

COVID 19 WCA Telephone Assessments – Guidance for HCPs (MED-COVID19TAG~001)

24th August 2020

Document control

Superseded documents

Version history

Version	Date	Comments
1k draft	24 th August 2020	Approved by DWP
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1c draft	8 th April 2020	Updated with further process guidance

Changes since last version

Section 2- Information in relation to handling of files removed (more appropriate to be in Operational/H&S guidance)

Section 4.1.1: Telephone assessment suitability.

References to clients with past history of self harm/ LCWRA risk previously applied removed.

References to those requiring interpreter (excluding BSL) removed.

Section 4.3: Wording on prognosis slightly amended with greater emphasis on applying a longer prognosis where this is appropriate.

Outstanding issues and omissions

Updates to Standards incorporated

Issue control

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1. Introduction

The COVID-19 pandemic is uncharted territory for every citizen of the UK. DWP services are a vital safety net for society, and as a key supplier CHDA have been asked to assist and adapt our operations in order to support the DWP and the vulnerable people that they serve.

The DWP have agreed the following advice will be provided by HCPs conducting telephone Work Capability Assessments:

LCWRA Yes or LCWRA No. (Including Risk LCWRA where appropriate).

All claimants will remain at least on the assessment rate, therefore LCW advice is not being given in this process.

No fit for work decisions will be made by DWP.

LCWRA Risk can be advised once the severe functional LCWRA categories have been found not to be appropriate.

This document will outline the processes involved in this new method of delivering Work Capability Assessments and provide HCPs with general guidance and support in considering evidence gathering and evaluation through a telephone consultation.

2. Processes to be followed when conducting telephone interviews for Work Capability Assessments

☐ Proof of Identity Procedures guide

Standard telephone identification processes should be followed as covered in the Proof of Identity Procedures guide. In addition some guidance on a script for the telephone assessment process is detailed below.

When telephoning claimants

It is imperative that proof of identity procedures are followed as detailed in the proof of identity procedures guide.

It is essential you establish the identity of the person to whom you are talking to at the outset.

The following script should be used:

“I’m X from the Centre for Health and Disability Assessments and I would like to speak to Mr/Mrs/Miss/Ms etc. (Use Full Name of claimant)”. No further details should be given until the claimant has been positively identified.

A positive identification of the claimant should be sought and this would normally be the claimant DOB, NINo or postcode.

If you are uncertain that the person to whom you are speaking is the claimant, terminate the call.

If the claimant is unavailable, make arrangements to call back, without revealing any further details appertaining to the nature of the telephone call.

Having established the identity of the claimant, there is then a need to explain why the telephone call is being made. The following form of words should be used:

“I am one of the Healthcare Professionals providing advice to the DWP on your claim to benefit, I need to get some details about your health problems and how they affect you day to day is this ok?”

Are you somewhere where you can hold a private conversation and not be overheard?

The Department for Work and Pensions (DWP) has temporarily suspended all face-to-face assessments for health and disability-related benefits. This is to protect people from unnecessary risk of exposure to coronavirus (COVID-19) during the current outbreak.

As an interim measure, we are doing Work Capability Assessments by telephone. We may not be able to get as much information as we could from a face-to-face assessment and we may not get enough to make a recommendation. However, we are doing our best to make recommendations where possible.

The purpose of this call is to identify people who should be getting a higher rate of benefit, where we can. **Please be reassured that you will not lose your benefit as a result of this call.**

If at any stage the claimant is not happy to proceed the call should be terminated and ESA/UC 85A min completed detailing the circumstances.

If any claimant is unreasonable or verbally aggressive on the phone this is unacceptable and the standard processes should be followed.

□ **Answering machine received when attempting to contact a claimant**

If, after attempting to make contact with the claimant, CHDA employees are presented with an answering machine, then personal information should never be left on the message.

The following claimant details should never be included in answering machine messages left by CHDA:

- NINOs
- Current or previous addresses
- Information about health conditions
- Their full name
- Dates of birth
- Family details
- Benefit details

- where it is clear that leaving a message would be inappropriate (e.g. clarify certain details about the claimant)

When leaving a message, you must be clear about what it is trying to achieve; keep the message brief and to the point, and relevant to the query concerned. You must also ensure the message ends by confirming next steps with the claimant in order to avoid any unnecessary further contact.

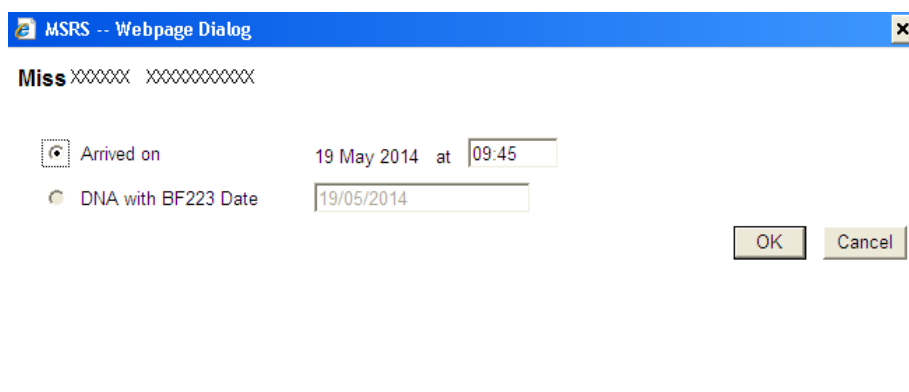
The following script, or something very similar, must be used:

“This is a message from Centre for Health and Disability for Mr/Mrs/Miss/Ms XXXX. We have been trying to contact you to commence the appointment you agreed to on (date and time) I shall attempt to call back in xxx minutes. Otherwise if you now cannot commence this appointment please contact our Help Desk on (local tel number)”

☐ **Commencing the Assessment on LiMA**

In order to commence the assessment the claimant must be shown as having ‘arrived’ on MSRS. This is completed as follows:

- Navigate to the ‘View Appointments by MEC by Day’ screen selecting the appropriate Telephone Assessment Centre, locate the appointment in question.
- Under the ‘Arrival Time’ column, a button will be visible that says ‘Arrival’ on it. Click this button.
- A small pop-up window will open asking for the time that the claimant arrived. Enter the time the call starts in the text-box and click ‘OK’.



MSRS -- Webpage Dialog

Miss XXXXXX XXXXXXXXXXXX

Arrived on 19 May 2014 at 09:45

DNA with BF223 Date 19/05/2014

OK Cancel

Note: The arrival time MUST be entered when the claimant accepts the call. Failing to do so will result in you being unable to start the assessment on LiMA.

☐ **The role of a companion**

As per WCA Handbook Guidelines, the role of a companion can be vital to offer the claimant support and especially where there are issues with insight, the information they provide can be essential for effective information gathering. It may therefore be useful if a claimant has a companion in person present who lives in the same household, to instruct the claimant to use “speakerphone” facilities. If the person does not live in the same household, it may be possible for them to be dialled in through the phone line, however; this may not be technically possible in all cases.

☐ **Unexpected findings Process Guide**

If during the course of the customer contact it is felt that a UE 1 is required, please ensure that you have explained this to the customer and obtained consent, where possible. Please refer to the UE1 guidance located on the intranet for full scope.

The general concepts of UE1 should be followed, however it should be noted, there are some potential changes to process during this period:

- UE1 – Verbal consent must be obtained and be recorded as such on the form “Verbal consent obtained by telephone”
- Where a claimant declines consent, the normal processes should be followed
- A telephone call to the GP will be required in all cases as colleagues are unable to fax from their home. Please attempt twice, if you are unable to get through to the surgery after 2 attempts, please escalate to the nominated GP liaison HCP who will then pick up further contact. In the event that the GP is not contactable please make every effort to contact any other contact available, such as CPN. If contact is still not made then the relevant emergency service contact should be made. Please ensure that you keep track of any failed contact on an FRR4 and link with your local Clinical Assurance Lead (CAL) for advice and guidance.
- For emergency situations, the current processes should be followed.
- In the event that an electronic version of the UE1 form is unavailable please complete a hard copy and return to the BSC where a colleague will post the relevant copies to the GP, customer and retain a copy on file.

☐ **Safeguarding Policy**

If you have a safeguarding issue then follow the process and raise with your Quality Assurance Lead (QAL). The Safeguarding Lead and should be contacted for any queries in the absence of a QAL, or should there be escalation requirements.

☐ **Follow Up/Welfare Calls**

- General Claimant Welfare

If during the course of the telephone assessment the customer becomes too distressed to continue, or hangs up before you have had a chance to conclude the assessment, please ensure that you follow up by contacting them to make sure that they are ok. A follow up call should occur within a couple of hours at most. If you are unable get in touch with them, please escalate to your QAL. It may be identified at this point that the UE1 or Safeguarding process should be invoked, so please do so if indicated.

- Claimant expresses thoughts of self harm or suicide

If you are on a call and the claimant threatens to commit suicide or to self-harm:

- Remain calm and listen to the caller
- Take the threat seriously
- Ask the claimant if you can help by gaining their consent to contact a family
 - member, their GP, the Samaritans or the emergency services
- Alert your QAL and ensure that you have support to deal with each case
- Complete an on-line incident report with detailed information of the
 - conversation with the claimant and any other actions taken. Ensure that the report includes the claimant's NINO.

- DWP Welfare Checks

If a claimant reveals details such as extreme financial difficulties where the DWP may be able to assist, please notify DWP through the procedures outlined in the "Protocol for Illness VCC" available on the knowledge library.

