Training & Development

Industrial Injuries Handbook 1 for Health Care Professionals
The Principles of Assessment

MED-S2/IIDBHB~001(a)

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Foreword

This guidance has been produced as part of a continuous quality improvement programme for Health Care Professionals approved by the Department for Work and Pensions Chief Medical Adviser to carry out medical assessments in Industrial Injuries Disablement Benefits (IIDB).

All Health Care Professionals undertaking medical assessments must be registered Medical Practitioners or Registered Physiotherapists who in addition, will have undergone training in disability assessment medicine and specific training in IIDB. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

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

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

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

Office of the Chief Medical Adviser

5th February 2011
Purpose of this Handbook

The purpose of this Handbook is to act as a guide for Health Care Professionals (HCPs) who advise on claims under the Industrial Injuries Disablement Benefit (IIDB) Scheme.

The Social Security Act 1998 regarding Decision Making and Appeals (DMA) replaced the previous system of medical and lay Adjudicators with a single status Decision Maker (DM). DMA was introduced for Industrial Injuries Disablement Benefit (IIDB) from 5 July 1999. This Handbook provides the HCP with advice about how the various examinations and report forms should be completed to allow the Decision Maker to arrive at transparent and defendable decisions on IIDB.

The intention is that this Handbook with its references to the legislation and Upper Tribunal Judges (previously Commissioners) decisions should provide HCPs with information on the legislation that they must bear in mind when giving advice. However, it is not to be regarded as an authoritative statement of the law with regard to any particular case.

The handbook also provides guidance on practical procedural matters and the functions of HCPs. This document does not provide detailed summaries of the individual Prescribed Diseases. Whilst it does give a general background to basic requirements within prescribed disease reports, for more detailed information the reader is referred to Industrial injuries Handbook 2 - the Prescribed Diseases.

It is hoped that this handbook provides a good all-round source of reference for HCPs as well as providing an indication of what legislation should be consulted in cases of difficulty.
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1. **Part 1 – Introduction**

1.1 **Industrial Injuries**

The Industrial Injuries Scheme provides benefit for disablement arising from industrial accidents and prescribed industrial diseases. It also includes the associated benefits REA, CAA, ESDA and Unemployability Supplement.

1.2 **Prescribed Industrial Diseases**

The duties of HCPs in relation to Prescribed Diseases (PD) claims are in many respects similar to those in relation to accidents, but there are differences and these are explained in Handbook 2 - the Prescribed Diseases. Except where otherwise indicated, references to industrial accidents should be taken to include PDs (other than pneumoconiosis and other respiratory occupational diseases). Information about the respiratory PDs is not contained within this Handbook.

1.3 **Disablement Benefit**

A person has entitlement to disablement benefit if they suffer from a loss of physical or mental faculty resulting from an industrial accident or PD.

Disablement benefit is not payable until a period of 90 days (excluding Sundays) has elapsed. The period starts from the day of the relevant accident or the date from which the loss of faculty first existed in a PD case.

However, payment of benefit will only occur when the extent of the resulting disablement amounts to:

- 14% or more still present on the 91st day after an industrial injury or date of onset for most PDs, or
- 20% or more in the case of occupational deafness, or
- 1% or more in cases of pneumoconiosis or byssinosis. Diffuse mesothelioma, and primary carcinoma of the lung associated with asbestosis or prolonged exposure to asbestos, where diagnosed, are universally deemed to be assessed at 100%

Single assessments of less than 14% do not qualify for payment. However if they can be aggregated with any other assessment, in respect of one or more accidents or PDs over a common period, then payment can be awarded if the total amounts to 14% or more.

Aggregation applies to assessments of 1% and above but in the instance described above, a non-payable assessment is rendered payable by virtue of aggregation. Aggregation does not apply to assessments of less than 1%.
Other factors that apply are:

An assessment of disablement of less than 20% in respect of occupational deafness does not aggregate with any other assessment.

An assessment of disablement in respect of pneumoconiosis, byssinosis or diffuse mesothelioma may be aggregated with other assessments for accidents or diseases. Aggregation only applies to assessments of 1% or above.

### 1.4 Disablement Questions

The disablement questions, on which an HCP gives advice, are:

Whether the accident or PD has resulted in a relevant loss of faculty?

At what degree the extent of disablement resulting from the loss of faculty is to be assessed?

What period is to be taken into account by the assessment?

Where disablement is assessed at less than 14% and the assessment does not aggregate with other assessments to give 14% or more, the assessment must be final—but not necessarily for life. Where the assessment is 14% or more, or if less than 14% aggregates with other assessments to give 14% or more, the assessment can be provisional or final.

The advice that a disablement assessment is to be finalised does not necessarily mean that it must be for life. Finalised assessments can be advised for any period of time which is consistent with the likely prognosis of the injury or disease under consideration.

It can be noted here that not all disablement assessments follow the above rules. In PDs A10, D3, D8 and D8a the rules differ - where there is a successful claim the assessment must be made life final at the initial assessment.

### 1.5 Meaning of Loss of Faculty, Disability and Disablement

These terms are not defined in Social Security legislation but from decisions of the Social Security Upper Tribunal Judges (previously commissioners) and the higher courts. It is reasonable to regard them as having the following interpretations:
Loss of Faculty

Legislation envisages this as resulting from the injury and from which, in turn, there results some disability. It may perhaps be best described as a total or partial loss of power or function of an organ of the body. Loss of faculty includes disfigurement. It is not itself a disability but is a cause, actual or potential, of one or more disabilities.

The Commissioner has said that the question whether a person suffers a loss or reduction of faculty should be judged by comparing the claimant’s condition resulting from the accident with their condition apart from it.

This should be done without reference to the possibility of the consequences of the loss of faculty being mitigated by some artificial aid, such as spectacles - but see under “Disability” below.

Relevant Loss of Faculty

This means the loss of faculty resulting from the relevant injury.

Disability

This means the inability, total or partial, to perform a normal bodily or mental process as well as a person of the same age and sex whose physical and mental condition is normal. The Commissioner has said that the availability of artificial aids should be taken into account in considering whether and for how long loss of faculty would result in a disability.

Disablement

This is the overall effect of the relevant disabilities that is the overall inability to perform the normal activities of life or the loss of health, strength and power and mental activity to enjoy a normal life.

As a result of a decision by a tribunal of Upper Tribunal Judges (previously commissioners), the HCP, and on appeal, the Tribunals Service is asked to specify what constitutes the relevant loss of faculty (see Part 4 Paragraph 4.5) when determining the assessments of disablement.

1.6 Claims made before 1.10.86 with assessments under previous legislation

HCPs will continue to see a small number of cases dating from before 1.10.86 that will be determined under different arrangements. These arrangements apply through to assessment for a final period.

Aggregation does not apply for finally assessed claims for which a gratuity has been paid. Where a pension in lieu (PIL) has been paid, this will be flagged on the Bl8 (the outer jacket of the file). Aggregation may apply in these cases.
1.7 Industrial Injuries Advisory Council (IIAC)

This is a statutory body established by the National Insurance (Industrial Injuries) Act 1946 and provides independent advice to the Secretary of State on matters relating to the Industrial Injuries Disablement Benefit scheme.

The Council meets 4 times annually and its role is defined in the Social Security Administration Act 1992:

To advise on the prescription of diseases.

To advise on matters referred to it by the Secretary of State. Draft proposals concerning the Industrial Injuries Disablement Benefit Scheme made to the Council for consideration and advice.

To advise on any other matter relating to IIDB scheme administration.

The Council is a non-executive body and has no power or authority in individual cases or in the decision making process.
2. The IIDB Approved HCPs' Responsibilities to the Decision Maker

2.1 Providing Advice

Section 2 of this Handbook covers the relationships between the Decision Maker and the Health Care Professional and sets out the scope of the HCPs' role.

HCPs have two areas of responsibility when dealing with any IIDB case. Firstly there is a duty to provide good Customer Service to the Department for Work and Pension Decision Maker. Secondly there is a Professional duty to deal fairly with the claimant and provide an environment where the claim can be fully explored.

An IIDB Approved HCP always acts in an advisory capacity. At no point will a HCP decide entitlement to benefit-this authority rests solely with the DM.

An IIDB Approved HCP can be expected to:

- Provide advice on whether there is a relevant loss of faculty and if so to describe what that is
- Provide advice to the DM on the relevance of any disability to the accident under consideration
  - Advise when a Prescribed Disease can be diagnosed.
  - Advise when a PD is due to the nature of the occupation.
  - Advise the DM on suitable disablement assessment in relation to industrial injuries and also PDs.

Employed and experienced HCPs can be called upon to:

- Provide advice to the DM at the accident consideration stage. That is advice to the DM about whether the incident that has been accepted resulted in a fresh pathological change (which can also be referred to as personal injury) and whether it was related to employment.
- Give medical advice to the DM for Reduced Earnings Allowance claims, or of Industrial Death Benefit. See Part 6 Paragraph 6.5.
- Provide medical advice on claims for Constant Attendance Allowance (CAA), Exceptionally Severe Disablement Allowance (ESDA)
- Give advice in Old Scheme cases, and Unemployability Supplement (US).
2.2 Circumstances when an HCP is disqualified from a Case

An HCP should not consider any case if they:

Are or may be, directly affected by the case, or

Have taken any part in the case:-

 As a healthcare practitioner regularly attending the claimant, or
 To whom any question has been referred for report, or
 As a witness, or
 As an employer.

When, during consideration of a case, an HCP finds that they are disqualified, action on the case should cease and the papers noted accordingly. If another HCP qualified to consider the case is not immediately available, the claimant will have to be referred to another HCP at a later date.

2.3 Professional Standards

Clearly defined Professional Standards apply to all HCPs undertaking work on behalf of the DWP. While there are common issues with general medical professional standards there are additional responsibilities placed on the HCP examining a claimant for benefit purposes.

To ensure that these standards and a high degree of technical competence are achieved and maintained, training, audit and feedback will be provided.

The full details of the Professional Standards expected are set out in Part 7 of this Handbook.

2.4 Completion of the Report Form

The HCP completes a report form to record the claimant’s statement and the HCP's clinical findings. The HCP then gives an opinion on the questions for determination, and details of any assessment given. The various forms are listed in Appendix A.

In the event of an appeal, copies of the report forms will be supplied to the Tribunals Service, and claimant or representative. Copies will also be supplied to the claimant or representative on request at any other time. It is therefore important that the reports, in particular the medical terms, should be legibly written (or typed) in black ink, expressed in clear language and with abbreviations kept to a minimum.
Your opinions are the conclusions based on an exercise of clinical judgement. However, your advice must be based on the evidence available within the report, together with any evidence held on file or provided by the claimant.

It is your responsibility to advise in non-medical terms and give a logical evaluation of the evidence that supports and justifies the advised assessment and period. (See 5.10 Justification of advice)

If you are asked to give advice on multiple claims (often multiple injuries to the same area, or multiple PDs e.g. A11 & A12), the statement must be specific to each case, so that it covers the issues pertaining to that case. If elements of the statement are the same then photocopies of the statement must be placed in each file. Clinical findings need to be relevant to the specifics of the case. If they are the same for both cases, and you prefer not to write them out in full again, photocopies must be placed in each case file. It is not enough to state “See attached file” or “see BI613 for PD XX”

Files can become separated, so it is necessary to ensure copies are on file so that the next practitioner seeing the case has access to the statement and clinical findings. Furthermore, when a case goes to appeal, any attached file may not be copied or attached. Cases may go before a tribunal or even an Upper Tribunal Judge (Commissioner) without medical evidence, merely a reference to another document which is unavailable.

2.5 Circumstance where examination is not possible

Where the claimant is deceased or too ill to be examined, the HCP should give advice on the basis of the available evidence. This evidence may include a statement, for example from a spouse or relative or close acquaintance. FME may also be sought.

When the claimant lives abroad, the HCP gives advice, with the claimant’s consent, on the basis of a report obtained from the local doctor.

2.6 Loan of Hospital Case Notes to HCPs

When a claimant has attended hospital for an accident or PD, the hospital case notes or a précis of them (on form BI127) and any X-rays may, subject to the claimant’s consent, be available to the HCP to assist in the findings.

Hospital case notes must be treated as highly confidential as they are supplied only on a doctor to doctor basis and cannot therefore be made available to claimants or other non-medical persons. Requests for the disclosure of actual case notes (rather than an extract or précis) even if made in accordance with the terms of the Access to Medical Records Act, 1990, will be referred by the DWP to the holder or owner of the records. This procedure avoids difficulties that could otherwise arise, for example, through different views on what constitutes harmful information.
If any relevant information in the case notes seems to be at variance with facts otherwise before the HCP, the claimant’s comments on the apparent discrepancy should be invited and recorded so that they may become part of the documentary evidence.

Where a hospital has provided a précis of hospital case notes on BI127, this becomes part of the documentary evidence before an HCP. Where the original case notes or photocopies of them have been supplied by the hospital, an HCP should extract and record verbatim the relevant clinical and factual information on form BI127A, which then becomes part of the report. The extract made by the HCP must not be in the form of a précis or summary.

Under an agreement (FDL (93) 79) with the National Health Service Executive updated in HSC 1999/001 original case notes are provided subject to their return within 10 days. (In Scotland and Wales the agreements are HDL(2002)32 and WHC(2003)26 respectively.) If the medical examination cannot be arranged within that time, the HCP will be provided with either photocopies of the notes or an extract of relevant notes prepared by another Medical Services HCP.

If both an extract and the case notes are available to the HCP, the HCP should be satisfied that the extracts are sufficient for their determination. If not, the HCP should make further extracts.

### 2.7 Other Medical Evidence available to HCPs

The HCP may have other medical evidence supplied, for example a report from the claimant’s own medical attendant or a consultant report, which has been presented by the claimant or requested by the DWP or a previous HCP or other Medical Services HCP.

If an HCP is unable to give an opinion on the available evidence, the papers should be returned to the appropriate administrative office with details of the further information required. This may be a consultant report, hospital case notes or report from the claimant’s medical attendant where these were not previously obtained. Whenever a consultant report is requested, an HCP should state clearly the type of consultant to be approached and prepare the necessary questions.

The HCP must indicate on the medical report form all the evidence that has been considered including medical reports and extracts or précis of hospital case notes. It is not sufficient to say, for example, “contents on file” or “HCNs”, since this will not make clear to future readers – HCPs, Tribunals and Upper Tribunal Judges (previously known as Commissioners) – what has been considered in reaching the opinion. The Practitioner must list the evidence considered, with dates where relevant, and where HCNs have been obtained, an extract must be completed on form BI127A.

The HCP must draw attention to any conclusions different from those expressed in the evidence considered and must give reasons for the different view. This should all be in terms understandable by the DM, claimant or other lay person.
2.8 Disclosure of Documents

In circumstances detailed in Paragraph 3.4, copies of the HCP’s report, including the evidence considered by the HCP, will be supplied to the Tribunal Service, the claimant or their representative. There are special arrangements for withholding information that would be medically harmful to the claimant (see below).

2.9 Harmful Information

Harmful information is information of which the claimant is unaware and which would be seriously harmful to his health if it were to be disclosed. If an examination, a medical report, the original hospital case notes, an extract of case notes or a précis on form BI127 reveals such information, the facts should be recorded in full and these facts can be taken into account by the HCP. Harmful information should be removed or replaced with innocuous wording in the report and in an extract made of the hospital case notes.

This information should be recorded on a separate sheet, which is suitably headed as Harmful Information. Therefore, in the event of the case papers being circulated, (as in Paragraph 3.12) innocuous wording is used and the harmful information is not disclosed in the copy to the claimant.

A prominent note should be attached to the file drawing attention to the presence of harmful information.

2.10 Embarrassing Information

Information that may be embarrassing to the claimant, a medical attendant or any other person but which is not harmful information (see Paragraph 3.13) cannot be excluded from copies of documents sent to the claimant. Information of this type should not be recorded as evidence unless it is strictly factual, relevant to the claim and essential to the decision. The question of relevance is for the HCP to decide.

2.11 Rehabilitation of Offenders Act

General Background

Under the Rehabilitation of Offenders Act 1974, after the expiry of a rehabilitation period a conviction becomes “spent”. The rehabilitation period varies in length, depending on the sentence imposed; but some sentences can never be spent. Once a conviction becomes spent, the person is treated for a number of purposes as if they had never been convicted of the offence in question.

The intention of the legislation is that, once a conviction becomes spent, any question relating to criminal convictions, such as for job or insurance application forms, can, with certain exceptions, be answered in the negative.
Medical Services

The ROA makes it an offence for anyone with access to criminal records to disclose a spent conviction unless authorised to do so.

Only malicious allegations of spent convictions would carry a risk of legal action for defamation of character, if the claimant could prove that the allegation was made with malice.

Information received by Medical Services

HCPs will from time to time receive information that relates to current or spent criminal convictions, either directly from a claimant during interview or in factual reports from a third party such as a GP. HCPs need to understand the implications of the ROA in order that they can deal appropriately with such information.

If a report submitted to the DWP or MS by a third party makes reference to a criminal conviction, the author will not contravene the ROA unless they have access to the person’s criminal records.

In the case of a factual report from a GP or hospital, this risk would be so unlikely that it can reasonably be disregarded. The information in such a report is likely to have come from the claimant.

HCPs can therefore accept in good faith that reference to criminal convictions in third party reports, without risk of contravening ROA. Such information should, however, be treated like any other potentially embarrassing information, unless mention of the conviction is directly relevant to the benefit claim in question.

Medical Reports provided by HCPs

Similarly, since neither the DWP nor MS will normally have access to a person’s criminal record, any information about convictions will have come from the claimant. Hence, if there is good reason for the HCP to record such information, because it has material relevance to the claim, then this may in good faith be done without fear of contravening the legislation. If a claimant wishes a conviction to be recorded on the medical report, the HCP should:

- Confirm with the claimant that they are content for the information to be disclosed in the report.
- Record the information together with a note stating; “I confirm that this information has been incorporated at the request of the claimant.”

In practice if a claimant refers to convictions while giving a statement to an HCP, the HCP should normally exclude such evidence unless it is impossible to give a fair opinion without it.
2.12 Confidential Information

Information that is marked ‘In Confidence’ or ‘Confidential’ but is not harmful should not be revealed to the person to whom it refers, without the consent of the originator of the information. If consent is not given, the HCP cannot use this information in any advice.

2.13 Incomplete Advice (Rework)

Incomplete advice will require a report to be returned to MS and this procedure is described as “Rework”. This might occur when:

- A report is not signed or dated by the HCP.
- The report is difficult to read.
- The HCP does not initial corrections or alterations.
- The HCP fails to answer any of the following relevant questions:
  - Whether the claimant is suffering from the PD.
  - Whether the PD or Industrial Accident resulted in a relevant loss of faculty.
  - What loss of faculty resulted.
  - Clear assessment of the resulting disablement.
  - The period of the assessment.
  - Provisional or final period for the assessment not given.
- The advice is not explained in terms understandable to a DM.
- There is inconsistency between the evidence and any given advice.

When a report is returned as incomplete, the HCP must insert the omitted part, which should then be signed and dated. An omitted signature should also be dated if it is added at a date later than the examination.

2.14 Inadmissibility of Evidence in Courts of Law

In the event that an HCP is requested or ordered to attend any court regarding any matter connected with their work for the DWP, whether or not in connection with the case of a particular claimant, they should notify their local Medical Manager immediately. The DWP may wish to reply on behalf of the HCP who is asked to give evidence about any such matter. However, in practice, it is very unlikely for an HCP to be requested to attend court, in their capacity of work for the DWP.
3 Health Care Professionals and the IIDB Claimant

3.1 General Approach to Claimants

The DWP is committed to providing a benefit delivery service that is claimant orientated, helpful, accurate, prompt and cost effective. HCPs working for Medical Services, on behalf of the DWP, must adopt the same approach.

Claimants must be treated with courtesy and, in the performance of medical examinations, their dignity and comfort must be respected. They should never be asked to perform any action that they would be likely to find distressing or painful.

These principles are consistent with Medical Services Professional Standards, which are referred to at 2.3 and in provided in more detail in Section 7 of this Handbook.

3.2 Non-discrimination

In discharging their duties, HCPs should have regard to the provisions of legislation which make it unlawful to discriminate against a claimant on grounds of colour, race, gender, sexual orientation, nationality, ethnic or national origin.

Discrimination occurs if a person is treated unfairly or less favourably than another person, or is excluded or disadvantaged on any of the aforementioned grounds. It also occurs if a requirement or condition, which cannot be strictly justified, is applied which adversely affects or favours one particular group more than another.

The provisions of the two paragraphs above should not be read as overriding the express requirements of the law relating to Social Security decision making which require the HCP to compare the disabled person with a normal person of the same age and sex when determining the assessment of disablement.

3.3 Identification of the Claimant

The report form includes a question on identification which, although impersonation is rarely encountered, should always be answered. Medical Services are required to ensure that individuals presenting themselves for examinations are who they say they are.

Medical Services must examine the actual claimant, not any person who comes to the MSEC or is encountered in the domiciliary situation masquerading as the claimant. Therefore, reasonable steps must be taken to ensure that we are fulfilling the Customer’s wishes.
The guidance presented at Appendix D is for both administrative and medical staff at MSECs and HCPs conducting DVs, and explains how to verify the claimant's identity.

3.4 Telephone Contact with Claimants

There are occasions when telephone contact is made with claimants. For instance, this might occur if the HCP is trying to establish contact to arrange a suitable time for a DV examination. Clearly there are many potential pitfalls in these situations and so to avoid these problems, guidance for both administrative and medical staff is set out at Appendix E.

3.5 Representation of Claimants

Claimants will often feel more at ease when accompanied, and indeed this may be a prerequisite to enable them to come to the Examination Centre.

