person is familiar, without being accompanied by another person on each occasion.	15
	GAc For the majority of the time is unable to get to a specified place with which the person is familiar without being accompanied by another person.	9
	GAd Is frequently unable to get to a specified place with which the person is familiar without being accompanied by another person.	6
	GAe None of the above apply.	0
19. Coping with social situations.	CSa Normal activities, for example, visiting new places or engaging in social contact, are precluded because of overwhelming fear or anxiety.	15
	CSb Normal activities, for example, visiting new places or engaging in social contact, are precluded for the majority of the time due to overwhelming fear or anxiety.	9
	CSc Normal activities, for example, visiting new places or engaging in social contact, are frequently precluded, due to overwhelming fear or anxiety.	6
	CSd None of the above apply.	0
20. Propriety of behaviour with other people.	IBa Has unpredictable outbursts of, aggressive, disinhibited, or bizarre behaviour, being either: (i) sufficient to cause disruption to others on a daily basis; or (ii) of such severity that although occurring less frequently than on a daily basis, no reasonable person would be expected to tolerate them.	15
	IBb Has a completely disproportionate reaction to minor events or to criticism to the extent that the person has an extreme violent outburst leading to threatening behaviour or actual physical violence.	15

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
	IBc Has unpredictable outbursts of, aggressive, disinhibited or bizarre behaviour, sufficient in severity and frequency to cause disruption for the majority of the time.	9
	IBd Has a strongly disproportionate reaction to minor events or to criticism, to the extent that the person cannot manage overall day to day life when such events or criticism occur.	9
	IBe Has unpredictable outbursts of aggressive, disinhibited or bizarre behaviour, sufficient to cause frequent disruption.	6
	IBf Frequently demonstrates a moderately disproportionate reaction to minor events or to criticism but not to such an extent that the person cannot manage overall day to day life when such events or criticism occur.	6
	IBg None of the above apply.	0
21. Dealing with other people.	DPa Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others even for brief periods, such as a few hours; or (ii) causes distress to others on a daily basis.	15
	DPb The person misinterprets verbal or non-verbal communication to the extent of causing himself or herself significant distress on a daily basis.	15
	DPc Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others for longer periods, such as a day or two; or (iii) causes distress to others for the majority of the time.	9
	DPd The person misinterprets verbal or non-verbal communication to the extent of causing the person significant distress to themselves for the majority of the time.	9
	DPe Is unaware of impact of own behaviour to the extent that: (i) has difficulty relating to others for prolonged periods, such as a week; or (ii) frequently causes distress to others.	6

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
DPf	The person misinterprets verbal or non-verbal communication to the extent of causing the person significant distress to themselves on a frequent basis.	6
DPg	None of the above apply.	0

Appendix E - IB \ PCA Descriptors & Exemption Categories

PHYSICAL DESCRIPTORS

<i>Activity</i>		<i>Descriptors</i>	<i>Points</i>
WALKING ON LEVEL GROUND WITH A WALKING STICK OR OTHER AID IF NORMALLY USED*	a	Cannot walk at all	15
	b	Cannot walk more than a few steps without stopping or severe discomfort	15
	c	Cannot walk more than 50 metres without stopping or severe discomfort	15
	d	Cannot walk more than 200 metres without stopping or severe discomfort	7
	e	Cannot walk more than 400 metres without stopping or severe discomfort	3
	f	Cannot walk more than 800 metres without stopping or severe discomfort	0
	g	No walking problem	0
WALKING UP AND DOWN STAIRS*	a	Cannot walk up and down one stair	15
	b	Cannot walk up and down a flight of 12 stairs	15
	c	Cannot walk up and down a flight of 12 stairs without holding or taking a rest	7
	d	Cannot walk up and down a flight of 12 stairs without holding on	3
	e	Can only walk up and down a flight of 12 stairs if goes sideways or one step at a time	3
	f	No problem in walking up and down stairs	0
SITTING IN AN UPRIGHT CHAIR WITH A BACK BUT NO ARMS	a	Cannot sit comfortably	15
	b	Cannot sit comfortably for more than 10 minutes without having to move from the chair	15
	c	Cannot sit comfortably for more than 30 minutes without having to move from the chair	7
	d	Cannot sit comfortably for more than one hour without having to move from the chair	3
	e	Cannot sit comfortably for more than two hours without having to move from the chair	0
	f	No problem with sitting	0
STANDING WITHOUT THE SUPPORT OF ANOTHER PERSON; MAY USE A WALKING STICK	a	Cannot stand unassisted	15
	b	Cannot stand for more than a minute before needing to sit down	15
	c	Cannot stand for more than 10 minutes before needing to sit down	15
	d	Cannot stand for more than 30 minutes before needing to sit down	7
	e	Cannot stand for more than 10 minutes before needing to move around	7
	f	Cannot stand for more than 30 minutes before needing to move around	3
	g	No problem standing	0

