

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training and Development Unit

Guidance for Examining Health Care Professionals

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Foreword

This guidance has been produced as part of the training programme for Health Care Professionals seeking approval by the Department for Work and Pensions Chief Medical Adviser to carry out assessments in Disability Living Allowance and Attendance Allowance.

All Health Care Professionals undertaking medical assessments must be registered medical or nursing practitioners who in addition, have undergone training in disability assessment medicine and specific training in Disability Living Allowance and Attendance Allowance. 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 medical or nursing practitioners, the Health Care Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this 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 Health Care Professionals.

Office of the Chief Medical Adviser

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1. Abbreviations

AA	Attendance Allowance
CMA	Chief Medical Adviser
CMO	Chief Medical Officer
CMS	Complaints Management System
CRT	Customer Relations Team
DBC	Disability Benefits Centre
DCPU	Disability Contact and Processing Unit
PDCS	Pensions, Disability and Carer Service
DLA	Disability Living Allowance
DLAAB	Disability Living Allowance Advisory Board
DM	Decision Maker
DV	Domiciliary Visit
DWP	Department for Work and Pensions
EHCP	Examining Health Care Professionals
GMC	General Medical Council
GP	General Practitioner
MEA	Medical Examination Assistant
MM	Medical Manager
MSEC	Atos Healthcare examination centre
MEC	Medical Examination Centre
NINO	National Insurance Number
NMC	Nursing and Midwifery Council
VCC	Virtual Contact Centre
VPP	Viable Practitioner Pool
VPPC	Viable Practitioner Pool Centre

2. About this Guide

This guide is for use by Examining Health Care Professionals who carry out examinations on behalf of the Department for Works and Pensions for claims to Disability Living Allowance (DLA) and Attendance Allowance (AA). It is intended to be used as pre-course reading for new EHCPs prior to attending a training course and to be used thereafter as a reference source. It provides new material and recommendations for best practice that will be essential information for existing EHCPs.

This Guide provides information on the following topics:

- The Department for Work and Pensions.
- Atos Healthcare
- Background and features of DLA and AA.
- Decision Maker's role.
- EHCPs role.
- Report forms and how to complete them.
- Good practice techniques for conducting disability assessments.
- Risk management of problem situations.
- Quality systems - customer satisfaction, complaint procedures and audit.
- Procedures for dealing with unexpected clinical findings and with abortive visits.

3. The Department for Work and Pensions (DWP)

3.1 Introduction

Disability Living Allowance was introduced in 1992 and has its origins in the Social Security reforms instigated in 1984 by the Minister for Social Security. The Office of Population Censuses and Surveys was commissioned to undertake a comprehensive survey of the extent of disability in Great Britain, which resulted in the publication of a White Paper "The Way Ahead - Benefits for Disabled People".

One of the main proposals was the introduction of a new benefit (Disability Living Allowance - DLA) that would:

- 1) Bring together Attendance Allowance and Mobility Allowance as one benefit for claimants whose disabilities began before the age of 65; and
- 2) Offer financial assistance to less severely disabled people not covered by the old scheme.

Attendance Allowance continues for people over 65.

Initially the Benefits Agency was established as an Executive Agency of the Department of Social Security in 1991. Subsequently the Department for Work and Pensions was created in June 2001, its purpose being, "to promote opportunity and independence for all."

3.2 Structure of the DWP

The department's services to customers are provided through (amongst others):

- Jobcentre Plus – helps people of working age to find work and receive the benefits to which they are entitled
- Disability and Carers Service

3.2.1 Pensions, Disability and Carers Service (PDCS)

The Disability and Carers Service is part of the Pension, Disability and Carers Service (PDCS), an executive agency of the Department for Work and Pensions.

The Pension, Disability and Carers Service vision is "**Working together to make lives better**".

The benefits administered to people with disabilities and their carers by the PDCS are:

- Disability Living Allowance (DLA)
- Attendance Allowance (AA)

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- Carers Allowance (CA)
- Vaccine Damage Payment Scheme

CA is paid to carers of people in receipt of DLA or AA.

4. Atos Healthcare

4.1 Introduction

The contract to provide Medical Services to the Benefits Agency (and subsequently the DWP) was awarded to Sema Group in 1998. Medical Services then became part of SchlumbergerSema and subsequently part of Atos Origin in 2004 becoming Atos Healthcare in 2007.

Atos Healthcare is an integrated medical and administrative division of Atos Origin with 12 main medical centres based in the main population centres in the UK. Atos Healthcare provides the medical expertise to DWP for the following main benefits

- Incapacity Benefit (IB)
- Industrial Injuries Disablement Benefit (IIDB)
- Disability Living Allowance and Attendance Allowance (DLA and AA)
- Vaccine Damage.

The Viable Practitioner Pool Centre (VPPC) is responsible for the initial aspects of recruitment, payment and contract management of Examining Health Care Professionals (EHCPs) on behalf of Atos Healthcare. Atos Healthcare itself is responsible for training and ongoing support of EHCPs. Atos Healthcare, and in turn the VPPC, keep accurate updated lists of practitioners, their availability and the range of work that they can perform.

4.2 Role of Atos Healthcare

Atos Healthcare help the Decision-Making Authorities to reach fair and proper decisions on eligibility for benefit by providing them with:

- Disability assessment advice
- Interpretation of medical evidence.

Atos Healthcare Examining Health Care Professionals have specialised expertise as Disability Analysts. Examining Health Care Professionals assess a person's restrictions and limitations caused by disability, and advise the Decision-Maker in accordance with the relevant legislation. For DLA, this advice is formulated around the care and mobility needs likely to arise in the course of a person's daily life.

We are also committed to the delivery of the highest possible quality of service to claimants and to our customers. This is reflected in Atos Healthcare's Professional Standards and Service Level Agreements.

4.3 Conditions of work

Atos Healthcare Examination Centre (MSEC) allocates work when it becomes available. Examinations may take place in the MEC or in the claimant's home (DV).

EHCPs are (mostly) self-employed and there can be no guarantee of case numbers. For DVs, EHCPs are required to return the completed casework within the agreed number of working days (12) from the date of issue of the request. In the MEC, the cases are returned as they are completed in the session.

The VPP is responsible for the payment of fees for the examination and report and expenses for mileage, postage, and telephone costs. Queries on payment due should be made to the VPPC or allocations sections, according to local practice.

For DVs, the allocations section in the MSEC sends cases to the EHCP nearest to the claimant when practicable, taking into consideration travelling costs and the availability of EHCPs. The allocations sections are also responsible for:

- Processing fee and expense claims.
- Monitoring clearance times and abortive visits, and
- Resolving problems over case delay, visiting difficulties, and the completion of expenses claims.

Any complaints about the standard of the EHCP service are referred by the PDCS or directly from the claimant to Atos Healthcare for investigation. The complaints procedures are covered in more detail in section 15 of the guidance.

4.4 Professional Standards

There are clearly stated Claimant Service Standards common to all areas of work and additional standards for each benefit. All the standards are periodically measured.

The standards relevant to EHCP work are set out in Appendices A and B and EHCPs are expected to adhere to these when carrying out their work.

5. The role of the Examining Health Care Professional

5.1 Introduction

The role of the EHCP is to provide reports, which may be:

- Required by the Decision Maker (DM) to determine entitlement to Disability Living Allowance or Attendance Allowance.
- Requested by the claimant.
- Required by the Tribunals Service to determine entitlement to DLA or AA.

EHCPs may be asked to examine and provide a medical report on a DLA or AA claimant at any stage of the decision-making process. The DM may decide this when:

1. The self-assessment statement has not been completed
2. Further evidence or clarification is required
3. A factual report is inconclusive or not obtainable

GPs or hospital doctors usually provide factual reports. They usually contain mostly clinical information, which the EHCP may be required to interpret from a functional viewpoint.

5.2 Training and approval

Experienced full-time Registered Medical Practitioners train EHCPs. This may be supplemented with additional input from DMs.

Training is given on:

- The ethos of the Department for Work and Pensions.
- Equal opportunities policy and relevant legislation.
- Atos Healthcare's Professional Standards.
- Customer service.
- Disability awareness.
- Benefit awareness.
- Decision making awareness.

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- Examination technique and report completion.
- Approval.
- Quality systems and audit.
- Interview technique.
- Fraud awareness.
- Risk management of problem situations.
- Administrative arrangements.
- Complaints procedures.

5.2.1 Initial training

This consists of five steps:

1. Trainer-led training day: Disability Analysis for New Entrants
2. Stage 1 training: A two-day, trainer-led course. All Candidates must attend.
3. Stage 2: Obtaining a pass mark in a Multiple Choice Questionnaire (MCQ) examination at the end of Stage 1
4. Stage 3 training: observation of a local trainer performing an EHCP assessment, followed by observation of the candidate by the trainer.
5. Stage 4 training: 100% targeted audit and feedback of cases until four 'A' grades have been achieved.

Further cases may be selected at stage 4 at the Medical Manager's discretion. Standard audit protocols are used. The feedback method is at the discretion of the mentor e.g. telephone, letter or in person.

After completion of these cases, the candidates will have a formal review with their mentor. This interview will be structured according to certain advisory guidelines. On satisfactory completion of this process, the Medical Practitioner's name is submitted to the CMA for approval.

5.3 Ongoing training

When procedural or legislative changes occur, updated information is circulated to EHCPs. Atos Healthcare provides details of Continuing Medical Education and each EHCP has a Personal Training Plan. The details of update training and feedback are logged.

Where an EHCP is not meeting the required standards for reports, further training may be offered at the discretion of Atos Healthcare, but persistent failure to achieve the standards required will result in non-allocation of further work.

5.4 Auditing of reports

EHCP reports will be subject to periodic monitoring by employed Atos Healthcare doctors. DMs may also refer reports for monitoring if they contain weaknesses.

EHCPs will be informed of the outcome of this monitoring. If the standard of reports is unsatisfactory, and this includes illegible writing, a decision on remedial training will be made before any more work is offered. More information on the quality systems will be provided later in the guide (section 14.2 and Appendix C).

6. Main features of Disability Living Allowance & Attendance Allowance

6.1 Disability Living Allowance (DLA)

Disability Living Allowance is a non-contributory, non-means tested and tax-free benefit that is based on an assessment of care and mobility needs for people with disability. DLA is payable to those with qualifying needs where the claim is made before the age of 65. Where DLA entitlement is established before the 65th birthday, DLA can run on beyond the age of 65. The Decision Maker (DM) treats any claim for DLA as a claim for both care and mobility components:

- **Care** - payable to those who need help with personal care or who have difficulty planning and preparing a main meal.
- **Mobility** - payable to those with mobility problems due to a physical difficulty with walking, or with a need for guidance or supervision when walking in unfamiliar places out of doors due to physical or mental health problems.

Personal care means attention to bodily functions or supervision/watching over to prevent substantial danger to themselves or others.

A DLA claim consists of both components. Care component entitlement can be considered from birth. The higher rate mobility component cannot be awarded before the age of three years. The lower rate mobility component cannot be awarded before the age of 5 years.

There are lower, middle and higher rates to the care component. The mobility component is payable at lower and higher rates.

6.2 Attendance Allowance (AA)

AA is payable to those whose needs arise after the age of 65 (or who claim after that date) and it relates to personal care only. AA does not have a Mobility component. It has two care rates, lower and higher, which are equivalent to the middle and highest rates of DLA care component.

6.3 Decision making

The non-medical DM decides the rate of benefit to which the claimant is entitled, basing their judgements on the law. The system also allows for:

- A speedy reconsideration of a decision usually by a different DM
- Appeals against the original and reconsideration decisions organised by the Tribunals Service
- Appeals against the Tribunals Service decisions on a point of law to the Judges of the Upper Tribunal and then, with leave, to the Court of Appeal (matters of

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fact cannot be the subject of appeal to Judges of the Upper Tribunal or to the Courts).