□ **Neurological Conditions List by Practitioner Type**

This guidance remains unchanged in terms of the case types each HCP can normally assess.

However; for the Covid telephone assessments, it has however been agreed with the DWP that if during the course of an assessment a neurological problem becomes apparent that has **no impact** on LCWRA advice, the LCWRA advice relating to the non neurological condition can still be provided.

If the neurological condition uncovered during the telephone call does potentially impact on LCWRA advice, this should be handed over to a HCP trained in the assessment of the neurological condition.

For example: A client with a diagnosis of depression is interviewed. Severe problems with personal action are identified due to very low mood early on during the interview. The client then also mentions they had a “mini stroke” 2 years ago that does not affect them other than very slight tingling in one arm occasionally. In this case, LCWRA advice on Personal Action as a result of depression can still be given to the DM. There would be no need to hand over or abandon the assessment.

☐ Practical Issues

Abandonment of call due to technical issues (inadequate telephone reception, lack of appointee presence etc).

- All reasonable measures should be made to ensure the assessment can proceed – e.g. ask the claimant to move room, take off headset to improve reception etc.
- Only abandon assessment if UCB applies, severe claimant distress, or otherwise instructed by a senior colleague.
- If assessment cannot proceed – document using FRR4, & ESA/UC85Amin, and notify nominated administration colleague in local BSC.

☐ Finishing a call

The following script should be used:

Thank you for your time today
I have asked all the questions I need to ask in relation to your assessment
Do you have any questions you want to ask me?
Following this call, your report will be reviewed and you will be contacted by letter in relation to the next steps.

As I said at the beginning, the purpose of this call is to identify people who should be getting a higher rate of benefit where we can. When I review your report, I may not be able to make a recommendation about your capability to work without seeing you face-to-face. If this happens, **you will continue to be paid your current rate of benefit** and we will invite you to a face-to-face assessment as soon as we can once they resume. **Please be reassured that you will not lose your benefit as a result of this call.**

In the meantime please do not hesitate to contact the DWP if there is a change in your circumstances, for example if you have a new health condition or if there is a change in your existing condition.

Is there anything further you would like to discuss before I end the call?

Thank you again for the time today.

3. Evidence Gathering and Evaluation in the WCA

3.1 Overview

The following information serves to remind HCPs of key concepts of evidence gathering and critical evaluation in the WCA. This information relates specifically to information normally obtained or available during the assessment.

Careful evidence gathering and subsequent evaluation of this information form the foundation principles for the advice provided in the WCA.

Many of these core principles remain very similar in terms of the type of information that must be considered regardless of whether this is through a telephone or face to face interview and the information below should serve as a reminder of good practice.

It is acknowledged that some evidence such as visual observations and physical examination of the client will not be possible through a telephone interview and general advice on these issues will be provided in section 4 of this document.

3.2 Key Principles of Critical Evaluation of Evidence

As an HCP providing functional assessment advice, you are required to utilise evidence from a variety of sources.

You may have documentary information from professionals, the claimant, or other interested parties and you must evaluate all the available evidence in order to formulate an opinion.

Bear in mind that your aim is to reach a position where you are able to convey advice to the Decision Maker that is complete, justified and consistent. This will require you to balance the evidence available against the information required.

As you gather additional items of evidence, you are able to evaluate whether you have sufficient data to enable you to advise the Decision Maker. If you conclude that you still have insufficient evidence, you must focus your attention as to where and how you should search for further relevant information to allow you to advise the Decision Maker on the balance of probability.

Remember there are 5 key types of evidence:

- I. **Medical Knowledge**
- II. **Independent Medical Evidence (IME)**
- III. **Independent Medical Opinion (IMO)**

IV. Verifiable Medical Information (VMI) – verifiable medical fact**V. Claimant Provided Opinion (CPO)**

During an assessment, IME and IMO may or may not be available, but in all cases, you should consider and evaluate any evidence available based on the 5 key evaluation criteria of:

- ☐ **Accuracy**
- ☐ **Authority**
- ☐ **Objectivity**
- ☐ **Currency**
- ☐ **Coverage**

Regardless of whether an assessment is conducted at face to face level or via a telephone, there are always going to be areas where you can ensure you control aspects of the above features.

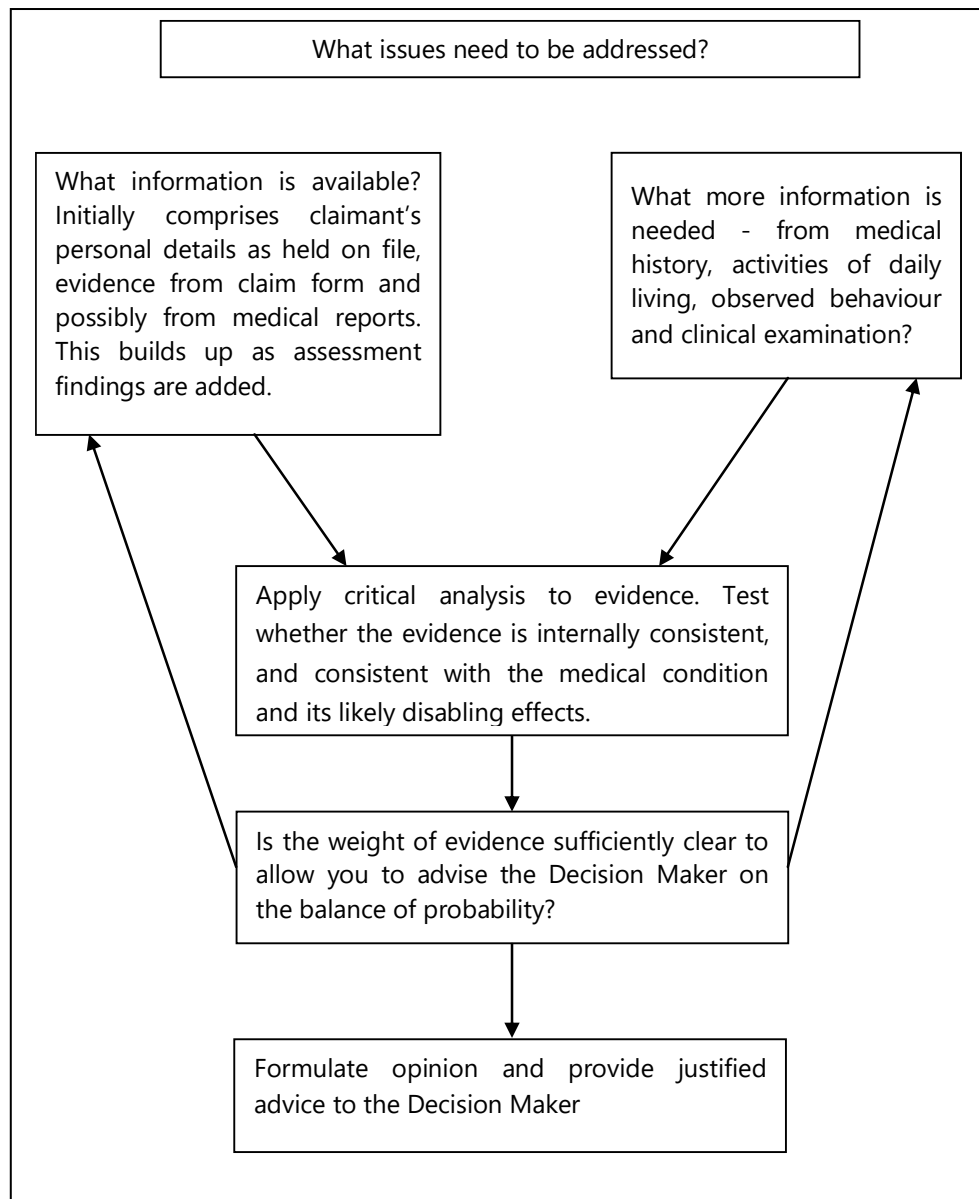
Your medical knowledge is there to enable you to listen and evaluate whether is being said is reasonable and consistent with the medicine. If you are unsure of up to date details of a less frequently encountered condition, ensure you consult EBM resources and use the BNF to take on details of medication.

In terms of CPO, VMI and coverage, you and your history taking skills are essential to ensure you have obtained adequate information from the claimant/appointee/companion to allow you to provide advice to the Decision Maker. Remember that some of the normal evidence you gather such as observations and examination will not be available, so it is essential that you gain as much information as possible and address any inconsistencies in the evidence obtained.

Remember it is imperative that you gather adequate data to ensure you can clearly advise on LCW vs. LCWRA.

Ensure you consider the Evidence Cycle whenever providing advice to the Decision Maker – see over.

The Evidence Cycle



A large amount of the evidence and completing the evidence cycle can come from the clinical history and typical day. It is therefore essential that you revise some key concepts of best practice in obtaining and recording the clinical history and typical day history.

As indicated previously, some areas of evidence will not be available by phone and the HCP must be adaptable in this setting in the current climate. Some slight adaptations to your usual face to face techniques may be required and some additional questions may help with this missing evidence to the point you are in a position to provide advice on the balance of

probability to the DM. Core to this, is effective history taking and exploration. In terms of CPO, VMI and coverage, you and your history taking skills are essential to ensure you have obtained adequate information from the claimant/appointee/companion, including addressing any inconsistencies to allow you to provide advice to the Decision Maker.