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
RISING FROM SITTING FROM AN UPRIGHT CHAIR	a Cannot rise from sitting to standing	15
	b Cannot rise from sitting to standing without holding on to something	7
	c Sometimes cannot rise from sitting to standing without holding on to something	3
	d No problem with rising from sitting to standing	0
BENDING AND KNEELING	a Cannot bend to touch knees and straighten up again	15
	b Cannot bend or kneel as if to pick up a piece of paper from the floor and straighten up again	15
	c Sometimes cannot bend or kneel as if to pick up a piece of paper from the floor and straighten up again	3
	d No problem with bending and kneeling	0
MANUAL DEXTERITY	a Cannot turn the pages of a book with either hand	15
	b Cannot turn a tap or control knobs on a cooker with either hand	15
	c Cannot pick up a coin which is 2.5 centimetres or less in diameter with either hand	15
	d Cannot use a pen or pencil	15
	e Cannot tie a bow in laces or string	10
	f Cannot turn a tap or control knobs on a cooker with one hand	6
	g Cannot pick up a coin which is 2.5 centimetres or less in diameter with one hand	6
	h No problem with manual dexterity	0
LIFTING AND CARRYING	a Cannot pick up a paperback book, with either hand	15
	b Cannot pick up and carry a 0.5 litre carton of milk with either hand	15
	c Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity with either hand	15
	d Cannot pick up and carry a 2.5 kilogramme bag of potatoes with either hand	8
	e Cannot pick up and carry a 0.5 litre carton of milk with one hand	6
	f Cannot pick up and carry a 2.5 kilogramme bag of potatoes with one hand	0
	g No problem with lifting and carrying	0
REACHING	a Cannot raise either arm to put something in the top pocket of a coat or jacket	15
	b Cannot raise either arm to his/her head to put on a hat	15
	c Cannot put either arm behind his/her back to put on a coat or jacket	15
	d Cannot raise either arm above his/her head to reach for something	15
	e Cannot raise one arm to his/her head to put on a hat	6
	f Cannot raise one arm above his/her head to reach for something	0
	g No problem with reaching	0

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<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
SPEECH	a Cannot speak	15
	b Speech cannot be understood by family or friends	15
	c Speech cannot be understood by strangers	15
	d Strangers have great difficulty understanding speech	10
	e Strangers have some difficulty understanding speech	8
	f No problem with speech	0
HEARING WITH A HEARING AID IF USED	a Cannot hear sounds at all	15
	b Cannot hear well enough to follow a television programme with the volume turned up	15
	c Cannot hear well enough to understand someone talking in a loud voice in a quiet room	15
	d Cannot hear well enough to understand someone talking in a normal voice in a quiet room	10
	e Cannot hear well enough to understand someone talking in a normal voice in a busy street	8
	f No problem with hearing	0
VISION IN NORMAL DAYLIGHT WITH GLASSES	a Cannot tell light from dark	15
	b Cannot see the shape of furniture in the room	15
	c Cannot see well enough to read 16 point print at a distance greater than 20 centimetres	15
	d Cannot see well enough to recognise a friend across the room	12
	e Cannot see well enough to recognise a friend across the road	8
	f No problem with vision	0
CONTINENCE	a No voluntary control over bowels	15
	b No voluntary control over bladder	15
	c Loses control of bowels at least once a week	15
	d Loses control of bowels at least once a month	15
	e Loses control of bowels occasionally	9
	f Loses control of bladder at least once a month	3
	g Loses control of bladder occasionally	0
	h No problem with continence	0
REMAINING CONSCIOUS OTHER THAN FOR NORMAL PERIODS OF SLEEP	a Has an involuntary episode of lost or altered consciousness at least once a day	15
	b Has (above) at least once a week	15
	c Has (above) at least once a month	15
	d Has had (above) at least twice, in the six months before the test is applied	12
	e Has had (above) once in the six months before the test is applied	8
	f Has had (above) once in the three years before the test is applied	0
	g No problems with consciousness	0