A tribunal for DLA/AA consists of a:

- Legal chairperson
- Medical member
- Person experienced in dealing with the needs of people with disabilities.

All members have an equal say in the decision. The chair can give a legal interpretation of the evidence and the doctor can use expertise to interpret the medical evidence for the other members. The medical member of the tribunal does not conduct a formal physical examination. However, tribunal members can interpret observations made of the appellant during the proceedings, if he/she is present.

Appeals on non-disability issues are directed to the Tribunals Service, which determines the appropriate constitution of tribunal to review the situation.

6.4 Self reporting

Claims for DLA and AA use evidence provided by the claimant indicating how, in their opinion, the illness or disability restricts essential daily activities.

This gives claimants an opportunity to make a full written statement about themselves and the effect their present condition has on their lives.

Claimants are also encouraged to submit supporting evidence from relatives, carers or Health Care Professionals. This gives the DM a better picture of the person's care and mobility needs. Therefore, claims can sometimes be decided without medical examination or the need for other information to be obtained.

Where necessary, further evidence may be sought in the form of a Factual Report. DMs are also able to seek medical advice from Health Care Professionals employed by Atos Healthcare to provide an interpretation of the available evidence. Atos Healthcare Health Care Professionals are able to consult with the Disability Living Allowance Advisory Board (DLAAB) when advising DMs.

There are however situations when a medical examination is required. In some cases a claimant may prefer an Examining Health Care Professionals to examine them rather than complete the self-assessment questionnaire. In other cases, the DM may not be able to determine entitlement without a medical examination and report to assist in clarifying the evidence.

6.5 Disability criteria

DLA and AA are both designed to recognise the extra costs incurred from long-term disability and the care and mobility needs are used as proxies for these extra costs. The basic principles behind the two allowances are the same. There are, however, some significant differences between them.

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6.6 Personal care

To qualify for the lowest rate of the care component of DLA, a person will have to be so severely disabled physically or mentally that one of the following apply:

- Need attention from another person for a significant portion of the day in connection with bodily functions for a single period or a number of periods.
- Aged 16 or over and cannot plan and prepare a cooked meal for themselves if they have the ingredients.

The following criteria refer to the *middle* and *highest* rates of the care component in DLA:

- Need frequent attention from another person throughout the day in connection with their bodily functions.
- Need continual supervision throughout the day by another person to avoid substantial danger to themselves or others.
- Need prolonged, or repeated, attention from another person during the night in connection with his or her bodily functions.
- Need another person to be awake for a prolonged period or at frequent intervals during the night to watch over them, to avoid substantial danger to themselves or others.

There are also special provisions for people undergoing renal dialysis twice or more a week.

6.7 Three rates of the care component

The three rates of the care component are:

CARE COMPONENT RATE	QUALIFYING CONDITIONS
Highest	Payable if the person needs help both day and night, or has a life expectancy of six months or less.
Middle	Payable if the person needs frequent help during the day or night. Some people who are on dialysis may also get this rate.
Lowest	Payable if the person needs help for a significant portion of the day only, or if aged 16 or over, has difficulty planning and preparing a main meal for themselves, given the ingredients.

6.8 Mobility problems

6.8.1 Criteria for the higher rate mobility component

A person qualifies for the mobility component at the higher rate if:

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- He/she is suffering from a physical disablement such that they are unable to walk or virtually unable to walk.
- He/she falls into one of a number of special categories for which it has been determined that a higher rate of the mobility component will be payable.

This includes people:

- Unable to walk.
- Virtually unable to walk i.e. those individuals whose ability to walk out of doors is so limited having regard to the distance, speed, length of time or manner in which they can make progress on foot without severe discomfort.
- For whom the exertion required to walk would constitute a danger to their life, or would be likely to lead to a serious deterioration in their health.
- Who have had both legs amputated at levels through or above the ankle, or who have one leg amputated and are without the other leg, or who are for any reason without both legs to the same extent as if they had been amputated either through or above the ankle.
- Who are deaf and blind to the prescribed degree and, because of the combined disabilities, they need help from another person to reach their desired destination out of doors.
- Who are severely mentally impaired and suffer from severe behavioural problems and satisfy the conditions for the highest rate of the care component as described in paragraph 8.6.

6.8.2 Criteria for the lower rate mobility

A person qualifies for the mobility component at the lower rate if:

- He/she can walk but cannot take advantage of this faculty over unfamiliar terrain out of doors without guidance or supervision most of the time (e.g. people who are blind or who have learning difficulties).

6.8.3 Summary of the mobility rates

The two rates of the mobility component are:

MOBILITY COMPONENT RATE	QUALIFYING CONDITIONS
Higher	Payable if a person: 1. Is unable to walk, or 2. Is virtually unable to walk, or 3. For whom the exertion required to walk would lead to a serious deterioration in their health, or

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	4. Has had both legs amputated at or above the ankle, or 5. Is both deaf and blind, or 6. Is severely mentally impaired, displays severe behavioural problems and is entitled to the highest rate of the care component.
Lower	Payable if a person can walk but cannot take advantage of this facility outdoors in unfamiliar routes without guidance or supervision most of the time

To qualify for the mobility component the person's condition must be such that they would benefit from enhanced facilities of locomotion. For the lower rate, the person must be able to go out if they have guidance or supervision.

6.9 Attendance Allowance

To qualify for AA, a person must be so severely disabled physically or mentally that they need one or more of the following:

- Frequent attention from another person throughout the day in connection with bodily functions.
- Continual supervision throughout the day by another person to avoid substantial danger to themselves or others.
- Prolonged or repeated attention from another person during the night in connection with bodily functions.
- Another person to be awake for a prolonged period or at frequent intervals of the night to watch over them, in order to avoid substantial danger to themselves or others.

6.9.1 The two rates of AA:

Attendance Allowance rate	Qualifying Condition
Higher	Payable if the person: 1. Needs help both day and night, or 2. Has a life expectancy of six months or less.
Lower	Payable if the person needs help during the day or night. Some people who are on dialysis may also get this rate

6.10 Qualifying periods

For each component of DLA, the need for help must have existed for at least three months and must be expected to exist for at least a further six months, unless the claimant is terminally ill.

For AA the qualifying period is six months unless the claimant is terminally ill. There is no requirement to satisfy a future need.

6.11 Terminal illness cases

Such cases are dealt with under provisions known as the Special Rules.

A person, who claims DLA or AA on the grounds of terminal illness, where this has been confirmed, is taken to have satisfied the conditions of entitlement for the highest rate care component or the higher rate of AA, as appropriate.

A person is defined in the Social Security Contributions and Benefits Act 1992 as terminally ill if they are suffering from a progressive disease and death in consequence of that disease can reasonably be expected within six months.

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A person claiming DLA on the grounds of terminal illness does not have to satisfy the qualifying period or the prospective test for either component. To qualify for the higher rate mobility component, they must satisfy one of the relevant criteria (see Para 6.8) but there is then no qualifying period.

Attendance Allowance

The qualifying period is waived for an AA claim if the claimant is terminally ill.

6.12 Children under the age of 16

For children under the age of 16, the disability criteria for DLA are modified as follows:

- For the care component, the child must require substantially more care from another person than a child his or her age would normally require.
- For the lower rate of mobility component, a child (over 5 years of age) must need substantially more guidance or supervision from another person than a child of the same age in normal physical and mental health would require.
- The higher rate of mobility components can be considered from the age of three.

7. Factors considered by the Decision Maker - care

7.1 Severe disability

For both DLA and AA, the DM must consider if the person's needs arise because of physical and/or mental disability.

The person does not need to be ill or chronically sick.

7.2 Attention

Attention is defined as helping someone in connection with his or her bodily functions. Attention must be close and intimate, i.e. spoken or physical and must be carried out in the presence of the disabled person. The important factor is whether a particular task is one that a person would normally do for himself or herself.

Examples of bodily functions

Examples of bodily functions (in DLA and AA) include:

- Breathing
- Hearing
- Seeing
- Communicating
- Eating and drinking
- Walking
- Sitting
- Sleeping
- Cleanliness and skin protection (including being turned in bed)
- Getting into or out of bed
- Dressing/undressing
- Going to the toilet (including undressing, wiping and re-dressing).

Bodily functions do not include shopping or other domestic tasks, many of which would normally be undertaken by a home carer. Certain tasks, for example dealing with soiled bedclothes, can be taken into account if the activity takes place at the same time and as part of the activity of attending to the disabled person.

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The DM can take into account attention in connection with a bodily function in order to undertake a reasonable level of social, religious or cultural activity.

7.3 Supervision/watching over

Supervision/watching over is a more passive role than attention. It means being present and ready to intervene, if required, to prevent substantial danger. By night, this can only be satisfied by the need for another person to remain awake to watch over the claimant to prevent substantial danger.

The DM will take account of the following factors when considering the need for supervision:

- The medical condition is such that there might be substantial danger either to the disabled person or to someone else.
- The substantial danger is a real possibility.
- The need for supervision to ensure that the claimant avoids the substantial danger.
- The need for another person to remain awake to supervise the claimant for a prolonged period or at frequent intervals.

7.4 The main meal test

The main meal test is used to establish a person's ability to perform key daily tasks and is one of the commonest causes of problems to the DM when they analyse EHCP reports.

Key points on the main meal test

- It is not a test of cooking ability but a measure of a person's physical and mental capacity to carry out complex activities.
- Factors such as the type of facilities or equipment available, or cooking skills, are irrelevant.
- Whether a person actually prepares and cooks a main meal is not the issue; it is whether that person is capable of performing these or similar tasks.

Note:

The use of microwave ovens, prepared meals, frozen vegetables or aids and appliances other than of a very basic nature will **not** be taken into account.

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Factors to consider are (using appropriate simple equipment and readily available aids):

- Planning a meal.
- Peeling and chopping vegetables safely.
- Using the taps safely.
- Using a cooker safely.
- Coping with hot pans.
- Undertaking the process in a hygienic manner.

The ability to plan a main meal is important. Some people who have a mental disability may be able to carry out all these tasks separately, but may still be unable to prepare and cook a main meal because they cannot plan it or undertake all the necessary tasks in a logical way without help or supervision. It is, therefore, a test of upper limb functions, manual dexterity, balance and co-ordination, and mental competence, including motivation.

7.5 Are the needs reasonable?

The DM will take into account what attention or supervision/watching over is reasonably required, **not** what is or is not being received.

A person may require more care than is being given. This is of particular importance when the needs of people with disabilities living alone are being considered. They may be attempting to carry out activities that are beyond their capabilities but circumstances dictate that they must. Conversely, over-protective carers may give a person more help than is needed and therefore prevent them from achieving independence.

When considering the frequency and duration of need for attention or supervision, the DM aggregates different needs arising from any particular cause, as well as those arising from different causes.

7.6 Age

The age of an individual must be taken into account. A person's age may have an effect on how a disability affects them. For example, a child who develops diabetes aged 6 needs more care and supervision than a person who develops that same condition when aged 30.

Many elderly people have more than one disability, which in isolation may not seem severe, but the overall effect of the combined and often minor disabilities combined with effects of ageing and frailty, may present a significant need.

7.7 Aids to help the disabled

A further consideration is whether the claimant uses aids to reduce the need for help. For example, a person who would otherwise need help to get upstairs may achieve independence with one or two stair rails.

DMs would not normally take account of what aids a person could but does not use. The exception would be where a person is not using an aid which apparently they are able to use, and is readily available and which many others in their situation do use.