3.3 Reminder of Best Practice in exploring the Clinical History

As experienced HCPs, you are all aware and well versed in the area of obtaining a clinical history.

In a telephone interview, there are different challenges to history taking. Always consider these general points when conducting assessments by phone:

3.3.1 Customer Care issues

Customer care issues remain important when conducting telephone assessments. Points relevant to a telephone assessment include:

- **Never underestimate the claimant's capability**
- **Speak in a normal voice – not a shout or a whisper**
- **Speak a bit slowly but not too slow**
- **Avoid making long conversations**
- **Avoid noisy rooms and reduce background noise as much as possible**
- **Repeat if necessary**
- **Avoid changing subject quickly**
- **Allow claimant time to respond**
- **Make sure that the individual is managing to follow the conversation**

The information below information is provided to you as a reminder and a prompt of the areas that must be explored.

3.3.2 Clinical History Taking (Physical)

You must ensure you obtain details of:

- ☐ Duration and Progression of condition
- ☐ Symptoms

- ☐ Exacerbating or relieving factors
- ☐ Variability
- ☐ Investigations such as X-rays, CT scans, MRI scans, etc
- ☐ Any formal diagnosis made by a healthcare professional dealing with the claimant's care
- ☐ Treatments such as medication, physiotherapy, surgery, etc
- ☐ Hospital treatment
- ☐ Impact of any therapies
- ☐ Use of any aids or appliances
- ☐ Ongoing input from specialists, etc.
- ☐ Exploring and addressing inconsistencies

This list is not exhaustive and you should use your skills to ensure the areas you cover are adequate for each individual case.

Other Key points to note in Clinical History:

- **All** conditions stated by the claimant in the questionnaire (ESA50 / UC50), included in the file (WCA55) and during the assessment must be mentioned. There may also be evidence such as previous reports or a MED3 available on the computer programme MSRS, these must also be scrutinised carefully for a note of any conditions not already stated
- The condition history is one of the key sources of evidence, and should contain sufficient detail to enable the HCP to proceed with the assessment with a broad idea about the likely significance of the condition in relation to the stated disability
- You must take a clear history of each condition, particularly when it is likely to be a source of significant disability. Where there has been improvement, this must be made clear to the DM. A history that is too brief, such as “had bowel surgery 1 year ago” with no further elaboration is unlikely to be helpful to the DM
- In unilateral conditions, the side affected must be specified
- Variability must be addressed fully, not just “2 good days/5 bad”. Variation within the day and what the claimant can and cannot manage during good and bad spells should be explored. The frequency of exacerbations must be discussed and taken into account when providing advice to the DM

- Any exacerbating features or activities which cause a bad spell and any relieving features or activities which cause a good spell must be explored
- Current symptoms and their effect on function should be explored to determine whether activities can be performed safely, reliably, repeatedly, to an acceptable standard and in a reasonable time
- Where restrictions are indicated, the use of aids and appliances must be fully explored. Details should be obtained on whether aids have been prescribed or purchased by the claimant. The HCP must consider whether these could reasonably be used taking into account the diagnosis and any other problems which may be present. In circumstances where a claimant has been prescribed an aid but chooses not to use it, their reasons for choosing not to use the aid should be clearly stated
- When documenting the diagnosis the most appropriate option on the computer programme (LiMA) should be used. Where conditions are unrelated it is not appropriate to group them together, as an example, it would not be appropriate to group musculoskeletal conditions that have different origins and dates of onset. However, where the condition is osteoarthritis affecting many joints it is preferable to group the conditions together and record this as 'generalised osteoarthritis'
- When the diagnosis is confirmed, such as angina it is preferable to record this as 'angina' rather than 'cardiovascular problem'
- Medication - Dosages can be important; for example, where medication such as morphine is prescribed, or when a small dose of antipsychotic is used to control anxiety. It is not sufficient to write "normal dose"
- The reason for taking a particular medication should be documented especially if the medication can be used for various medical conditions – for example a claimant who has hypertension and anxiety, who is on propranolol for his anxiety, the propranolol should be documented as being taken for the anxiety and not as used for cardiac conditions
- The relevance of any reported side effects of medication must be provided
- No third party information should be documented within the report, in particular details of any alleged assault or abuse which has resulted in physical health issues
- Details of any convictions should only be recorded where appropriate and relevant to the assessment, with the claimant's consent. Details should still be recorded in non specific terms, such as 'past forensic history'
- If the claimant is accompanied by family members, carers, support workers, social workers etc, they may be able to provide useful information particularly in cases where claimant has difficulty expressing their problems
- Caution must be exercised if domestic abuse is mentioned, especially if the claimant has a companion, as they may be unaware of this or indeed may in fact be the perpetrator.
- Aspects of sexual function are not appropriate to explore in the WCA.

3.3.3 Clinical History (Mental Function) – Key points

- In assessing mental function, the clinical history can be the key to determine overall level of function. Remember, at this time, there may be alterations to a person's symptoms and level of care. With the current restrictions, normal escalations of care may not be happening in the manner normally expected and this must be taken into account when evaluating evidence. In addition, previous support from friends and relatives may be restricted which could result in a person's condition worsening as a result of isolation.

You must ensure you obtain details of:

- ☐ Duration and Progression of condition (especially in recent weeks)
- ☐ Symptoms
- ☐ Exacerbating or relieving factors
- ☐ Variability
- ☐ Exploring and addressing inconsistencies
- ☐ Self Harm/Suicidal Ideation - past or present
- ☐ Investigations where relevant, such as, CT scans, MRI scans, etc
- ☐ Any formal diagnosis made by a healthcare professional dealing with the claimant's care
- ☐ Treatments such as medication, cognitive behavioural therapy, group therapy, detoxification, etc
- ☐ Hospital treatment
- ☐ Mental Health Act provisions
- ☐ Care Programme Approach
- ☐ Impact of any therapies
- ☐ Ongoing input from specialists etc.
- ☐ Informal support from friends and relatives and recent changes to their support network

This list is not exhaustive and you should use your skills to ensure the areas you cover are adequate for each individual case.

Key points to note in the Mental Function Clinical History:

- **All** conditions stated by the claimant in the questionnaire (ESA50 / UC50), included in the file (WCA55) and during the assessment must be mentioned. There may also be evidence such as previous reports or a MED3 available on the computer programme MSRS, these must also be scrutinised carefully for a note of any conditions not already stated
- The condition history is one of the key sources of evidence, and should contain sufficient detail to enable the HCP to proceed with the assessment with a broad idea about the likely significance of the condition in relation to the stated disability
- The HCP must take a clear history of each condition, particularly when it is likely to be a source of significant disability. Where there has been improvement, this must be made clear to the DM. A history that is too brief, such as “had psychosis 2 years ago, now fine” with no further elaboration is unlikely to be helpful to the DM
- Self harm / suicide history must be explored in detail – with details including any past history, need for hospitalisation or specialist input, any ongoing self harm, any ongoing suicidal thoughts / plans /intent. This must always be done in a sensitive manner. By telephone, this is extremely important. You must actively listen to what is being said, bearing in mind you will not have the usual non verbal clues to judge their reactions when discussing this. Carefully consider a welfare follow up call or whether the unexpected findings processes must be applied.
- Variability must be addressed fully, not just “2 good days/5 bad”. Variation within the day and what the claimant can and cannot manage during good and bad spells should be explored. The frequency of exacerbations must be discussed and taken into account when providing advice to the DM. This is particularly important in conditions with substantial variability such as Bipolar Illness
- Any exacerbating features or activities which cause a bad spell and any relieving features or activities which cause a good spell must be explored
- Current symptoms and their effect on function should be explored to determine whether activities can be performed safely, reliably, repeatedly, to an acceptable standard and in a reasonable time
- When documenting the diagnosis the most appropriate option on the computer programme (LiMA) should be used. Where conditions are unrelated it is not appropriate to group them together, as an example, it would not be appropriate to group along history of depression and a new diagnosis of dementia.
- When the diagnosis is confirmed, such as Bipolar disorder it is preferable to record this as ‘Bipolar disorder’ rather than ‘Mental Health problem’
- Medication - Dosages can be important; for example, where medication such as a small dose of antipsychotic is used to control anxiety rather than the higher dose for psychosis. It is not sufficient to write “normal dose”

- The reason for taking a particular medication should be documented especially if the medication can be used for various medical conditions – for example a claimant who has hypertension and anxiety, who is on propranolol for his anxiety, the propranolol should be documented as being taken for the anxiety and not used as an antihypertensive
- The relevance of any reported side effects of medication must be provided
- No third party information should be documented within the report, in particular details of any alleged assault or abuse which has resulted in mental function issues
- Details of any convictions should only be recorded where appropriate and relevant to the assessment, with the claimant's consent. Details should still be recorded in non specific terms, such as 'past forensic history'
- If the claimant is accompanied by family members, carers, support workers, social workers, CPNs, etc, they may be able to provide useful information particularly in cases where claimant has learning disability, cognitive impairment or poor insight
- Caution must be exercised if domestic abuse is mentioned, especially if the claimant has a companion, as they may be unaware of this or indeed may in fact be the perpetrator. Remember, during these unprecedented times, the incidence of domestic abuse may be higher than normal and you must be both sensitive **and very cautious** if this issue is mentioned. If you feel the process is increasing the risk (e.g. the abuser is the companion) then consider terminating the call or giving the person an opt out. Safeguarding must be considered.
- Aspects of sexual function are not appropriate to explore in the WCA.