* Only take the highest descriptor from walking or stairs, not both

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MENTAL HEALTH DESCRIPTORS

<i>Activity</i>	<i>Descriptors</i>	<i>Points</i>
COMPLETION OF TASKS	a Cannot answer the telephone and reliably take a message	2
	b Often sits for hours doing nothing	2
	c Cannot concentrate to read a magazine article or follow a radio programme	1
	d Cannot use a telephone book or other directory to find a number	1
	e Mental conditions prevents them from undertaking leisure activities previously enjoyed	1
	F Overlooks or forgets the risk posed by domestic appliances or common hazards due to poor concentration	1
	g Agitation, confusion or forgetfulness has resulted in mishaps or accidents in the 3 months before the test is applied	1
	h Concentration can only be sustained by prompting	1
DAILY LIVING	a Needs encouragement to get up and dress	2
	b Needs alcohol before midday	2
	c Is frequently distressed at some time of the day due to fluctuation of mood	1
	d Does not care about his appearance and living conditions	1
	e Sleep problems interfere with his daytime activities	1
COPING WITH PRESSURE	a Mental stress was a factor in making him stop work	2
	b Frequently feels scared or panicky for no obvious reason	2
	c Avoids carrying out routine activities because he is convinced they will prove too tiring or stressful	1
	d Is unable to cope with changes in daily routine	1
	e Frequently finds there are too many things to do that he gives up because of fatigue, apathy or disinterest	1
	F Is scared or anxious that work would bring back or worsen his illness	1
INTERACTION WITH OTHER PEOPLE	a Cannot look after himself without the help of others	2
	b Gets upset by ordinary events and it results in disruptive behaviour problems	2
	c Mental problems impair ability to communicate with other people	2
	d Gets irritated by things that would not have bothered him before he became ill	1
	e Prefers to be left alone for six hours or more each day	1
	F Is too frightened to go out alone	1

PCA EXEMPTION CATEGORIES

These were defined as follows:

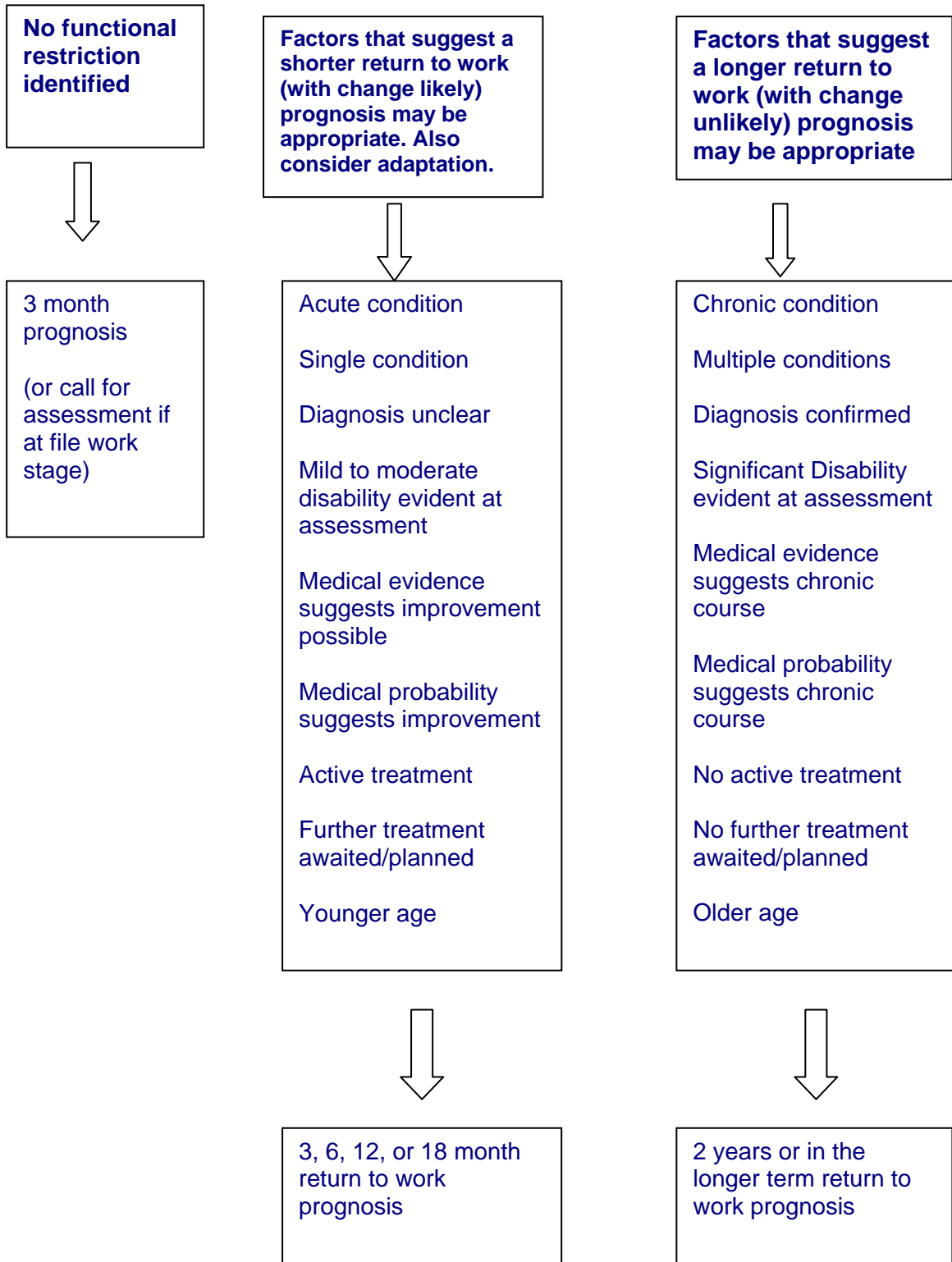
- Severe learning disabilities, defined in legislation as a condition which results from arrested or incomplete development of the brain, or severe

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damage to the brain which involves severe impairment of intelligence and social functioning.

- Severe and progressive neurological or muscle wasting disease.
- Progressive impairment of cardiorespiratory function which severely and persistently limits effort tolerance.
- An active and progressive form of inflammatory polyarthritis.
- Dense paralysis of the upper limb, trunk and lower limb on one side of the body.
- Multiple effects of impairment of function of the brain and/or nervous system causing motor, sensory, and intellectual deficits.
- Severe mental illness, defined in legislation as the presence of mental disease which severely and adversely restricts his social functioning, or his awareness of his immediate environment.
- Severe and progressive immune deficiency states characterised by the occurrence of severe constitutional disease or opportunistic infections or tumour formation.

Appendix F - Prognosis Matrix



Appendix G - Glossary of Terms

Throughout this document you will various terms and abbreviations used. The following is a list of some of these terms.

ESA Employment and Support Allowance

Revised WCA Revised Work Capability Assessment

LCW Limited Capability for Work: The term used to identify those with a certain degree of disability defined in the legislation which means there are likely to be limitations on their ability to engage in work.