Companions will be able to give useful information, particularly in cases where the claimant has mental health problems, learning difficulties, or communication problems, or people who stoically understate their problems.

Occasionally, a companion may wish to give their own opinion on the claimant's disability too forcefully, perhaps giving a biased view.

You should use your own judgement in weighing the companion's evidence. If the companion is too intrusive, then you should point out that the claimant must be allowed to express their view. If this strategy is unsuccessful the companion should be asked to leave.

The physical examination is not normally completed in the presence of the companion, but if the claimant wishes this, and gives consent for their presence during the examination, then this should be documented in the report.

3.5.1 Interpreters

Where the claimant is not fluent in the HCP’s language, it will be necessary for the claimant to be accompanied by an interpreter. The HCP should make a note on the front page of the report form, of the name of the interpreter and the language being interpreted.

Under these circumstances the assessment may take longer than usual, as adequate time will be needed for questions and responses to be interpreted. You must not appear to rush or frequently interrupt the process. You must be aware of the possibility that the interpreter may be expressing their own views and conclusions rather than those of the claimant.
Medical Services

If the claimant attends without an interpreter and you cannot continue satisfactorily, then the interview should cease and the claimant should be requested to attend again with an interpreter. A note of the circumstances should be made on the IIDB report.

3.6 Discussions between HCPs and Claimants

As explained above, the claimant and any person whom the doctor has allowed to be present can present their views to the HCP. However, it is no part of the function of an HCP to discuss with the claimant or with an accompanying person the provisions of the Industrial Injuries Scheme, the assessment, and possible entitlement to benefit or medical treatment. Enquiries about these matters should always be referred to the local DWP office or to the claimant’s own medical attendant, as appropriate.

3.7 Audio or Video Tape records of Examinations

Any requests by claimants to tape an examination should not be directly refused, but our policy in these circumstances should be fully explained to them. The Department for Work and Pensions (DWP) never requires that a medical assessment for the purpose of advising on entitlement to state sickness or disability benefits be recorded on audio or videotape.

Claimants may request that their interview and assessment by Medical Services in respect of a benefit claim be recorded either on audio or videotape. Such a request can only be agreed with the prior consent of the HCP, and then only if stringent safeguards are in place to ensure that the recording is complete, accurate, and that the facility is available for simultaneous copies to be made available to all parties present. The recording must be made by a professional operator, on equipment of a high standard, properly calibrated by a qualified engineer immediately prior to the recording being made. The equipment must have facility for reproduction so that all parties can retain a copy of the tape.

The responsibility for meeting the cost of the above requirement rests with the claimant.

Any request by a claimant for an assessment to be audio or videotaped must be declined unless the above safeguards are in place. The claimant must instead be offered the opportunity of an assessment in the presence of a companion or other witness. If the claimant refuses this opportunity and refuses to proceed with the assessment, you should return the file to the DWP with a note explaining the situation.
3.8 **Unauthorised taping**

It is for Atos Healthcare, in conjunction with their legal advisers, to determine the action to be taken in the event of a claimant making an audio or video recording without the prior knowledge and consent of the HCP, or without ensuring that the safeguards defined above are in place. If you suspect a customer of trying to film or record an assessment the following action should be taken:

Advise the customer that such action is not permitted, explain why not, and ask them to switch the device off. If the customer refuses to comply:

- The assessment should be suspended
- The customer should be offered the opportunity of a rescheduled assessment in the presence of a companion or other witness such as a chaperone. This should be recorded as CSHU (1E Claimant issue).
- If they refuse the offer of a rescheduled assessment, the file should be returned to DWP with a note explaining the situation. The referral should be closed on MSRS, as a withdrawn referral (i.e. C700).
- Inform your site manager and/or medical manager immediately.

3.9 **Taking of Notes during an Examination by Claimant or Companion**

From time to time you may encounter a situation where the claimant is accompanied by a companion and either the claimant or companion may wish to take notes during the assessment.

Persons who are entitled to be in attendance are always entitled to take notes. This is because it is for their own purposes and not an official record of the process.

To attempt to deny the right to do so is likely to be contrary to Human Rights legislation.

To request a copy of the notes is unlikely to be helpful – it will place you in the position where you will be obliged to review the notes and comment on their reliability. However, you should record in the medical report, the fact that notes were being taken. The following warning should also be given and the fact documented in the report.

"Where notes are taken by you, we consider it of assistance to both myself, as the examining doctor, and yourself to point out the following:

1. It is your right to take notes for your own use and benefit."
2. The notes will not be included in the Report I make save for the fact that notes were taken and further, they are not accepted by myself or the DWP as an official record of this examination.

3. If the notes are subsequently produced at any time for any purpose, such as part of an appeal process, I the Examining Doctor, my employer and the Dept of Work and Pensions reserve all rights to challenge anything in the notes in the event we are asked to comment on the content of the notes at a future time.

4. You are free to use your notes as you choose but if you chose to publicise the notes (other than in connection with correspondence with the DWP or under any appeal procedure) I would ask that you do not publicise my name. “

3.10 Unexpected Findings

Situations arise when HCPs carrying out disability assessments may come across information that they feel should be reported to the claimant’s General Practitioner. The current guidance for HCPs on dealing with the release of unexpected findings to a claimant’s General Practitioner is based on the guidance from the General Medical Council (GMC) on issues of confidentiality. Advice from a medical defence organisation on medico-legal interpretation confirms that the Human Rights Act 1998 applies to the provision of medical assessments for Benefits purposes, with consequences for this particular topic.

The following paragraphs provide instructions for HCPs about Medical Services’ process for dealing with these rare but important situations.

General Medical Council Guidance

In August 2000 the GMC issued guidance to all Registered Medical Practitioners on aspects of confidentiality. This set out the responsibilities and obligations for medical practitioners when providing information about patients (including DWP claimants). Paragraphs 33-35 of the GMC’s guidance dealt with doctors who have contractual obligations to third parties, such as HCPs working for MS on behalf of DWP, and made it explicit that information should not be passed on without the claimant’s consent unless there were exceptional circumstances. The GMC recommend that doctors make every effort to explain to claimants why information should be passed on to those responsible for their medical care.

There may be rare occasions, when despite the claimant's inability or refusal to give informed consent, the HCP’s professional judgement indicates that information must be disclosed. This discretion must be exercised within the GMC guidelines, and HCPs must be prepared to justify their decision to take such action. The types of circumstances when unauthorised disclosure by HCPs would be justified include:

When the release of that information is necessary to protect others from risk of death or serious harm.
Medical Services

When the claimant requires urgent medical treatment, but the medical attendant cannot be contacted within a suitably rapid period of time.

When the individual is not competent to give consent.

All HCPs are strongly advised to read these guidance notes from the GMC. If any HCP does not have a copy then this can be obtained from the GMC at 178 Great Portland St, London W1 W5JE (Tel. 0845 357 8001)

Procedures for Unexpected Findings

The detailed process to be followed is set out in Appendix C.
4 Part 4 - Industrial Accidents

4.1 Identification and Determination of Relevance

The statutory chain of causation giving rise to a right to "disablement benefit" on the part of a claimant is:

An accident arising out of and in the course of employment, resulting in

A personal injury, leading to:

A loss of mental or physical faculty, leading to:

One or more disabilities, resulting in:

Disablement.

The Relevant Accident

Before a case is referred to an HCP to advise on the disablement questions, a DM will have decided that the claimant sustained an industrial accident. This does not mean that the examining HCP is bound to find an injury and a relevant loss of faculty.

4.2 Disablement Assessment principles in IIDB

In IIDB, Disablement is assessed by employing the established principles of the 5 steps of Disability Analysis:

1. Taking the claimant's statement.
2. Making and recording observations made during examination.
3. Conducting the clinical examination and recording the findings.
4. Logical Evaluation of all available evidence to allow consistent advice to DM about:
   - The nature of the injury.
   - The loss of faculty.
   - The disabilities.
   - The level of disablement and its duration.
5. Justification of medical opinions by explanation of any inconsistencies or conflicts within the evidence.
4.3 Taking the Claimant’s Statement

You should ask the claimant for:

Details of the circumstances of the accepted Industrial Accident.

The nature of any injuries sustained.

The treatment at the time of the accident, and since, and any proposed ongoing treatment.

The problems resulting from the injuries sustained with a record of their chronological development/resolution.

The effects on work, leisure and other daily activities.

Medical history and occupational/social history.

In every assessment, you must ensure that they have fully documented the past history. This should include documentation of negative responses as well as positive. For example, in the case of a claimant with back pain the HCP must specifically record whether there is any history of previous back problems.

In addition, you should ensure that they have enquired about, and documented where relevant, any history of subsequent problems developing after the relevant accident or onset of the Prescribed Disease being considered. This should include any subsequent injury, whether or not this was related to the occupation.

The claimant must agree the statement, which should be read aloud or the claimant given the opportunity to read it over, before being asked to sign the form.

4.4 Making Observations

As with all disability analysis you should observe the claimant as part of the overall examination.

These observations, where relevant to the claim under consideration, should be recorded in the examination section to provide a further aspect of evidence of functional ability.

4.5 Conducting the Clinical Examination

You must seek the claimant’s express permission before carrying out any physical examination. Consent must not be assumed. Consent should be verbal but this should be noted in the report with a comment such as, “Details of the physical examination were explained to the claimant who gave their consent.”
You should conduct a general examination to identify all disabling conditions and will vary with the individual circumstances. You should examine the injured parts, taking care to identify which one of a pair of organs or limbs is affected, and the non-injured member of a pair of organs or limbs should be examined and the findings recorded accurately. Professional judgement is necessary when requesting removal of items of clothing.

A diagrammatic sketch should be made of all scars identifying those due to the relevant accident, and you should record all measurements in metric units.

When carrying out a musculoskeletal overview (MSO) examination, you should usually be able to complete this aspect of the assessment whilst the claimant is wearing loose indoor clothing, provided that you are checking to confirm normality. If you suspect an abnormality, and thus are led towards a regional inspection and examination, it would be usual to ask the claimant to remove the relevant items of outer clothing in order to complete this task.

It will never be necessary to ask a claimant to remove items of intimate underwear or to carry out intimate examinations (that is examinations of the breasts, genitalia or rectum) as part of the disability functional assessment.

If your actions were ever queried, you should be able to justify anything that you have asked the claimant to do, with regard to undressing and their participation in the examination process. Similarly you should be able to justify any omissions that you have deliberately made in these areas, particularly if these might be considered to deviate from usual disability assessment practice.

As the assessment proceeds, you must explain any request that they make to the claimant to remove clothing, and explain every step of the examination process, so that there can be no misunderstanding about movements they are asked to perform or clinical tests you are carrying out.

Please note also that use of needles is not considered appropriate in the context of disability assessment medicine, and thus the testing of pinprick sensation should not be undertaken with any sharp instrument. It is possible to test sensation without risk of skin injury, e.g. using a specially designed simple probe or an opened paper clip, which is blunt-ended. In such instances it is essential to advise the claimant appropriately of the nature and purpose of this part of the examination and to gain their consent to such a procedure before progressing with the test. The testing instrument must be discarded after use.

It should be noted that if a peak flow reading is recorded as part of the assessment for any reason, it is important to document the type of peak flow meter used—either “Wright” or EU. This is because studies have identified some peak flow meters are accurate in the mid range but at the high and low ends of the range they are less accurate. A new EU standard for peak flow meters has been established and any new peak flow meter will be compliant with this standard. A conversion table is available for non-compliant meters. It is not necessary for you to carry out this conversion.
When carrying out a physical examination, you should use medical professional judgement to decide when it is appropriate to offer a chaperon, or to invite the claimant to have a relative or friend present. In this context, the duty of the chaperon is to protect you from any possible complaints about unethical conduct, and the chaperon's role is merely to remain in the room whilst you examine the claimant, unless you ask the chaperon for assistance. This guidance assumes particular significance when the doctor and claimant are of the opposite sex.

If a chaperon, relative or friend is present, you should record the fact on the report form, making a note of the person's identity. If the claimant does not want a chaperon, you should record that the offer was made and declined.

Give the claimant privacy to undress and dress. Do not assist the claimant to remove clothes unless they request assistance.

**Removal of Back or Limb Supports**

Where removable supports have been applied to a limb or back, examination should normally be carried out after removal, unless the claimant has been instructed by their own medical advisers, physiotherapists etc. not to remove them. It is up to you to be satisfied that the removal of the supports and the examination itself will not harm the claimant. If the supports are not removed, you should consider advising a provisional assessment for an appropriate period based on the disability present with support in situ.

### 4.6 Logical Evaluation

#### 4.6.1 Medical Evidence before the HCP

Further advice on handling medical evidence held within the file or supplied at the examination by the claimant has been outlined in Part 2 Paragraphs 2.9 to 2.12 and Part 3 section 3.9.

You must record any Consultant reports, précis or extract of hospital case notes or other medical evidence that has been considered and are material to the advice given. If you present an opinion that can be interpreted as contrary to that evidence then the reasons for that opinion must be carefully recorded.

#### 4.6.2 The Nature of the Injury

The HCP has to advise the nature of the injury resulting from the industrial accident and record this as specifically as possible, avoiding general descriptions. Examples of this are; fracture of (L) radius rather than injury to (L) arm; detached retina (L) eye rather than injury to (L) eye.

A consequent injury is one that results directly from the accident and must be treated as part of the relevant injury.
4.6.3 The Loss of Faculty

You have first to be satisfied that it is more probable than not that the claimant has suffered a loss of faculty as a result of the relevant accident, before going on to advise on disablement.

You are not bound in any way by the findings and advised assessments of an earlier report or Tribunal decision. You should consider the disablement question afresh each time. Logical evaluation of the up to date evidence will allow a reasoned and supported opinion, which may differ from views previously expressed. Where you reach conclusions different from those already expressed by a previous HCP or Tribunal, or from those given by a doctor who has reported on the claimant, you must draw attention to the different conclusions and outline the reasons for reaching them within the report.

If the case should subsequently go to Tribunal, both the claimant and the members of the Tribunal will wish to know the reasons for these alternative views.

However, you must not advise what decision should have been given for any previous period. It is not part of your role, with the benefit of hindsight, to correct earlier advice.

There is deemed to be no loss of faculty if the resulting disablement is assessable at less than one per cent. However, the Social Security Commissioner has pointed out that it is desirable to distinguish between cases where there is no relevant loss of faculty and those where there is a relevant loss of faculty, but the resultant disablement does not amount to one per cent.

Moreover, you are required to advise whether or not there is a loss of faculty before considering disablement. Therefore, if you consider that there is a loss of faculty, but that the resulting disablement amounts to less than one per cent, an affirmative answer should be recorded to the loss of faculty question and a loss of faculty entered as described below. You should then assess disablement at less than 1%.

You should record the relevant loss of faculty by specifying what function of an organ or part of the body has been impaired by the injuries resulting from the relevant accident. For example:

- Reduced movements of right thumb.
- Loss of vision of left eye.
- Stiff and restricted spinal movements.
- Loss of confidence and lowered mood.
- Reduced movement of the left knee joint with instability.

The relevant loss of faculty should be described as locally as possible and reflect the loss of function of the injured part.
Medical Services

Where the claimant is suffering from a psychological or psychiatric condition, the HCP must consider whether or not this condition was caused by or materially aggravated by the relevant accident. If it was, it should be shown as a relevant loss of faculty.

4.6.3.1 No Relevant loss of faculty beyond the 90th day

When the HCP is of the opinion that the relevant loss of faculty does not extend beyond the 90th day, the BI 118 accident should be addressed as follows:

Ideally the form would ask at Part 5.3 of the BI118 (accident):

Part 5.3.a) From what date has the relevant loss of faculty existed?

Part 5.3.b) Does the RLOF extend past the 90th day?

Yes □ - go to Part 6

No □ - go to Part 9.

However as there is no facility to amend the form in the foreseeable future the advice to HCPs on the completion of section 5.3 of the BI118 (accident) is as follows:

- At Part 5.3 put the date LOF began, and add “but did not extend beyond 90th day – see Part 9”.
- Do not complete Parts 6, 7 and 8.
- Complete Part 9 giving and explanation and justification of your opinion.

4.6.4 The Disabilities

Once an HCP has advised that there is a relevant loss of faculty resulting from the accident, it should be considered whether any disability results.

Only then can an HCP proceed to assess the disablement arising in accordance with the principles in Schedule 6 to the Contributions & Benefits Act 1992 (see Appendix B and Part 5 for the principles of assessment).

The HCP should record the relevant disability suffered by the individual as a result of the accident or PD, with specific reference to the function of the organs, limbs or part of limbs involved. Where the injured part is one of a pair of organs or limbs it is desirable to record the resulting disability of the pair of organs or limbs.

For example, where the injury was a fractured calcaneum, the disability should be described as “Impaired ankle function”. Disability from PD A11 should be described as “Impaired hand function” or even “Impaired finger function”. Disability arising from a neck injury would be “Impaired cervical spine function”. 
Medical Services

The HCP should consider whether any other unrelated conditions (i.e. not resulting from the industrial accident) contribute to the overall disability. If so, the HCP should record the disability as only partly relevant to the industrial accident and record the conditions which are the other effective causes of the overall disability.

4.6.5 Other effective causes of disability

Conditions in the same organ or limb, not related to the accident or Prescribed Disease, must also be considered and their disabling effects must be represented in the frame of the assessment. The examining HCP should first consider:

Would this condition be present even if the accident had not occurred?

And if YES:

Would this condition cause disablement within the period under consideration?

If the answer to both these questions is YES then a P (partially relevant) condition has been identified and it must become a part of the assessment structure.

4.6.5.1 If such a condition pre dated the industrial accident it should be described as O (Pre) e.g.

A claimant suffers a Right shoulder injury, which is to be considered for an IIDB claim. However this claimant has a pre-existing rotator cuff injury (non-Industrial) on the other shoulder. There is disability arising from the non - Industrial left shoulder problem so this constitutes an O-Pre condition. The overall upper limb disability for this claimant is a combination of the effects of the Right and the Left shoulder problems. However, an appropriate amount must be subtracted to recognise the pre-existing upper limb functional restriction caused by the non – industrial related shoulder problem. The final amount should then reflect the functional restriction caused by Industrial accident and the worsening effect of the other effective causes.

The above detail is only intended to describe how an O-PRE condition is identified. For a fuller explanation of how to assess other effective causes of disability and disablement the reader is referred to Section 5.6

4.6.5.2 If such a condition developed after the date of the industrial accident it should be described as O (Post) e.g.

Consider the same claimant described above, and how his disabilities are defined if the Left Non -Industrial shoulder accident occurs after his Industrial injury to the Right shoulder. In this case the later Non Industrial injury becomes the O-Post condition. Assessment of this combination of disabilities is complex. Advice from a senior and experienced HCP is recommended before completing such a report.
The above detail is only intended to describe how an O-Post condition is identified. For a fuller explanation of how to assess other effective causes of disability and disablement the reader is referred to Section 5.6

4.6.5.3 Consequential Injuries

Not all later developments are unconnected to the original accident. Some conditions only arise because of the effects of the original accident. An example of such a situation is an unstable knee joint directly relevant to an Industrial accident where the injured party suffered a torsion injury of the joint. At a later date this claimant falls because of his unstable knee and further damages the ligaments of the same knee (or even the other knee!). An examining HCP may consider that the second accident only arose because of the disabling effects of the first Industrial Accident and -even though the second injury did not occur in work- its effects are a direct consequence of the first accident. If such a series of events can be supported by evidence, a fully relevant assessment is appropriate. Such circumstances are not common and an examiner would be assisted by case discussion with an experienced IIDB examiner before completion of the report.

4.6.5.4 Proneness to a disability

For example, detached retina in high myopia cannot be regarded as another effective cause of disability unless you consider that it would have caused disability within the period under consideration, even if the accident had not occurred. When there is clear evidence of pathology present before the relevant accident, but not causing disability, and unlikely to do so during the period under consideration, this condition should be considered as unconnected. Any other conditions found, which have no effect upon the disablement resulting from the relevant loss of faculty, should be recorded as unconnected.

4.6.5.5 Changes in Relevance

You should bear in mind that the relevance of disability arising from an accident or Prescribed Disease can change with time, as effects recover or worsen and other disabling conditions progress.

4.6.5.6 The Armed Forces Compensation Scheme

When considering a claim for an accident, the HCP should be aware of the situation where a claim is made for an accident when a previous claim has been made under the War Pensions or Armed Forces Compensation Scheme.

The Armed Forces Compensation Scheme (AFCS) came into force on 6\textsuperscript{th} April 2005. This scheme replaced War Pensions (WP) for any injury or illness, caused by service in the Armed Forces, on or after that date. WP will continue for injury or illness prior to 6\textsuperscript{th} April 2005.

AFCS is not assessed by percentage disablement as with WP, but is set at a tariff level depending on the disability.
Medical Services

IIDB claim form should provide this information at section 6.

You should consider whether the AFCS injury/disease is another effective cause of disability, and advise accordingly, using the normal principles relating to O pre/O post conditions.

Where the AFCS injury/disease is different to the one claimed for IIDB, the claimant may be entitled to both benefits.

In either case, you should explain and justify the advice being given.

4.6.6 The Disablement

The HCP should describe how the relevant disabilities, as affected by other effective causes disable the claimant in the ordinary activities of life. For example, if the disability is described as “impaired function of lower limbs”, this determines the activities described. So, in this example, particulars of gait should be given together with details of how far the claimant can walk, whether they use a stick or crutches, whether they wear a surgical boot or appliances, whether they can ascend and descend steps, squat and rise etc.

When the nature of the injury, or the loss of faculty, or the disability or the disablement sustained as a result of the industrial accident is unclear, you should consider adjourning the assessment to allow further medical evidence to be obtained. In this event you must specify the nature of the evidence required and the source from which it should be obtained. In general adjournments for FME are more likely to be of value where relevance to the accepted accident is uncertain.