3.4 Reminder of Best Practice in exploring the Typical Day History

As experienced HCPs, you are all aware and well versed in the area of obtaining a typical day history.

In a telephone interview, there are different challenges to history taking, and the below information is provided to you as a reminder and a prompt of the areas that must be explored.

One other aspect to consider is that during this time, FME may not be as available as normal and it is therefore essential to carefully explore inconsistencies in the typical day and address these in the advice to the DM.

The typical day history is an integral part of the very important functional history step in disability analysis. By using effective communication techniques, a well-focussed history is vital in the evidence gathering process to assist in completing the WCA report. The typical day provides an account of how the claimant manages activities on a day to day basis and is personalised for that individual. The focus is on what that individual can and cannot do and how they manage with various activities.

The typical day needs to explore and expand on areas where the claimant indicates a problem or where a problem is likely. In the clinical history the symptoms experienced by the individual are explored, but the typical day explores the functional impairment these symptoms cause for that individual. For example, if in the clinical history the claimant reports a broken arm, when thinking about the typical symptoms resulting from a broken arm (such as pain, reduced movement and strength), activities that cover upper limb function (reaching, picking up or moving things and manual dexterity) need to be considered. Exploring activities such as washing, dressing, cooking, lifting the washing basket, hanging out the washing, using a mobile phone, writing, etc. could be explored to indicate how these symptoms affect the function of that individual

A carefully structured typical day provides a good overview in a reasonably chronological order of what the claimant is able to do from rising time to going to bed and also comments on sleep quality. By covering the different time periods and ascertaining how the person manages the activities indoors and outdoors for a range of relevant activities of daily living, a good typical day can usually be obtained with sufficient detail and clarification.

The condition, symptoms and likely functional impact must be considered and can help you to obtain pertinent information from some rich and fertile areas in the activities of daily living that can be explored to help probe and clarify how the claimant is functioning.

The typical day does not have to be a series of questions, but information can be obtained by inviting the claimant to “Tell me about...” or “Describe how you manage...”

Six key “lines of enquiry” may help with exploring and clarifying the typical day:

- **Who**
- **What**
- **When**
- **Where**
- **How**
- **Why**

Points to consider when taking a typical day history:

- Following a chronological structure will ensure all parts of the day and night are considered.
- Remember at this time you may have to consider the typical day before lock down measures were in place and what their day now looks like. For example, it is important to identify whether a lack of activity is simply down to the lock down measures or whether the lack of activity is a result of deterioration in the condition.
- A chronological structure will also cover the activities of daily living such as washing, dressing, eating, drinking.
- The typical day needs to clarify the duration, frequency, location of activity, range of activities, limitations and any use of aids and appliances.
- The use of aids and appliances needs to be explored, including information on who advised them, source, problems using them, or reason why if not using an advised aid/appliance.
- The typical day needs to expand on and address any variability reported. Variability must be addressed in detail whether several times a day, diurnal, weekly, monthly etc.

Some mental health conditions are known to have significant variability in the intensity and nature of disabling symptoms; for example bipolar disorder and psychotic illness.

- The ability to reliably repeat an activity in a reasonable time frame and the ability to do an activity safely needs to be considered.
- When considering any activity exploration should clarify the duration, frequency, location of activity, any aids used, any limitations such as pain, etc.

For example, if there are problems with mobility, the discussion must not only cover where they go and how often but also the manner of mobilising (walking, wheelchair, crutches etc), distance covered, speed and time taken, halts, rest periods and use of mobility aids.

Enough detail is required to justify your advice. For instance, it is not sufficient to state, "Goes out for walks occasionally". Is there a reason they can only manage this occasionally? How frequent is 'occasionally'? How long do they manage to walk for? Do they use any aids/appliances? These questions may well open up fertile areas for further exploration.

Similarly in Mental Function, if there are problems with going out the house due to anxiety or paranoia, the discussion must not only cover where they go and how often but also whether they go alone, who do they go with, what would happen if they had to get to an urgent appointment, etc.

- It is essential that fatigue is explored, including degree of fatigue and consequences of pushing oneself. Other symptoms such as pain and breathlessness that may be the main factor in limiting their ability to mobilise or may compound the problem.

Fatigue may be the prominent feature of certain conditions such as chronic fatigue syndrome or fibromyalgia, however fatigue can also play an important part in many other conditions.

For example, if a claimant with chronic fatigue syndrome is able to walk 10 minutes at a slow pace to the local shops once a week but he/she is very tired on returning home; exploration needs to cover how they manage after. He/she may be unable to unpack the shopping or do any other activities for the remainder of the afternoon and may have significant fatigue on the days following the activity.

- Explore and clearly document specific examples of incidents or events, especially involving accidents and falls and any preventative actions taken.

For example, someone may have had kitchen accidents and therefore no longer makes main meals due to significant problems with grip affecting their ability to lift items such as pots. The claimant may have also had accidents with a regular sized kettle and had to switch to a travel kettle or use a kettle tipper due to lifting difficulties.

For example, someone may have reported having a fall on the stairs. Further exploration may ascertain this is not a frequent occurrence and had occurred while visiting a friend's residence where there was no rail. However, at home where there are rails, the claimant is able to manage reliably.

Enough detail is required to justify your advice. For instance, it is not sufficient to state, "Goes out for walks occasionally". Is there a reason they can only manage this occasionally? How frequent is 'occasionally'? Do they have problems with lack of motivation, anxiety, or any other issues? These questions may well open up fertile areas for further exploration.

In Mental Function, someone may have had kitchen accidents and therefore no longer makes meals due to significant problems with concentration. Do they remember not to cook, do they have to leave

a message to remind them not to cook or do they completely forget and keep cooking resulting in more accidents?

- If someone has stopped an activity, it is not sufficient to simply state “no longer cooks meals”. This does not provide enough information to robustly justify your advice on function. For example, a person may choose not to cook due to motivation problems, domestic circumstances, cognitive issues, or a number of different physical restrictions.
- Sufficient detail needs to be obtained to avoid making inaccurate inferences about the claimant’s functional ability.

For example, if a claimant states that “the cat eats tinned cat food” and the information is used to support advice on manual dexterity, you must ensure you are clear on the details; Does the claimant open the can? Do they have any difficulty? Do they use any aids? Does someone else feed the cat? etc.

Or, if a claimant states that “I have no problems shopping” and the information is used to support advice on going out, you must ensure you are clear on the details. Does the claimant go alone? Do they have any difficulty? Why do they have difficulty? How often do they do this? How do they travel to the shops? What type of shops do they go to? Do they shop online? etc.

- Terms such as ‘some’, ‘often’, ‘occasionally’, ‘sometimes’, ‘frequently’ and ‘mostly’ should be avoided. Instead, reference should be made to the actual frequency of occurrence where this can be elicited.

For example, “occasionally manages the stairs at home” tells you very little. However “goes up and down the stairs 4 times a day, holding on the rail, one step at a time” gives a much better indication of the ability of that individual to use the stairs and walk on a daily basis. You should clarify whether the claimant is actually walking up/down the stairs and not using a stair lift or lift.

- Phrases such as “walks to the shop” should be avoided. Instead, distance/timing must also be recorded and any need for halts, length of halt and ability to continue or repeat the activity.

For example, “He manages to walk for 3 minutes at a slow pace to the shops on a normal day. On a bad day, about twice a month, where the pain is more significant, he can only mobilise within the house as pain in his knees prevents him walking greater distances. He uses a walking stick when out but holds on to the furniture indoors.”

- The information obtained from the claimant must be documented as accurately as possible, and extreme care must be taken not to misinterpret or misrepresent what is said by the claimant.
- When documenting the typical day, spelling and grammar must be of a standard that the intent of the message is clear and keeping in mind that what is required is a professional report.
- Concise, spaced paragraphs make it easier to read the report and identify the important details used to justify your opinion on the claimant's function.
- Enquiry into the typical day should be performed in a sensitive manner, probing and exploring activities as necessary, while avoiding irrelevant or third party information. The most effective way to obtain a typical day is to start with open questions and then use more closed questions to obtain further detail and clarification.
- During the typical day it may also become apparent that the claimant has a thought disorder or lacks insight. This needs to be carefully explored and documented to include the effect this has on function.
- Some mental health symptoms are associated with distress. Enquiry into the typical day should be done in a sensitive manner, probing and exploring activities as necessary, while avoiding irrelevant or third party information, and not be so intrusive as to cause distress.

4. Specific Clinical Considerations for Telephone Assessments

This section contains information that you may find useful to assist you adapting your approach from face to face WCA to the telephone assessment process.

4.1 General Issues

Refer to section 1 of this document for details on specific processes such as POID and UE1 etc. to be followed.

All advice must be given “on the balance of probability”. This puts a significant emphasis on evidence gathering through the clinical history and any other evidence available, logical reasoning and clear justification addressing any possible inconsistencies such as lack of input in the current circumstances.

4.1.1 Claimant Groups who are not suitable for a telephone consultation

During the Filework Process, the HCP will screen out cases who meet the below criteria, however; this list is not exhaustive and you as the HCP must use your clinical judgement based upon information held, as to the appropriateness of a telephone consultation. You should have a low threshold for discussion with colleagues.