Readily available aids are those that cost least and do not require adaptation of the home. For example: blocks to raise a chair, raised toilet seat, adapted cutlery, walking stick, and also simple bars, grips and rails. A commode is usually readily available if required. However, in considering the use of a commode the DM must be satisfied that a private place is available in the house for its use.

7.8 Day or night supervision/attention

The DM will need to consider whether a need arises during the day and/or night. The time the disabled person goes to bed is not a factor. Night has been defined in case law as the time the household closes down. This is particularly important when considering the needs of children.

7.9 Children

For children under the age of 16, the DM has to decide if the attention or supervision/watching over required is significantly greater than that needed by a healthy child of the same age. The main meal test is not applied to children under the age of 16.

7.10 Variable needs

In many conditions, the level of disability varies over time. Multiple sclerosis is a good example of this. Asthma, particularly in children, is another. These conditions are characterised by periods of remission and relapse during which the need for help can change greatly. Other conditions can vary markedly from day to day, e.g. chronic fatigue syndrome, whilst others, such as rheumatoid arthritis with its morning stiffness may vary throughout the day.

What is important to the DM is the overall level of disability for the majority of the time, not the actual level on a particular day, or the needs during an acute exacerbation or period of remission.

Guidance on the application of disability analysis disciplines and the evaluation of evidence particularly in variable conditions will be provided later in this guide.

8. Factors considered by the Decision Maker - mobility

8.1 Unable or virtually unable to walk

Inability or virtual inability to walk can be caused by cardiac or respiratory disorders or disorders affecting the balance as well as disabilities directly affecting the lower limbs.

Only the effects of physical disability can be taken into account when deciding if a person is unable or virtually unable to walk. A person who refuses to walk for any reason but can walk if persuaded would not normally be regarded as incapable of walking. The decision on whether a person's inability to walk arises from a physical disability can be complex and is one for the DM to make, taking account of various legal precedents. The important thing is to record as much detail as possible about the individual and the way his/her walking is affected, in order to allow this decision to be made in a reasonable way.

In assessing the level of walking ability, no account is taken of the person's individual circumstances such as:

- Where they live.
- Whether they have access to public transport.
- Whether they work.
- What type of work they do.

Factors that are taken into account (walking on even terrain out of doors without severe discomfort):

- Distance
- Speed
- Length of time
- Manner

No one factor is decisive.

8.2 Exertion

A person whose legs are capable of the physical movements of walking but who is prevented from doing so because of other physical problems can be regarded as unable or virtually unable to walk if:

- The effort required to walk would endanger his/her life; or

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- It would be likely to have an adverse effect on his/her health.

8.3 Amputations

People who have had both legs amputated at or above the ankle and people without the use of both legs are taken to be unable to walk irrespective of their actual ability to walk using prostheses. In these cases, the DM will look for appropriate corroboration.

Unless there are potential care needs, examination is not normally necessary.

8.4 Walking aids

When assessing a person's walking ability with walking aids, consider the following factors:

- The use of appropriate prostheses or aids already supplied (except for a person without both legs to the same extent as if they had been amputated) or which could be supplied, and
- Whether they are mentally and physically able to use them.
- Ability to weight bear on the aid.
- Where only one lower limb is weight bearing then the method of progress using crutches is "swinging-through". This does not constitute walking.

8.5 Deafness and blindness

People who are both deaf and blind as defined below and (as a result of the combined disabilities) need the help of another person to reach an intended or required destination, are regarded as unable to walk and hence will qualify for higher mobility component.

The prescribed degree of disability due to blindness is 100%. This is defined as loss of sight to such an extent as to render the claimant unable to perform work for which eyesight is essential. This normally equates to a visual acuity of <6/60, or inability to count fingers beyond 50 cm. However, other factors, for example the extent of any visual field loss should also be taken into account.

The prescribed degree of disability due to deafness is 80%. Clinical tests should confirm that the claimant is not able to hear and understand a shouted message at a distance of one metre, out of doors (i.e. with an element of background noise). Case law has established that DMs will normally be required to establish the level of hearing impairment by means of an audiogram and applying a similar type of assessment to that taking place in occupational deafness in the Industrial Injuries Disablement Benefit.

8.6 Severe mental impairment

A small number of people with severe mental impairment (SMI) who are physically able to walk also have behavioural problems. These may be so extreme and unpredictable that they need someone to be present watching over them whenever they are awake and that person regularly needs to intervene and physically restrain them to prevent injury or damage.

This group has been described in the regulations as those who have arrested or incomplete physical development of the brain, which results in severe impairment of intelligence and social functioning, to the extent that they have severe behaviour problems and qualify for the highest care component. If all these conditions are satisfied, they will qualify for the higher rate of the mobility component.

Severe impairment of intelligence can be generally described as being 3 standard deviations below the average IQ of 100. Therefore, usually, a person with severe impairment of intelligence will have an IQ of 55 or less. However, whilst IQ is a good starting point in determining intelligence, it is useful intelligence that has to be considered. For example, an autistic person, with an IQ of 80 and who is a brilliant musician, may lack sufficient social skills to make use of this intelligence in other areas.

Incomplete physical development of the brain refers to the situation where a person's brain has failed to grow in the proper way and this can be demonstrated physically. On examination of a person's brain, where nothing appears physically wrong, but the function of the brain is nevertheless deficient, then development is said to be arrested. The current consensus view is that the brain reaches full development in most people in the late twenties, and invariably before the age of 30 years.

It is therefore possible for someone who suffers an insult to the brain before the age of 30 years to be considered severely mentally impaired. It may also be possible for some people who develop severe mental illness before the age of 30 to be regarded in this way, if the illness can be identified as arising from arrested or incomplete physical development of the brain. Conditions that develop after the age of 30, including degenerative conditions such as Alzheimer's disease, would **not** be considered to have caused severe mental impairment because the problem arose after the brain was fully developed. However, it will always be necessary for the other conditions relating to intelligence and social functioning to be fulfilled before a person can qualify for a higher rate mobility award.

The above conclusions have been defined by case law and must be accepted for decisions relating to DLA/AA.

8.7 Guidance and supervision

There are many severely physically or mentally disabled people who are physically capable of walking but are not independently mobile on foot. They may need guidance from another person or may need supervision most of the time because they:

- Have impaired vision and cannot find their way.

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- Do not recognise danger.
- May injure themselves or others.
- May get lost or forget where they are going.
- Need active encouragement or persuasion to continue walking.

Any ability to follow well-known routes without help is discounted, such as going to a local shop or the use of a bus service regularly. Any supervision that is not directed towards helping the person find their way must also be discounted.

8.8 Intermittent problems

When a person's walking ability varies or the need for guidance or supervision is intermittent, the level of disability over a period of time will be taken into account when determining the claimant's overall needs.

When a person's walking ability is intermittently interrupted, e.g. if they have epilepsy, it is a question of degree and frequency as to whether or not they can be considered to satisfy the conditions for an award. (Such a person may require assessment as under Paragraph 8.7 above, but with due regard to the purpose of any supervision required.)

In situations where there is considerable variability, it is vital to give as much information as possible to the DM. It is helpful to record, if possible, details of the status on good and bad days and the frequency of good/ bad days etc.

8.9 Children

Guidance or supervision needed for children (up to the age of 16) has to be significantly greater than that required for a healthy child of the same age.

8.10 Benefits of getting out and about

In addition, the DM must take into account whether or not the person will benefit from getting out. This relates to general mobility and is not confined to the act of walking. In general terms, a person may be considered able to benefit if they are in any way conscious of change. A person who can walk but needs guidance or supervision to walk out of doors must be willing to go out to be able to benefit.

9. Equal Opportunities and other legislation

9.1 Equal Opportunities Policy

As an EHCP acting on behalf of Atos Healthcare you are expected to adhere to the Equal Opportunities Policy. In all aspects of our work, there is no place for any suggestion of discrimination or harassment.

9.2 Race Relations Act 1976

The Race Relations Act 1976 makes it unlawful to discriminate against individuals on the grounds of:

- Colour
- Race
- Nationality
- Ethnic origin
- National origins.

Discrimination occurs whenever a person, on racial grounds, treats an individual less favourably than others. In addition, discrimination occurs if a person applies a requirement or condition that cannot be justified irrespective of race.

It is our practice to inform claimants that if they have difficulty understanding English then an interpreter may accompany them. An interpreter should be present if language difficulties would make it difficult for you to make a proper assessment of a claimant's condition.

If it is evident that an interpreter is required, you should explain matters as best you can to the claimant. In the MEC, the MEA should be informed. If this situation arises on a DV, then the MSC should be telephoned. Arrangements will then be made for the assessment to be performed later, when an interpreter will be provided. Note that a minor (child under 16 years old) is not an appropriate interpreter, and alternative arrangements should be made.

9.3 The Sex Discrimination Act 1975

The Sex Discrimination Act 1975 makes it unlawful to discriminate against anyone or treat anyone less favourably on grounds of gender.

If a justified complaint is received that an individual has been discriminated against on the grounds of race or gender, that Medical Practitioner will no longer be used to carry out examinations. This action may be in addition to any civil proceedings that the claimant may wish to bring.

9.4 The Rehabilitation of Offenders Act 1974

9.4.1 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; 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 Rehabilitation of Offenders Act makes it an offence for anyone **with access to criminal records** to disclose a spent conviction **unless authorised to do so**. The intention of the legislation is that once a conviction becomes spent, any question relating to criminal convictions in, for example, job or insurance application forms, can, with certain exceptions, be answered in the negative.

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

9.4.2 Implications for Examining Health Care Professionals

Atos Healthcare practitioners may receive information that relates to current or spent criminal convictions, either in factual reports from a third party, e.g. a GP, or directly from the claimant during interview. Therefore, we need to understand the implications of the Rehabilitation of Offenders Act so that this information can be dealt with appropriately.

If a report submitted to the DWP or Atos Healthcare by a third party refers to a criminal conviction, the author will not contravene the Act 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.

Therefore, Atos Healthcare Practitioners can accept in good faith that reference to criminal convictions in third party reports does not risk contravening the Rehabilitation of Offenders Legislation. However, such information should be treated like any other potentially embarrassing information, unless mention of the conviction is directly relevant to the benefit claim in question.

Similarly, since neither the DWP nor Atos Healthcare 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 EHCP to record such information – i.e. it is materially relevant to the claim – then he or she may do so, in good faith, without fear of contravening the legislation. If a claimant wishes to have mention of a conviction recorded on the medical report, the EHCP should:

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

9.5 The Disability Discrimination Act 1995

The EHCP is not required to provide an opinion on whether the claimant's medical condition or disability is likely to satisfy the Disability Discrimination Act [DDA] 1995.

Under the DDA, it is unlawful to treat a person less favourably than another because of their disability.

The Act covers:

- Employment
- Education
- Access to premises used by the public
- Provision of goods, services and facilities
- Accommodation
- Buying premises including land
- Clubs and associations
- Sport
- Administration of Commonwealth Government Laws and Administration

9.5.1 Definition of Disability within the DDA

Disability within the meaning of the Act is defined as follows:

A physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

When considering if the DDA applies, the underlined areas are important.

Impairment may be physical or mental, due to illness, accident or congenital abnormality. Mental impairment includes mental illness (but this does not need to be clinically well-recognised) and learning difficulties. It excludes certain conditions such as a tendency to criminal or sexual acts.

Impairment will affect normal day-to-day activities only if it has an adverse effect on one of the following:

- Mobility
- Manual dexterity
- Physical co-ordination

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- Contenance
- Ability to lift, carry or otherwise move everyday objects
- Hearing, speech or corrected eyesight
- Memory or ability to concentrate, learn or understand
- Perception of risk of physical danger

Substantial is defined as more than minor or trivial. Therefore the presence of impairment, limited activity and/or reduced participation (as per the International Classification of Functioning, Disability and Health) does not necessarily mean a person is covered by the Act. For example, a pianist who loses part of their little finger would not fall within the meaning of the Act since this would not cause a substantial effect on their ability to perform the activities of day-to-day living.