4.7 Justification of advice

This topic together with information on assessment is fully covered in Part 5 of this document.
5 Assessing the Extent and Period of Disablement and the Justification of Advice

5.1 General

Assessment of relevance of the loss of faculty to the claimed industrial accident, and of duration of the resultant disablement, has always been an integral part of Industrial Injuries Disablement Benefit (IIDB) assessments.

A Commissioner’s decision in connection with Compensation Recovery (recovery of benefit payment by the DWP, where IIDB has been paid for an accident but which later results in compensation from a private insurance organisation) means it is now even more important to ensure accurate assessment of both these factors.

5.2 The Law


The effect of the law is that:

1. The assessment of disablement has to be made without reference to the special circumstances of the claimant other than age, sex and physical and mental condition. Inability to follow a particular occupation, loss of earnings or additional expense because of the effects of the accident does not affect the assessment of disablement.

2. The disabilities to be taken into account are all the disabilities incurred as a result of the relevant loss of faculty to which the claimant may be expected to be subject during the period taken into account by the assessment.

3. The period of assessment is that period over which the average assessment of disablement is expected to remain constant. Should there be any significant fluctuation in the level of disablement, as may occur following surgery, separate assessments should be made for the appropriate periods (split assessment).

4. Where there are other effective causes of the relevant disabilities any disablement to which the claimant would have been subject in any event, even if the accident had never happened because of some congenital defect, injury or disease not directly attributable to that accident, should be excluded from the assessment of disablement; but
5. Where relevant disability is worsened by the presence of some congenital defect, injury or disease not directly attributable to that accident the assessment may be increased, in specified circumstances, to take account of such worsening in arriving at the assessment of disablement.

### 5.3 The Assessment

The Contributions & Benefits Act requires that an assessment of disablement shall be expressed as a percentage which shall not be more exactly specified than is necessary to determine a claimant’s entitlement to disablement benefit. For payment purposes assessments between 14% and 100% that are not multiples of 10 are rounded in accordance with legislation and treated as multiples of 10. This ‘rounding’ is a task reserved exclusively for the DM and the HCP should assess the individual disabilities and the total assessment of disablement should be recorded as an exact percentage. This enables subsequent HCPs, DMs, tribunal members, and the claimant to appreciate how the total assessment was determined, which would not be apparent from a rounded figure alone.

The total assessment of disablement advised can be in excess of 100%. The HCP should give the actual assessment, not limit it to 100%. Thus if there is improvement at a later date but the assessment still remains above 100% it allows benefit to continue to be paid at the maximum rate.

### 5.4 Scheduled Assessments

Schedule 2 of the General Benefit Regulations (see Appendix B Part 1) sets out certain degrees of disablement for specified injuries (referred to as scheduled assessments). These amounts were prescribed on the assumption that the injury had been caused to an otherwise healthy person and had resulted in an uncomplicated and stable condition. Although the schedule contains an assessment for total deafness the PDs Regulations also contain specified assessments for occupational deafness (PD A10) as described in Handbook 2-the Prescribed Diseases

#### 5.4.1 Injuries embracing Scheduled Assessments

Where the sole injury resulting from the accident is one specified in the Schedule, the General Benefit Regulations give an HCP discretion to advise on the increase or reduction in the scheduled assessment in a particular case, where the Schedule does not provide a reasonable assessment for that case. It is important that the HCP gives adequate reasons when advising the DM why this variation is appropriate.

In addition, the General Benefit Regulations indicate that if the scheduled assessment is 100 per cent, no offset need be made from that figure if the HCP is satisfied that it represents a reasonable assessment in the circumstances. Under this provision, the HCP may regard a person as so disabled by an accident that an assessment of more than 100 % would be considered appropriate.
Medical Services

For example, an industrial accident might have caused blindness to an extent greater than the provisions in item 4 of the schedule (unable to perform any work for which eyesight is essential). In that event 100 % might still be regarded as an appropriate assessment even allowing for some offset for the disablement which resulted from a pre-existing condition.

The HCP is entitled to advise a considerable offset; for example, where a minor industrial injury raises to the 100 % level a person’s disablement which would in any event have been assessable at a high level without the intervention of the industrial injury.

5.4.2 Multiple Injuries embracing Scheduled Assessments

A panel of Upper Tribunal Judges (previously commissioners) has indicated that multiple injuries, not themselves constituting any specific item in the schedule of prescribed injuries, are not to be regarded as a scheduled injury merely because they constitute an aggregate of injuries each of which is specified in the schedule.

Accordingly the disablement arising from such multiple injuries is not necessarily the aggregate of the assessments for the separate scheduled injuries.

For instance, an industrial accident results in loss of index finger (scheduled degree of disablement 14%) and two phalanges of the middle finger (9%), the disablement resulting from these injuries is not necessarily the aggregate of the separate scheduled assessments (23 %). This figure would unreasonably amount to more than the scheduled degree of disablement for the loss of the two fingers (20 %)

It is for the HCP to advise the appropriate assessment of disablement in the particular circumstances of the case.

5.5 Assessment of Non-Scheduled Injuries

HCPs should use the scheduled assessments for specified injuries as a guide to the appropriate assessment for non-scheduled injuries. Appendix B – Part 1 contains Scheduled assessments that are prescribed in Schedule 2 of the Social Security (General Benefit) Regulations 1982. Appendix B – Part 2 contains guidance on levels of assessments commonly used by The Tribunals Service. Whilst the latter do not carry the full authority of legislation, they are useful benchmarks for use by an HCP when considering a non-scheduled injury.

When assessing disablement the following is always borne in mind:

- How the claimant's function compares to a person of the same age and sex who is physically and mentally normal
- How the suggested assessment of disablement compares with the Scheduled assessments.
For example, The Schedule of Assessments indicates that the disablement resulting from the amputation of the tips of all the fingers of one hand would attract an assessment in the order of 22 to 25%. Consider a case of PDA11 where the claimant describes intermittent blanching and tingling in 4 fingers of the hand. Using the Schedule of Assessments to "benchmark" hand disabilities it is evident that such a high assessment cannot be justified in the A11 case. This process is intended to show how the Schedule can be used to maintain a perspective when considering Non Scheduled conditions.

5.6 **Other effective causes of disability and disablement**

In many cases the overall disablement not only results from the relevant accident or PD, but also from other conditions which are not related to the accident under consideration- these are referred to as "other effective causes" See also Part 4, Paragraph 4.6.

The reasons for advising that a condition constitutes another effective cause rather than a direct consequence of the accident or PD should be clear to both the DM and the claimant.

Remember that the relevance of a disability to a specific event may change over time. With degenerative changes in particular a phrase which is often used in specialist reports is “the accident brought forward the onset of symptoms by x years”. That is to say, the degenerative change, which was already present, would have caused problems eventually, whether or not the accident had occurred. In that instance, the resulting disablement may be held to be fully relevant at the time of the accident, but over a period become partly relevant, as the role of the degenerative pathology increases, to a point where the effect of the accident may be held not to be relevant, with 100% of the disablement attributable to other causes.

As the assessing practitioner you are not bound by previous advice on relevance.

5.6.1 **The O (Pre) Conditions**

If the conditions giving rise to another effective cause of the disability predate the industrial accident, they should be described as O (Pre), even if the disability they cause does not arise until after the date of the industrial accident or PD. If the HCP is satisfied that, even if the relevant accident had not occurred, the claimant would have been disabled to an assessable extent during the period under consideration due to a condition recorded as O (Pre), the extent of that disability has to be excluded (offset) from the assessment.

There is a calculation set out below to achieve this. The HCP should first assess the overall disability, in global terms, (e.g. upper limbs, lower limbs, spine, vision or hearing) arising from both the RLOF and the O (Pre) conditions for the period under consideration (G). This overall assessment should include an additional, but usually small, assessment that represents the interaction between the O-Pre condition and the effects of the accident (I).
From this gross assessment (G) the HCP should deduct or offset (N) the extent of disability which would have been present during that period from the O (Pre) conditions, had the relevant accident not occurred (G-N).

The remainder should be recorded as the ‘net’ assessment, and will, therefore, include any increased disability that arises from the interaction between the relevant loss of faculty and the O (Pre) conditions (I). No further addition in respect of the ‘greater disablement’ effect of the O (Pre) conditions should be made.

5.6.2 The O (Pre) Calculation:

1. Identify and assess Global disablement = G
   (Not necessarily the same as “gross” disablement on the form)
2. Identify and assess disablement had accident Not occurred, = N
3. Identify any Interaction = I
4. Identify the Relevant disablement attributable to accident/injury = R
5. Therefore, the formula is: -
   \[ G = R + N + I \]
6. Hence, the assessment of disablement relevant to the accident = Global Assessment – disablement had accident not occurred. That is:
   \[ O (Pre) \text{ Net Assessment} = (G-N) = (R+I) \]

5.6.3 The O (Post) Conditions

If the conditions giving rise to another effective cause of the disability post-date the industrial accident, they should be described as O (Post).

The legislation directs that the effects of greater disablement due to interaction of any O (Post) condition can only be considered if the net assessment arising from the relevant loss of faculty and any O (Pre) conditions is first assessed at 11% or more. When a level of 11%-or more- is reached, an addition is made for just the greater disabling effects of the later condition. The full effects of the later condition are not added. This can prove a complex calculation and it is as well to bear in mind that the addition is usually a very small sum of less than 5%.

1 The net assessment should be determined first. This may only involve a single relevant condition or may require O-Pre calculations. No account is taken of the O (Post) condition in determining this assessment at this stage.
2 If the net assessment is less than 11%, no further action is taken with regard to the O (Post) condition.
3 If the net assessment is 11% or more, any greater disablement due to interaction of the O (Post) condition must be assessed, and an appropriate addition made of that to the net assessment. The addition must not fully represent the assessable disability arising from the extraneous O- (Post) condition. It must increase the assessment only to the extent that the O-(Post) condition worsens the effects of relevant disability.

5.6.4 Calculation of Disablement for an O (Post) Condition

1. What was the disablement before the O (Post) condition arose?
2. If less than 11% then no further addition is needed.
3. If more than 11% proceed as follows:
4. Establish the interactive additional disability created by the O (post) condition
5. This is best calculated by considering the overall disability and removing the level of disability which the O (Post) condition ALONE would merit
6. This leaves the net condition plus the interactive effects of the O (Post)
7. Remove the net figure from this figure and that leaves the usually very small amount which can be attributed to interaction alone
8. Use this small assessment as an addition to the net assessment at the O(Post) section of the form
9. Finally it is as well to recall that an O (Post) condition is an unusual event! Most HCP’s would benefit from a case discussion with an experienced IIDB examiner, before finalising their report

5.7 The Former C conditions

Until 16 December 1992 any conditions which had the effect of making the relevant disability more disabling, while not themselves causing the relevant disability, were assessed differently from O (Pre) or O (Post) conditions. They were called connected or ‘C’ conditions. Any greater disablement due to the interaction of the ‘C’ condition was assessed and an addition made, irrespective of the net assessment calculated as above.

The Commissioner’s Decision R (I) 4/94 of 16 December 1992 established that there was no legal basis for C conditions.

Now, on rare occasions an HCP may have to reassess or review an assessment that contained a ‘C’ condition, and there are now 3 choices. The HCP will need to consider whether it is another effective cause of disablement and whether any greater disablement arising is an O (Pre) or O (Post) condition or indeed whether it must be regarded as unconnected.

For example, consider a claimant who injures a leg in an industrial accident, such that he needs to use crutches to stand or walk. Therefore, any condition of the hands or arms which prevents the use of crutches will also impair locomotion and will worsen the effect of the relevant disability, albeit indirectly. The condition should be recorded as an O (Pre) or O (Post) condition and should be assessed as above.
5.8 Greater Disability arising from the Interaction of the Effects of Two or more Industrial Accidents or PDs

A claimant may suffer from more than one industrial accident and/or PDs. Any greater disability arising from the interaction between the effects of the accidents or diseases may only be taken into account in the assessment of disablement for the later or latest of those accidents or diseases.

Thus, where a claimant has had two industrial accidents, the provisions, regarding O (Post) conditions referred to above, cannot be applied in assessing the disablement from the first accident.

However, any greater disability arising from interaction between the effects of the two accidents can be taken into account in the assessment of disablement for the second accident, where the earlier accident is recognised as an O-Pre condition in the assessment.

5.8.1 Successive accidents

Where it is necessary to decide whether any identifiable disablement is attributable to a previous industrial accident, the HCP is not bound by any advice on relevance of particular conditions or assessments of disablement given by a previous HCP, or Appeal Tribunal or DM. It is for the HCP to advise what part, if any, of the claimant’s condition, during the period covered by its assessment is attributable to an earlier accident, and should give their own advice on assessment of the resulting disablement.

For instance, a claimant with a 10 % life assessment for inability to bend resulting from industrial injury to the back subsequently suffers a second industrial accident to the back, which further restricts bending capacity. The appropriate assessment for the effects of the second accident must take into consideration what degree of disablement the claimant would have been suffering, as a result of the first accident, during the period under consideration. The HCP would not be bound automatically to adjust the assessment by 10 %, merely because this was the degree of disablement resulting from the first accident, as assessed by the earlier HCP or appeal tribunal, in the light of the circumstances prevailing at that time. However, where a different offset is used (less or more than the 10% in the assessment for the first accident) then this will require a very full explanation, both for the DM and the claimant.

As described above, any greater disablement resulting from the interaction between the effects of the two accidents would be taken into account in the assessment for the second accident only.
5.9 Period and Type of Assessment

General

The period of assessment is a medical opinion, on the likely length of time that the relevant disablement will persist at the assessed level. It is a prognosis based on the medical aspects of the case.

The period of assessment relates to the relevant loss of faculty, and not to any other effective cause. When the RLOF recovers there may be on-going disablement due to other causes. It should be clear in the HCP’s report the reason(s) why the HCP is of the opinion that any on-going disablement does not result from the relevant accident or disease.

An assessment may be for any length of time but the intention of legislation is that, where possible, a final assessment shall be made, either for a limited period or for life. The period of assessment advised should be based on the HCP’s knowledge of the natural history of disease. The HCP should consider the period carefully and only advise that a life assessment is appropriate when the justified medical opinion is that the disablement will last for life. For example, a soft tissue injury is likely to cause problems for a period of months at most. Hence a “life” assessment would be inappropriate in the majority of cases.

Disablement benefit is not payable until a period of 90 days (excluding Sundays) has elapsed. The period starts from the day of the relevant accident or in PD cases, the date of onset.

Before the end of the period covered by a provisional assessment, the claimant will be referred for re-examination by an HCP for reassessment of any remaining disablement resulting from the relevant loss of faculty. If a reassessment is appropriate it must commence on the day following the expiry of the previous assessment.

If you form the opinion that the previous advice was incorrect, then you should record this in the report, giving full reasons for your opinion.

5.9.1 Assessments less than 14 %

An assessment of less than 14% must always be a final assessment unless it can be aggregated with any other assessment.

This does not mean that the assessment has to be for life, if recovery is possible. The length of the assessment should be based on the medical prognosis of how long the condition is likely to last, and this can range from any short period up to life.

An assessment can be for as little as “less than 1%”.

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5.9.2 Assessments greater than 14%

Assessments of 14% or more may be either provisional or final, either to a date or for life.

An assessment should take account of the period during which the customer has suffered and may be expected to suffer from the relevant loss of faculty, at the assessed level. But as described above, the length of the assessment should be based on the medical prognosis of how long the condition is likely to last, and this can range from any short period up to life.

5.9.3 Split Assessments

If the assessment varies over time, which may be retrospective or prospective, then a split assessment should be recommended. This mechanism reduces the need for repeated examinations to reassess a claimant during a period of ongoing treatment, and often allows a more logical approach to the assessment of the resulting disablement.

For example, a claimant injures his knee resulting in a period of time in plaster followed by a recovery period, followed by complete recovery. The assessment in this case would be x% for the period in plaster, followed by y% to a date final.

This type of medical advice is given on form BI118X. This form is used to replace the appropriate pages of the initial, reassessment or change of circumstance forms in the BI118 series.

5.9.4 Factors to Consider when advising on Period of Assessment

What is the probability of this level of disablement lasting for life?

Consider:

The underlying condition.

What is the natural history of this condition, irrespective of whether it is linked to an occupational cause?

What is the likelihood that eventually a constitutional cause will be the cause of disablement as opposed to the occupational cause?

The age of the person. Is it likely that the condition will be last for life in a relatively young person?

Is it likely that any other effective cause will eventually be the only source of disablement?

For example a back strain is not likely to have an effect for life. Most back strains recover within weeks or months. Therefore, it would be appropriate to advise a short-term final date as prognosis in such an instance if recovery can be reasonably expected.
5.9.5 Aggregation

The DM may aggregate disablement arising from 2 or more claims made on or after 30 September 1986. In the light of case law, there may be certain circumstances where a gratuity has been paid, which will be available for aggregation with claims made from 1 October 1986.

Whenever a claimant is referred for advice on assessment from the DM all other B18s will be attached and all other assessments available for aggregation will be listed.

5.9.6 Aggravation or Acceleration of Disability arising from Congenital Defect or Earlier Injury or Disease

An industrial accident may aggravate a disability, which already exists as the result of a pre-existing condition, or it may accelerate the onset of a disability. If it is judged that by a certain date the claimant’s disablement has reached, or will reach, a state which it would have reached, even if the industrial accident had not occurred, the HCP may consider advising a final assessment for a limited period.

If the HCP is satisfied that the disability arising from the accident will have a permanent effect, over and above the normal progression of the pre-existing condition, then consider advising a life assessment. If a constitutional condition is present, the results of a minor injury may simply be made worse by that condition.

For example, if an injured toe in a person with a circulatory defect does not heal, the assessment for the toe will be for a longer period than for a similar minor injury to a normally healthy person. It should not include an assessment for any disability from the constitutional condition that would have existed apart from the injury.

If the injury is adjudged to have led directly to more serious development of the condition, such as amputation, the disability from that condition may be assessed for a period as though it were a result of the accident. The period may vary. If, for example, the HCP considers it likely that the more serious development would never have taken place without the intervention of the accident the period could be for life.

If the HCP considers that a safe estimate can be made of a date by which that development would have taken place in any event, the HCP may deem it appropriate to advise a final assessment ending on that date. Alternatively, an HCP may advise a life assessment for the affected toe but not for the amputation. For example, it could be considered that the condition, which arose immediately from the injured toe, would have continued for life, had the limb not been amputated because of other incidents or the natural progression of the constitutional condition. This would be analogous to the established practice of giving an assessment for a limb, disabled in an industrial accident, even after the whole limb is lost in a subsequent non-industrial accident.
5.10 Justification of Advice in IIDB

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

The justification section should be used to:

- Clarify medical issues.
- Appraise and prioritise the medical evidence that has been elicited during the assessment.
- Appraise any documentary FME that is available on file or that is presented (it is not sufficient merely to note on the BI118 that it has been seen).
- Highlight and elucidate any conflicting evidence, including any emanating from the claimant’s statement.
- Explain the medical reasoning.

In justifying the advised period and percentage level of assessment, the HCP can make reference to the Scheduled Assessments which are levels of disablement that are valid in law. They are included in Schedule 2 to the Social Security (General Benefit) Regulations 1982, which sets out certain degrees of disablement for specific injuries and they should, by extrapolation, be employed to help explain the assessment.

Justification should show that the advised assessment is consistent with the clinical findings and other evidence within the file, and that it is in keeping with the consensus of medical opinion, that is, a body of medical professionals would agree that the advice was reasonable.

5.10.1 Examples of Good Practice in Justification

**Diagnosis - Prescribed Disease cases**

Justification of advice on the diagnosis question in a Prescribed Disease should cover the following points:

- Nature of any condition present.
- Diagnosis.
- Relationship to work, holidays, weekends.
- Any pre-existing conditions and any conditions developing subsequently.
A clear explanation for any signs, symptoms present which are not attributable to any PD, but which might cause confusion.

In Prescribed Disease cases, particular care is needed to support non-diagnosis with clear, understandable justification.

Her condition does not appear to be allergic dermatitis as patch tests were normal.

An irritant dermatitis is unlikely, as it would have been confined to those areas that were directly exposed to the chemicals used at work.

Her condition has not been improved by avoidance of potential sensitisers at work, either by short absences or by leaving her job X months ago.

She suffered from childhood eczema. She now suffers from hay fever, which is commonly associated with eczema. The family history of asthma supports a hereditary predisposition to eczema.

The features described favour a diagnosis of eczema rather than an occupational cause. I am unable to advise that PDD5 is diagnosed.

Disablement - Prescribed Disease & Accident cases

Points to support the HCP’s justification at Part 9 of the BI118 should cover:

Concise, jargon free review of the functional effects of the accident or PD.

Significant points from

- statement (particularly daily living activities which indicate the level of function)
- informal observations
- formal examination

It is helpful to compare the level of disablement to the Scheduled assessments, either directly or indirectly, in the latter case by referring to disablement as being minimal, mild, moderate etc.
Example 1: Justification for an assessment of 15% for impaired upper limb function following injury resulting in a dislocated shoulder:

*He has a shoulder injury with damage to the tissues around the joint. He has pain, some muscle wasting, restriction of movement in all planes of up to half, and consequent difficulties with pulling garments over his head, driving, and playing darts. These findings equate to a mild disablement.*

*The assessment is consistent with my clinical findings and observations.*

Example 2: Justification for an assessment of 3% for impaired mental function following development of depressive illness consequent on an industrial injury:

*His depression has led to minimal disablement and is directly related to the accident with no previous history and no other cause. His sleep is disrupted and he has lost interest in activities he previously enjoyed, but he remains quite alert with no signs of self-neglect.*

*The assessment is consistent with my clinical findings and observations.*

Medical advice that is unsupported by justification and devoid of explanation will fail to satisfy the DM's needs. In the absence of adequate justification, the DM will be left uncertain as to how much reliance they can place on such advice when formulating their decision.
HCPs are also required to provide medical advice on claims for Change of Circumstance, Reduced Earnings Allowance (REA), Constant Attendance Allowance (CAA) and Unemployability Supplement (US). In all cases the DM makes the decision on entitlement for REA, US, CAA and also for Widow’s Pensions, for which no medical advice is sought.