“Treat as LCW”: The term used for claimants who are considered to have limitations on their ability to work due to specific criteria defined in the legislation namely having certain types of regular treatment, pregnancy around dates of confinement, radiotherapy and restriction on work due to a Public Health Order.

LCWRA Limited Capability for Work Related Activity: The term used to describe those with the most severe conditions where it would be considered unreasonable for them to engage in any type of work related activity or training. Those who meet criteria to be considered as having LCWRA are entered into the Support Group. LCWRA may be as a result of severe functional restriction or certain specific circumstances such as Terminal Illness.

WFHRA Work Focussed Health Related Assessment: A face to face assessment conducted by an Atos Healthcare HCP to explore the claimant’s views on their abilities and restrictions in relation to work and health.

WFI Work Focussed Interview: A series of interviews conducted by a Personal Adviser at the Job centre Plus (or private contractor) to help those with limited capability for work to begin a journey towards work readiness and ultimately employment.

TI Check (also known as SR check) Terminal Illness Check/ Special Rules check: An initial stage of ESA Filework completed by those who claim they are terminally ill.

PBC Pre-board check: A stage of filework completed on all claimants at their initial referral other than cases where definitive advice has been provided at the TI check

LCWRA Only Advice referrals: A type of referral where the Decision maker has identified “treat as LCW” and requests advice on LCWRA status

ESA 55: The file jacket where documentation relating to the claim is inserted

ESA 50 A form completed by claimants detailing their medical problems and stating their functional abilities and restrictions in both physical and mental function activities.

Medical Services

ESA 50A A form completed by claimants who have been identified as having “treat as LCW” by the DM and where FME is not available or adequate to provide advice on LCWRA status. The form is an abridged version of the ESA 50 and relates to LCWRA criteria.

IB Incapacity Benefit

PCA The medical assessment process to those applying for Incapacity Benefit

IB85 The medical report completed by an HCP following a face to face assessment to advise the Decision Maker about the PCA

IB85A A report produced advising on Filework outcomes in Incapacity Benefit

FME: Further Medical Evidence

113: A form used to request FME. Used in Incapacity Benefit (IB113) and ESA (ESA 113)

FRR2: A form used to request FME where there is a requirement for specific questions to be addressed.

FRR3: A form used to request FME from an HCP other than the claimants GP

FRR4: A form used to document any telephone contact with the claimant or any HCP involved in their care.

ESA 85 The medical report completed by an HCP following a face to face assessment to advise the Decision Maker on LCW/LCWRA status

ESA85A A report produced advising on Filework outcomes in ESA

ESA86 A form used to record advice on LCWRA only clerical referrals

DLA Disability Living Allowance: Disability Living Allowance is a non-contributory, non-means tested and tax-free benefit that is based on an assessment of care and mobility needs for people with disability. DLA is payable to those with qualifying needs where the claim is made before the age of 65.

AA Attendance Allowance: is a non-contributory, non-means tested and tax-free benefit that is based on an assessment of care. AA is payable to those whose needs arise after the age of 65 (or who claim after that date) and it relates to personal care only. AA does not have a Mobility component.

DAL/AA Special Rules Claim: A type of claim within the DLA/AA benefit for those claiming a terminal illness.

MSRS: Medical Services Referral System: An automated workflow and case management system used to register details of Incapacity Benefit and ESA claims.

SMART: System for Medical Allocations, Referrals and Tracking. An IT system used in Atos Healthcare by administration staff with a variety of functions including recording of appointments and brief outcomes of advice relating to DLA/AA claims.

DV Domiciliary Visit

Medical Services

DWP	Department for Work and Pensions
GMC	General Medical Council
GP	General Practitioner
MEC	Medical Examination Centre
NINo	National Insurance Number
NMC	Nursing and Midwifery Council
PV	Potentially Violent (Now obsolete – see UCB)
IRG	Incapacity Reference Guide – list of coded conditions \ diagnoses the DM uses to record diagnosed cause of incapacity.
UCB	Unacceptable Claimant Behaviour

Observation form

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