- Claimants who refuse to participate in a telephone consultation
- Claimants without a phone
- Request for a recorded assessment
- Claimants requiring BSL Interpreters
- Claimants with hearing difficulties unable to use a phone
- Claimants with speech difficulties
- Mental health problems with impaired insight
- LD (only appointee should be contacted) – if no appointee- no contact with claimant. Exception - Where the only learning disability listed is Dyslexia and / or Dyscalculia a telephone assessment can be carried out.

4.1.2 Neurological Conditions and Practitioner Type

HCPs will continue to only assess conditions they are trained to assess in the current guidelines, i.e. Non neuro, Peripheral neuro or complex

neuro. Although there will be no physical examination performed in telephone assessments, the restrictions on conditions the HCP is trained to assess still stand. Where a condition is identified that requires a complex neuro HCP, this case will have to be transferred to a complex neuro trained HCP, **unless LCWRA advice can be provided for a non neurological condition present (See section 2).**

4.1.3 Clinical Support

It is acknowledged that telephone consultations can be challenging without all the normal evidence available such as observations and examination findings. If you are unsure about the possibility of claimants understating problems due to lack of insight etc, or are struggling to address inconsistency in the history to provide well justified advice, you can discuss the case with a senior clinician locally or CAL. For Safeguarding issues, please follow the safeguarding policy.

4.2 LiMA Considerations

LiMA does mandate certain sections in the report.

If there are areas of the report you cannot complete, you should use free text – such as “Examination not completed as COVID telephone assessment”. The use of free text should then allow the screens to move on.

HCPs must be careful with recording observations and read the wording from LiMA to ensure what is recorded reflects the telephone setting. For example if noted to be breathless on talking, free text may be required as the LiMA wording may imply “seen” rather than “heard”.

So before submitting a report – you must check any standard LiMA phrases are accurate to the report.

4.3 Prognosis or re-referral advice

Although we give advice on the balance of probability, in most cases the normal full body of evidence will not be available (observations, examination findings, further evidence) and therefore a 6 month prognosis should be given in cases where evidence is felt to be lacking. If however; there is **strong evidence that a longer prognosis should apply**, for example, previous report confirmed a chronic deteriorating condition and all evidence gathered in the telephone assessment continue to suggest ongoing deterioration, prognosis advice should be given in line with the evidence. This applies to conditions that have not improved as well as those that have deteriorated.

4.4 Further Evidence on the Day of Assessment

There will be times where the claimant has additional evidence that was not available at the time of questionnaire submission. In this case, you should ask the claimant to read out the information (for example a recent hospital letter). If the claimant has literacy problems and is unable to read this to you, you could ask if there is another person available in the household that the claimant is willing to share the contents of the letter with who could read this to you. If this is not possible, you should note in the report that the claimant was unable to read FME and has been advised to get a copy of this sent to the DWP.

4.5 Lower Limb Activities

The following information should provide you with brief prompts and issues to consider specifically during a telephone interview.

4.5.1 Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or used – Activity 1

LCWRA Criteria:

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be, worn or 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*

4.5.1.1 Overview

This activity mainly refers to lower limb function, however consideration of upper limb function / cardiorespiratory function / fatigue / exercise and effort tolerance / balance problems is important to determine ability to perform activity reliably, repeatedly and safely, in a reasonable time, and ability to use appropriate aids and appliances.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria

Remember that normal visual clues that may prompt discussion on issues such as fatigue through appearance or low BMI will not be present so it is imperative you carefully enquire about these issues.

Walking speed reminder

- Normal: 61-90m/min
- Slow: 40-60 m/min
- Very slow less than 40m/min

Self-propelling manual wheelchair - estimated speed of 0.5 metres per second (considered relatively slow) – can cover 50 metres in 100 seconds
Wb refers to ability to mount or descend 2 steps

4.5.1.2 Areas to consider in history taking:

- ☐ General considerations of condition history and typical day history

Clarification is required for any issues mentioned by claimant to determine whether this is a longstanding issue, whether it is related to their medical condition, or whether the issue relates to current restrictions (for example need for self isolation, stay at home advice, etc.)

How far or how long can the person walk / mobilise?

Is the claimant going to the shops – small local shop, supermarket, etc. – if yes, how long / how far do they manage to mobilise for?

Is the claimant going out for some exercise - if yes, how long / how far do they manage to mobilise for?

What stops them going further? Ask about pain, breathlessness, weakness, fatigue, etc.

Any halts? Reason for this, how long do they need to rest for, how far can they walk / mobilise after halt

Ask claimant to describe their pace of walking – slow, normal, fast – you may have to ask them to compare their pace with family/friend's as you will not have the opportunity to see their actual pace

Ask claimant to describe their gait if having problems with mobility – any falls, any specific reason for falls, unsteady, limping, etc. You may have to assist with prompts such as trips, stumbles, shakiness etc.

Use of aids or appliances – type, prescribed or not, if not using any check reason why, any difficulty in using aids or appliances, do they help?

Use of any braces, prosthesis, orthotics, etc. – how do these help the claimant

Type of house, any steps or stairs, how do they manage these – e.g. one step at a time, rails, stair lift, etc.

Do they mobilise in garden or yard, if these are available? How long or how far?

Any activities around the house or outdoors – housework, regular activities performed outdoors, hobbies, etc.

Do they drive, do they have an adapted car, can they normally travel on public transport? Can they normally walk to the bus stop, tram, tube, etc? How far is this or how long does it take them?

Remember, at this time, normal activity has been restricted, so you will have to ensure you cover what an average typical day represents rather than restrict this to the period of UK Government isolation and social distancing measures.

☐ Musculoskeletal / neurological problems

Without information obtained from direct observations and physical examination, you may have to ask the claimant to describe their symptoms or problems in more detail

This may include asking the claimant to describe any deformity in limbs, stiffness or reduction in movement, any weakness, spasms or contractures, joint swelling, redness over joints, scars, lower limb swelling, difference in size of limbs (muscle wasting, shortening of limbs, etc.), amputations, involuntary movements, etc.

Remember both upper and lower limbs

For example – describe to me where you feel the pain in your leg, can you describe how your knee looks or feels, how far can you bend and straighten your elbow, what happens if you bend your knee fully, can you make a full fist with either hand, etc.

Example: Generalised arthritis. On regular analgesia. Had right knee replacement 2 years ago, now waiting for left knee replacement (no date for surgery yet). Right knee no longer painful since surgery but still has residual stiffness – cannot bend it more than a right angle, although can straighten it fully. Left knee constantly painful, cannot straighten it fully and cannot even make a right angle when bending it, knee is swollen and tender to touch. It looks twice the size of the right knee. Also has problems with most finger joints – index, middle fingers on left hand; and middle and ring fingers on right hand – joints of fingers themselves are swollen and cannot bend fingers fully to make a fist. Problem with right elbow – constant pain and stillness, cannot bend and straighten elbow fully without pain, movements restricted to half of what able to complete with left elbow.

☐ Cardiorespiratory problems

Ask about any breathlessness at rest, on talking, on mobility, on dressing / washing, on performing housework, etc.

Are they managing to give a good history over the phone or do they need to stop to catch their breath?

Do they have any other symptoms – chest pain, cough, fainting, wheeze, etc?

Any recent results from blood pressure measurements or peak flow measurements done at home or at GP surgery, etc that they could read out to you?

Any lower limb swelling, discoloration in lower limbs, etc?

☐ Chronic fatigue / fibromyalgia / chronic pain / etc. – full exploration of any variability required

How long can the claimant perform an activity for?

How often / how soon can they repeat an activity?

How long do they need to rest after an activity?

Remember that a person living with chronic pain or chronic conditions may have associated mental health problems and you may wish to refer to sections on mental health to ensure full exploration of all problems present

4.5.2 Standing and sitting - Activity 2

Sa – refers to ability to transfer between adjacent seated positions – this reflects trunk, upper and lower limb function

Sb and Sc – refer to the ability to sit and/or stand, alone or in combination. While standing, one hand has to be free to perform an effective work function

LCWRA Criteria:

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

4.5.2.1 Areas to consider in history taking:

- ☐ General considerations of condition history and typical day history

Ability to get up or move from bed or chair – can they do this independently, do they use any aids or need help from others, what type of aids are required (transfer board, rails, hoist, etc.) How do they manage if others are not around to help?

Ability to toilet independently

Ability to get in/out of car / public transport

Remember you will have no visual clues to see potential difficulties with transferring, so make sure this is clearly explored to ensure LCWRA is covered well for this area.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria

How long can the person sit for – meals, watching television, reading, hobbies, leisure activities, socialising, etc.

Does the person need to stand up and move about after being seated, or need to lie down – after how long do they need to do this, and how often do they need to do this?

How long can the person stand for before having to sit or lie down – consider activities such as standing in shower, queues, kitchen tasks, other household activities, hobbies, leisure activities etc. Do not assume, ask whether the person sits or stands to perform an activity.

Use of any aids and appliances – prescribed or not, do they help, if not used why?

Any problems with balance, coordination falls, etc.? Remember you will not have the normal visual clues – ask the person to describe these to you as much as they can.

☐ Musculoskeletal / neurological problems

Please refer to information in mobilising section – you may need to ask the claimant to describe their symptoms, joints, etc. in more detail

Can they sit for the duration of the telephone assessment?

Remember upper and lower limbs

For example: back pain, no neurological symptoms, unable to sit for more than 45 minutes without having to move and stretch, no need to get up and move about or to lie down. No upper limb problems. Tired after standing more than 15 minutes and has to sit down. No need to lie down or move about.

☐ Pressure sores

May need to ask about change of dressings if relevant, any specific management, how frequently they need to change posture, use of specific mattress / cushions / etc.