6.1 Change of Circumstance

At any point after a decision has been made, the Claimant may submit an application for change of circumstances. Usually the claim is made because they feel there has been a deterioration in their condition since the decision was made. Sometimes the claim will be because they are coming to the end of a finalised award and they feel that their condition has persisted.

However, where the decision has been given post DMA (5/7/99), once a finalised award has come to an end it ceases to apply and cannot be superseded on the grounds of “change of circumstances”. This means that any such application for change of circumstance which is received after the assessment period has ended has to be treated by the DM as a new claim. If, for example, you form the view that the injury or prescribed disease is no longer causing any effects, then you should advise that there is no loss of faculty rather than saying that no worsening of the relevant condition has occurred.

In accident cases where a final decision was made prior to 5.7.99, that decision is treated as incorporating a decision that there is no loss of faculty from the day after the end of that period, indefinitely. Where a “no loss of faculty” decision was made before 5 July 1999 that decision remains in operation indefinitely. In these types of cases, where a claimant notifies that their condition has worsened, and you form the opinion that that there has indeed been a change, either worsening or improvement, then you should advise that there has been a change of circumstances.

When advising on a Change of Circumstances case there are 3 possible outcomes: that the effects of the condition have improved, worsened or there is no change. If you advise that there has been no change you offer no further advice, but simply provide justification for your opinion.

In order to accept that there has been a change, you must be able to demonstrate medical fact to account for the change. A change of opinion is not enough. A medical ‘fact’ is generally an issue or issues which are not specific to the case being advised on, but are issues that are more or less universally accepted by the medical profession.
Examples of medical ‘facts’ are:

- soft tissue injuries recover in months and do not cause life-long disability
- transection of the spinal cord causes paralysis below the level of the spinal cord damage
- an injury to the lumbar spine will not have effects in the upper limbs
- development of angina after a back injury is due to atheroma in the coronary arteries, not the back injury.
- a shoulder injury does not cause carpal tunnel syndrome

Note: It is not sufficient to quote the above; there must be an explanation of the medical facts.

For example: an injury to the lumbar spine will not have effects in the upper limbs because the nerves from the lumbar region supply the lower limbs only. The upper limbs receive their nerve supply from the spinal nerves in the neck. It is not anatomically possible for an injury to the lower back to have an effect in the upper limbs.

Example 1. Knee injury with 10% gross (less 3% for pre-existing OA knee) for 1 year to 31 March 2008. The advice given was that by this date all remaining disablement would be attributable to pre-existing osteoarthritis of the knee, and therefore a date final assessment was recommended. The claimant made a claim for change of circumstances review on 5 April 2009. This must be treated as a new claim. Your opinion is that some of the disablement was still due to the relevant accident, this is an opinion and not sufficient, you must identify a fact to support your opinion. Your medical advice should be whatever is appropriate and the DM should deal with the consequences. Thus if the HCP is of view that the change took place within the period of an earlier assessment he/she should say so. Similarly, if the HCP is of the view that the earlier advice was wrong in some respect he should say how and why.

Example 2. A knee injury was finalised at 10%, fully relevant, for 1 year to 31 March 2004. After 5 years a claim for change of circumstances is made, reporting deterioration, when you undertake the assessment you do so knowing that medically it is reasonable to expect the development of post traumatic arthritis following disruption of the knee joint. Therefore if you find that there has been deterioration due to the development of arthritis, the medical facts support your opinion that there has been worsening. However, because of the DMA legislation, this has to be treated as a new claim. The assessment of disablement should begin when the OA became disabling.

Example 3. A knee injury was finalised at 10%, fully relevant, for 1 year to 31 March 1999. After 10 years a claim for change of circumstances is made, reporting deterioration, when you undertake the assessment you do so knowing that medically it is reasonable to expect the development of post traumatic
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arthritis following disruption of the knee joint. Therefore if you find that there has been deterioration due to the development of arthritis, the medical facts (which must be documented and explained) support your opinion that there has been worsening and a change of circumstances can be advised. The assessment of disablement should begin when the OA became disabling.

Example 4. A knee injury was finalised at 10%, fully relevant, for 1 year to 31 March 2009. On 1 January 2009 he claims that his knee has worsened. As the claim is within the existing award it can be treated as a change of circumstances. Your advice is that there is no loss of faculty as there is full, pain-free movement and no difference between the injured and non-injured knee from xx xx xxxx. You should advise what you is medically appropriate with regard to the date, and let the DM deal with the legal aspects.

In conclusion:

if there is an existing award, then you can advise that there is a change of circumstances

if the previous award was post 5 July 1999 and there is no existing award, the claim must be dealt with as a new claim. The HCP should give the true medical position and the DM should then apply the correct legislative criteria.

if the previous award was pre-5.7.1999 then irrespective of whether it is no LOF or there is an assessment, and there has been a change, you can advice that there has been a change of circumstances.

advice that there has been a change either improvement or worsening must be supported by a medical fact or facts.

a difference of opinion is not a fact.

6.2 Reduced Earnings Allowance (REA)

REA is only available in respect of accidents prior to 1/10/90 or to diseases where the date of onset is prior to 1/10/90. REA compensates for loss of earnings due to accident or disease, rather than the disablement caused.

REA is a separate allowance, not an increase of disablement pension, payable when a claimant has a disablement assessment of 1% or more and who as a result of the relevant loss of faculty resulting from an accident or PD is:

Incapable, and likely to remain permanently incapable of their regular occupation, and is incapable of other work of an equivalent standard which is suitable in their case, or

Incapable of their regular occupation or other work of an equivalent standard at all times during the period for which the disablement assessment is at least 1%.
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The first situation above is known as the permanent condition, and the second is known as the continuous condition.

In considering claims for REA, the DM may require medical advice on:

- The question of the claimant’s fitness for employment in his regular occupation.
- If the relevant loss of faculty contributes materially to incapacity for their regular occupation.
- Whether such incapacity is likely to be permanent.
- The question of the claimant’s fitness for other employment.

Give advice on form BI118H by answering carefully all the questions and giving details of any material changes in the claimant’s condition since any previous report. This is particularly important when you are not assessing the claimant’s disability at the same time.

**Regular occupation**

You are supplied with details of what is to be regarded, for the purposes of the claim, as the claimant’s regular occupation and a description of the duties involved with particular reference to the physical effort or dexterity needed. If more detailed information is required, you should question the claimant about the aspects of their regular occupation and record any significant factors which affect their opinion.

**HCP’s opinion on incapacity for regular occupation**

When giving an opinion on incapacity for the regular occupation, due regard should be paid to the details of the physical strain involved. If you are of the opinion that the claimant is unfit to continue working in their regular occupation, this should be indicated whether the relevant loss of faculty contributes materially to the claimant’s unfitness and wherever possible, do so by giving a definite answer, yes or no.

An opinion that a claimant is likely to be permanently unfit for their regular occupation as a result of the relevant loss of faculty is not necessarily inconsistent with a provisional disablement assessment. Such an opinion should be given where appropriate, bearing in mind the nature of the relevant loss of faculty in relation to the requirements of the regular occupation. Where you consider that some other factor, such as old age, is a contributory cause of unfitness, this should clearly be indicated.

Where you are of the opinion that:

- The claimant is fit for his regular occupation, or
The relevant loss of faculty does not contribute materially to their incapacity for their regular occupation.

Then the reasons for your opinion should be given as these will assist the DM when they are considering any further medical evidence.

Suitable alternative employment

Where you are of the opinion that the claimant is incapable of their regular occupation, you are asked to indicate whether the claimant is capable of any remunerative employment, and if so, what physical and mental limitations are imposed by any other condition.

This advice will help the DM to consider what employment may be considered suitable for the claimant. Occasionally, you will be asked to advise on fitness for a specific alternative employment that will be described.

REA following Tribunals Service appeal or previous HCP Decision

There should not be a problem with giving advice in REA cases where you disagree with a Tribunals Service decision, or with a previous HCP’s advice on diagnosis. The main issue is whether the REA advice (or any advice for that matter) is supported by the evidence, and the consensus of medical opinion, and is well explained.

If you are of the opinion that a loss of faculty does not contribute materially to the incapacity for work, then you should emphasise the point when giving REA advice. After all, 100% disablement does not necessarily cause incapacity for work at the regular occupation, but a 1% disablement may do, as it all depends on the nature of the condition and the nature of the work. It is normal practice to state that a person who is diagnosed with PD A11 should not work in an occupation that involves the use of vibrating tools. However, such advice should not be given if you considers that the available evidence does not support the diagnosis of PD A11.

As with all advice, there should be sufficient explanation given to the DM to allow understanding of the reasons for the opinion and advice. The justification should list the relevant evidence and the reasons for drawing the conclusions that have been made now. There is no purpose served by making overt criticism of the earlier decision(s). It is then for the DM to weigh the evidence and decide entitlement to REA.

6.3 Unemployability Supplement (US)

Unemployability Supplement was abolished as an increase of IIDB from April 1987, existing claimants could retain entitlement. But claims can continue to be made under the Pneumoconiosis, Byssinosis and Miscellaneous Disease Benefit Scheme and the Workmen's' Compensation Scheme. The most common type of referral is a renewal.
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In considering such claims the DM will need medical advice on the following:

Whether the claimant is incapable of work.

If the incapacity is due to the relevant loss of faculty.

Whether the incapacity is likely to be permanent.

Medical advice is given on form BI118F.

Incapacity for work

To qualify for the supplement, a person must be incapable not merely of following their regular or pre-accident employment, but of work generally. For the purposes of the supplement, a person may be treated as incapable of work, even though not entirely incapable provided that the loss of faculty is likely to prevent their earnings exceeding the prescribed earnings level.

Due to the relevant loss of faculty

The incapacity for work must be due to a material extent to the relevant loss of faculty. Where the effects of the relevant loss of faculty are in themselves incapacitating, the fact that the effects of any other unconnected condition might also be incapacitating is of no significance.

In a case where the relevant loss of faculty in itself was not sufficient to render the claimant incapable of work, the Commissioner held that if that loss when added to the claimant’s existing unconnected ailments changed him from a man who was capable to one who was incapable of work, it could be accepted that incapacity was due to the relevant loss of faculty.

Where a claimant’s incapacity results from a combination of relevant and unconnected conditions, you are asked to give as much information as possible to enable the decision maker to decide whether the conditions for an award of the supplement are satisfied.

Permanent incapacity for work

A claimant should be regarded as likely to remain permanently incapable of work if their incapacity is likely to be for life and prevents them from earning their own livelihood by any kind of work which, having regard to their abilities and general circumstances, they could reasonably be expected to take up, and adapt themselves to, after suitable training.

6.4 Constant Attendance Allowance (CAA)

CAA is an increase of disablement pension, which may be paid to a person, whose disablement has been assessed at 95% or more, resulting in a 100% pension, and the claimant:
Medical Services

Is dependent on attendance for the necessities of life.

Needs attendance because of the relevant loss of faculty, and

Is likely to need attendance for a prolonged period.

Before CAA can be granted, the DM requires to be satisfied that the claimant needs attendance every day to a substantial extent, but not necessarily all day, for help with the ordinary necessities of life. This need is likely to exist for a prolonged period, that is, for at least 6 months.

You should interpret the phrase, “the necessities of life” freely. There are obvious interpretations including:

- Eating
- Drinking
- Sleeping
- Natural functions.

However, a claimant can also expect a reasonable degree of physical and mental comfort and the disablement may create special “necessities of life”. For example, some applicants may need to eat or drink more frequently than others, or needs may be increased by incontinence, insomnia, bed sores or vomiting.

The allowance is not granted in respect of help in housework or other purely domestic purposes, or for only slight intermittent attendance such as help in dressing or undressing.

Medical Advice

When you advise that assessment is 95% or more, you should normally consider and advise on the claimant’s need for attendance. Advice is also sought when the period for which CAA has been granted is due to expire. Advice is provided on form BI118D.

In the light of the general considerations described in the information concerning CAA, you are asked to give as much detail as possible of the nature, the extent and frequency as well as the reason for the help required. The object is to obtain as comprehensive a picture as possible of the claimant's actual capabilities and needs as these affect their day to day activities. For example, incontinence may be a limiting factor in the extent to which a motorised vehicle could otherwise be used.

Exceptionally Severe Disablement Allowance (ESDA) ESDA is a long-term supplement to CAA.

It is payable when:
Medical Services

A claimant is entitled to CAA at a higher rate than normal maximum, or

Claimant would be entitled to CAA at a higher rate than the normal maximum but is in hospital, and

The need for that level of attendance is likely to be permanent.

There are no actual considerations for you to make with respect to ESDA. The DM automatically decides entitlement at the same time CAA is granted, if the criteria are satisfied.

ESDA is not payable if the claimant’s condition is expected to improve and the rate of CAA to be reduced in the future.

The DM will usually consult the HCP for an opinion before finally deciding on entitlement. The DM will require advice from the HCP on the prognosis of the medical condition and the likelihood of any variation in the level of attendance needs.

6.5 Industrial Death Benefit

Industrial Death Benefit (IDB) is a benefit payable to the widow or widower and children of a person who died as a result of an industrial accident or prescribed disease before 11th April 1988

The widow is entitled to IDB if when her spouse died she was

- Residing with him, or
- Receiving maintenance from him

A widower is entitled to IDB if when his spouse died he was

- Being wholly maintained by her and
- Permanently incapable of supporting himself

Referrals are rare; however, the IIDB DM may still get asked to give decisions on death by way of industrial accident or prescribed disease and may seek advice on specific issues
7 Professional Standards, Training, Approval, Revalidation and Audit

7.1 Professional Standards

Non-Discrimination

All the work of HCPs will be carried out in a manner consistent with the DWP policy of non-discrimination. In summary all of this recognises the right of everyone to be treated with respect whatever their gender, sexual orientation, race, religion, nationality, culture, age, health, (dis)ability, marital status and physical characteristics or appearance. Information about suitable words and descriptions to use when completing reports is given in Appendix F.

The above principles apply in the professional relationship between the HCP and the claimant and also in relation to the claimant's approach to the HCP.

Personal Conduct

In dealings with claimants and their representatives HCPs will be:

Accessible
Punctual
Reliable
Presentable
Approachable
Courteous
Friendly.

Examination

When carrying out an examination of a claimant, the HCP will:

Introduce themselves to the claimant and wear a name badge or offer other official identification.

Make the claimant feel welcome and at ease.

Be polite at all times.

Explain the purpose of the assessment.
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Explain what the assessment entails.

Allow the claimant time to give their history, asking questions in a non-adversarial manner and following the relevant benefit guidance.

Carry out a relevant examination to provide the information necessary to give and justify clinically reasonable advice.

Avoid any unnecessary discomfort, where possible assessing active movement of limbs before embarking on any passive movement; however passive movements should only be carried out if essential to the outcome of the assessment.

Advice and Reporting

When giving advice within a report:

The HCP’s advice will be objective, independent, fair and impartial, ethical, and given in accordance with the practitioner’s contractual obligations.

Advice will conform to the consensus of medical opinion and the balance of probability.

Advice will be of an appropriate depth, scope and focus, and presented with a clarity that will permit the DM to give reasonable consideration to the medical issues.
## Terms, Concepts and Definitions

<table>
<thead>
<tr>
<th>Objective</th>
<th>Based on evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Without the influence of carer responsibility, or involvement in any other aspect of the claim.</td>
</tr>
<tr>
<td>Fair and Impartial</td>
<td>With no personal interest, of any sort, in the outcome of the claim under consideration. Everyone has the right to work without fear of harassment. (This equally affects the practitioner’s relationship with the claimant and the reversed role). Every HCP (and all other employees and persons acting on behalf of Atos Healthcare has a duty to protect and respect this right. (Harassment is a generic term that encompasses bullying and victimisation).</td>
</tr>
<tr>
<td>Ethical</td>
<td>Conforming to the code of Professional Ethics as laid down by the HCP’s respective professional body.</td>
</tr>
<tr>
<td>Appropriate Depth</td>
<td>Sufficient factual detail obtained to support the advice.</td>
</tr>
<tr>
<td>Scope</td>
<td>Addressing all the questions asked. Covering all relevant issues, including details of an appropriate medical examination when required. Without reference to benefit entitlement. Answering questions posed by the claimant without compromising any subsequent decision making process.</td>
</tr>
<tr>
<td>Focus</td>
<td>Relevant. Medically logical. In accordance with contractual obligations. Further Medical Evidence if required should be appropriate, and obtained by the most economical method, but the latter should not be an overriding concern. Given in good time, taking account of any targets or deadlines.</td>
</tr>
</tbody>
</table>
Medical Services

<table>
<thead>
<tr>
<th>Clarity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concise.</td>
<td>In terms understood by the claimant (without any unexplained clinical jargon or abbreviations).</td>
</tr>
<tr>
<td>Legible when written.</td>
<td>It will be clear in its account of Further Medical Evidence usage.</td>
</tr>
<tr>
<td>Free of contradictions or conflicts.</td>
<td></td>
</tr>
</tbody>
</table>

**Testing the Standards**

All of the standards set out above are regularly measured in a number of different ways. These can be analysed nationally, by region, by local centre and for individual HCPs wherever they work:

- **Claimant surveys** highlight administrative and clinical issues.
- **Customer (e.g. DWP) surveys** also highlight administrative and clinical issues.
- **Rework** requests usually relate to major deficiencies in a report.
- **Peer group audit (IQAS)** is ongoing on randomly selected cases.
- **Direct observations** by experienced colleagues.
- **Complaints** received for both administrative and clinical issues. Further information on handling of complaints can be found in **Appendix G**.
- **The Tribunals Service** feedback usually refers to deficiencies in reports, but can raise professional standard issues related to examinations.
- **Pressure groups** for the disabled feedback issues from their clients.

This information shows that any work carried out on behalf of Medical Services is more likely to be thoroughly scrutinised than other medical work, even though it does not involve ongoing clinical care responsibilities.

**7.2 Approval**

Each benefit requires that the reporting HCP holds approval for that work from the Chief Medical Adviser (CMA) for the Department for Work and Pensions. This is granted once the HCP achieves the required standard in reports and demonstrates application of Medical Services Professional Standards.
Medical Services

Attendance at an IIDB training course is required, which is followed by a formal test of knowledge, and this, together with audit of the initial casework is presented and should all lead to Approval for IIDB assessment work on behalf of the DWP.

7.3 Revalidation

Continuing approval depends on satisfactory results from the Integrated Quality Audit Scheme (IQAS) and annually completing Continuing Medical Education (CME) courses provided by Medical Services, and this will assist with GMC Revalidation.

7.4 Medical Services Database

The Medical Services Database (MSD) is an electronic file that is maintained for every HCP working in any capacity for MS.

This contains essential details of each HCP, and information about each HCP’s Approval, Audit Record and also Continuing Medical Education (CME) attendance.

7.5 Continuing Medical Education

CME is provided annually by MS. All Approved HCPs must complete this in order to continue carrying out medical assessments on behalf of the Department of Work and Pensions.

7.6 Audit of Reports

It is essential that HCPs know something about the standards against which reports will be judged in the audit process.

The audit is carried out against defined standards and using a selection of attributes that a report should contain. These attributes are either applicable to all reports (generic) or defined by benefit or even by the nature of the form on which the HCP has had to report. The attributes for the latter categories will be presented later.

Below the generic attributes are set out, and these apply to most Atos Healthcare activities, not just IIDB assessments. The codes allow compilation of results on spreadsheets, and hence ease review of overall results.
Presentation and Process Attributes

<table>
<thead>
<tr>
<th>Key Requirements</th>
<th>Attribute</th>
<th>Attribute code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legible and clear</td>
<td>Legible</td>
<td>G06</td>
</tr>
<tr>
<td></td>
<td>Clearly presented</td>
<td>G10</td>
</tr>
<tr>
<td>In Plain English</td>
<td>Free from medical abbreviations</td>
<td>G12</td>
</tr>
<tr>
<td></td>
<td>Free from medical jargon</td>
<td>G13</td>
</tr>
<tr>
<td></td>
<td>In plain English</td>
<td>G15</td>
</tr>
<tr>
<td>Consistent</td>
<td>Consistent</td>
<td>G03</td>
</tr>
<tr>
<td>Procedurally Correct</td>
<td>In accordance with defined procedures and current advice</td>
<td>G04</td>
</tr>
<tr>
<td></td>
<td>In accordance with Legislation</td>
<td>G05</td>
</tr>
<tr>
<td></td>
<td>Appropriate response to incorrect documentation</td>
<td>G08</td>
</tr>
<tr>
<td></td>
<td>FME consideration recorded</td>
<td>G11</td>
</tr>
<tr>
<td>All Key Questions</td>
<td>Complete answers to all questions raised</td>
<td>G02</td>
</tr>
<tr>
<td>Addressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Justified</td>
<td>Advice adequately justified</td>
<td>G16</td>
</tr>
<tr>
<td>Medical Issues</td>
<td>Clear explanation of medical issues</td>
<td>G01</td>
</tr>
<tr>
<td>Fully Explained</td>
<td>Appropriately detailed</td>
<td>G09</td>
</tr>
<tr>
<td></td>
<td>Full clarification of contradictions and/or conflicts</td>
<td>G14</td>
</tr>
<tr>
<td>Non-prescriptive</td>
<td>Not compromising decision making</td>
<td>G07</td>
</tr>
</tbody>
</table>

These areas are looked at in all reports regardless of the benefit concerned.