Long Term includes the following:

- Has lasted at least 12 months
- Is likely to last 12 months
- Is likely to last the rest of the person's life (including terminal illness)
- Is likely to recur

When a person has a progressive condition, that person will be covered by the Act from the time the condition leads to an impairment which has some effect on ability to carry out normal day-to-day activities, even though not a substantial effect, if that impairment is likely eventually to have a substantial adverse effect on such ability. In addition, cancer, multiple sclerosis, and HIV infection are recognised by the Act from the point of diagnosis.

When considering if a person falls within the meaning of the Act it must be remembered that a person is still protected against discrimination even when their disability is controlled or treated. They are considered without the effects of any treatment. For example, a person with epilepsy is considered without their medication.

HCPs are referred to Module 5 of the Medical Services Continuing Medical Education Programme entitled 'The Disability Discrimination Act', for more detail on the DDA.

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10. Administrative guidance for the EHCP

This chapter describes the issues relating to examinations performed as domiciliary visits.

10.1 Making appointments for domiciliary visits

Key points:

- Arrangements for DVs are a major source of complaints against EHCPs, particularly regarding alleged insufficient notice of a visit.
- It is very important to follow the recommend practice as described below.

EHCPs are asked to note the following points when undertaking examinations in the claimant's home:

- Contact the claimant and offer an appointment for a visit as soon as possible after receiving a file. This appointment can either be made by a telephone and / or a letter. It is vital to offer sufficient (7 days) notice to allow:
 - a. The claimant and relatives or carers time to prepare for the examination.
 - b. To ensure the presence of an interpreter if needed.
 - c. A parent or legal guardian to be present when examining a claimant below the age of 16 years.
 - d. When an appointment has been made by telephone, it is good practice to confirm the appointment by letter.
 - e. When contacting the claimant by telephone the procedures outlined in section 10.2 should be followed. Ensure telephone calls are made at reasonable times.
 - f. When notifying a claimant of an appointment time, a maximum of a 1-hour window should be given. All reasonable efforts should be made to attend within that time. If you are running late or are unable to keep the appointment, it is important that the claimant is contacted to keep them informed.
- When an appointment is discussed on the telephone and a date less than 7 days in advance is agreed as being mutually convenient, the EHCP should record this fact on the report, and ask the claimant to sign that it is the case.

(Please Note: Some claimants allege that they were pressurised by the EHCP into accepting such appointments therefore recording the facts on the report can be important. It is very important to be aware of the sensitivities surrounding ensuring that the appointment time is mutually convenient).

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- Provide proof of identification for the claimant/carer as issued via your Medical Manager.
- Ensure that the person being interviewed and assessed is the person claiming benefit (see section 10.3).
- Return reports promptly within the agreed period, and make contact by telephone with the MSC if this is not possible.

10.2 Telephone contact with claimants

It must be ensured that Atos Healthcare 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 Atos Healthcare.

In all instances where contact is to be made with a claimant, the procedure outlined below should be followed.

10.2.1 Establishing the identity of the claimant

When making the telephone call it is essential that the identity of the person to whom the EHCP is speaking is established at the outset.

The following script or something very similar should be used:

“I’m XXX from Atos Healthcare 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 date of birth or NINO.

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

If the claimant is unavailable, arrange 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 then an appropriate letter should be used.

10.2.2 Informing the claimant of the reason for the telephone call

Having established the identity of the claimant, there is then a need to explain why the telephone call is being made. Something similar to the phrase, “I am one of the medical practitioners providing medical advice on your claim to benefit” would suffice.

10.2.3 Form FRR4 – Telephone Contact report for Further Information of Further Medical Evidence

Form FRR4 is to be used to cover documentation of all information and

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evidence obtained in the course of a telephone call. This would not normally be part of an EHCP's role.

10.2.4 Exceptional circumstances

There may be instances when the above procedure cannot be used because the claimant:

- **Is a child.** Under these circumstances, once contact has been made with a parent or guardian, a check should be made that the parent or guardian is the correct person to whom we should be speaking by verifying name and address details that are held on the referral. The identity of the child must then be checked by asking the parent or guardian to confirm the child's name and date of birth. Once satisfied that it is the correct child that is to be discussed, further information may then be divulged.
- **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 the date of birth, 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.
- **Requires an interpreter.** If, when making a telephone call to the claimant, it becomes obvious that an interpreter is required, the EHCP 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.
- **Has a medical condition that precludes a telephone conversation.** As in the case of an interpreter, once it becomes obvious that the claimant cannot speak on the telephone the EHCP should advise the person to whom they are speaking that a letter will be sent to them in due course. The telephone call should be terminated without divulging any of the claimant's details.

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 Data Protection Act.

10.3 Identification of the claimant at the assessment

Contractually, Atos Healthcare is required to ensure that individuals presenting themselves for examinations are who they say they are. Atos Healthcare must examine the actual claimant, not any person who may be masquerading as the claimant. Therefore, reasonable steps must be taken to ensure that we are fulfilling the Customer's wishes.

The form POID1 should be used. An example of this is in Appendix F.

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The MSC must complete the name and date of birth of the claimant at Part 1 and ensure that this form is then enclosed in the file/plastic wallet that is issued to an EHCP for a DV. The steps outlined below should be followed:

- The EHCP should identify themselves, who they visiting and the reason for the visit.
- Ask the claimant to provide identification such as a passport or driving licence.
- 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 (e.g. DLA 1 etc., if available) or the proof of identity offered, if signed
- Complete Part 2A 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 EHCP should ask the claimant more in depth questions relating to case history, to establish correct identity and determine whether the examination should continue. If the EHCP is 100% certain that the individual is not the true claimant, they should contact a FTMA or Medical Manager to authorise suspension of the examination. This should be done by telephone, either mobile or pay phone if necessary.

An individual **must not** be refused an examination unless the EHCP is 100% certain that the individual who has presented him or herself for examination is not the true claimant. In all other cases the EHCP should continue with the examination and complete the medical report as normal, marking the report that the claimant's identity is in doubt.

10.4 Special need requirement

Occasionally a claimant will request that, for example, a same sex EHCP performs the assessment, or that an interpreter be provided (e.g. for language, for the deaf, etc.) This fact is registered on the documents by the Customer, for administrative action by Atos Healthcare Centre (MSC) staff.

The general principle is that it is the responsibility of the MSC to make the necessary arrangements according to the nature of the special needs, and act as the point of liaison.

In the first instance, the Allocation Section will select an appropriate EHCP in the area. This may be all that is required, e.g. in the case of the claimant who requests a same sex EHCP or if there is a suitably qualified EHCP that speaks the required language. This will usually be the case when the claimant is examined at an MEC.

Where an interpreter is required for a MEC based examination, this will be arranged by the Allocation Section as necessary.

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Where an interpreter is required for a DV, the Allocation Section will alert the selected EHCP by telephone to expect the case. The Allocation Section will then proceed to identify an appropriate interpreter in the area, determine the interpreter's availability and obtain their agreement in principle to provide assistance. The Allocation Section will then raise a Purchase Requisition with the Finance section and complete it appropriately.

The Allocation Section will then post the annotated file to the EHCP, who makes a general arrangement with the claimant to perform the visit, and provisionally agrees a suitable day and time.

Clearly, it is helpful if the EHCP and claimant between themselves provide the MSC with a choice. If the claimant is unable to speak or understand English, the EHCP should notify the Allocation Section and give details of their availability. The Allocation Section will then contact the interpreter, giving the EHCP's availability and ask them to telephone the claimant to arrange a mutually agreeable appointment. The interpreter should then notify the Allocation Section of the agreed date and this information should be passed to the EHCP.

If an interpreter has not been required to arrange an appointment, time is allowed for the EHCP to contact the claimant. The Allocation Section will then telephone the EHCP to ascertain the proposed date and time for the visit. The interpreter should then be contacted to inform them of the arrangements and confirm that they are suitable.

Once all parties are content with the arrangements, the EHCP should then confirm the proposed time and date with the claimant, preferably by phone and letter. If an interpreter has been used to make these arrangements then the same interpreter should be contacted to convey this information to the claimant. In this circumstance, a telephone call should be sufficient.

If the arrangements are upset by unexpected events or difficulties, the Allocation Section will be the point of contact for all parties.

If the EHCP undertakes the visit and at this point identifies that an interpreter is required they should send the file to the Allocation Section for them to return it to the business unit for further information on required special needs.

Targets may be compromised by cases of this type. The following principles should be observed:

- It is essential that EHCPs remain aware of the constraints imposed by targets and make every effort on their part to ensure that the medical arrangements are put in place as efficiently as possible and with the minimum of delay.
- The Allocation Section must be kept up to date with all developments.

10.5 EHCP reports completed by a third party

No report for Atos Healthcare can be hand-written by anyone other than you as an EHCP.

A typewritten report, typed by a third party, is acceptable because it can be understood that the EHCP would have dictated that part of the report to their

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secretary before checking and signing the typed and completed form.

A typist (or indeed a wife/husband) engaged by an EHCP to complete a medical report is liable to prosecution for any breach of confidentiality from information they would gather or become aware of while typing reports. This arises under Section 123 of the Social Security Administration Act of 1992.

The Legal Advice is that a secretary, being a person who provides or is employed in the provision of a service (typing reports) to persons who are carrying out the administrative work of the Department (i.e. an EHCP) would fall within the provisions of the Act.

They would therefore be susceptible to any prosecution for any breach of confidentiality. This applies irrespective of whether or not the typist is an employee, or has signed a separate confidentiality agreement for other employed work, or is a spouse, partner, or friend of the Examining Health Care Professional.

Depending on the seriousness of the breach, it cannot be ruled out that the Department would also seek to prosecute the Medical Practitioner for using unauthorised staff in the generation of their reports and in the utilisation of the information.

The following procedure should be followed for the typing of reports:

- You should arrange for signature and retention of copies by both parties, of appropriate confidentiality undertakings by those you engage with for processing information.
- If you use the services of a typist, please write to your local Medical Manager to confirm that you have put a confidentiality agreement in place. Please send a copy of that letter to the VPPC. Please make sure that you enclose a copy of the signed confidentiality agreement in both letters as well as the name and address of your typist. When the correct documentation is in place, Atos Healthcare will send you a letter of permission to use the services of the particular typist and will retain copies of these documents on your personal file. This procedure will need to be repeated on any change of typist.
- Failure to obtain an appropriate confidentiality agreement may mean that you, the EHCP, may also run the risk of prosecution under The Act in the event of a breach of confidentiality by any unauthorised personnel with whom you have engaged.

10.6 Abortive visits (no report provided)

Inevitably, on some occasions EHCPs will make abortive visits when the claimant is not at home at the pre-arranged time. The procedures for dealing with such situations are to:

- Complete form AV1 (Appendix D) and leave that at the claimant's address. This form allows you to input the new details of when you will call again. You should arrange the second appointment within the specified target time (usually 15 days from the time the papers were dispatched from the MSC,

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unless otherwise stated). As 7 day's notice will have previously been give for the first appointment, it is not a contractual requirement to do so again. You should ensure that the claimant is given reasonable notice for the second appointment in the event that they wish to arrange for a representative to be present. If you are unable to complete the report within the specified timescales, contact the MSC for advice.

- In some special situations, cases will be marked by the DBC with a red star. In such situations use form AV2 (Appendix D).
- Fill in Page 2 – about the visit of the EHCP report form giving reasons for the aborted visit (see below)
- If the property looks uninhabited or you feel that the address may not be correct, telephone the MSC for advice, so they can confirm the address with the DBC.
- If, when you visit again, the claimant is still not at home, fill in the appropriate part of Page 2 - about the visit and return the file to the MSC.
- Please record details of time and date of telephone conversations in the space provided at the bottom of Page 2.
- Please Note: only two attempts should be made to examine the claimant.