☐ Abdominal / pelvic problems

Any surgery, other treatment

Description of type and site of pain or other symptoms

Relieving or exacerbating factors

You may need to explore any other symptoms – e.g. problems with continence

4.6 Upper Limb

The following information should provide you with brief prompts and issues to consider specifically during a telephone interview.

4.6.1 Reaching – Activity 3

LCWRA Criteria

Reaching

Cannot raise either arm as if to put something in the top pocket of a coat or

jacket

Remember this activity area reflects a bilateral problem and relates to shoulder function and/or elbow function. (WCA Handbook)

Reduced function in the activity may be encountered in a number of musculoskeletal conditions including: frozen shoulder; arthritis; cervical spondylosis; impingement syndrome; rotator cuff tears; instability and dislocations etc.

In addition to the usual areas to explore in the condition history, further descriptive details about the symptoms and effect on activities would help build an overall picture of how function is affected.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria.

Ask to describe how far they are able to reach (remember to cover the left side and the right side)

Ask the person to describe what happens – describe any pain, how reaching activities affect this For example:

- Describes they can only reach up to shoulder level with the right arm, if they go further the pain gets worse and have to stop.
- Describes frequent problems with the shoulder popping out of the joint when they reach upwards or outwards with the left arm. This is especially worse if reaching above shoulder level. (Consistent with dislocation) This may occur about 4 -5 times a month. Able to put back in place most times but has to visit A+E about once every 2 months if unable to put back into place. The right arm is OK and they are able to reach for things without pain.

This should then be supplemented with careful exploration of the activities of daily living. Ask for a clear description how the claimant manages any of the activities. Remember some of the activities of daily living to explore (as per WCA Handbook):

- Dressing and undressing (including reaching for clothes on shelves/in wardrobes)
- Hair washing and brushing
- Shaving
- Household activities such as reaching up to shelves; putting

shopping away at home; household chores such as dusting;
hanging laundry on a washing line

- Leisure activities such as aerobics, golf, painting and decorating

Remember to clarify what level of reaching; for example: unable to reach to the top shelves as these are above head height.

4.6.2 Picking up and moving or transferring by use of the upper body and arms – Activity 4

LCWRA Criteria:

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 a 0.5 litre carton full of liquid

Remember this activity relates mainly to upper limb power; however joint movement, sensory loss and co-ordination may also have to be considered. It is intended to reflect the ability to pick up and transfer articles at waist level. (WCA Handbook)

The ability to carry out these functions should be considered with the use of any prosthesis, aid or appliance.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria

Reduced function in the activity may be encountered in a number of musculoskeletal and neurological conditions including: arthritis; cervical spondylosis; traumatic injuries to the arm/forearm etc. Also remember neurological conditions affecting coordination and sensation may also have an impact on safety and reliability.

Make sure exploration covers if it is a unilateral or bilateral problem. Pain may be in one particular joint or more generalised in the limb. Ask the person to describe in some detail their symptoms. Ask them to describe any weakness in as much detail as possible. If required, ask them to describe any other neurological features such as poor coordination (may describe as clumsiness, tendency to drop things), tremor (shaking and can't pick things up) or loss of sensation etc.

For example:

- Currently having a flare up of rheumatoid arthritis. Describes pain and swelling in hands, wrists and forearms most days. They use wrist splints prescribed by the OT. Fingers swollen at the joints – describes knuckles swollen and the finger joints warm with the ones below the knuckles are swollen big and round. (This is consistent with proximal interphalangeal joint swelling in rheumatoid arthritis). They also describe trigger finger with the finger flexed in position and suddenly snapping back into place. The wrist is also warm too touch and hurts when moving. Unable to open bottles and jars even with the aids provided by OT. Manages to lift light items like the tea cup and a small pint bottle of milk but daughter leaves the cap off. Describes having to use the speaker phone to take call now as unable to hold the handset for long.
- Previous arm fracture and elbow dislocation (left) with nerve damage. Describes loss of strength in the left forearm since accident. Describes muscle wasting – forearm very small in size compared to the right forearm. Describes the fingers are like a claw as unable to form a fist or move fingers freely. Not much feeling in the in the left hand. In addition unable to straighten elbow out. No problems with the right arm.

This should then be supplemented with careful exploration of the activities of daily living. Ask for a clear description how the claimant manages any of the activities. Remember some of the activities of daily living to explore (as per WCA Handbook):

- Cooking (lifting and carrying saucepans, crockery)
- Shopping (lifting goods out of shopping trolley or from the supermarket shelves)
- Dealing with laundry/carrying the laundry
- Lifting a pillow
- Making tea and coffee
- Removing a pizza from the oven/ carrying a pizza box

4.6.3 Manual Dexterity – Activity 5

LCWRA Criteria:

Manual dexterity

Cannot either:

- (i) *press a button, such as a telephone keypad or;*
- (ii) *turn the pages of a book with either hand*

This activity relates to hand and wrist function. It is intended to reflect the level of ability to manipulate objects that a person would need in order to carry out work-related tasks. (WCA Handbook)

Remember to explore if any restriction is unilateral or bilateral. In the context of WCA if they can manage the activity with one hand then significant disability is unlikely. This applies to all the descriptors including use of a keyboard or mouse.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria

Reduced function in the activity may be encountered in a number of musculoskeletal and neurological conditions including: arthritis; cervical spondylosis; traumatic injuries to the arm/forearm, multiple sclerosis etc. Again it is important to describe any painful restriction in the wrist of hand joints, any loss of sensation, weakness, and coordination difficulties. For example:

- Bilateral Carpal Tunnel Syndrome. Describes weakness in both hands and difficulty making a fist to grip or pick up items like coins. Also finds it difficult they hold the hand in certain positions. Clarified, this may occur if tries to type on the key board or open jars with the right hand. Gets shooting pains in the hand and wrist and as a result. This is worse on the right despite having surgery on both sides. Left hand not affected as much, but still feels this is not up to full strength, but able to grip things better compared to the right. Feeling on the fingers on the left also better than those on the right. Describes loss of sensation to touch on the right. Clarified this is the thumb, index and middle finger mainly. Never regained any sensation despite the operation and physiotherapy; was re-referred to the hospital specialist but the appointment was cancelled last week. The right palm is also smaller than the left palm especially the between the wrist and base of the thumb. (Consistent with muscle wasting and loss of sensation that may occur in carpal tunnel syndrome.)

This should then be supplemented with careful exploration of the activities of daily living. Ask for a clear description how the claimant manages any of the activities. Remember some of the activities of daily living to explore (as per WCA Handbook):

- Filling in forms (e.g. ESA50/UC50, national lottery ticket)
- Use of phones, mobile phones, setting house alarms, light switches
- Paying for things with either cards or cash (Carefully clarify if able to manage contactless payments? Enter PIN? Pick up coins - using pincer grip or has to scoop coin up by pushing off the edge of counter etc?)
- Coping with buttons, zips, and hooks on clothing
- Cooking (opening jars and bottles; washing and peeling vegetables)
- Leisure activities such as reading books and newspapers; doing crosswords; knitting; Do-It-Yourself jobs
- Driving, including manipulating the fuel cap to refuel a car, using keys to open locks etc.
- Cooking (lifting and carrying saucepans, crockery)

4.7 Sensory Activities

Below are some key points to consider in terms of telephone assessments.

Remember claimants identified during Filework with significant hearing or speech difficulties would normally be excluded from telephone assessments.

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria

LCWRA Criteria:

Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person

Cannot convey a simple message, such as the presence of a hazard

Understanding Communication by

- i) **verbal means (such as hearing or lip reading) alone, or**
- ii) **non-verbal means (such as reading 16 point print or Braille) alone, or**

- iii) **any combination of (i) and (ii), using any aid that is normally, or could reasonably be, used, unaided by another person**

Cannot understand a simple message due to sensory impairment, such as the location of a fire escape

4.7.1 Overview of key points of the activity areas

Activity 6: Making self understood through speaking, writing, typing, or other means which are normally, or could reasonably be, used, unaided by another person

- All forms of communication – speaking, writing, typing or other normally used form which is unaided
- Ability to convey simple message
- Covers physical reasons unable to communicate
- Use of aids – technological assistance, tactile communication

Activity 7: Understanding communication by:

i) verbal means (such as hearing or lip reading) alone,

ii) non-verbal means (such as reading 16 point print or Braille) alone, or

iii) a combination of i) and ii),

using any aid that is normally, or could reasonably be, used, unaided by another person

- Ability to understand a simple message
- Use of verbal or non verbal means
- Verbal – hearing or lip reading
- Non verbal – reading 16 point print or Braille
- Use of aids – hearing aids, head phones, hearing loops, amplifiers for TV / radio / door bell, hearing dogs, interpreters

Activity 8: Navigation and maintaining safety, using a guide dog or other aid if either is or both are normally, or could reasonably be, used

- Descriptor considers the ability of an individual to get safely around familiar and unfamiliar locations
- Duration and speed of visual loss is likely to impact on a person's ability to adapt.
- Does the claimant report having a certificate of visual impairment
- Use of aids – glasses, magnifying glasses, hearing books, white or red/white sticks, guide dog

Remember – claimants with speech and/or hearing problems are normally excluded from telephone assessments. If during an assessment it comes clear that the claimant has a speech or hearing problem, termination of the assessment should be discussed with your CSL or QAL.