All results from audit, from the time of approval for each benefit, and data from Continuing Medical Education (CME) are retained on the Medical Services Database (MSD), for each HCP.

Definition and Interpretation of Generic Attributes

Many of the core “Attributes” described are features that are either referred to in the Professional Standards above or have been described in the earlier Parts of this Handbook, but the definitions and interpretations are set out below. From this and what is explained above the HCP can be confident that the audit criteria are objective. Attributes are similarly available for all the medical processes and forms in MS. The criteria are similarly defined for all attributes allowing objective audit.

**ATTRIBUTE**

“Legible” - The evaluation of legibility is inevitably a subjective task. However, some measure of the ease with which a product may be read is necessary in our business. A passage may be regarded as legible if it can be read at not less than half the average speed of printed text, and no key words or phrases are indecipherable.

**CODE**

G06
“Clearly presented” - Good presentation is an important component of clarity. Faced with a lengthy passage of free text it is often difficult for the reader to efficiently identify its components and structure. Underlined headings and logical sectioning of text greatly aid communication between author and reader.

“Free from medical abbreviations” - Medical abbreviations should not be used. Although most readers may know certain shorthand medical terms it is nevertheless good practice to avoid their use wherever there is any possibility of confusion.

“Free from medical jargon” - The use of medical jargon, which includes medical abbreviations, can lead to misunderstandings. The term "medical jargon" is distinguished from technical medical language (see “Clear explanation of medical issues”). Examples of medical jargon would be “Oedema ° cyanosis °….“ or “Nodes neck ↑↑ R>L”.

“In plain English” - The use of uncommon or long words where everyday, commonly used terms would be equally effective is not good practice. Sentences should be brief, clear and to the point.

“Consistent” - A report should be consistent in that it must contain no internal contradictions. A fact or opinion given in one part of a document should be in accord with all other components of the product.

“In accordance with defined procedures and current advice”- This attribute requires that a report must be procedurally correct. It should be prepared in accordance with current usage as defined in reference publications for HCPs.

“In accordance with legislation” - While the HCP’s role is wholly advisory and not statutory, the work is nevertheless carried out within the framework of current legislation. It is therefore a required attribute that advice is given in accordance with the law.

“Appropriate response to incorrect documentation” - The HCP should be able to recognise the fact that incorrect documentation has been provided. The HCP’s response will vary according to circumstances, but above all should not compound the error. It should reflect the needs of the business and the requirements of the customer.

“FME consideration recorded” - It is important that the customer is made clearly aware of the evidence which the HCP has considered in giving advice. Further medical evidence is of particular importance in this context.

“Complete answers to all questions raised” - No area of a report should be left incomplete. If the customer raises specific questions they should all be addressed.
Medical Services

“Advice adequately justified” - Advice, which is not accompanied by justification, is no more than a gratuitous opinion. This attribute requires that the author of a report give a clear explanation of the reasons for giving certain advice and the underlying evidence by which he was guided.  

“Clear explanation of medical issues” - A report written solely in technical medical terms is valueless to the non-medical customer. This attribute does not require that such terms be avoided, merely that they and the underlying medical reasoning are clearly explained for the benefit of the non-medical reader.  

“Appropriately detailed” - Excessive detail compromises clarity. Equally, failure to provide adequate information may compromise decision-making. Skilled report writing avoids these extremes.  

“Full clarification of contradictions and/or conflicts” - Conflicts of evidence should be addressed. Even where the HCP is unable to provide an explanation for such a conflict, he should demonstrate that the difficulty has been recognised.  

“Not compromising decision-making” – The HCP’s report should contain no allusion to entitlement to benefit, or express any view regarding the outcome of a case.
### Benefit Specific Audit

Below the audit criteria for BI118 Accident form are set out. Different audit criteria are applied to all types of examination and report. The various forms for IIDB are identified in Appendix A and many have their specific audit form and attributes.

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Requirements</th>
<th>BI 118 Accident Attributes</th>
<th>Attribute code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL EXAMINATION</strong></td>
<td>Date of accident given</td>
<td>S22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity at the time of the accident recorded</td>
<td>S06</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nature of the accident recorded</td>
<td>S38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immediate treatment</td>
<td>S33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subsequent treatment recorded</td>
<td>S56</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current symptoms described</td>
<td>S19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current medical treatment described</td>
<td>S18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate clinical and past medical history recorded</td>
<td>S10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant past history recorded</td>
<td>S49</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effects on everyday activities recorded</td>
<td>S25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any proposals for future treatment</td>
<td>S09</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focus on level of disability after 91st day</td>
<td>S34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other current health problems recorded</td>
<td>S42</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current work situation described</td>
<td>S20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ongoing compensation issues recorded</td>
<td>S41</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement written in first person</td>
<td>S61</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement signed by client [or carer/representative]</td>
<td>S54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate pen picture present</td>
<td>C10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clear record of a careful structured examination of all relevant areas</td>
<td>C01</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical findings expressed clearly and concisely</td>
<td>C03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Record of appropriate mental health assessment, if indicated</td>
<td>C08</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical tests appropriate to specific conditions applied and recorded</td>
<td>C13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measurements recorded properly and appropriately</td>
<td>C14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inappropriate signs clearly described</td>
<td>C06</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate examples of observed behaviour recorded</td>
<td>C12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Style of recording permits future comparison</td>
<td>C15</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL REASONING</strong></td>
<td>Injury identified and expressed correctly</td>
<td>R65</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss of faculty identified, expressed and dated correctly</td>
<td>R23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability properly identified and appropriately detailed</td>
<td>R54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevance properly assigned (FP)</td>
<td>R36</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevance properly assigned (O-PrePost)</td>
<td>R37</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Pre conditions appropriately assessed</td>
<td>R31</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O Post conditions appropriately assessed</td>
<td>R29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unconnected conditions appropriately recorded</td>
<td>R74</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability expressed appropriately</td>
<td>R55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment level appropriate</td>
<td>R10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start date correct</td>
<td>R38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duration of assessment appropriate</td>
<td>R56</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Period (final/provisional) appropriate</td>
<td>R69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medically reasonable and logical</td>
<td>R25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advice supported by adequately detailed justification</td>
<td>R14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate use of medical evidence</td>
<td>R47</td>
<td></td>
</tr>
<tr>
<td><strong>ALL MEDICAL ISSUESシーン</strong></td>
<td>FME clarified and interpreted when required</td>
<td>R63</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inconsistencies dealt with clearly</td>
<td>R20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advice conforms to consensus of medical opinion and balance of probabilities</td>
<td>R01</td>
<td></td>
</tr>
</tbody>
</table>

Industrial Injuries Handbook 1 for Medical Advisers
Principles of Assessment
MED-S2/IIDBHB~001(a)
Medical Services

Who reads the reports?

A DWP DM, who requires not just a history and examination, but also a well-expressed justification of opinions, sees all completed forms. Unsatisfactory reports are likely to be returned for Rework. Higher numbers of reworks than usual will trigger a more intensive audit.

An experienced Health Care Professional will regularly subject a small sample of each HCP’s work to an audit process. A Mentor will provide feedback on the outcome and all examining HCPs must be prepared to expect compliments, advice but also criticism, as these are all essential parts of this process.

There are appeals against the DM’s decisions. As a result the Tribunal members (legal Chairman and one or more medical members) will read the reports, which form a major part of the evidence.

It is very important to remember that the claimant always has a right to see the report, and a copy will be sent out in the event of an appeal. At the examination the claimant should not be shown the report, because at that stage it will be incomplete. However, the DM will have to forward a copy if it is requested.

Why is audit required?

Ensuring that an adequate standard of examination and reporting is being maintained nationally (forms part of the contract between Medical Services and the DWP).

Provides quality assurance for our customers within the DWP.

Quality assurance to other stakeholders such as The Tribunals Service.

Enhancing the Medical and Professional credibility of the process.

Allows management of performance issues.

Informs the Training and Development unit and the Medical Manager for analysis of training needs.

Continuing CMA Approval requires documentary evidence of good standard.

Revalidation by professional bodies also requires documentary evidence of good standard.
## Appendix A - List of HCP's Report and Advice Forms

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI118</td>
<td>Accident</td>
</tr>
<tr>
<td>BI118A</td>
<td>Reassessment report in accident cases</td>
</tr>
<tr>
<td>BI118A(OD)</td>
<td>Reassessment report in PD A10 cases</td>
</tr>
<tr>
<td>BI118A(OD)Supp</td>
<td>Insert for BI118A(OD)</td>
</tr>
<tr>
<td>BI118D</td>
<td>Advice on the need for CAA</td>
</tr>
<tr>
<td>BI118F</td>
<td>Advice on the need for UNSUPP</td>
</tr>
<tr>
<td>BI118H</td>
<td>Advice on claim for REA</td>
</tr>
<tr>
<td>BI118(OD) 11/04</td>
<td>Initial report in PD A10 cases</td>
</tr>
<tr>
<td>BI118R</td>
<td>Review for claimed change of circumstances (usually deterioration)</td>
</tr>
<tr>
<td>BI118X</td>
<td>Split assessment decision</td>
</tr>
<tr>
<td>MX6</td>
<td>Special report on injury to hands</td>
</tr>
</tbody>
</table>

### Other report forms and requests for evidence

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI127</td>
<td>Request for Hospital Case Notes</td>
</tr>
<tr>
<td>BI127A</td>
<td>Record of extract of Hospital Case Notes</td>
</tr>
<tr>
<td>BI127X</td>
<td>Request for x-rays</td>
</tr>
<tr>
<td>BI161B</td>
<td>HCP report based on documentary evidence</td>
</tr>
<tr>
<td>BI613</td>
<td>HCP examination report (advice about prescribed disease claim)</td>
</tr>
<tr>
<td>BI161L</td>
<td>Covering letter to Consultant to accompany report</td>
</tr>
<tr>
<td>BI161L(OD)</td>
<td>Covering letter to Consultant to accompany BI161(OD) in PD A10 initial cases</td>
</tr>
<tr>
<td>BI161L(OD)A</td>
<td>Covering letter to audiometer technician to accompany BI161(OD)A in PD A10 initial cases</td>
</tr>
<tr>
<td>BI161(OD)</td>
<td>Consultant report in PD A10 initial cases</td>
</tr>
<tr>
<td>BI161(OD)A</td>
<td>Audiometer technician report in PD A10 initial, reassessment and review cases</td>
</tr>
<tr>
<td>BI161(OD)B</td>
<td>HCP report based upon BI161(OD)A</td>
</tr>
<tr>
<td>BI161(PD)</td>
<td>Consultant examination and report for PDs, but not A10, A11 and D5</td>
</tr>
<tr>
<td>BI161(VWF)</td>
<td>Consultant examination and report in PD A11 cases</td>
</tr>
<tr>
<td>BI162L(OD)</td>
<td>Covering letter to Consultant to accompany BI162(OD) in PD A10 reassessment cases</td>
</tr>
<tr>
<td>BI162L(OD)A</td>
<td>Covering letter to audiometer technician to accompany BI161 (OD)A in PD A10 reassessment cases</td>
</tr>
</tbody>
</table>
Medical Services

BI162(OD)  Consultant report in PD A10 reassessment and review cases
BI205     GP report
BI205L    Covering letter to GP to accompany BI205
BI612     DM advice form for an Industrial Injuries Disablement Benefit
          Prescribed Disease Claim
MX5       Radiological examination and report
MX5L      Covering letter to accompany MX5
# Appendix B – Part 1: Schedule 2 to the Social Security (General Benefit) Regulations 1982

## Prescribed Degrees of Disablement

<table>
<thead>
<tr>
<th>Description of Injury</th>
<th>Disablement %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of both hands, or amputation at higher sites</td>
<td>100</td>
</tr>
<tr>
<td>2. Loss of hand and a foot</td>
<td>100</td>
</tr>
<tr>
<td>3. Double amputation through leg or thigh, or amputation through leg or thigh on one side and loss of other foot</td>
<td>100</td>
</tr>
<tr>
<td>4. Loss of sight to such an extent as to render the claimant unable to perform any work for which eyesight is essential</td>
<td>100</td>
</tr>
<tr>
<td>5. Very severe facial disfigurement</td>
<td>100</td>
</tr>
<tr>
<td>6. Absolute deafness</td>
<td>100</td>
</tr>
<tr>
<td>7. Forequarter or hindquarter amputation</td>
<td>100</td>
</tr>
</tbody>
</table>

### Amputation Cases - Upper Limbs (either arm)

<table>
<thead>
<tr>
<th>Description of Injury</th>
<th>Disablement %</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Amputation through shoulder joint</td>
<td>90</td>
</tr>
<tr>
<td>9. Amputation below shoulder with stump less than 20.5cms from tip of acromion</td>
<td>80</td>
</tr>
<tr>
<td>10. Amputation from 20.5cms from tip of acromion to less than 11.5cms below tip of olecranon</td>
<td>70</td>
</tr>
<tr>
<td>11. Loss of hand or of the thumb and four fingers of one hand or amputation from 11.5cms below tip of olecranon</td>
<td>60</td>
</tr>
<tr>
<td>12. Loss of thumb</td>
<td>30</td>
</tr>
<tr>
<td>13. Loss of thumb and its metacarpal bone</td>
<td>40</td>
</tr>
<tr>
<td>14. Loss of four fingers of one hand</td>
<td>50</td>
</tr>
<tr>
<td>15. Loss of three fingers of one hand</td>
<td>30</td>
</tr>
<tr>
<td>16. Loss of two fingers of one hand</td>
<td>20</td>
</tr>
<tr>
<td>17. Loss of terminal phalanx of thumb</td>
<td>20</td>
</tr>
</tbody>
</table>

### Amputation Cases - Lower Limbs

<table>
<thead>
<tr>
<th>Description of Injury</th>
<th>Disablement %</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Amputation through both feet resulting in end-bearing stumps</td>
<td>90</td>
</tr>
<tr>
<td>19. Amputation through both feet proximal to the metatarso-phalangeal joint</td>
<td>80</td>
</tr>
<tr>
<td>20. Loss of all toes of both feet through the metatarso-phalangeal joint</td>
<td>40</td>
</tr>
<tr>
<td>21. Loss of all toes of both feet proximal to the proximal inter-phalangeal joint</td>
<td>30</td>
</tr>
<tr>
<td>22. Loss of all toes of both feet distal to the proximal inter-phalangeal joint</td>
<td>20</td>
</tr>
<tr>
<td>23. Amputation at hip</td>
<td>90</td>
</tr>
<tr>
<td>24. Amputation below hip with stump not exceeding 13cms in length measured from tip of great trochanter</td>
<td>80</td>
</tr>
</tbody>
</table>
## Medical Services

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Amputation below hip and above knee with stump not exceeding 13 cms in length measured from tip of great trochanter, or at knee not resulting in end-bearing stump</td>
<td>70</td>
</tr>
<tr>
<td>26</td>
<td>Amputation at knee resulting in end-bearing stump or below knee with stump not exceeding 9 cms</td>
<td>60</td>
</tr>
<tr>
<td>27</td>
<td>Amputation below knee with stump exceeding 9cms but not exceeding 13 cms</td>
<td>50</td>
</tr>
<tr>
<td>28</td>
<td>Amputation below the knee with stump exceeding 13cms</td>
<td>40</td>
</tr>
<tr>
<td>29</td>
<td>Amputation of one foot resulting in end-bearing stump</td>
<td>30</td>
</tr>
<tr>
<td>30</td>
<td>Amputation through one foot proximal to the metatarso-phalangeal joint</td>
<td>30</td>
</tr>
<tr>
<td>31</td>
<td>Loss of all toes of one foot through the metatarso-phalangeal joint</td>
<td>20</td>
</tr>
</tbody>
</table>

### Eye injuries

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Loss of one eye, without complications, the other being normal</td>
<td>40</td>
</tr>
<tr>
<td>33</td>
<td>Loss of vision of one eye, without complications or disfigurement of eyeball, the other being normal</td>
<td>30</td>
</tr>
</tbody>
</table>

### Loss of fingers of right or left hand

**Index finger**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Whole</td>
<td>14</td>
</tr>
<tr>
<td>35</td>
<td>Two phalanges</td>
<td>11</td>
</tr>
<tr>
<td>36</td>
<td>One phalanx</td>
<td>9</td>
</tr>
<tr>
<td>37</td>
<td>Guillotine amputation of tip without loss of bone</td>
<td>5</td>
</tr>
</tbody>
</table>

**Middle finger**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>Whole</td>
<td>12</td>
</tr>
<tr>
<td>39</td>
<td>Two phalanges</td>
<td>9</td>
</tr>
<tr>
<td>40</td>
<td>One phalanx</td>
<td>7</td>
</tr>
<tr>
<td>41</td>
<td>Guillotine amputation of tip without loss of bone</td>
<td>4</td>
</tr>
</tbody>
</table>

**Ring or little finger**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Whole</td>
<td>7</td>
</tr>
<tr>
<td>43</td>
<td>Two phalanges</td>
<td>6</td>
</tr>
<tr>
<td>44</td>
<td>One phalanx</td>
<td>5</td>
</tr>
<tr>
<td>45</td>
<td>Guillotine amputation of tip without loss of bone</td>
<td>2</td>
</tr>
</tbody>
</table>

### Loss of toes of right or left foot

**Great toe**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>Through metatarso-phalangeal joint</td>
<td>14</td>
</tr>
<tr>
<td>47</td>
<td>Part, with some loss of bone</td>
<td>3</td>
</tr>
</tbody>
</table>

**Any other toe**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Through metatarso-phalangeal joint</td>
<td>3</td>
</tr>
</tbody>
</table>
Medical Services

49  Part, with some loss of bone  1

Two toes of one foot, excluding great toe

50  Through metatarso-phalangeal joint  5
51  Part, with some bone loss  2

Three toes of one foot, excluding great toe

52  Through metatarso-phalangeal joint  6
53  Part, with some loss of bone  3

Four toes of one foot, excluding great toe

54  Through metatarso-phalangeal joint  9
55  Part, with some loss of bone  3
Appendix B – Part 2: Notes on certain specific injuries

Limb amputation cases

Stump measurements

If a certificate of stump measurement issued by the artificial limb and appliance centre is not on file, it will be necessary for HCPs to make their own stump measurements. The amputation should be measured as shown below so that the appropriate award may be made.

The first points of measurement are:
- Upper arm: The tip of the acromion with the stump hanging down the side
- Forearm: The tip of the olecranon, which is best found when the forearm of stump is flexed to a right angle
- Above knee: The tip of the great trochanter
- Below knee: Antero-medial edge of the upper articular surface of the tibia when the knee is flexed

The second point of measurement is:

All cases: Over the end of the bone as palpated through the skin or scar tissue. In a below knee case this will be the end of the tibia and not the end of the fibula, and the measurement will be taken on the inner aspect of the stump and not, as in the above knee cases, on the outer aspect.

Assessment

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

Ankyloses

In assessing the disablement resulting from the complete fixation of joints, consideration needs to be given to the position in which the joint is fixed. Below are listed the usual optimum positions for ankylosed joints:

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

**Elbow:** The angle between humerus and forearm should be rather more than a right angle, at about 110 degrees. The forearm should be supinated, so that the palm is slightly upwards.
Medical Services

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

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

**Knee:** In 5 degrees of flexion

**Ankle:** 5-10 degrees plantar flexion of the foot

The following table notes the type of assessments for ankyloses, in the optimum positions, which have been given by Appeal Tribunals. However, the HCP advises the appropriate assessment for the individual claimant.

<table>
<thead>
<tr>
<th>Ankyloses in the Optimum Position</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>40 %</td>
</tr>
<tr>
<td>Elbow</td>
<td>40 %</td>
</tr>
<tr>
<td>Wrist</td>
<td>30 %</td>
</tr>
<tr>
<td>Hip</td>
<td>60 %</td>
</tr>
<tr>
<td>Knee</td>
<td>30 %</td>
</tr>
<tr>
<td>Ankle</td>
<td>20 %</td>
</tr>
</tbody>
</table>

**Flail joints**

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

**Injuries to hands**

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

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

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

**Hysterical conditions**

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

**Assessments for eye injuries**

Items 4, 32 and 33 of the scheduled assessments apply to injuries to the eyes. It is important that HCPs record the visual findings for both eyes showing visual acuity figures both before and after correction. See Part 1 of Handbook for Commissioner’s ruling on artificial aids.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Impaired vision</th>
<th>&quot;P&quot; relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defective left eye</td>
<td>O (Pre) (other effective cause)</td>
</tr>
</tbody>
</table>
Medical Services

Assessment for both eyes (right 6/18, left N©) 45%
Assessment for pre-existing defective vision (right 6/6, left NIL) 30%
Net assessment 15 % (45 offset 30)

(b) Claimant sustains injury to the right eye that results in corrected visual acuity of 6/24. Prior to the industrial accident right and left visual acuities each corrected to 6/12.

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

Aphakic eyes

Appeal Tribunals have normally taken account of the degree of tolerance and sensitivity to the wearing of a contact lens in assessing the degree of disablement (see later notes on aphakia and pseudophakia).

Deafness

The scheduled assessment for absolute deafness is 100 per cent. The pages overleaf include, for the information of HCPs, a note of assessments for other degrees of deafness, which have been given in the normal accident case by Appeal Tribunals. It should be noted that in the case of PD A10 (Occupational Deafness), disablement is assessed using the table of binaural disablement. This table must not be used for the purpose of assessing disablement when the deafness is as a result of an industrial accident.
Indicative assessments for non-scheduled injuries given by Appeal Tribunals:

Deafness

This is for deafness caused by industrial accident only - see later table for loss of hearing due to PD A10 (Occupational Deafness).