In the above circumstances, please provide full details of the reasons why you were unable to complete the form.

Examples of good practice in completing Page 2 – about the visit would be:

“I was unable to complete the EHCP report form because on the first occasion the claimant, who was profoundly deaf and who understood sign language, did not have a signer available. A signer was arranged for the second visit but was not present due to transport problems”

“I was unable to complete the EHCP report form because the claimant advised that he did not feel well enough to be examined on both occasions that I visited. The claimant refused to elaborate when I asked him for further details of why he did not feel well enough and advised that under no circumstances would I be given access to the house”

The following would not be sufficient:

“The claimant advised that he would not be examined”

Under no circumstances should you refer to the risk to benefit status. The Data Protection Act requires that you only include information on third parties that is relevant. Please attempt to anonymise any reference to third parties should it be necessary to include it.

For example:

“The claimant refused to allow me access because she said that she had to take

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her elderly relative to the hospital on both occasions when I called” **would be acceptable.**

However:

“The claimant refused to allow me access because she said that she had to take **her mother** to the hospital on both occasions when I called” **would be unacceptable.**

10.7 Non aborted visit (report incomplete)

When the claimant provides an account of their condition(s) and typical day, but is unable to co-operate fully in allowing you to carry out a physical examination AND you do not have sufficient information to confidently provide an opinion on mobility and/or care needs, this situation will apply.

This situation is likely to arise on the rare occasion when the claimant says they are, for example, too ill, or in too much pain, or it is a “bad day.” In this case, ask the claimant to sign a statement that records they are unwilling to be examined.

Under clinical findings in the report, please record your informal observations so that the Decision-Maker has some information on which to assess care and mobility needs. Wherever possible give your opinion, explaining that this is based upon informal observations only, at Section 3, box 21 of the form, in the box entitled “Please add any further information that you think would aid the decision maker”.

In the above circumstances, please provide full details of the reasons why you were unable to complete the form on page 2 of the report form.

10.8 The claimant refuses you entry

An attempt should be made to negotiate a mutually convenient time for a further visit. Ensure the claimant is given reasonable notice for the second appointment in the event that they wish to arrange for a representative to be present.

If the claimant refuses to agree a further appointment, you should inform them that you are obliged to attempt two visits to complete the report and provide a date and time on which you will return.

If on the second visit the claimant either is not at home or refuses you entry complete Page 2 of the EHCP report form – about the visit and provide the dates of the aborted visits.

10.9 Carrying out a requested DV where the Claimant is a Hospital In-patient

In rare circumstances Atos Healthcare are asked to carry out an assessment for DLA/AA, in the knowledge that the claimant is a hospital in-patient.

More often, this information will only become available when attempts are made

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to secure the appointment.

The in-patient status of a claimant may suggest a significant level of disability. In these cases, it should have been considered whether an examination is still essential, or whether information could be obtained from other sources to provide advice to the Decision Maker.

If the claimant is expected to be an in-patient for less than 4 weeks, it would often be appropriate to defer examination for a suitable period until the claimant can be assessed at home.

10.9.1 DV request for a known in-patient

In these cases, it will advise you on form DBD313a that the claimant is known to be in hospital.

In this case you should continue to arrange the visit but the following guidance must be adhered to:

1. The consent of the supervising consultant is mandatory. The consultant must agree that the visit can proceed, and that the claimant is fit to be assessed.
2. A relative or friend of the claimant must be present during the assessment unless the claimant expressly declines the presence of a companion.
3. The fact that consent has been obtained from both the consultant and claimant should be recorded in the report.

10.9.2 Other situations

Often, the information that a claimant is an in-patient will only become apparent when attempts are made to secure an appointment.

In this situation you should:

1. Contact the scheduling section and advise them of your findings.
2. Provide any information that you may have discovered about the reason and likely duration of their stay.
3. Hold the file pending further advice.

If you are asked to:

- a. Return the file:
Please return the file to the Atos Healthcare scheduling section marking form DBD313a 'Claimant identified as an in-patient' and providing any information that you may have discovered about the reason for, and likely duration of, their stay.
- b. Arrange the visit in hospital:
Please see the guidance in section 10.9.1 above
- c. Hold the file and arrange an appointment when the claimant is expected to return home:

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Follow the guidance from the Atos Healthcare Scheduling section and if at the second attempt to arrange an appointment the patient remains in hospital you should return the file to the Scheduling section following the guidance for an abortive visit (no report provided) at Section 10.6 above.

11. Recommended approach to Disability Assessment

There are some significant differences between the disability analysis examination and assessment and that performed in General Practice and hospital settings. A comparison of the roles of the Clinicians and the Disability Analyst is shown below in 11.1.

11.1 Comparison of role of Clinicians and Disability Analysts

	CLINICIAN (GP/CONSULTANT)	DISABILITY ANALYST
ROLE	<ul style="list-style-type: none"> • Diagnose • Treat 	Assess: <ul style="list-style-type: none"> - Functional limitations/restrictions (IB) - Care needs (DLA/AA) - Resulting from an illness, accident or impairment (IIDB)
HOW	<u>History</u> <ul style="list-style-type: none"> • Concentrate on presented symptoms • Need for consistency is not a key feature <u>Examination</u> <ul style="list-style-type: none"> • Focussed on making, or confirming, the diagnosis • Informal observations not always noted 	<u>History</u> <ul style="list-style-type: none"> • Diagnosis from clinician • Brief history of illness • Symptoms – how illness affects: <ul style="list-style-type: none"> • Function • Daily living activities • Looks for consistency in the overall picture <u>Examination</u> <ul style="list-style-type: none"> • Informal observations often very important • Objective examination looking for consistency and inappropriate signs (findings that do not indicate disease)
SPECIFIC SKILLS	<ul style="list-style-type: none"> • Diagnostic techniques • Detailed knowledge of therapeutic options 	<ul style="list-style-type: none"> • Objective assessment “disability” • Opinion/advice has to be fully justified for DM • Knowledge of legal framework when giving advice
OTHER	Usually the patients advocate <ul style="list-style-type: none"> • Acting in their best interest • Practitioner/patient relationship 	Not acting as patient’s advocate <ul style="list-style-type: none"> • Objective advice given in accordance with the law • Advice based on a detailed functional assessment

11.2 Disability analysis in DLA/AA

When carrying out DLA and AA examinations it is important to bear in mind:

- The contact with the claimant will be on a “one off” basis rather than as part of an ongoing professional relationship.
- The diagnosis has a different emphasis than it does in the clinical or therapeutic situation. It is however an important starting point for assessing the expected effects of the disability.
- It is vital to form and express your opinion on the effects of disability on that individual's daily life. In doing so, it is necessary to resolve any conflicts between what the claimant says and what would normally be expected from a particular disability. This is achieved by checking for consistency and determining whether the picture fits with the consensus of informed (and if possible evidence-based) opinion on the subject. Such an approach is the essence of disability analysis.
- Information can be elicited from several sources: the case papers, the claimant, relatives or carers, indirect observations and direct clinical examination.
- Full physical examination may not be required & is often unnecessary.
- The EHCP report should be based on an impartial and objective assessment of the claimant. It must be set out in the appropriate manner, and be easily read and understood by a non-medical person. The report should be internally consistent, and any apparent contradictions explained. Such contradictions may arise from the discrepancies between information given by the claimant (either in the claim form or verbally) and your subsequent opinion based on an overall assessment.

11.3 Definitions of disability and impairment

Disability analysts should understand the concepts of impairment and disability.

Key points

- Impairment is defined as: "Any loss or abnormality of psychological, physiological or anatomical structure or function".
- Disability is defined as: "Any restriction or lack of ability, resulting from impairment, to perform an activity in the manner or within the range considered normal for a person of the same age and sex".
- Disability analysts should interpret not what is wrong with the person but the functional limitations and restrictions which determine what the person is prevented from doing. People with the same impairment can have very different disability.

12. Completion of reports

12.1 Introduction

Key Points

- A written report must be completed legibly and must be in black ink as this makes it easier to photocopy.
- The report must be understandable to non-medical DMs and should not include complex medical terms or abbreviations without a clear explanation of meaning.
- Questions with Yes/No boxes must be ticked.
- Comments boxes must be completed whenever possible.
- Record start and end times of the assessment (arrival and departure for DVs).
- Record those present during the assessment and their relationship to the claimant.
- Any extra questions asked by the DM should be addressed.

Reports are requested in the following circumstances:

- The claimant has requested a medical examination.
- Insufficient evidence has been obtained from other sources.

The report form is divided into 3 sections:

- Section 1 – Claimant's account of their disabilities recorded by the EHCP
- Section 2 – Clinical findings
- Section 3 – EHCP's opinion regarding the claimant's function

For children it is important to report not only what care and/or mobility needs there are, but how these may differ from those of a healthy child of the same age.

Any measurements given must be recorded in metric units. If imperial units are used on a document that is part of the adjudication evidence, the DMs decision will be vulnerable to challenge. Estimates of distance, height and weight given by the claimant should be recorded in the stated units and not converted by the EHCP.

12.2 Recording information from the claimant

Some people will maximise their needs but others, particularly the elderly often minimise the amount of assistance that is needed or the difficulties they have in getting help. It is important that all help and assistance given is recorded. Conduct the interview, when possible, in the presence of the carer or relative and note the identity of that person in the report.

As an experienced medical practitioner, you will be well aware that some individuals find it difficult to express their problems in a clear and concise manner. Your role therefore is to help the claimant give as complete an account as possible of the help that the claimant/carer feels is needed. As the claimant may find it difficult to put this into words, a patient, relaxed attitude by the EHCP is important.

See the carer or relative alone if appropriate, to discuss facts that may not be known to the claimant, or are too embarrassing for the claimant to disclose.

This makes it possible to correct false impressions given by the claimant who may be unclear as to the amount of help needed. This situation can apply if the claimant is elderly, has severe learning difficulties, or a mental illness.

Claimants may also be reluctant to discuss bodily functions. Those with disability due to a mental impairment may not be clear of their actual care and mobility needs.

Please ensure that you adhere to the Atos Healthcare Professional Standards, recommended procedures set out in these guidance notes. You must also adhere to Equal Opportunity and any other relevant legislation.

In the interests of natural justice, if a claimant is already known to the EHCP as a patient (either past or present), then arrangements should be made for that claimant to be seen by another EHCP.

When recording information in the EHCP report form complete all of the boxes as required. A line through a blank section can avoid confusion.

12.2.1 The nature of the interview

The interview differs materially from the traditional consultation in medical practice. The aim of the traditional interview is to arrive at a diagnosis and plan future medical management of a patient. In the DLA/AA interview, you are gathering information that is used to assess the effects of disability on the claimant.

Detailed medical history taking is time wasting and unnecessary. All that is required are the essential medical details that impinge on present function.

12.2.2 Interview technique

It is important that the interview be carried out in a friendly, professional and non-confrontational way, in keeping with good customer service and in line with approved professional standards.

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In the MEC, you should meet the claimant and accompany them from the waiting room. This positive initial point of contact will help put the claimant at ease and is a natural courtesy. From your point of view, it provides an opportunity to observe the claimant outside the examination room, and extends the time spent in contact with them. Most importantly, it initiates the rapport between the EHCP and claimant that is essential to an effective interview.

The claimant may be apprehensive, and it is good practice to explain the process and purpose of the interview and examination. Allow time for the claimant to settle down before beginning the interview proper. This is time well spent as it allows the interview to proceed more smoothly and productively thereafter. It is also useful to explain that the clinical examination is not in any way a general "check up", but is focused on the areas that affect the claimant in their everyday life. This explanation may forestall any criticism that the medical examination was not thorough.