4.7.2 Areas to consider exploring

Remember, you will not be able to check distance or near visual acuity by telephone, so your history must be detailed to try to establish the extent of the visual problem. Also remember you will not be able to observe how a person navigates to suggest significant visual field restriction.

- Who completed the questionnaire and why it was not completed by the claimant if completed by another person (For example was the writing on the form too small?)
- Aids – what do they use, are they helpful? Any aids they are not able to use and why? If using aids such as a magnifying glass, how much or how long can they read with this.
- Do they use sign language, Braille or assisted technology? If not why not – have they ever considered it?
- Do they have a CVI? Can they or a companion provide details of any acuity/visual field deficit recorded there?
- Ability to move around indoors – do they trip over things, has the house been adapted. Do they bump into doorways they cannot see to the side of them?
- Ability to self administer medication – taking correct medication, reading dose, taking small tablets, adjusting dose of medication such as insulin
- Ability to drive

- Ability to care for others / pets
- Ability to use public transport (in normal circumstances) – identify public transport vehicles, read bus numbers / information boards / timetables, use ticket machines, ask for ticket, listen for announcements, give destination
- Ability to go out alone - making their way on the street, cross the road safely, navigate around obstacles / people / kerbs
- Socialising with family, friends, neighbours (Under normal circumstances)
- Social events – ability to order at a bar / restaurant, read menu, order a take away
- Hobbies - reading, television, art work, craft work, sports. If reading – do they know what text size is used on phone/kindle/tablet etc

RNIB guidance indicates the following

“The size of a font is described in point size. Large print is generally 16 to 18 point size. Giant print is anything larger than this. Regular print is usually 10 or 12 point”¹.

This may provide some guidance into likely visual abilities along with other evidence.

- Ability to cook meals / prepare hot drinks – peeling and chopping vegetables, using hot pans, reading recipes, reading labels on food items, checking cooker dials, pouring hot liquids
- Any falls or accidents in the house or outdoors
- Shopping – write a list, getting there, getting correct items, asking for items, use of money or cards
- Ability to use a telephone / computer / deal with correspondence / read or use Braille fluently

4.7.3 Some conditions to consider

Glaucoma / cataracts

Retinopathy generally causes problems with peripheral vision before central visual loss. When exploring peripheral vision consider:

¹ <https://www.rnib.org.uk/information-everyday-living-reading/large-and-giant-print>. Accessed on-line 7/4/2020

- Do you cross the road yourself? Where do you cross? Do you have any difficulty? Describe how you look for traffic
- If someone walks up to you from the side, can you see them coming?

Traumatic Brain injury (complex neuro)

Traumatic brain injury can affect the speech, understanding and visual areas of the brain (Mental health conditions may also be part of a traumatic brain injury and will need to be considered in addition). For sensory impairment consider:

- Does the claimant have difficulty forming the words, finding the correct word to say or giving inconsistent responses
- Do they report any visual disturbance, ask them to explain where it is and what vision appears like in that area

4.8 Continence

Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bedwetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used – Activity 9

LCWRA Criteria:

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

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria.

4.8.1 General Points

- Problems with incontinence to be taken into account only whilst the person is conscious / awake.
- Risk of incontinence – has to be high for majority of the time
- Mobility issues may be taken into account, but only when there is a bladder / bowel problem, not simply the mobility problem alone
- Sensitive and careful exploration is required

- Clarification is required for any issues mentioned by claimant to determine whether this is a longstanding issue, whether it is related to their medical condition, or whether the issue relates to current restrictions (for example need for self isolation, stay at home advice, etc.)

4.8.2 Areas to consider in history taking:

Remember that no examination is performed for continence so as in face to face assessments, a detailed history is paramount.

Duration – How long has it been present for? Has it been present for a few months, a few years, several years?

A specific time frame should be provided where possible, e.g. 6 months, 3 years, 10 years, etc.

Progress – Is it remaining the same, getting better, getting worse?

Was there a specific cause such as an injury, surgery, infection, inflammatory bowel disease, or did it develop gradually?

Are there any aggravating or relieving factors?

How often is it happening?

Does it happen only at specific times? - For example during the night only, during a seizure, following intake of specific food/drink, indoors or when out, etc.

How severe is the incontinence? – Dribbling of urine, slight loss on coughing or sneezing, full voiding, slight soiling, more extensive loss of faeces?

Do they use any aids and appliances? – Pads, continence pants, catheters, mattress protectors, other continence products, stoma and bag, etc. Do the aids or appliances control the loss? Where do they get these from? – Shop, District Nurse, Continence Specialist? If not using any, why?

Do they have to change their clothing because of the incontinence and if yes, how often?

Have they spoken to their GP about this?

Have they been given a formal diagnosis?

Have they had any investigations – urine/blood tests, ultrasound, endoscopy, urodynamic tests, MRI, etc.? Do they know the results of the investigations?

Have they been referred for any specialist advice?

Have they had any treatment – medication, advice on lifestyle changes, pelvic floor exercises, bladder training, self-catheterisation, specialist dietary advice, biofeedback, electrical stimulation, surgery? If yes, what has been the effect of the treatment – has it helped?

If on medication – what type of medication are they on, at what dosage, do they have any side effects from the medication?

Have they required any hospital inpatient or outpatient treatment?

Do they have any specialist / hospital letters and are they willing to share the details of these?

Do they have any other symptoms – pain, recurrent infections, constipation alternating with diarrhoea, pain, rectal bleeding, fatigue, skin problems due to incontinence or any aids/appliances in use, etc.?

How does the condition or the symptoms affect day to day function? – Any problems with going out, shopping, housework, socialising, travelling, etc.

Does it vary? – Within the day, good and bad days/weeks/months, what makes it better or worse?

4.9 Consciousness during Waking Moments

4.9.1 General Points

This function covers any involuntary loss or alteration of consciousness resulting in significantly disrupted awareness or concentration occurring during the hours when the claimant is normally awake and which prevents the claimant from safely continuing with any activity.

Such events occurring when the claimant is normally asleep should not be taken into consideration.

The descriptors relate to the frequency with which such episodes of lost or altered consciousness occur. (WCA Handbook)

Different types of epilepsy may be present such as absence seizures, generalised tonic-clonic seizures or partial seizures. In addition, consciousness can be lost or altered by several medical conditions, for example: hypoglycaemia, cardiac arrhythmias, syncope, non-epileptic attack disorder (dissociative seizure), narcolepsy.

4.9.2 History – Key points

As per a face to face WCA, the clinical history is very important area where the majority of the evidence to inform the advice is obtained. Below are some key reminders.

In addition to establishing how long the problem was present it is useful to clarify the following in some detail:

- Is there a specific cause or trigger for the episode of lost/altered consciousness? – seizure, severe hypoglycaemia, cardiac arrhythmia
- Are there any aggravating or relieving factors?
- Do they have any warning signs / aura?
- What happens during a seizure/loss or altered consciousness? Any awareness of surroundings during or after? Are they shaking/incontinent/bite tongue? Do they fall?
- How often are they happening? How long do they last for? Do they have a seizure diary? Dates of last seizures etc. Could they read this out to you?
- If altered consciousness, do they require help from another person during the episode?
- What happens after a seizure/episode of loss or altered consciousness? – Are they able to carry on with their activities, do they feel drowsy or confused, do they get any other symptoms? How long are they impaired after?
- Have they had any injuries as a result of a seizure/loss or altered consciousness?
- Have they spoken to their GP about the episodes of loss or altered consciousness?
- Have they been given a formal diagnosis?
- Have they had any investigations – blood tests, MRI, EEG, etc? Do they know the results of the investigations?
- Have they been referred for any specialist advice?
- Have they had any treatment – medication, special diets, use of special devices (such as vagus nerve stimulator), surgery? If yes, what has been the effect of the treatment – has it helped?

- If on medication – what type of medication are they on, at what dosage, do they have any side effects from the medication?
- Have they required any hospital inpatient or outpatient treatment?
- If any recent hospital /clinic letters ask for if willing to share (read out) and record details
- How does the condition affect day to day function? – Any problems washing, cooking, going out alone, participating in any hobbies or sports, caring responsibilities, etc
- Do they wear any medical alert jewellery or cards?
- Have they been advised not to drive or work at heights / close to machinery / etc?

Remember all the best practice points about telephone interviews. Prolonged pauses or periods of silence may occur if the claimant is having an absence seizure. Check on welfare and make sure OK. If the claimant has full loss of consciousness, then more urgent action may be necessary especially if there is no one at the residence with the claimant. A more thorough welfare check should be performed. Also use the unexpected findings process as appropriate.

4.10 Mental Function

Remember the history must be adequately detailed to differentiate between LCW/LCWRA criteria.

When obtaining a history, be mindful of the lack of non verbal clues and information. Carefully consider whether a person may be overstating their abilities and take this into account when evaluating all the evidence. Also remember lack of insight and cognitive issues. For example a person in a face to face assessment may state they wash and dress wearing clean clothes every day; however you may observe evidence of poor self care. Remember if possible to use information from a companion if present.

Key points for Mental Function Activity Areas

Below is a reminder of some key aspects of the activity areas. For further detail, refer to the WCA Handbook.