Degree of hearing attained with both ears together

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shout not beyond 1 metre</td>
<td>80 %</td>
</tr>
<tr>
<td>Conversational voice not over 30 cms</td>
<td>60 %</td>
</tr>
<tr>
<td>Conversational voice not over 1 metre</td>
<td>40 %</td>
</tr>
<tr>
<td>Conversational voice not over 2 metres</td>
<td>20 %</td>
</tr>
<tr>
<td>Conversational voice not over 3 metres:</td>
<td></td>
</tr>
<tr>
<td>(a) one ear totally deaf</td>
<td>20 %</td>
</tr>
<tr>
<td>(b) otherwise</td>
<td>Less than 20 %</td>
</tr>
</tbody>
</table>

Notes on assessments for deafness

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

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

Right CV 2 metres
Left CV 30 cms
Right and Left 1 metre
Assessment = 40 %

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

**Splenectomy**

Increasing evidence shows that the removal of the spleen may lower natural resistance to certain organisms and removal of the spleen also involves loss of tissue. Appeal Tribunals having taken these factors into account have assessed the degree of disablement resulting from the removal of the spleen at between 2% and 5%.

**Orchidectomy**

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

**Nephrectomy**

The Commissioner held in decision R(I)14/66 that where a person loses a kidney then as a matter of law it must necessarily mean that there is a loss of faculty. The extent of disablement resulting from that loss of faculty is for the medical authorities to give advice on and in this respect regard must be had to the loss of reserve useful function. Where the other kidney is functioning normally Appeal Tribunals have assessed the degree of disablement at between 5% and 10%.

**Aphakia and Pseudophakia**

Industrial injuries involving the eyes may result in aphakia or pseudophakia which may be unilateral and bilateral. In aphakia the lens is surgically removed and the patient is given thick pebble cataract spectacles or contact lenses to correct the visual acuity.

In the majority of cases treatment gives rise to pseudophakia. The damaged lens is removed and a plastic intraocular lens is inserted.

All of these treatments have drawbacks. Spectacle lenses produce a reduced visual field and there is considerable distortion. Contact lenses can be inconvenient, require a degree of manual dexterity and can be difficult to manage particularly if near vision is considerably reduced. Intraocular lenses provide a fixed focus and loss of accommodation.

**Note:** the following reflects the consensus of opinion of the Ophthalmologist members of Appeal Tribunals.
Assessment of Disablement in Aphakic and Pseudophakic Eyes

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

Note: there may be additional factors, which may lead to a higher assessment such as, cosmetic disfigurement of the eye. The individual must be compared with a normal person of his or her own age. Loss of accommodation in a young person would be more disabling than that in a person in the age group in which presbyopia is a normal feature.

Unilateral Aphakia

Spectacle lenses 9%
Contact lenses 6%

Bilateral Aphakia

Spectacle lenses 22%
Contact lenses 16%

Pseudoaphakia

Unilateral 3%
Bilateral 8%

Valuation Table – for reduction in Visual Acuity

This Valuation Table is reproduced from the Report of the 18th International Congress of Opthalmology (1958).
Reduction of Vision: Compensation Rates (Figures in percentages)
NOTE: These assessments are for defective vision without special features and are based on the visual defect measured, after correction with glasses by the ordinary test only.

**Occupational Deafness (PD A10)**

The Binaural disablement may be read directly off the table below.

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

<table>
<thead>
<tr>
<th>Pure Tone HL dB</th>
<th>50-53</th>
<th>54-60</th>
<th>61-66</th>
<th>67-72</th>
<th>73-79</th>
<th>80-86</th>
<th>87-95</th>
<th>96-105</th>
<th>106+</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-53</td>
<td>20</td>
<td>22</td>
<td>24</td>
<td>26</td>
<td>28</td>
<td>30</td>
<td>32</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>54-60</td>
<td>22</td>
<td>30</td>
<td>32</td>
<td>34</td>
<td>36</td>
<td>38</td>
<td>40</td>
<td>42</td>
<td>44</td>
</tr>
<tr>
<td>61-66</td>
<td>24</td>
<td>32</td>
<td>40</td>
<td>42</td>
<td>44</td>
<td>46</td>
<td>48</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>67-72</td>
<td>26</td>
<td>34</td>
<td>42</td>
<td>50</td>
<td>52</td>
<td>54</td>
<td>56</td>
<td>58</td>
<td>60</td>
</tr>
<tr>
<td>73-79</td>
<td>28</td>
<td>36</td>
<td>44</td>
<td>52</td>
<td>60</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>68</td>
</tr>
<tr>
<td>80-86</td>
<td>30</td>
<td>38</td>
<td>46</td>
<td>54</td>
<td>62</td>
<td>70</td>
<td>72</td>
<td>74</td>
<td>76</td>
</tr>
<tr>
<td>87-95</td>
<td>32</td>
<td>40</td>
<td>48</td>
<td>56</td>
<td>64</td>
<td>72</td>
<td>80</td>
<td>82</td>
<td>84</td>
</tr>
<tr>
<td>96-105</td>
<td>34</td>
<td>42</td>
<td>50</td>
<td>58</td>
<td>66</td>
<td>74</td>
<td>82</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>106</td>
<td>36</td>
<td>44</td>
<td>52</td>
<td>60</td>
<td>68</td>
<td>76</td>
<td>84</td>
<td>92</td>
<td>100</td>
</tr>
</tbody>
</table>
Appendix C - Procedures for Unexpected Findings

Procedures for dealing with Unexpected Findings when the Claimant provides written Informed Consent

Examples of the relevant forms, UE1 (Rev) and UE2, are included in this Appendix.

Unexpected findings can arise during the course of an examination, whether at a MSEC or during a domiciliary visit (DV). When an HCP identifies a need to pass information about a claimant to the GP then the claimant must be provided with a reasonable explanation. The discussion should deal with:

- The nature of the information to be passed to the GP;
- The reasons for wanting to disclose this information; and
- A request for consent to release of the information.

The HCP should record relevant details of the discussion both in respect of the information given to the claimant and the claimant’s response. For example; “I advised your patient that he should report the symptom of coughing up blood to you and he said that he would arrange an appointment as soon as possible”. These details should be recorded on form UE1 (Rev) in the section:

“I have examined your patient/reviewed your patient’s file* in connection with their claim to benefit. I believe that you will wish to be aware"

Informed written consent from the claimant should be obtained on the UE1 (Rev) form and the procedural guidance must be followed in full.

The claimant should be given a photocopy (or carbon copy if photocopying facilities are not available) at the time of the examination.

The HCP’s findings must be communicated to the claimant’s GP within 24 hours, provided that the claimant has given consent for this release.
Guidance when the Examination is in a MSEC

For work carried out in a Medical Services Examination Centre (MSEC), the procedure will depend upon the urgency of the situation. Remember the 24-hour target for passing information to the GP.

Contact by telephone: (UE1 (Rev) should be used as a record of the conversation)

If the HCP considers it necessary, contact can initially be made by telephone, followed by written confirmation using form UE1 (Rev). If the HCP does telephone the GP, they should use the section:

“I have examined your patient/reviewed your patient’s file* in connection with their claim to benefit. I believe that you will wish to be aware……...” on form UE1 (Rev) to record a note of the conversation.

Contact by letter: (UE1 (Rev) use and distribution)

If used as a letter, four copies of UE1(Rev) must be made before issue to the GP. One is handed to the claimant, one kept on the claimant’s file, one placed in the HCP’s file and one is kept in the CSD file.

Pensions and Overseas Cases (POD)

In Pensions and Overseas Directorate cases, and if the claimant does not have a UK based GP, advise them to seek medical attention, and provide them with an additional copy of the UE1 (Rev) detailing the clinical findings.

Claimant does not have a GP

If a claimant is not registered with a GP, the guidelines set out in the POD section above should be followed.

Completed UE1 (Rev)

On completion of the UE1 (Rev) pass it to the MEA/ receptionist.

Action to be taken by MSEC administrative staff:

When the MEA/Receptionist receives the completed UE1 (Rev) four photocopies are produced then;

Return one copy to the HCP, to be handed to the claimant

Fax the completed UE1 (Rev) form to the claimant’s GP (if GP’s fax number is not known the MEA/Receptionist must obtain it by telephoning the GP) and also post a copy by 1st class post immediately.

File a copy of the completed UE1 (Rev) in the claimant’s file.
Issue a copy of completed UE1 (Rev) to CSD at the appropriate MSC.

**Action to be taken by CSD staff:**

File a copy of the completed UE1 (Rev) in the HCP’s personal file (to be kept for a minimum of 10 years)

Place a copy on the CSD file that has been set up for this purpose. (retained for 3 months).

**Guidance when the HCP is conducting a Domiciliary Visit (DV)**

**The HCP’s role**

Most reports completed during a DV will not be seen by a medical member of staff when they are returned to the MSC. It is therefore the responsibility of the HCP to report any unexpected findings to the claimant’s GP by telephone and record details of the conversation on form UE1 (Rev).

A copy of the UE1 (Rev) form must be handed to the claimant. If neither copying facilities nor carbon paper are available, the doctor must make an exact copy on a separate UE1 (Rev). For this purpose, each HCP will have been issued with three spare copies of form UE1 (Rev) along with a piece of carbon copy paper.

**Each DV issued will also contain one copy of form UE1 (Rev) and HCPs should contact their respective MSC to replenish their stocks of UE1 (Rev) forms.**

Telephone contact must be made in all cases, to ensure compliance with the 24-hour deadline.

In addition, in all cases, a UE1 (Rev) form must be completed and attached in a clearly visible position at the front of the examination report. This should include details of the information passed by telephone to the claimant’s GP. The file must then be returned to the MSC as normal. There the administration clerk will issue the completed UE1 (Rev) to the GP, after taking copies for CSD (retained for 3 months), the claimant’s file and the HCP’s personal file (to be retained for a minimum of 10 years).

Similar general principles must be applied in the rare cases that are examined in the consulting room or office.

**Revised procedures for dealing with unexpected findings when the claimant refuses consent to release information**

If the claimant refuses to give consent, the HCP should not normally make any attempt to contact the GP by telephone or by letter. The claimant should be asked to sign the relevant section of the UE1 (Rev) to indicate this refusal.
In these circumstances, the HCP should only complete the form partially, so as to provide the claimant’s name and NINO for identification purposes, and details of the clinical condition that raised concern. There is no need to complete the GP contact details, as the form is not intended for despatch. Nevertheless, copies of the partially completed UE1 (Rev) should be retained on the claimant’s file, the CSD file and the HCP’s personal file, in accordance with current guidance.

A factual description of the unexpected finding should be included in the examination report in the usual manner.

**When the claimant refuses consent to release information and also refuses to sign the UE1 (Rev)**

If the claimant refuses to give consent and, in addition, also refuses to sign to relevant section of the UE1 (Rev) form, the HCP should annotate the form with details of the circumstances. The process should then follow the above procedure.

**When the claimant refuses consent to release information but the HCP’s professional judgement identifies the need to release information**

Whenever the claimant refuses to provide consent (written or verbal) despite the HCP’s best endeavours to explain why this is necessary, the HCP must respect that views but also must determine whether disclosure is still essential (see paragraph 38 of the GMC guidance). If the release is considered essential then the HCP must complete all relevant sections in the UE1 (Rev), providing justification for the disclosure despite the claimant’s refusal to provide oral or written consent.

In these circumstances, the usual unexpected findings process must be followed in full to ensure that a copy of the UE1 (Rev) is sent to the GP, contact is made by telephone, and copies are filed as stipulated.

**General Procedural Guidance**

**Harmful Information**

If the unexpected findings should be regarded as Harmful Information; that is, if they imply some previously undiagnosed life-threatening disorder of which the claimant is unaware, there is no need to write down the putative diagnosis on the UE1 (Rev). The HCP should confine the account to the clinical findings. Discussions with the claimant would need to reflect the sensitivities of the situation.

**Referral to hospital**

Circumstances may occur when it necessary to refer the claimant to hospital immediately. In these instances, a hospital referral letter must be issued to the claimant followed up with a telephone call to the GP confirmed in writing using a UE1 (Rev) form, which should be fully completed to include the claimant’s signed agreement whenever practical.
If a signed agreement is not practical, for example the claimant is unconscious or is in such a condition that is would be insensitive to request a signature (e.g. experiencing a myocardial infarction), the HCP should briefly describe the situation on form UE1 (Rev).

Once again all telephone conversations between the examining HCP and the claimant’s GP, hospital staff or paramedics must be recorded on the UE1 (Rev).

If the claimant refuses to be referred, the HCP will need to consider whether the circumstances fulfil the exceptional criteria in which unauthorised disclosure to the GP is professionally justified. The HCP should make such a judgement in strict accord with the precepts outlined in the GMC guidance.

**Advising the claimant**

In all instances of unexpected findings the claimant must be advised to consult their GP/Medical Carer in the near future, and the degree of urgency communicated to the claimant will depend upon the clinical judgement of the HCP. Due sensitivity must be observed when advising the claimant to attend their GP and the HCP’s manner must ensure that there is not undue concern.

**Undiagnosed mental health conditions**

In all cases where a previously undiagnosed mental health disease has been identified, the procedure on disclosure described above should be followed in full, leading where indicated to completion of a UE1 (Rev) form to the claimant’s GP providing details of the condition assessed.

However, this does not imply that a UE1 (Rev) should invariably be completed in every case in which a mental health assessment has been performed.

If in any circumstances there is doubt on the correct way to proceed, HCPs should consult available experienced colleagues or CSD for advice.

**Customer Service Desk**

**Role of CSD**

CSD will be an initial point of contact for HCPs who have queries regarding the action to take and all other enquiries.

CSD will set up and maintain a file containing copies of all completed UE1 (Rev) forms in date order. This will assist CSD staff in dealing with enquiries from GPs and Medical Carers. Copies must be retained for a minimum of three months.

CSD will be able to call upon the services of an experienced HCP if any difficulty is experienced.
Unexpected findings arising during the course of file work

A HCP may wish to pass on information uncovered in the documentary evidence about which the GP may be unaware, then consent of the claimant must be obtained first. This situation might include the discovery of an abnormality on an X-ray that has been commissioned for benefit assessment purposes.

The HCP should write to the claimant and request the claimant's written consent for disclosure. A first-class reply paid envelope for reply should be enclosed. The letter must indicate the nature of the information that is intended to send to the GP, although this must be done in a manner that avoids undue alarm. The following might be a suitable form of words:

“You recently had a chest x-ray in connection with your claim for Industrial Injury Disablement Benefit. The Radiologist who has reported on this x-ray has suggested that a follow-up check may be advisable. We wish to pass on a copy of the Radiologist's report to your GP so that s/he is aware of this advice.”

The letter should be passed to the CSD Team Leader who should take a photocopy of it and place the copy in the CSD compendium file, giving it a five-day B/F.

Following a positive response to the request for consent the HCP should then contact the GP by telephone on the same day. This is important to reduce the likelihood of the claimant contacting the GP before Medical Services has had an opportunity to pass on the relevant information. In addition to telephoning the GP, the HCP must also complete form UE1 (Rev) with the relevant details. Then the administration clerk will issue the completed UE1 (Rev) to the GP, after taking copies for filing as above. In file work cases only it is not necessary to issue a copy of the UE1 (Rev) to the claimant, as they will already have been provided with relevant details in the earlier letter seeking their consent.

After five working days if the consent has not been returned the HCP will telephone the claimant and ask if the letter has been received and is being returned. Details of the telephone call and any conversation should be recorded on the back of a photocopy of the request letter. Following the telephone conversation:

- If the claimant informs the HCP that the letter has been/will be returned wait for a further two days for the letter. If no reply is received after a verbal reminder, then it should be assumed that consent is withheld.

- If claimant refuses to reply to the letter the HCP should refer to the section on GMC Guidance in Part 3 of this Handbook.

Copies of the letter requesting consent, results of any telephone conversations, and consent or refusal to consent should be held in the CSD file, the HCP’s file and the claimant’s referral file.

The Request for Consent letter example (Form UE2) below can be used for this purpose.
To: 

GPs Fax No: 

From: 

Tel No: 

Our Ref. (NINO): 

Date: 

Dear Doctor

Information about your patient:
Name: Date of Birth: / /
Address: 

I examined your patient* reviewed your patient’s file* in connection with their claim to benefit. I believe that you will wish to be aware that in the course of this I have found the following:

Claimant Consent:
I confirm that the examining doctor has discussed with me the reasons for the release of information to my GP and I give consent* / do not give consent* to the release of that information. (* delete as appropriate) 

Signed: ___________________________ (claimant) Date: / /

Please note that:
[ ] I have discussed/forwarded my reasons for requesting consent to release information to their GP but the claimant has declined/not responded. However in my professional judgement I believe that the release of that information is indicated for the following reasons:

[ ] GP notified by telephone 

Time notified GP : [] 

[ ] I have advised your patient to consult you

Yours sincerely,

Signed: ___________________________ (Doctor) Date: / /

Name (Print): ________________________________

Official Use Only

(tick): 

Faxed to GP: 

Sent to GP: 

Claimant copy: 

Copy (tick): 

CSD

Claimant’s File

Doctor’s File

Initials/date/location

Initials/date/location

Do Not Weed (DWP Purposes Only)
Dear [Title] [Claimant Surname]

Re: Request for disclosure of information to your General Practitioner

Your claim/appeal for benefit has been referred to Medical Services by the Department of Work and Pensions (DWP) for medical advice. Whilst reviewing your claim to benefit medical findings have come to light within the documentary evidence of which your General Practitioner (GP) may be unaware and I would be grateful if you would sign the declaration below in order that Medical Services can release this information to him/her.

The nature of the information that we wish to communicate to your GP is as follows:

________________________________________________________________________________________________________________________

I would also recommend you contact your GP for advice as soon as possible after returning your consent.

Please note that it is necessary for Medical Services to have your consent before we can proceed to release information to your GP. If consent has not been received within five days from the issue of this letter Medical Services will contact you by telephone on this matter.

Please find enclosed a stamped address envelope.

Yours sincerely,

Medical Adviser

Claimant Consent:

I confirm that the doctor has provided the reasons for the release of information to my GP and I *give consent / *do not give consent to the release of that information. (* delete as appropriate)

Signed: ___________________________ (claimant) Date: / / 

Name: ___________________________
Appendix D - Identification of Claimants at Examination

The Identification Procedure

A procedure has been devised that will help establish the claimant’s identity and also reassure the claimant that there is a check and it is proving to be successful.

Form POID1, shown at the end of this Appendix, is used to assist the identification of a claimant by their signature. This form is used for claimants attending the MSEC and also for those visited at their homes.

Claimants attending the MSEC

When a claimant arrives at the MSEC, they will be presented with, and requested to sign the POID1. The form asks for the claimant’s name, date of birth, signature and date.

The Receptionist will then:

- Ask the claimant to provide identification as specified in the Proof of Identity Procedures - MED/S3/POI01001.
- Circle the evidence provided on the form. (See table that shows the relevant codes and lists the acceptable forms of ID).
- As an additional cross check, compare the signature to the claim form or the proof of identity offered.
- Complete Part 2A of the POID1.
- Place the POID1 into the claimant’s file.

If the claimant’s signature does not match the claim form but the claimant has produced an acceptable form of identification the HCP is discreetly informed about the discrepancy prior to the examination. The HCP will then ask the claimant questions relating to case history, to establish correct identity and determine whether the examination should continue.

The HCP will then:

- Complete Parts 2 A and B of POID1 by ticking the boxes as appropriate.

If the HCP is unable to establish correct identity the Receptionist should:

- Ask an employed HCP to authorise refusal of the examination (if there is not an employed HCP on site the Receptionist will need to contact CSD).
Medical Services

- Ask for fax/written confirmation that the examination should not proceed.
- Attach the confirmation to the file.

The claimant should then be told that as they are unable to provide reasonable proof of identity Medical Services are unable to continue with the examination. It should be explained to the claimant what forms of identification are acceptable.

- Complete Parts 2 A and B of POID1 by ticking the boxes as appropriate.

The form will be returned to the Customer in the claimant’s file.

Domiciliary Visits

The POID1 is also used for DVs. The MSC must complete the name and date of birth of the claimant at Part 1 and ensure that this form is enclosed in the file/plastic wallet that is issued to the HCP for a DV.

At the start of the DV the HCP will:

- Identify himself or herself to the claimant so that he/she is clear about who they are, who is to be seen, the reason for the visit, and the nature of the examination.
- Ask the claimant to provide identification as specified in the Proof of Identity Procedures (MED/S3/POI01001). This is also noted in the AL1C.
- Circle the evidence provided on the form.
- Ask the claimant to sign the POID1.
- As an additional cross check, compare the signature to the claim form or on the proof of identity offered, if signed.
- Complete Part 2 A of POID1 by ticking ‘N/A’. Then complete 2 B.
- Place the POID1 into the claimant’s file.

If the claimant’s signature does not match the claim form but the claimant has produced an acceptable form of identification the doctor should ask the claimant questions relating to case history, to establish correct identity and determine whether the examination should continue.

If the examining HCP is 100% certain that the individual is not the true claimant, they should contact an employed HCP or CSD to authorise suspension of the examination. This should be done by telephone, by mobile or pay phone if necessary.

An individual must not be refused an examination unless the examining HCP is 100% certain that the individual who has presented for examination is not the true claimant.
## PROOF OF IDENTITY SLIP

Please complete part 1 with the claimant’s details.