12.2.3 Claimant accompanied by relative, friend, carer.

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. You must remain sensitive to the specific situation and comply with the individual's wishes.

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 too forcefully his or her own opinion on the claimant's disability, perhaps giving a biased view.

You will 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 actual physical examination is not normally done in the presence of the companion, but strictly with the claimant's consent, and if it appears a reasonable request, then the companion should be allowed to be present.

12.2.4 Interpreters

Where the claimant is not fluent in your language, it will be necessary for the claimant to be accompanied by an interpreter. It is important that you make a note of the name of the interpreter and the language being interpreted on the front page of the report form.

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

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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 report form.

Note that a minor (child under 16 years old) is not an appropriate interpreter, and alternative arrangements should be made.

12.2.5 Interview skills

As an essential component of the examination process, the interview requires you to possess appropriate skills. These include:

- Active listening
- Effective questioning
- The use of clear and understandable language
- The use of positive body language
- Active Listening involves-
 - a. Keeping an open mind and being prepared for all responses to questions
 - b. Summarising what has been said
 - c. Listening "between the lines"

12.2.5.1 Effective questioning

This is aimed at gaining a mental picture of the claimant in his or her own environment and circumstances. In this way, we obtain an overall view of the way in which their disability affects their day-to-day life:-

- **Open questions** invite an open response and encourage the claimant to provide a narrative answer.
- **Closed questions** are best confined to establishing or clarifying a fact, or restoring the direction of the interview if the claimant begins to digress.
- **Extending questions** enlarge upon an established topic and allow the claimant to expand on information already given.
- **Linking questions** pick up an earlier point and help to steer the conversation in a particular direction.
- **Clarifying questions** allow the EHCP to check their understanding of the issues being discussed.

In general, only one question should be asked at a time. Complicated, limited response and leading questions should be avoided.

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12.2.5.2 The use of clear and understandable language

It is essential that you use language and terms that are clear, familiar and comprehensible to the claimant. Otherwise, misunderstandings are inevitable and a clear view of the claimant's disability will not be obtained.

12.2.5.3 The use of positive body language

Many EHCPs already possess this skill. However, the interview can involve a good deal of writing, and the claimant may feel isolated and excluded as a result. It is good practice to minimise the effects of this by interrupting your writing from time to time, however briefly, to restore direct contact with the claimant.

It is also very important to face away from the computer screen at frequent intervals, to ensure eye contact is maintained and develop an essential rapport with the claimant.

12.2.6 Good assessment techniques

This section provides a practical six-step summary to promote consistent good practice in assessing all individuals. (Clearly, some points will only apply in the DV setting).

Step 1: Before the assessment – setting the scene for interview by:

- Following the recommended process for making the appointment
- Allowing the claimant time to arrange for a relative or carer to be present
- Be aware of any background information provided.
- Arriving at the agreed time

Step 2: Structuring the interview - introductions

- Ensure that you take time to introduce yourself to the claimant and carers.
- Establish the identity and roles of those present.
- Check the claimant's identity against the details provided.
- Reduce distractions if possible (e.g. loud TV in the background etc)
- Ensure the environment is conducive to making a professional assessment of disability e.g. quiet, well lit and comfortable

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Step 3: Explanations of why you are there, what you would like to do and how you would like to do it.

1. Explain that your aim is to:

- Provide further information for the DM who is dealing with the claimant's case.
- Listen to the individuals needs and carry out an assessment.
- Prepare a report which will help the DM to come to the right decision.

2. Explain that you wish to:

- Record information focussed on the individuals needs.
- Take any information from the carer or relative if required.
- Carry out an appropriate examination.
- Describe what this may involve.
- Emphasise the intention to avoid distress or discomfort.
- Give an indication of how long the assessment will take.
- Explain that you will be taking notes.

Step 4: Clarification

- Check if the claimant and carer have any specific concerns about the assessment etc.
- Establish their feelings and attitudes and try to allay any anxieties.
- Answer any questions about the purpose or format of the assessment.

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Step 5: Conducting the assessment – communication

- Use good listening techniques.
- Remember eye contact and body language.
- Be patient and show interest in the individual.
- Keep an open mind while obtaining the statement allowing the claimant to express their needs etc as fully as possible.
- Be aware of areas of likely sensitivity
- Gain explicit permission to perform a clinical examination.
- Explain what you are about to do step by step throughout the assessment.

Step 6: Ending the assessment – closure

- Ask if the claimant or carer has any further questions and respond to them appropriately.
- Explain what happens next i.e. that the report and any other relevant information will go to DM.
- Inform them that if they wish to check on the progress of their claim that they should contact the number provided in the appointment letter.
- **Do not** discuss the possible outcome of the claim

12.2.7 Recording the interview

Details about the claimant will have been entered on the report form by the administration staff, and you should check these.

The time of start of examination is when you first make contact with the claimant. The time that the examination ends is when the EHCP or the claimant leaves. The time that the form was finally completed should also be added.

List all the current diagnoses. Ensure that all conditions referred to by the claimant and on file are included. Previously unidentified conditions that are revealed during the assessment should also be added.

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In many instances the entries will be symptoms rather than exact diagnoses. Your role is to assess disability, and for that reason, precise diagnoses do not add to the Decision Maker's understanding of the report. Only be specific if you have good evidence of the diagnosis. If you write "Lumbar disc protrusion" rather than "Low back pain" and it transpires at a Tribunal that investigations revealed spondylolisthesis then the whole value of the evidence you have provided for the Decision Maker is undermined.

12.2.7.1 Details of any hospital treatment or investigations

Details of any hospital treatment or investigations should be recorded. It is most important to keep this information brief, concise and relevant to the present disabilities. Note whether the claimant continues to attend hospital, and the likely date of any proposed treatment procedure or investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks time".

12.2.7.2 Medication

Record all regular medication whether prescribed or bought over the counter. Record the dose without using shorthand or abbreviations.

Explain the purpose of the medication, for example:

- "Beclomethasone inhaler - an inhaled preparation for asthma prevention"
- "Diclofenac - an anti-inflammatory drug for arthritis."

It is helpful to comment on any analgesics being taken. This may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. "He takes an average of 12 paracetamol (painkillers) a week, usually over three days" provides a picture for the Decision Maker that will support your description of variability and pain later in the report. It is also useful to comment on the potency of the analgesic.

Note any side effects of medication reported by the claimant, the likelihood of them occurring and whether these are likely to affect function. For example, it would be unlikely that anti-convulsant medication caused such severe drowsiness that care needs resulted. Conversely, a marked tremor due to the side effects of anti-psychotic drugs, thus affecting self care, is possible.

Explain any additional medication used to ameliorate side effects e.g. the use of lansoprazole in dyspepsia related to the use of NSAIDs.

12.2.7.3 Reported impairments and functional restrictions

You should record an account of the claimant's problems and the functional limitations imposed by them e.g. "Variable pains in both elbows which restrict his/her ability to lift a saucepan or kettle" and "Suffers with anxiety which prevents him/her from going out alone".

It is also important to record the response of the claimant to his or her current treatment.

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Most important is an outline of how a typical day is spent in the light of the reported limitations.

12.2.7.4 The typical day

Although not always easy to elicit, a careful and well-focused history of a typical day will greatly help you in completing the rest of the report. If you obtain and record appropriate information at this stage, it will provide you with factual evidence of the claimant's abilities, which you can then use to support your opinions.

Note that the phrase 'typical day' refers to the 24 hours in a day i.e. it includes night-time.

You must write this section in the third person. It is a record of the claimant's everyday life, without interpretation by the medical examiner. You should make it clear that this is the claimant's account of their disabilities and not your opinion. If someone else gives information on the claimant's behalf (e.g. a parent on behalf of their child), then this should be noted.

It is a factual description of how the claimant's condition affects them in day-to-day life as elicited by careful interview, using the recommended techniques referred to in this handbook. Properly completed, it is of great help to the decision maker.

The account of the 'typical day' should provide the DM with information regarding the following:

- Getting up
- Washing, dressing
- Using the toilet and continence
- Help with medication and other treatments
- Rising from a chair
- Preparation of food and eating
- Going to bed
- Help needed during the night e.g. toilet and medication
- Ability to walk indoors and outdoors
- Ability to use a wheelchair if required
- The nature of any falls and if they occur indoors or outdoors
- Need for supervision e.g. to avoid dangers or self neglect

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- Getting around outdoors (including any supervision required)
- Role of carers (including the help required and the functional problem they overcome e.g. "The claimant cannot bend to their feet, therefore their carer ties their shoe laces.")
- Communicating with others (including interpretation of sign language, help when visiting people or places, special equipment e.g. writing pad, telephone, special computer etc)
- The effects of the disability present upon hobbies, interests, leisure pursuits and activities connected with religious beliefs

It is useful to focus on areas of activity affected by any disabling conditions. For example in cases of low back pain, bear in mind activities which involve sitting, rising from a chair, walking, using stairs, bending and standing.

You should give specific examples of activities, e.g. "Has no problems filling and emptying the washing machine or tumble dryer".

Also, avoid making a statement such as "Can only walk 50 metres" as this may well be taken as fact by the Decision Maker or the Appeal Tribunal. Better would be; "Says he only walks 50 metres", then give an example of what the claimant actually does, as far as walking is concerned, on an average day: "Walks to the shops and back (about 200 metres in all) but says he has to stop at least twice due to back pain".

12.2.8 Examinations carried out in the MEC

The process of carrying out the assessment in the MEC is little different from that carried out in the domiciliary setting, with one important exception. You will be unable to assess the claimant's home surroundings and their ability to function in that environment.

To make up for this you will need to take a careful history from the claimant about the difficulties of managing within the home, aids used etc.

Areas for focus would be whether there are any stairs inside or leading up to the home, if toilet facilities are on the same level as the main living area, if there is a shower or a bath etc.

If you consider a commode would enable the person to be self-caring for toilet needs, then obtain details of whether it could be sited in the relevant room, e.g. is there enough space for a commode?

When looking for evidence of self-neglect it will be more important to record a pen picture of how the claimant appears to you on the day of assessment, in terms of personal hygiene and nutritional status.

The opportunities to observe the claimant's gait, balance and mobility are likely to be greater in the MEC setting compared to a DV.

12.2.9 Additional information

In exceptional circumstances, you may feel that additional clinical information is required. In such situations then you should seek the advice of a Registered Medical Practitioner at your local Atos Healthcare Centre e.g. if there is no carer or relative present and there are major difficulties with communication.

12.3 Physical examination in EHCP assessments

You should seek the claimant's express permission before proceeding to carry out any physical examination that you deem to be necessary. It is vitally important to understand that consent is not assumed.

Explicit consent to the examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report. A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

The precise extent and nature of the examination will depend entirely on the circumstances of each individual case. You must use your professional judgement to decide what examination is indicated, and whether the claimant should be asked to remove any clothing in order to complete this assessment effectively.

When carrying out a musculoskeletal overview examination, you should usually be able to complete this aspect of the assessment whilst the claimant is wearing loose indoor clothing, if 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 for you to ask the claimant to remove the relevant items of outer clothing in order to complete this task.

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, explain any request you make of 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.

Virtually all movements should be active and not passive. Only ask claimants to demonstrate activities within their own limits.

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 a disability functional assessment.

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Please note also that use of needles is not appropriate in the context of disability assessment medicine, and thus the testing of pinprick sensation should not be undertaken.