Activity 11 – learning tasks

- Completion of a simple, moderate or complex task
- Learn and retain information
- Consider how long taken to learn a task

LCWRA Criteria:

Learning tasks

Cannot learn how to complete a simple task, such as setting an alarm clock

Activity 12 – Awareness of every day hazards (such as boiling water or sharp objects)

- Ability to recognise the risk from common hazards
- Reflects lack of understanding and insight to danger
- Consider the level of supervision to maintain safety of individual (what is needed rather than available)

LCWRA Criteria

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*

Activity 13 - Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks)

- Initiate and successfully complete action without need for prompting
- Habitual activities not considered (e.g. brushing teeth)
- Action must be effective and purposeful

LCWRA Criteria

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

Activity 14 - Coping with change

- Change to normal routine
- Inability to cope which significantly alters day to day life

LCWRA Criteria

Coping with change

Cannot cope with any change to the extent that day to day life cannot be managed

Activity 15 – Getting about

- Travel without support from another person
- Means of travel, timekeeping or planning not considered
- Inability to cope which causes anxiety or distress

Activity 16 – coping with social engagement due to cognitive impairment or mental disorder

- Face to face interaction
- Significant lack in confidence or anxiety in social interaction
- Meaningful interaction rather than simple 'yes/no', 'hello'

LCWRA Criteria

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

Activity 17 - Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

- Difficulties in social behaviour

- Needs to be evidence of a disorder of mental function

LCWRA Criteria:

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

4.10.1 Areas to consider exploring in the history:

Remember that non verbal clues will not be possible during a telephone assessment. Mental State examination will also be very limited. You must ensure very sensitive questioning, checking the person is coping, and allowing pauses if becoming upset. You must consider whether the call should be continued or abandoned. If abandoned you must ensure a follow up welfare check or any other action required is instigated. Remember UE1 and safeguarding issues must be considered and processes followed.

Remember appointee status- that the appointment cannot continue even by phone unless the appointee or nominated representative is present.

Before you start the assessment, ask if anyone is present and if not, do they wish a household member to be present. It would be prudent to ascertain if there is another person in the house, even if the claimant does not want them to listen to details of the assessment, in case any interventions are required.

Remember with current social distancing measures, you will have to adapt the history taking to a more “normal typical day” but also explore how and why things have changed in the current climate. (For example, are they just compliant with Government guidelines and choose not to bother getting dressed as unable to go out, or is their mental health condition deteriorating to a point they are unable to cope with getting washed/dressed etc).

Some areas below serve as prompts for areas to explore in the mental function history. To try to assist in ascertaining likely level of disability, you may have to ask the claimant to describe more how it makes them feel when for example meeting strangers, heart racing, sweating as you will not see these clues over the phone the way you might when seeing a person face to face.

- Who completed the questionnaire and why it was not completed by the claimant if completed by another person

- Getting washed and dressed – complete independently, appropriate clothing, dressed in correct order
- Ability to self administer medication – taking correct medication, reading dose, taking small tablets, adjusting dose of medication such as insulin
- Ability to learn new tasks – what, complexity, time span, how often need to be shown and length of recall, repeat the action
- Ability to keep self safe – accidents, injuries, support available
- Complete daily tasks – washing, dressing, food , drinks, reasonable time
- Able to prioritise tasks – do shopping and bills before spending on leisure
- Ability to care for others / children / pets
- Household chores – what are they doing, able to complete, able to prioritise, switch tasks, manage new appliances
- Ability to use public transport –read information boards / timetables, use ticket machines, ask for ticket, listen for announcements, give destination
- Ability to go out alone - cross the road safely, navigate around obstacles / people / kerbs
- Going to chemist, GP, hospital
- Managing appointments and changes to appointments
- Socialising with family, friends, neighbours (In normal circumstances). How do they feel when faced with a stranger? Do they get flushed/sweat, heart racing etc.
- Social events – ability to order at a bar / restaurant, order a take away (in normal circumstances)
- Hobbies - reading, television, art work, craft work, sports
- Ability to cook meals / prepare hot drinks – plan a meal, peeling and chopping vegetables, using hot pans, reading recipes, pouring hot liquids
- Shopping – write a list, getting there, getting correct items, asking for items, use of money or cards
- Managing post, correspondence and bills
- Anger and aggressiveness – any incidents when lost temper, with police,

banned from pubs, shops etc

- Ability to drive

Self harm / suicide history –

- With telephone assessments body language visual cues, for example, verbal nods, facial expression, eye contact are not possible
- Therefore questioning needs to be empathetic and extra thought needs to be considered when asking about self harm and suicidal thoughts
- **Remember during this time, people are living in uncertain times and facing social isolation so this area must be approached with great care.**
- **If a person divulges thoughts, the care of the claimant is paramount and Unexpected Findings Processes/Safeguarding policies must be followed including urgent intervention from other services if required.**

4.10.2 Some scenarios to consider:

Severe depression (personal action)

- Do you need prompting to get washed? Do you have help washing? Who helps you? How often do you need help?
- Do you get your own clothes ready? Are you able to dress yourself?
- How do you feel talking to me? Did someone need to help you get ready for the call? Are they still with you?

Anxiety (difficulties going out)

- Where are you able to go? How often do you go out?
- Are you able to go to a new place? How does it make you feel if you have to go somewhere new? Do you manage to go?
- Do you go out on your own? Who goes with you? What support would you need to go somewhere new?
- How do you feel this conversation is going? Would this be better face to face in the assessment centre?

Psychosis (appropriateness of behaviour)

Remember – those lacking insight would be considered inappropriate for telephone consultation, however; in situations where this was not evident at Filework you may find yourself on a call with a person experiencing psychotic symptoms. Carefully consider whether if this is uncovered during a telephone assessment whether continuing is appropriate. In all cases, ensure only enough information to advise on LCWRA is gathered to minimise the duration of the call thus reducing any stress on the claimant. Always consider whether a UE1 is required or a welfare check.

- Do you worry/feel that people are talking about you? What do they say? Do they ever tell you things to do? What do they tell you?
- Do you go out on your own? Where do you go?
- Do you talk to people? Do you have problems with being around other people? Why is that?
- How do you feel talking on the phone today? Did someone need to help you get ready for the call? Are they still with you?

4.11 Treat as LCW/LCWRA Criteria

4.11.1 Treat as LCW

Not applicable currently

4.11.2 Treat as LCWRA

Again, usually a clinical examination is not necessary, however; remember the loss of visual prompts for issues such as frailty, weight loss etc for areas such as chemotherapy, radiotherapy etc.

You may also wish to review WCA Handbook section 2.3.2 and 3.8.2.

Some specific considerations are detailed below:

Terminal Illness

These claimants should ideally be identified at filework, however; in the current climate there may unfortunately be instances when this situation is identified at telephone assessment. This may be due to restricted GP and hospital clinic resources. There may have been a recent change in condition or new information may have become available in the time between the TI/SR check and preboard check phases at filework.

Questions regarding terminal illness must be asked sensitively and if a claimant confirms they have been given a terminal illness diagnosis then further details regarding this diagnosis should be obtained and documented.

If claimants have access to hospital letters then dictation of relevant information regarding the prognosis can be taken from the claimant. Discussion should include confirming with the claimant whether a DS 1500 has been discussed by specialist or GP; or if they have a DS 1500 but have not yet been able to send the form to the DWP due to current social restrictions and isolation.

Chemotherapy/ Radiotherapy

As described in the WCA Handbook, this LCWRA criterion should be applied where claimants are:

- Likely to receive treatment for cancer within the next 6 months
- Receiving treatment for cancer
- Recovering from treatment for cancer

Claimants may have been awaiting or receiving chemotherapy and/or radiotherapy prior to the current pandemic. This treatment may have been temporarily suspended until hospitals are able to restart the service again. In this situation, it is vital for healthcare practitioners to gather detailed information surrounding the diagnosis and treatment plan. If claimants have access to hospital letters then dictation of relevant information regarding the diagnosis and treatment can be taken from the claimant. Claimants may be unaware of when treatment is to start again and these claimants should still be considered to meet this criterion. Prognosis or re-referral period for these claimants should be medically logical and guided by the current pandemic climate.

Pregnancy Risk

This criterion describes significant problems of pregnancy where there would be a serious risk to the mother or foetus if she were to engage in work related activity. It must be noted that current government advice for self isolation in pregnancy during the pandemic does not itself constitute pregnancy risk.

Evidence regarding pregnancy risk should be gathered in the same fashion as a face to face assessment. If claimants have access to hospital letters then dictation of relevant information regarding the diagnosis and treatment can be taken from the claimant.

Mental/Physical Risk LCWRA

These claimants may have deteriorated since the last assessment during the pandemic due to isolation and lack of family, social and clinical support. They will likely have reduced support from GPs and mental health services meaning they are vulnerable to deterioration. The UE1 process and guidance must be considered and adhered to and HCPs may wish to familiarise themselves with the Unexpected Findings Process Guide which can be found on the online portal.

Healthcare practitioners may identify new claimants where mental/physical risk LCWRA needs to be advised. The history should be sensitively explored in order to gather appropriate evidence, yet care should be taken not to cause distress as effective communication will be reduced during telephone consultations.

During telephone assessments, HCPs must remember that the majority of communication is non-verbal and they will not have mental state examination findings to support their advice.

Eating and drinking

During telephone assessment, further consideration must be given to these claimants, in particular those with mental health issues, such as anorexia or bulimia, who may deteriorate during the current pandemic due to additional stress and lack of family, social and clinical support. A suspension of routine clinics for mental health services may result in these claimants not being identified by specialist services and healthcare practitioners may be the first to identify these claimants. HCPs need to consider whether a UE1 is indicated.

Observation form

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