**PART 1**

**Full Name (please print)**…………………………………………………………………………………………

**Date of Birth**………………………………………………………………………………………………………

**Signature**…………………………………… **Date**………………………………..

---

**PART 2**

*For office use only*

<table>
<thead>
<tr>
<th>PP</th>
<th>ECID</th>
<th>SAL</th>
<th>HOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>DP</td>
<td>CGC</td>
<td>BC</td>
<td>HODOC</td>
</tr>
<tr>
<td>WS</td>
<td>BANK</td>
<td>MC</td>
<td>TU</td>
</tr>
<tr>
<td>BSOC</td>
<td>TP</td>
<td>PRV</td>
<td>AC</td>
</tr>
<tr>
<td>BILLS</td>
<td>GV3</td>
<td>DVLC</td>
<td>HMFC</td>
</tr>
<tr>
<td>LARC</td>
<td>LAP</td>
<td>CB</td>
<td>CRED</td>
</tr>
</tbody>
</table>

A) Has correct identity been established by Receptionist/MEA? [ ] Yes [ ] No [ ] N/A

*If ‘No’ or ‘N/A’ complete B*

B) Has Examining Doctor been able to establish correct identity? [ ] Yes [ ] No
Medical Services

<table>
<thead>
<tr>
<th>TYPE OF IDENTITY</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services will accept as evidence of identity one of the following</td>
<td></td>
</tr>
<tr>
<td>Claimant's own passport</td>
<td>PP</td>
</tr>
<tr>
<td>European Community identity card</td>
<td>ECID</td>
</tr>
<tr>
<td>Standard Acknowledgement (for those seeking asylum in the UK)</td>
<td>SAL</td>
</tr>
<tr>
<td>Alternatively, Medical Services will accept any three of the following documents as proof of identity</td>
<td></td>
</tr>
<tr>
<td>Birth certificate</td>
<td>BC</td>
</tr>
<tr>
<td>Marriage certificate</td>
<td>MC</td>
</tr>
<tr>
<td>Travel pass</td>
<td>TP</td>
</tr>
<tr>
<td>Form GV3 (one way travel document issued by UK embassies abroad)</td>
<td>GV3</td>
</tr>
<tr>
<td>Local Authority rent card</td>
<td>LARC</td>
</tr>
<tr>
<td>Certificate of identity issued by the Home Office to the Claimant</td>
<td>HOID</td>
</tr>
<tr>
<td>Forms issued by the Home Office to the claimant</td>
<td>HODOC</td>
</tr>
<tr>
<td>Police registration certificate</td>
<td>PRC</td>
</tr>
<tr>
<td>Full driving licence</td>
<td>DVLC</td>
</tr>
<tr>
<td>Life assurance policy</td>
<td>LAP</td>
</tr>
<tr>
<td>Divorce/annulment papers</td>
<td>DP</td>
</tr>
<tr>
<td>Recent wage slip</td>
<td>WS</td>
</tr>
<tr>
<td>Trade union membership card</td>
<td>TU</td>
</tr>
<tr>
<td>Adoption certificate</td>
<td>AC</td>
</tr>
<tr>
<td>Cheque book</td>
<td>CB</td>
</tr>
<tr>
<td>Cheque guarantee card</td>
<td>CGC</td>
</tr>
<tr>
<td>Bank statements</td>
<td>BANK</td>
</tr>
<tr>
<td>Building society pass book</td>
<td>BSOCY</td>
</tr>
<tr>
<td>Paid household bills in the name of the Claimant</td>
<td>BILLS</td>
</tr>
<tr>
<td>Certificate of employment in Her Majesty's Forces</td>
<td>HMFC</td>
</tr>
<tr>
<td>Store or credit cards</td>
<td>CRED</td>
</tr>
</tbody>
</table>
Appendix E - Telephone Contact with Claimants

This procedure has been produced to ensure that Medical Services complies with the Data Protection Act (DPA) when contacting claimants or their Appointees by telephone. It must be followed by all persons either working for or on behalf of Medical Services.

In all instances where contact is to be made with a claimant, by either HCPs or administration staff, the procedure outlined below should be followed. This includes all telephone contact made with claimants to arrange an appointment at a Medical Services Examination Centre (MSEC) or for a Domiciliary Visit (DV).

Establishing the Identity of the Claimant

When making the telephone call it is essential that the HCP or administrative person establish the identity of the person to whom they are talking at the outset.

The following script or something very similar must be used:

“I'm Dr X (admin staff to give full name) from Medical Services and I would like to speak to Mr/Mrs/Miss/Ms (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 DOB or National Insurance Number (NINO).

If you are uncertain that the person to whom you are speaking is the claimant, then you must 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. If the claimant cannot be contacted via the telephone the alternative procedure, using the appropriate letter, should be followed.

Informing the Claimant of the Reason for the Call

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

“I am one of the doctors who provides medical advice on your claim to benefit”

OR

“I have been asked by one of the doctors who provides medical advice on your claim to benefit to obtain further information”
Medical Services

**Exceptional Circumstances**

There may be instances when the above procedure cannot be used due to the fact that:

- The claimant is a child (DLA cases only, never for IIDB).
- The claimant has an Appointee.
- The claimant requires an interpreter.
- The claimant has a medical condition that precludes a telephone conversation.

If any of these circumstances arise whilst contact is being made by telephone, greater care must be exercised to ensure that we remain within the confines of the DPA.

**Claimant has an Appointee**

If the referral shows that the claimant has an Appointee, a check should initially be made to verify that we are talking about the correct claimant by checking DOB, address and NINO. Once this is confirmed, the person who claims to be the Appointee should be asked for verification of their name and address that will be shown on the referral. Further information may then be divulged.

**Claimant requires an Interpreter**

If, when making a telephone call to the claimant, it becomes obvious that an interpreter is required, staff should advise the person to whom they are speaking that a letter will be sent to the claimant in due course. The telephone call should be terminated without divulging any of the claimant’s details.

**Claimant has a Medical Condition that prevents speaking on the Telephone**

As in the case of an interpreter, once it becomes obvious that the claimant cannot speak on the telephone staff should advise the person to whom they are speaking that a letter will be sent to the claimant in due course. The telephone call should be terminated without divulging any of the claimant’s details.

In all cases staff must use a common sense approach when making contact with a claimant by telephone.
Appendix F - Personal Descriptions of Claimants

General Principles

The following general principles must always be observed when making descriptions of claimants on the examination report forms:

- The description must be relevant to the matters that are under consideration in the report and its inclusion should add value to the report.
- If the relevance may not be immediately obvious to all the persons who are liable to read the report, it must be fully explained.
- The description must be phrased in terms that will not cause offence.

Descriptions of Race or Ethnic Origin

The process of Disability Analysis requires HCPs to specifically consider the manner in which disability affects the individual whose case is being assessed. Within this process, the focus must rest clearly on what the person can and cannot do as a consequence of their accident, injury or medical condition. A person's race or ethnic origin will almost never prove relevant to such considerations.

Consequently, in the context of the examinations that are conducted on behalf of customers of Medical Services, references to racial origin are almost universally unnecessary, and the inappropriate use of such descriptions is liable to cause offence.

HCPs are advised that the use of inappropriate descriptions may, in certain circumstances, lead to an action being brought against the author under the Race Relations Act 1976 or the Sex Discrimination Act 1975.

Descriptions of race or ethnic origin must not be confused with details of nationality, citizenship or place of birth, and it is not anticipated that any circumstances will arise where references to such matters could be considered appropriate.

If during the assessment the HCP knows that they will be recording a description of race or ethnic origin, it is advisable to explain why and to check it with the claimant or representative to ensure accuracy.

It follows that a description of race or ethnic origin should only be incorporated in a report where there are overriding and compelling medical reasons for including such information. If the HCP considers that a description of race or ethnic origin is essential, the reason for its inclusion should be made explicit and the description used should be factual and expressed as categorised in the Census, as follows:
Medical Services

- White
- Black – African
- Black – Caribbean
- Black – Other (please specify)
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other (please specify).

Note that these categories do not cover all situations, such as those of mixed race.

Descriptions of Personal Appearance

References to personal appearance are not infrequently made in reports prepared for benefit purposes, but there is no place for gratuitous comments. Personal appearance should not be described unless there is a clear and unambiguous reason for doing so. The linkage between any reference to personal appearance and the functional assessment must be made explicit.

Information that adds no value to the report should be omitted altogether such as comments concerning simple obesity with no related disability, length of hair, tattoos, body piercing etc.

Where obesity is contributing to or exacerbating disability, this fact should be mentioned. It is better to avoid the word ‘obesity’, even though it is medically defined. It is preferable to refer to the Body Mass Index, with a suitable explanation, or to use the term ‘overweight’.

Unwarranted inferences from a person’s clothing, style of dress, make-up, jewellery or general appearance should not be made, and comment on such matters unless the observations form an integral part of the medical evidence should be avoided. However, for example a description of a person as ‘untidy and unkempt’ may provide useful information to support an assessment of someone with cognitive impairment, learning disability, etc., or it may illustrate a particular degree of functional limitation.

Comments that convey a positive impression of the claimant’s appearance, such as ‘neatly dressed’, may add useful information in those cases where the individual’s ability to care for their appearance forms a relevant part of the assessment. However, account must be taken of factors such as help provided by another person or the degree of difficulty experienced by the individual in attaining their appearance. The effects of a fluctuating disorder on an individual’s day to day ability to dress and present themselves must also be considered.

Exercise caution in drawing inferences from isolated observations. Adhere to the principles of disability analysis and consider any information derived from the person’s personal appearance in conjunction with all other relevant evidence before drawing any conclusions.
The circumstances of the case will often dictate whether or not the inclusion of certain information is relevant. For example, a comment on the fact that a claimant was wearing nail varnish on her toenails would not normally be merited. However, this situation would be altered if the claimant's disability were related to a back condition. In such a case it would be appropriate to include this information as justification of the advice given in relation to activities that require bending, provided that it was ascertained and recorded that she had applied the varnish without assistance from another person.

**Descriptions of Attitude and Mood**

The attitude of the person to the assessment process should only be commented upon if it has affected the conduct of the examination, or if uncooperative behaviour occurs that is attributable to the claimant's medical condition. In such cases, full factual details should be provided.

It follows that it is appropriate to include details in the report in cases where the claimant smelled of alcohol or was intoxicated as a result of substance abuse (including alcohol).

When carrying out an assessment of a claimant's mental health, it is normally entirely appropriate and relevant to comment upon such characteristics as mood, features of anxiety, and interpersonal skills.

**Premature Termination of Examination**

There are two sets of circumstances where an assessment should be terminated without attempting completion of the examination:

- The behaviour of the claimant poses a threat to you, or to others present.
- Persistent non-co-operative behaviour by the claimant.

Where such circumstances occur, full details need to be documented.

Despite such early termination it may be possible at times for the HCP to give sufficient advice for the DM to complete the action on the case. This would often be the best course of action because recalling the claimant may only expose another HCP to the same problem.
Appendix G - Complaints against Health Care Professionals

Definition of a Complaint

The current definition of a complaint is an expression of dissatisfaction about the services provided by Medical Services that originate from a claimant.

A complaint can be made:

- By the claimant or their authorised representative, including MPs.
- Verbally or in writing. Verbal complaints can be made in person or by telephone.

There are exclusions from this working definition, as follows;

- Complaints passed to the DWP not relating to MS, such as those relating to the benefit process, entitlement, appeals or policy matters.
- Media enquiries even if relating to a specific claimant.
- Feedback where the comments are of a general nature.
- MPs enquiries, when not acting on behalf of a claimant.

Dealing with Dissatisfaction - the Initial Procedure

When a claimant is dissatisfied with the service received from MS the formal complaint procedure is followed.

Some complaints are received directly from the claimant or representative and other complaints about MS are referred from the DWP to the nominated Complaints Manager in MS, for investigation and response.

A complaint leaflet is available on request to further explain the formal process. The leaflet is issued to callers who wish to lodge a complaint in person, and the leaflet is issued with an acknowledgement letter on receipt of a written or telephoned complaint.

If an HCP receives a complaint during the examination they are asked to do everything possible to rectify the situation to the satisfaction of the claimant. If this is not possible the complaint should be recorded and referred to the Nominated Complaint Manager responsible for the examination centre.
Complaint Manager

On receiving a complaint the Complaint Manager will arrange for a full investigation to take place. This may involve asking for a copy of the medical report and/or other documents to be provided from the DWP, asking for written comments from the HCP or arranging for the claimant, HCP and any other witnesses to be interviewed.

The Complaint Manager will then write to the complainant with a full explanation and, where appropriate, with an apology.

Escalation of Complaint

If the complainant remains dissatisfied with the response further investigation will take place. The complaint will be referred to the Manager responsible for the area where the complaint originated. Any fresh issues will be investigated and addressed, or a fuller explanation will be offered to the complainant. The relevant Manager will sign the response.

Independent Tier

If the complainant continues to be dissatisfied, although all issues have been addressed, the complaint can be referred to the Independent Tier of the complaint process. The Independent Tier is made up of people who are not part of MS or the DWP. They will look at the complaint and decide if it has been handled correctly. This will include looking at whether or not all issues have been identified and addressed, whether the complaint was dealt with promptly and efficiently, whether sufficient investigation was undertaken and the appropriate individuals asked to comment. The Independent Tier cannot decide whether or not the responses given to the complainant were adequate or correct, nor can it comment on the decision of the DWP on the benefit claim, or the opinions expressed by an HCP in the medical report.

Medical Services Client Liaison Group

In being referred to the Independent Tier the complaint is also escalated to the Client Liaison Group, acting on behalf of Medical Services’ senior management team. This will provide confirmation that the complaint has been handled to the satisfaction of the senior management team and action will be taken to provide a suitable remedy if appropriate. Client Liaison Group is a focal point for drafting responses to parliamentary correspondence and for the provision of advice and guidance to MS managers.
Medical Services

Listening to Feedback and Learning from Mistakes

MS value the information gathered from claimants who feel they have cause for complaint. Statistics gathered on the volumes and types of complaint received are passed to the DWP as a requirement of their contract. This information is also summarised, along with information from claimant surveys and other enquiries and feedback in a quarterly report. This is used to formulate an ongoing action plan for improvement of quality of service and this is passed to the DWP with details of progress made.

What do Claimants Complain About?

Complaints are categorised according to their nature:

- **HCP’s manner or conduct** – examples include allegations that HCPs were “rude, arrogant, did not listen, did not write down everything said, did not give name, inappropriate examination, did not read back report before requesting signature of claimant, inappropriate comments etc”.
- **Content of examination** – disagreement about whether or not certain clinical tests should have been used. This might include whether blood pressure should have been taken, whether chest should have been examined under or over clothing etc.
- **Length of examination** – that is too long or too short
- **Clinical findings** – such as what the HCP has written on the medical report as his opinion or conclusions about the claimant’s level of function or degree of restriction.
- **Administrative issues** – includes lack of warning regarding date of examination, not sufficient time to make arrangements to attend or for child care etc.
- **Other** – complaints about administrative staff and about issues not directly the concern of Medical Services which may require comment.

Complaints about HCPs

The majority of complaints concern the circumstances of the actual medical assessment by the HCP. A survey of complaints arising from all types of benefit assessments in the past has shown;

- 24% refer to the HCP’s manner.
- 27% refer to the content of the examination.
- 17% refer to the clinical findings.

Specific complaints relating to HCPs are pursued based on the seriousness or complexity of the complaint.
Medical Services

**Serious complaints**

A serious complaint cannot be precisely defined but would normally fall into one of the following areas:

- Assault as a consequence of examination.
- Injury as a consequence of examination.
- Inappropriate intimate examinations.
- Missed diagnosis of a serious nature.
- Racial abuse.
- Sexual abuse.
- Serious breaches of professional conduct.
- Theft or fraud.

The Serious Complaints Investigation Team (SCIT) is normally comprised of a senior Health Care Professional and a senior member of the Administration team. The SCIT will conduct a detailed investigation that involves notification to the HCP of the complaint and subsequently interviewing the HCP, claimant and any appropriate witnesses. A HCP may be suspended while a serious complaint is being investigated.

On conclusion of the investigation the Chief Medical Officer will decide the appropriate action in consultation with the Medical Manager and with Medical Services HR or Viable Practitioner Pool (VPP), as appropriate. The need for disciplinary or other remedial action will be considered. In the case of a substantiated serious complaint made against a contracted HCP, VPP will be informed that no further work will be offered to that HCP.

**Complex complaints**

These are complaints that include a number of areas of complaint (see above).

The nominated Complaints Manager will co-ordinate action on these cases in liaison with a Medical Manager, or nominated HCP. A copy of the complaint is issued to the HCP, requesting their view and comments about the circumstances of the complaint.

The Medical Manager would be involved in preparing the response to the claimant and is responsible for taking appropriate personnel action, including recording the outcome in order to track trends etc.
Medical Services

**Straightforward complaints**

The local Medical Manager, or nominated HCP, will advise the nominated Complaints Manager of the appropriate investigation. If a full investigation is required, then action continues to obtain the HCP’s comments, as above.
Appendix H - Legislation Governing the Industrial Injuries Scheme

Acts

Social Security Contributions and Benefits Act 1992 (SS C&B Act)
Social Security Administration Act 1992 (SS Admin Act)

Regulations

Social Security (Adjudication) Regulations 1995 (SS Adj Regs)
Social Security (Industrial Injuries) (PDs) Regulations 1985 (SS PD Regs)
Social Security (General Benefit) Regulations 1982 (SS Gen Ben Regs)
Social Security (Claims and Payment) Regulations 1987 (SS C&P Regs)
Social Security Act 1998 and DMA Regulations (SS DMA Regs)
Schedule 6 to the Social Security Contributions and Benefits Act 1992 (Schedule 6)
Appendix I - Abbreviations used in the Text

General

CMA  Chief Medical Adviser (to Department for Work and Pensions)
CSD  Customer Service Desk (at MSC)
DLA  Disability Living Allowance
DM  Decision Maker
DMA  Decision Making and Appeals
DPA  Data Protection Act
DV  Domiciliary Visit
DWP  Department for Work and Pensions
FME  Further Medical Evidence (GP, Hospital, Consultant or other report)
GMC  General Medical Council
GP  General Practitioner
HAVS  Hand Arm Vibration Syndrome
HWWD  Health Work and Welfare Division (formerly known as Corporate Medical Group CMG)
ID  Proof of Identity
IIAC  Industrial Injury Advisory Council
IIIDB  Industrial Injuries Disablement Benefit
HCP  Health Care Professional
MEA  Medical Examination Assistant
MEC  Medical (Services) Examination Centre
MS  Medical Services (the company providing medical services to DWP)
MSC  Medical Service Centre (centre for administrative functions of MS)
MSEC  Medical Services Examination Centre
MSO  Musculo-Skeletal Overview (screening examination for limbs and spine)
Medical Services

NINO  National Insurance Number
PD   Prescribed Disease
PIL  Pension in lieu
POD  Pensions and Overseas Directorate
ROA  Rehabilitation of Offenders Act
SoS  Secretary of State
SS   Social Security
VWF  Vibration White Finger

IIDB Specific Terms

CAA  Constant Attendance Allowance
ESDA Exceptionally Severe Disablement Allowance
IIDB Industrial Injuries Disablement Benefit
LOF  Loss of Faculty
REA  Reduced Earnings Allowance
RLOF Relevant Loss of Faculty
US   Unemployability Supplement
Appendix J - Mental Health issues in IIDB

The Industrial Injuries Scheme recognises that the effects of an accident or prescribed disease can include mental health problems. These may arise as a secondary response to the functional impairments in any diagnosed Industrial Injury or Prescribed Disease. On less frequent occasions, Mental Health symptoms can be the sole disability arising from an Industrial Injury - but that is uncommon.

Stress and any other mental health issue arising in the work place do NOT of themselves constitute a Prescribed Disease. The word "Stress" is ambiguous, as it can refer to both the incident and the reaction to the incident. Such an unsatisfactory term should be avoided and the HCP is advised to use recognised medical terminology in a report. However "Stress" cannot be avoided in a statement if the claimant wishes to define their symptoms in their own words and that includes the word "stress". In such a case it is even more important that the HCP seeks a description of the symptoms which the claimant attributes to the accepted incident.

Post Traumatic Stress Disorder is a recognised medical term and is defined and explained in section 1.1.1. Unlike many physical problems, mental health problems are rarely the result of a single factor. While the claimant may attribute all his/her mental health problem to the accident or prescribed disease, this is rarely the case. Care is therefore needed to establish causation, relevance, and prognosis, so that correct attribution to an occupational cause can be made.

The consideration of mental health conditions in relation to IIDB calls for careful evaluation of the events and factors in the claimant’s past history, the mental state, and the nature of the mental health problem. When formulating advice, HCPs should remember that:

- Mental health conditions are common: approximately 30% of GP attendance is due to mental health disorder; and over 30% of IB claimants have a mental health condition as a primary or secondary cause of their incapacity

Causation is almost always multifactorial, and involves:

- predisposing factors, e.g. genetic predisposition, childhood experiences
- precipitating factors, e.g. stressful life events, acute physical illness, drugs
- perpetuating factors, e.g. social circumstances, lack of social support

Co-morbidity is common e.g. up to 90% of PTSD sufferers have other mental health problems such as depression, anxiety disorder, or substance abuse
Providing advice on an Accident claim with mental health concerns

HCPs may be asked for advice at the **accident declaration stage** in cases where a Mental Health problem is outlined in the claim. The Decision Maker needs advice on whether there has been a personal injury (a fresh pathological change).

With regard to the personal injury question, a Commissioner said that in order for the personal injury element of the accident question to be satisfied there had to be a ‘recognisable psychiatric illness’. Hence, for example, feelings of sadness at an upsetting event (e.g. a line manager shouting at the person) are considered to be a normal physiological response and not a recognised psychiatric condition.

Decision Makers request advice on accident claims where mental health conditions are described as resulting from a stressful incident in work, such as an argument with a manager; a poor performance report; being ‘sent to Coventry’ etc. When advising in such a claim, the HCP should remember that in the vast majority of cases the reaction is a normal reaction to a life event. It is normal to be upset by such events, just as it is normal to be happy or elated by good news. The HCP should have a full description of the event(s), which are claimed to have caused the mental health problem. The HCP’s report should critically evaluate the documentary evidence in order to advise on whether or not personal injury has occurred.