When carrying out a physical examination, you should use your professional judgement to decide when it is appropriate to offer a chaperone, or to invite the claimant to have a relative or friend present. In this context, the duty of the chaperone is to protect you from any potential complaints about unethical conduct, and the chaperone's role is merely to remain in the room whilst you examine the claimant, unless you ask the chaperone for assistance. This guidance assumes particular significance when the EHCP and claimant are not of the same gender.

If a chaperone, relative or friend is present, you should record the fact on the report form, making a note of the person's identity. In the MEC, one of the MEAs can act as a chaperone if required.

If the claimant does not want a chaperone, you should record that the offer was made and declined.

Give the claimant privacy to undress and dress. Do not assist the claimant in removing clothing unless you have clarified with them that your assistance is required.

When recording the relevant findings of your assessment, in some situations it will be important to note normal findings e.g. normal reflexes and muscle tone. In others, recording inappropriate findings may be required. Sufficient detail should be included, with measurements in metric units (imperial units can be used as supplementary indications).

12.3.1 Examination of vision

If the claimant wears spectacles, they must be worn when testing visual acuity. It is important to assess vision for its usefulness outdoors and to consider the acuity over the whole visual field. A Snellen's chart or similar should be used for distance vision, and a standardised reading test chart for near vision.

12.3.2 Examination of hearing

If the claimant wears a hearing aid, it must be worn when assessing hearing. It is important to test the claimant's understanding, not just their ability to react to sound. The test should take the form of a simple instruction or question, shouted if necessary, from one metre behind the claimant.

Take into account background noise when assessing the usefulness of the hearing out of doors.

If there is any indication of hearing loss, the ears must be examined and any pathology or obstruction noted.

12.3.3 Examination of peak flow

The Wright-McKerrow scale, used on hand held mini-peak flow meters, is less accurate at the high and low ends of its range. Therefore asthma may be under-diagnosed and treatment suboptimal.

A new EU standard was introduced in 2004 for all new mini peak flow meters (EN 13826).

The difference between the two scales is not likely to affect assessment of function.

A well maintained, good condition peak flow meter can still be used. An algorithm can be used to convert the old scale to the EU standard (available at www.peakflow.com).

The conversion does not have to be done by the EHCP. However, when documenting peak-flow, record whether a "Wright" or "EU" meter was used e.g. PFR 450 l/min (Wright) or PFR 450 l/min (EU).

12.4 Mental state examination

It is important to provide information about the claimant's mental state in the appropriate part of the report form. This may be to confirm that the individual's mental state is normal. However, the reasons for your opinion must be recorded with reference to mood, appearance, thought processes, speech etc.

Any evidence of mental illness should be recorded. If the claimant appears to be confused or has an altered perception of their condition it is strongly advised you seek additional information from a relative or carer. Where this additional information is not available in the examination setting then you should provide as much detailed information as you can to the DM.

12.5 Your opinion

You must form your own opinion, considering the history, observations, examination and any other evidence available, on whether the reported limitations are reasonable.

If your opinion of the claimant's capabilities differs from their own, it is very important that you record your opinion and sufficient additional information with adequate clinical details to make it clear why you have come to a different conclusion.

Internal consistency of the report is important for the DM. If the EHCP expresses a reduction in function there should be evidence that justifies that opinion e.g. particular clinical findings.

Record details of any aids used by the claimant, which reduce the need for help. You do not need to report on aids a claimant could, but does not use, unless it is clear that the claimant is not using an aid which:

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- In your opinion, they are able to use;
- Is readily available; and
- Many others in their situation use.

In these circumstances record the basis for your opinion, including:

- Full details of why the aid is appropriate.
- How the aid would help.
- How easily the claimant could obtain the aid.
- The claimant's reasons for not using the aid.
- A description of the claimant's home circumstances if necessary.

Key point

Your opinion on the person's capabilities should take into account the use of all appropriate aids and appliances, even if they are not in fact used by the claimant but which could be readily available to them.

When giving your opinion regarding falls, the risk of falling also needs to be considered. A claimant does not have to have a history of falls for an EHCP to form a medical opinion that they are at risk. This is particularly true in Attendance Allowance.

12.6 The assessment of mobility

Your opinion on the claimant's walking ability must be consistent with your clinical findings, informal observations and your assessment of the stage of their illness. This takes into account the level of investigation and treatment and the likely effects of the condition on a person of that age, but is **not** based on a formal walking test. It is likely that the claimant's walking ability will be observed informally at home or in the MEC. In the DV scenario, the claimant's functional ability on stairs may be seen.

If the claimant is not seen to walk, the assessment of walking ability is made based on:

- Observation of limb, spinal and cardio-respiratory function.
- Your clinical findings in relation to lower limb function and musculature, co-ordination, balance and cardio-respiratory status.

Your opinion considers the claimant's walking distance outdoors on level ground, before the onset of severe discomfort.

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People's estimates of distance and time tend to be inaccurate. However they can usually say where they walk to e.g. the local shops, bus stop etc. You may know how far this is from local knowledge.

Generally speaking, a person who can easily manage around the house and garden is unlikely to be limited to a walking distance of less than 200 metres. Similarly, a person who can walk around a large supermarket is unlikely to be limited to less than 800 metres.

Key points for assessing walking ability

- Someone walking at an average speed manages about **61 - 90 metres in one minute (i.e. up to** the length of a football field).
- Walking at a slow speed equates to **40 - 60 metres** in one minute.
- Walking at a very slow speed equates to **less than 40 metres** a minute

In very rare circumstances, it may be necessary to ask the person to undertake a walking test. However, it is not recommended as it is of limited value and may cause distress. This should be adapted to meet the individual circumstances but ideally should involve asking the person to walk outdoors, on level ground at their normal pace, for 2 minutes. The accuracy of observations recorded during the test is important and special note should be taken of a deviation from the normal. Data should include the distance walked, the time taken, and any change in pulse rate during the test. These factors should be accompanied by qualitative observations on gait, balance, manner of progress, along with an estimate of the level of pain or discomfort experienced. The number, duration and nature of any pauses should also be recorded.

Take the use of a walking stick or any other support into account. If the claimant has had an amputation, consider the use of any prostheses that have been supplied. If not supplied, the prostheses the claimant would be capable of using to improve their walking ability.

It is important to differentiate between guidance from another person and the physical support of another person. If the claimant can only walk with the support of another person, this does not constitute walking. In this situation, give your opinion on the claimant's independent walking ability.

If a person's walking ability varies, take account of the overall ability over a period of time not just their ability on the day of the examination. When walking is interrupted by sudden stops, describe the nature and frequency of the interruptions.

It is important to differentiate between stops that are of the person's own making and stops that are due to a physical condition for which a rest is justifiable.

When a person is able to walk but needs a companion when outdoors, it is important to record precisely what active help is needed due to a physical or mental disability, e.g. guidance, encouragement or persuasion.

12.7 The assessment of care needs

12.7.1 Attention needs

In section three of the report form you will provide your opinion regarding any attention needs. It is important to fully justify your opinions, particularly if you disagree with the claimant or other evidence on file. Your opinion should take into account:

- The claimant's stated needs
- Observed findings
- Examination findings
- Any other information that may be on file.

Also, the use of aids needs to be considered. Examples that may be appropriate are:

- A urine bottle
- A commode
- Special cutlery and crockery
- Walking sticks, crutches
- Bath aids – grips, seat/stool, step, lifts
- Shower aids - seat, wheelchair access etc
- Toilet aids – grips, raised seats, frame
- A monkey pole over the bed, grips etc
- Height of bed
- Design and height of normal seat
- Kitchen aids – adapted openers, spikes
- Dressing aids - helping hand etc.

The above list is not comprehensive.

Your report must show if the claimant could use these aids but personal circumstances prevent it. If it would be unreasonable for the claimant to change their circumstances to accommodate the use of aids, discount their potential use.

12.7.2 Care at Night

Accuracy in obtaining and assessing needs at night is vitally important, especially regarding the frequency and/or length of time help is needed. It may be quite straightforward to obtain this information when the same needs arise every day or night. However, the need for help will be intermittent for many people, especially at night.

It is realised that night needs can be particularly difficult to assess accurately, but your assessment must be consistent with your clinical findings and your professional knowledge of the needs likely to arise from the identified disability or disabilities.

The DM requires an opinion regarding the need for help at night from the available evidence.

If a need is present in your opinion, always explain why it is the same as, or different from, that described by the claimant, in type, frequency and/or amount. When providing your opinion, it does not include time spent providing comfort or companionship.

Note that elderly people often understate rather than exaggerate any disability present.

12.7.3 Supervision Needs

When giving your opinion on the need for supervision, consider if reasonable, common sense precautions could be taken to prevent danger arising. Such precautions should be:

- Practicable
- Available
- Affordable

For example, securing doors and windows and fitting a stair-gate might reduce the risk of injury to a child with learning difficulties. However, the household will still need to go about its business in a reasonable manner. The modifications should take account of this. In addition, any such modification must not infringe on the individual's personal freedom.

Determine if dangerous situations have occurred in the past and if they are likely to happen in the future. This includes situations that may be dangerous to other people as well as the claimant. It is important to describe details of past dangerous situations if possible from a knowledgeable third party (e.g. carer) so that future risk can be assessed.

Even if there have not been any problems in the past, still give your opinion on the likelihood of future dangerous situations.

12.8 Epilepsy Questionnaire

This should be completed in full if there is any suggestion of seizure activity. Blackouts, dizzy spells, funny turns and panic attacks should be addressed clearly elsewhere in the report for the Decision Maker.

For example, in any insulin dependant diabetic there should always be a clear description about whether hypoglycaemic episodes occur. If they do, record whether there is a warning, how often they occur, what help is needed from another etc. Although the associated altered consciousness is not dealt with in the Epilepsy Questionnaire, it should be covered in detail through main part of the report.

It would be very unusual for a person with epilepsy of several years duration to not have seen a specialist and had investigations.

Status epilepticus is a life threatening condition which always results in hospital admission.

12.9 Functional prognosis

The likely prognosis of current functional problems and conditions should be provided for the DM. This should include, where relevant, the expected effects of any known planned treatment.

12.10 Variability of conditions

It is important to provide as much information as possible regarding the nature and extent of any variability in function.

A severely disabled person is entitled to DLA or AA for **a period throughout which** they satisfy, or are likely to satisfy, the conditions of entitlement to the benefits (The Social Security Contributions and Benefits Act 1992). 'A period throughout which' is one throughout which the conditions of entitlement usually are, or likely to be, satisfied on more days and/or nights of the week than not.

In practice, until a Court of Appeal judgement in 2002, DLA or AA would not be awarded in most cases unless the conditions of entitlement were met on 4 days and/or nights of the week or more. The Court of Appeal held that the 'period throughout which' test could be satisfied on as little as one day (or night) a week providing this need arises on a regular basis.

In the House of Lords ruling on this case, of July 31st 2003, Lord Hoffman stated that the decision should be based on consideration of the whole period, identifying whether in a general sense the person can fairly be described as a person who is unable, as a result of disability, to carry out the specific tasks of self care and day to day living. This is an exercise in judgement rather than an arithmetical calculation of frequency.

When completing the report form, you should record the frequency of good and bad days, as well as if the assessment was carried out on a good or a bad day.

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As an EHCP, you need to be aware of the need to advise the DM on the variability of the care/mobility needs of the claimant. On all EHCP reports, you must ensure that you record **your own opinion** about variation in disability, and consequently on function, from day to day.

Where a client describes variability in their condition and/or its effects on function, or where the EHCP identifies a variable/intermittent condition or where the DM requests information about variability, EHCPs should:

- Advise on the level or care/mobility needs for the majority of the time

And

- Give an indication of the claimant's condition on bad days together with:
 - a) The frequency of the bad days
 - b) Advice regarding whether the bad days follow a regular or predictable pattern
 - c) The care/mobility needs on a bad day

It is important to appreciate that, **in addition** to recording the claimant's reported variability, you are being asked to express **your opinion** about the level of variation that you would expect to take place, given the circumstances of the case under consideration. In so doing, it is important to recognise that the variation that a claimant reports in their **level of symptoms** will not necessarily translate into a significant variability in their **level of function**.