As with all advice to Decision Makers, full justification must be given, in language which will be readily understood by a non-medical person. If the advice differs from opinions expressed by other health professionals, the reasons for the difference of opinion must be explained. For example, the claimant’s own medical practitioner may concur with the claimant’s view of causation, and this view may have been formed entirely on the basis of the patient's description without access to further evidence. It is quite in order for the advising HCP to oppose the GP, or other carer's opinion, but it is necessary to explain why the alternative view has been advised.

The HCP needs to consider the following:

- Is the described accident of such a nature that a personal injury to mental health has probably taken place?

  In line with the Commissioner's decision, the HCP must seek to identify the existence of a recognised psychiatric condition. Given the subjective nature of such a complaint, some evidence of its nature and extent is required from external sources e.g. the GP

- Is the described Mental Health condition a manifestation of a condition already in existence, and which is subject to variable effects?

  Variable constitutional mental health problems can still be temporarily worsened by an incident in work

A response to a DM on such a case requires experienced Disability Analysis skills and expert advice from within the local medical team, or from elsewhere, is recommended.
Medical Services

**Post Traumatic Stress Disorder**

An understanding of the aetiology and nature of PTSD is fundamental to the provision of accurate and evidence based advice on an Accident Claim of this type.

The condition of PTSD is a recognised psychiatric disorder. This is defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV, 1994) and the World Health Organisation's International Classification of Diseases (ICD-10). An essential component of the diagnosis and the causation is that the condition must arise in response to a serious antecedent accident.

IIAC has provided the following clarification and guidance on PTSD and the Accident Provisions of the industrial Injuries Scheme:

The stressor must be a highly traumatic, single event that is, or could readily be perceived to be, life-threatening or extremely dangerous to the claimant or others i.e. it should cause or threaten death or serious injury to the sufferer or others present at the time. It should be quite outside the realms of normal human experience and sufficient to cause severe distress in almost anyone, not merely unpleasant or threatening to livelihood or lifestyle.

Exposure to such a major stressor does not automatically result in PTSD in all individuals. Generally, only 15% of those exposed to a severe, life-threatening situation subsequently develop PTSD.

Predisposing factors include:

- a previous history of psychiatric disorder;
- gender – the disorder is more common in women than men;
- prolonged childhood separation from parents;
- a family history of mental illness; and
- Age – PTSD is more common in the children and the elderly.

PTSD is characterised by high levels of co-morbidity; up to 90% of cases have other mental health problems such as manic-depressive disorder, anxiety disorder, alcoholism or substance abuse.

DSM IV and ICD-10 set out the important diagnostic features of PTSD. The person’s response to the event includes initial intense fear and helplessness or horror, leading to avoidance of circumstances resembling or associated with the event. Characteristics of PTSD include intrusive and distressing memories of the event causing it to be 'relived' ("flashbacks"), and symptoms of persisting psychological distress and increased arousal. There must be accompanying clinically significant distress and impaired social or occupational functioning.
Symptoms normally arise within 6 months of the stressful event. There are few long-term studies of prognosis in PTSD but a range of outcomes has been described. The average duration is no more than two years following onset, but in 1% of cases symptoms can persist for many years.

The expert psychiatrists consulted during an IIAC review agreed that exposure to a life-threatening event was one of the key diagnostic criteria for acute stress reaction and PTSD, and that claims of PTSD from minor events were not consistent with the diagnosis and should not be substantiated. For this reason the HCP needs a full description of the event before such a referral can receive consideration.

**Where Mental Health problems arise from an accepted accident**

When advising on the effects of such an accident, the HCP’s report to the decision maker needs to cover the following points:

- a full description of the event(s) claimed to have caused the mental health problem
- a full occupational history

A detailed past medical, social, and family history – these are particularly important where the occupation is inherently risky, e.g. police force, fire service, yet the claimant is claiming a mental health condition arising from incidents that one would consider a routine part of the job.

Where PTSD is being claimed, the HCP needs to obtain a full description of the claimed precipitating event, to ensure it fulfils the criteria for a diagnosis of PTSD.

**Relevance in such circumstances**

Even where the injury causes only mental health problems without any physical effects, the contribution of other effective causes to the overall disability must be considered when advising on relevance. It is unusual for any mental health disability to be fully relevant to the accident/prescribed disease.

There is often some pre-disposing MH issue, which, providing there is evidence that it would have created an assessable disablement in the period under consideration, requires an offset.

Useful criteria to consider when determining relevance are:

- The incident must be of adequate, proportionate severity
- It must be close in time to the onset of the mental health disorder
- The nature of the incident must be related to the nature of the mental health problem. For example, minor psychological upset does not cause PTSD
Medical Services

The mental health disorder should improve with time, unless there are clear perpetuating factors. If there are perpetuating factors, they must be mentioned, and their relationship to the incident and work issues must be discussed. Impeding factors can include medical, domestic, social or occupational factors.

A previous history of psychiatric disorders or the presence of a chronic MH disorder should be addressed. These may constitute another effective cause of disablement, which will require an offset in the assessment, or can affect the duration of the assessment.

Mental Health problems arising from the effects of a physical injury

On occasions a claimant describes a mental health problem, which has been triggered by the effects of the physical RLOF. The accident itself is not said to have caused the problem, but the claimant indicates that anxiety or depression has arisen because of ongoing pain/ delay in recovery/reduced mobilty or other concerns about the effects of the injury. These secondary psychological effects more commonly present as a reactive depression or anxiety, but they can take the form of any mental health disorder.

Mildly disabling injuries should not, of themselves, create a reactive anxiety or clinical depression. Low mood or worry is a normal human response to the inconvenient outcomes of an injury. These are not usually a clinical depression or anxiety and should not be separately assessed. The assessment given to the disability arising from the physical RLOF can be considered to have taken into account such a mild and natural response.

Where the injury and relevant disability are of significant proportions then this may give rise to additional, identifiable mental health reactions, which require to be assessed.

Even in those circumstances the Mental Health problem may not be fully relevant to the accident under consideration. Other factors may contribute to the described psychological problem e.g.

- a previous depression has been rekindled by the effects of the recent accident,
- an obsessive compulsive disorder has been exacerbated by worry about recovery
- other social or domestic concerns are contributing to the overall mental state

The following algorithmic approach may help to answer such issues:

The examining HCP should "test" their logical evaluation of the evidence by asking themselves these questions:
1) "Would this mental health complaint be present even if the accident had never occurred?" This simple approach tests the probability of the condition arising from the accident under consideration. If the answer is "YES, it would be present even if the accident had not occurred" then the Mental Health condition is not relevant to the accident and should be recorded as Unconnected.

2) The examining HCP should consider if the physical disability arising from the accident is of such an order that it is likely to trigger a mental health response. That is to say "is there a reasonable correlation between the physical effects of the accident and the mental state?" The HCP should seek to gain understanding of the claimant's pain levels, disappointments concerning recovery, protracted treatment plans, sleeplessness, worry about mobility restrictions and problems with adaptation to disability etc. If there is no clear link to the physical problem - the Mental Health problem is more likely to be due to other factors.

3) If the accident and its effects are accepted as likely to lead to a reactive depression or anxiety - then the examining HCP should consider - "is this described mental health problem fully relevant to the accident or are other factors identified?" If other effective causes can be outlined then an offset is appropriate.

It follows that evaluation of the case can only take place with a full understanding of:

- The physical RLOF and the disablement arising from this
- The nature of the secondary mental health complaint
- Recognition of what is a normal human response to injury, immobility or pain
- The background of interactive situations and conditions in the claimant, which may lead to other effective causes of mental health issues - this includes previous mental health problems in the past history, other social, occupational or domestic problems.

Four outcomes can arise from this logical approach:

- The description does not constitute a separate mental health problem and is a natural response to the injured physical state. In this case the Assessment of physical disablement can be considered to have taken that into account. An explanation is necessary for the Decision Maker who will need to appreciate why the MH symptoms have not attracted a separate assessment. In this instance justification should be along the lines of the described feelings of low mood/worry/loss of confidence etc come within the spectrum of a normal response to this injury and its associated recovery/treatment phase. These feelings can be reasonably expected during the period under consideration and have been adequately addressed within the assessment given for the physical disability. This does not constitute a separate and relevant Mental Health disorder.

- A Mental Health condition is identified but is not relevant to the accident under consideration. It can be more reasonably attributed to other causes e.g it is constitutional, or a reaction to factors unrelated to the accident. This is defined as UNCONNECTED and again Justification of that opinion is required for the Decision Maker.
The Mental Health condition is a fully relevant outcome of the accident—the RLOF can be defined in various ways dependant on the nature of symptoms e.g. as

- Reduced social functioning
- Loss of confidence
- Reduced concentration
- Loss of well being with low mood and sleep disturbance

The Mental Health condition is accepted as being Partially Relevant and an offset is made for the other identified effective cause.

Where the Mental Health condition is assessed, in most circumstances, a short period of award should be advised. As the relevant physical condition improves there is good reason to expect a recovery in mood and confidence and general well being. The Mental State may fully recover before the physical condition does. An HCP should give very careful consideration to any exceptional claim where the Mental Health problems persist beyond the physical issues arising from the accident. Given the current reasonable expectation of recovery in Mental Health conditions, care should be taken to avoid prolonged or early Life awards.

**Mental Health in Prescribed Diseases**

Stress, other mental health disorders and Post Traumatic Stress Disorder are not Prescribed Diseases. It follows therefore that Mental Health issues can only be considered when the physical effect of the accepted PD is accompanied by a reactive or secondary psychiatric disorder. This is a rare occurrence; however when a mental health complaint is described in response to the disability arising from a Prescribed Disease, such conditions should be assessed following the principles outlined above.

**Assessments of Mental Health disablement**

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

**Normal mental health/Virtually no disablement**

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

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

**Very Mild Problems**

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

**Mild Problems**

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

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

Disturbances in appetite or eating disorders may occur interfering with social activities. Insomnia may be a problem.

**Mild to Moderate Problem**

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

**Moderate Problems**

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

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

Moderately Severe Problems

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

Severe Problems

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

Very Severe Problems

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

Appendix A  NHS Agreements

HDL (2004) 32

Dear Colleague

THE DISABILITY DISCRIMINATION ACT 1995
IMPLEMENTATION OF SECTION 21
ACCESS AUDIT PROGRESS INFORMATION

Summary

1. The purpose of the letter is to seek updated information from NHS Scotland Bodies on their progress in:

   a. undertaking access audits of premises in the context of the need for service providers to make reasonable adjustments to premises or to the way they provide services, under Section 21 of the Disability Discrimination Act 1995 which comes into force in October this year; and,

   b. putting in place service strategies that involve reasonable steps to ensure services provided in the community are available to all patients including those with a disability.

Background

2. NHS Circular HDL(2002)80, issued on 1 November 2002, required NHS Scotland Bodies to submit to the Department reports on the progress of access audits from which NHS services are provided, categorised as per the care groups outlined within Paragraph 10.1 of Annex A to HDL(2002)80. Annex A also provided details of the Access Audit Toolkit produced by the NHS Scotland Property and Environment Forum to assist healthcare bodies in the access audit process.

4. Colleagues should be now be aware of the importance of including in access audits premises from which NISScotland patients receive treatment from independent contractor services (medical services, dental services, pharmacies, and optometry) and the need for NISScotland Boards to develop strategies to address any shortcomings highlighted from their access audits.

Other information

Dental Services in the Community

5. Colleagues will be aware that there are particular challenges in ensuring that the facilities from which dental services are provided in community meet the requirements of the Disability Discrimination Act. NHS Circular HDL(2002)80 underlined the importance of Boards surveying not only property owned or leased by NHS Bodies but also that owned by independent contractors. SEHD is aware that action in relation to dentistry (delivered by employed staff and by independent contractors) has been patchy and an additional purpose of this letter is to reinforce the need for:

- an audit of all premises from which dental services are provided in the community; and
- a plan of action which demonstrates how those premises that comply will be available to meet the needs of patients locally as part of an overall service access strategy.

6. SEHD fully recognises that it may not be "reasonable" in terms of the Act to make some premises fully compliant, but there should be plans in place in each area which allow patients to have access to fully compliant facilities within the local area. These plans need to be developed in consultation with professional and patient interests. SEHD has already made funding available to NHS Boards (ref NHS HDL(2003)164) to help raise awareness and provide training across all the contractor services.

Other Contractor Services

7. The same principles as outlined in paragraphs 5-6 above also apply to general medical services, community pharmacies, and optometry.

Action

8. Addressees should ensure that this notice is brought to the attention of all appropriate staff within their area of responsibility.

9. Chief Executives should ensure that a copy of this letter is made available to all independent contractors (medical, dental, pharmaceutical and optometric) and to the relevant professional advisory committees, in order to provide the context for approaches from NISScotland Boards or their agents seeking to complete outstanding premises audits.
10. Addressees are requested to submit to the Scottish Executive Health Department’s Property Branch updated information on the progress to date of access audits, an overview of any shortcomings arising from these audits and an estimate of the costs of reasonable steps needed to ensure access to services for all patients in accordance with Section 21 of the Disability Discrimination Act 1995. The audit of and action plan for contractor services, including dental services, should be a component part of that return.

11. Audit progress information should be apportioned as per the following care groups:

- Acute Premises
- Primary Care premises owned or leased by NHS Boards
- Property owned/leased by General Medical Practitioners
- Property owned/leased by General Dental Practitioners
- Property owned/leased by Community Pharmacists
- Property owned/leased by Optometrists
- Property owned/leased by other practitioners where NHS patients are treated

12. Audit progress information should be submitted no later than 30 July 2004 to:

Ian Grieve
Scottish Executive Health Department
Directorate of Performance Management and Finance
Property Branch
Basement Rear
St Andrews House
Edinburgh EH1 3DG
Email: ian.grieve@scotland.gsi.gov.uk

Yours sincerely

Peter Collings
Director of Performance Management & Finance
The Provision of Patient Information by NHS Trusts to the Department of Social Security

Requests for information used for Benefit Assessment Purposes

For action by: NHS Trusts - Chief Executives

For information to: Health Authorities (England) - Chief Executives
NHS Trusts - Directors of Finance
Health Authorities (England) - Directors of Finance

Further details from: Stuart Perry
Room 3W06
Quarry House
Quarry Hill
Leeds
LS2 7UE
0113 254 5429

Additional copies of this document can be obtained from:

Department of Health
PO Box 410
Wetherby
LS23 7LN

Fax 01937 845 381

It is also available on the Department of Health website at http://www.open.gov.uk/doh/coinh.htm

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8th January 1999

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The Provision of Patient Information by NHS Trusts to the Department of Social Security

Requests for information used for Benefit Assessment Purposes

Summary

This circular describes how NHS Trusts should handle requests for patient information from the DSS, its executive agencies (Benefits Agency and War Pensions Agency) and contractors who will be providing medical services on behalf of the Benefits Agency and the Independent Tribunal Service. These requests for patient information will be sought in order to assess individual claims for a range of social security benefits and war pensions.

Action

With immediate effect all NHS Trusts should apply this guidance and comply with the directions contained in this letter and accompanying Annex. In particular, they should note:

- requests from the contractor/DSS for the provision of hospital case notes, X-rays and factual reports in respect of a client’s claim for benefit should be supplied without charge;
- for the provision of hospital case notes the contractor/DSS would prefer to receive photocopies of the original documents, unless otherwise specified;
- requests should be met within ten working days of receipt;
- the guidance does not alter the position regarding the charging by practitioners of third parties for the provision of information which is deemed not to be reasonably incidental to their contractual duties relating to the prevention, diagnosis or treatment of illness, which forms part of the services provided by the practitioner’s employing authority under Section 3(1) of the NHS Act 1977.
- it is not necessary for patients or their representatives to exercise their rights under the Access to Health Records Act 1990 to obtain information to support a claim for benefit.

Background and Other Information

This guidance has been issued as an update to original guidance contained in HSC/93/7/9 which has now expired. Detailed background information is contained in the accompanying annex.

8th January 1999
Health Service Circular

Associated Documentation

FDL/93/79.

This circular has been issued by:

COLIN L REEVES
DIRECTOR OF FINANCE AND PERFORMANCE

8th January 1999
ANNEX

The Provision of Patient Information by NHS Trusts to the Department of Social Security
Background Information

Introduction

This annex provides background information to NHS Trusts on how they should handle requests
from the DSS, its executive agencies (Benefits Agency and War Pensions Agency) and
contractors who will be providing medical services on behalf of the Benefits Agency and the
Independent Tribunal Service for:

(a) the provision of hospital case notes;
(b) X-rays; and
(c) factual reports.

Purpose of Information

In order to assess the benefit claims of their clients it is often necessary for the contractor/DSS
to request sight of hospital case notes, relevant X-rays or to have a factual report prepared.
This is in order that the claim can be objectively considered.

Prompt and accurate responses from providers are essential if the contractor/DSS is to meet its
own obligations to its clients in terms of the timely and accurate assessment and payment of
benefit. These standards of service delivery are guaranteed in the Benefits Agency’s Customer
Charter.

In terms of the general delivery of public services, this has the same relevance and significance
to a customer of the Benefits Agency as the Patient’s Charter does for a hospital patient. It is
therefore essential that all parts of the NHS appreciate the importance of these types of
information request. Unnecessary delays in this area may in some cases result in a personal
impact on a patient equally as much as delaying treatment itself.

Responsibilities

All NHS bodies should note that it is essential to the contractor/DSS that:

(a) for the provision of hospital case notes the contractor/DSS would prefer to receive
photocopies of the original documents, unless otherwise specified;
(b) NHS Trusts should undertake to meet such requests within ten working days of receipt;
(c) the contractor/DSS handles all information received in a manner that is in accordance
with NHS policy on the secure handling of patient confidential information. Further, the
patient will be aware that the contractor/DSS may be required to make such requests
and authorisation from the patient is an integral part of the benefit claim form;
(d) requests from the contractor/DSS for the provision of hospital case notes, X-rays and
factual reports in respect of a client’s claim for benefit should be supplied without
charge.
Medical Services

Charging

It is useful to expand upon the final point made above. The NHS has never levied charges on the DSS for the supply of hospital case notes, X-rays and factual reports. Therefore, the total purchasing power that exists in the NHS includes not only the cost of treatment but the provision of information to the contractor/DSS as well.

The DSS has, quite rightly, never been funded to pay for copies of hospital case notes, X-rays and factual reports as there has been a long history of these being provided without charge. There is, consequently, no justification for the introduction of charges.

Rationale for providing the service without charging

In essence, a universal charging system is not thought desirable for the following reasons:

(a) a charging system will not produce any financial gain to the NHS;

(b) it will add to the level of administration needed;

(c) this would be a complex exercise requiring all providers to establish their individual costs in a similar manner as for treatment services;

(d) the sums involved would be small;

(e) the exercise would involve expenditure for providers (cost accounting, invoicing, debtor control etc) that would otherwise be available to spend on patient care.

(f) the impact on DSS administration is likely to equal that to NHS Trusts.

Health Authority involvement

From a contractor/DSS viewpoint, the processing of benefit claims can be subject to delay if information from providers is not promptly received. Any such delays can have a very material impact on a DSS customer.

Health Authorities should be aiming to gain the maximum level of service for their resident population. Therefore, they should appreciate the impact that delayed receipt of Social Security benefits may have on a person and would naturally wish to prevent any such disadvantage affecting their residents. Providers should therefore accept that purchasers will consider the timely provision of information to the contractor/DSS as implicit in their dealings with providers.
Dear Colleague

PROVISION OF PATIENT INFORMATION TO THE DEPARTMENT FOR WORK AND PENSIONS (DWP) FOR BENEFIT ASSESSMENT PURPOSES

Purpose

1. This circular sets out procedures to be followed when patient information is requested by the Department for Work & Pensions (DWP) or its agencies.

2. A key point to note is that responses to such requests should be made promptly with, in all instances, the information provided free of charge.

Background

3. In order to assess benefit claims, it is often necessary for the DWP, or its agencies (Jobcentre plus, Social Security, Child Support Agency — previously the Benefits Agency, the Veterans Agency — previously the War Pensions Agency, and contractors providing medical services on behalf and the Appeals Service) to request:

   (a) hospital case notes;
   (b) x-rays;
   (c) factual reports in respect of a client's claim for benefit.

4. Prompt and accurate responses from NHS providers are essential if the DWP (and associated agencies) is to meet its Charter obligations to clients in terms of the timely and accurate assessment and payment of benefit. The processing of benefit claims can be subject to delay if information from the NHS is not promptly received. Any such delays can have very material impact on a client.

5. The policy was, and remains, that the NHS should not levy charges on the DWP or its agencies for supplying the above information.

6. In addition to this, the following responsibilities apply:

   • NHS Trusts/Local Health Boards should meet requests for information within ten working days of receipt;
   • Unless otherwise specified, for the provision of hospital case notes, the DWP/agencies would prefer to receive photocopies of the original documents, unless otherwise specified;
   • The DWP/agencies will handle all information received in a manner that is in accordance with NHS policy on the secure handling of patient confidential information. The patient will be made aware that the DWP/agencies may require to make such requests and authorisation from the patient is an integral part of the benefit claim form.
Action

7. Chief Executives should ensure that this guidance is implemented with immediate effect, and to note in particular that DWP requests for information regarding an individual’s claim for benefit should be supplied without charge and within 10 working days of receipt.

8. Any queries about this circular should be referred to David Boyland (on 029 2082 5537).

Yours sincerely

JOHN HILL-TOUT
Director
NHS Performance, Quality and Regulation Division
Observation form

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