Your advice must be based on what is medically reasonable in that case, and must be adequately justified. This last statement is, of course, true for all the advice that you give in all your reports.

When completing the report form, it is important to note:

- In Section 1 of the report form, the claimant's description of any variability is recorded.
- In Section 3 of the report form, the EHCP records their fully justified opinion regarding any variability of all conditions identified.
- If a condition does not (or is not likely to) vary in its disabling effects, it is important to record this for the DM in Section 3 (e.g. the disabling effects of a below-knee amputation performed 10 years ago, considered in isolation, would not be expected to vary).

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Examples

The following examples illustrate the salient points

- 1) A claimant with mechanical back pain reports that the symptoms are worse on 1 to 2 days every 1 to 2 weeks. The EHCP would usually conclude that the level of function should not vary significantly even though the pain may be worse on some days. The medical basis for this opinion is that mechanical back pain does not cause substantial fluctuations in function over this type of time scale. The EHCP might possibly also refer to the general advice that people with back pain should usually try to keep mobile.
- 2) A claimant with mechanical back pain tells the EHCP that in addition to the level of pain and functional problems that they usually experience, there are occasional exacerbations of back pain when mobility is severely limited for three or four days. These episodes occur irregularly and infrequently; there have been two of these episodes in the last one and a half years. The EHCP would mention this in the account and state that this is consistent with the natural history of back pain. However, in this situation, the EHCP would not need to describe in detail the level of functional problems during these exacerbations, as the claimed variability is irregular and infrequent.
- 3) A claimant with multiple diagnoses e.g. ischaemic heart disease, type 2 diabetes mellitus and generalised joint disease may be seen on an average day. However, they may claim that they need more help getting out of bed and with self-care on a bad day. They may also state that they do not go out on bad days because of joint pains. If observation and musculoskeletal examination by the EHCP are all normal, or if they only demonstrate minor functional deficit, the EHCP should say that significant variation in function is unlikely in the absence of physical signs indicating significant joint disease.
- 4) A claimant with proven ischaemic heart disease might say that their angina is worse when walking outdoors when the weather is cold or windy. The EHCP may well agree that this would be an aggravating factor. However, the frequency is quite unpredictable, as it is weather related.
- 5) A claimant with episodes of migraine reports they have acute episodes once or twice a week during which they are prostrated for a short period of time. There is supportive evidence for this, in that the claimant is taking prophylactic treatment in addition to treatment for acute attacks. They are also attending their GP regularly as well as a neurology outpatient clinic. In such circumstances, the EHCP may conclude that the claimed variability in function is reasonable, as it follows a medically recognisable pattern with the condition and is consistent with the medical management being provided. However, a different conclusion may have been drawn if the collateral evidence, indicative of more severe disability, had been absent i.e. if medical management had been less active.

12.11 Unexpected findings (see Appendix E)

It is your responsibility to report any serious abnormality that is detected, e.g. a significantly raised blood pressure in someone not diagnosed as hypertensive, to the claimant's GP by telephone and in writing.

Appendix E contains procedural guidance for all examining EHCPs on this important topic that you should refer to.

12.12 Harmful, embarrassing and confidential information

Anyone who claims DLA or AA is entitled to see **all** the evidence used to decide his or her claim. Information contained in a document that has been used to reach a decision cannot be withheld from the claimant unless it is harmful.

The distinction between this and other forms of sensitive information i.e. what is embarrassing or confidential, should be clearly understood.

12.12.1 Harmful information

Harmful information is information of which claimants are unaware, and which would be *seriously* harmful to their health if divulged to them.

The EHCP will encounter such information in one of three possible ways. It may arise:

- From a third party source, for example a relative or carer, or
- In the form of a factual report offered by a relative, the contents of which are unknown to the claimant, or
- In the form of unexpected abnormal clinical findings which suggest a serious, life-threatening condition.

In the first instance above, the EHCP should write down the information on a separate piece of paper, headed "Harmful Information", include the claimant's name and NINO and ask the person providing the information to sign the paper.

In the second instance, the evidence should be accepted, marked "Harmful Information" and placed in the file.

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). You should confine yourself to an account of the clinical findings. Discussions with the claimant would need to reflect the sensitivities of the situation.

If harmful information is identified in the course of file work, it should be annotated as such, making the DM is aware of this fact.

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12.12.2 Embarrassing information

Information that may be embarrassing to the claimant, carer or professional colleague but is not harmful cannot be excluded from copies of documents sent to the claimant. Do not record information of this type in reports. Examples include:

- Criticism of the diagnosis of the claimant's condition, or of their medical care and treatment.
- Criticism of an EHCP who examined the claimant on a previous occasion.

It is especially important to be aware of mentioning convictions or prison sentences with regard to the Rehabilitation of Offenders Act, 1974 (see section 9.4).

Before a decision is reached on a claim, the author of the embarrassing information should be contacted to see if they would like to rephrase their report. However, if a decision has already been made with this information available to the DM, it **must** remain on file and **must** be copied to the client where necessary.

12.12.3 Confidential information

Any letter or report that is headed "Confidential" or "In Confidence" should not be generally disclosed. The DM cannot use this information. The information can be used however if the author of the letter is prepared to remove the confidentiality statement. The holder of the information should approach the author.

Do not record any information under this heading on your report.

If the claimant gives the EHCP information, but asks for it not to be recorded, they should be informed that it cannot form part of the decision making process.

12.13 Personal descriptions in medical reports

12.13.1 General principles

The following general principles must always be observed:

- 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.

12.13.2 Descriptions of race or ethnic origin

The process of Disability Analysis requires EHCPs to consider specifically 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 because of their underlying 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 Atos Healthcare, references to racial origin are almost universally unnecessary, and the inappropriate use of such descriptions is liable to cause offence. In addition, 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.

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 you consider 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:

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

These categories do not cover all situations, e.g. those of mixed race.

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 you know that you 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.

12.13.3 Descriptions of personal appearance

References to personal appearance are not infrequently made in reports prepared for the DWP. You should appreciate that 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 e.g. 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'.

You must avoid drawing unwarranted inferences from a person's clothing, style of dress, make-up, jewellery or general appearance, and you should avoid commenting on such matters unless the observations form an integral part of the medical evidence. 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, you must take into account such factors 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.

12.13.4 Descriptions of attitude and mood

The attitude of the person to the assessment process should only be commented upon if it has affected your ability to conduct the examination in a normal manner, 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 because of substance abuse (including alcohol).

There are two sets of circumstances where you should terminate an assessment without attempting completion, as follows:

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

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

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.

12.13.5 Practical application for EHCP assessments

An appropriate general clinical appearance of the claimant should be recorded in Section 2 of the report form. Descriptions can give the DM a mental picture of the claimant and makes it easier for them to interpret the rest of your report.

Some examples include:

- "A frail elderly lady who needed three attempts to get out of her chair".

Or

- "A large and very strong 10 year old who constantly demands attention and has no appreciation of household dangers".

12.14 The assessment of Chronic Fatigue Syndrome (CFS)

12.14.1 CFS – clinical features

CFS, ME and fibromyalgia form part of a continuum of disorders, which share common features that may include any or all of:

- Unexplained fatigue often made worse by physical exertion.
- Muscle pain.

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- Sleep disturbance.
- Disturbance of mental functioning: poor concentration, poor short-term memory, depression.

Symptoms of CFS are predominantly subjective. There are various sets of diagnostic criteria, such as the Fukuda Criteria, but none of them is definitive. All were developed for research, rather than clinical, purposes. There are rarely any positive clinical findings on examination.

There is still debate in medical circles about the aetiology and pathophysiology of CFS, neither of which is yet clearly understood. Nevertheless, assessment of the functional impact of CFS on a person's life can be made without full understanding of the underlying condition.

12.14.2 Medical assessment for benefit purposes

Despite clear recognition by both the Department of Health and the DWP that CFS is a real and disabling condition, some EHCPs still display varying degrees of scepticism. Such scepticism is not in keeping with Atos Healthcare Professional Standards, and it is not acceptable when EHCPs are carrying out assessments on behalf of the DWP.

People with CFS may have encountered such scepticism among treating clinicians, and may as a result adopt a defensive attitude. It is important for you to help them understand you are open-minded, prepared to listen to them, and you will complete a fair and objective report.

When assessing a benefit claimant, remember that you must always take careful account of the effects of fatigue, of variability of symptoms, and of the ability to reasonably sustain any given activity, not just the ability to perform it once. Remember that you must carefully evaluate all the evidence, and especially whether the person's description of their disability is consistent with their daily activities and lifestyle. This aspect is particularly important when assessing a condition, such as CFS, where there are usually few if any overt clinical findings.

Because of the possible effects on mental functioning of CFS, it will almost always be appropriate to assess the claimant's mental state. People may express concern or resentment at this, and may accuse you of believing "it's all in their mind". You need to help people understand that this does not mean you believe the condition is "all in their mind", but that it is important for you to get a full picture of its functional effects, mental/psychological, as well as physical. You may find it helpful to give an explanation such as "I'm going to ask you some questions to help me understand how your condition affects your memory, mood, and concentration".

13. Risk management for the EHCP

13.1 Potentially aggressive situations

As with every branch of clinical medicine, situations arise when the consultation runs into difficulties. Such situations can arise from a variety of reasons including claimant anxieties and fears as well as through the direct consequences of their clinical conditions. Clearly, EHCPs do not have a prior understanding of the claimants concerns, personality and background.

The most important factors are the EHCP's own:

- Awareness of the possibility of difficulties.
- Early anticipation and detection of problems that the consultation may be running into problems.
- Ability to adjust and adapt the style or conduct of the consultation.

From your clinical experience, you will already be familiar with the use of varying interview and communication techniques to manage the consultation process using verbal and non-verbal approaches.

The following are some points to remember:

- Always treat everyone impartially and sympathetically, and be seen to do so.
- Some claimants use bad language and gestures as a normal means of communication. Nobody, however, is expected to suffer severe abuse, especially if it is sexual or racial in nature. If you suffer such verbal abuse, tell the claimant that the assessment will be terminated if the abuse does not cease immediately and record the information on form IF1.
- Spend time explaining and reassuring the claimant and exploring potential areas of concerns and anxieties.
- Be friendly but firm.
- Be seen to be in control of the situation, in a pleasant manner.
- Never retaliate by word or deed even if provoked, and remain calm.
- Do not continue in the face of persistent abuse or aggression.
- Observe exits as you arrive, and remain between the exit and the claimant.

Good practice points are dealt with in more detail earlier in this guidance.

Key Points to minimise the risk.

EMPs should:

- Preview the papers.
- Note anyone identified as a potentially violent claimant by the DBC.
- Use any local knowledge of people or addresses which pose greater risk.

All serious incidents involving a member of the public should be reported using the procedures described below.

Such incidents include:

- Severe or persistent verbal abuse.
- Assault of whatever degree.
- Serious threats.
- Intimidation.
- Serious or persistent harassment.

This applies whether the person committing the act is the claimant, their relative or a member of their household and whether it occurs before, during or after the assessment.

If you believe a visit may be risky, you can take another person as an escort. You should have a local contact with the allocation section to arrange an escort if you need one.

If you are ever subjected to abuse or violence then you should report the incident as soon as possible to Atos Healthcare. Form IF1 should be completed for every incident. It may also be advisable to inform the police. If you need help or advice about such incidents, and to obtain the forms, then your local Atos Healthcare contact will be pleased to assist.

13.2 Audio or video taping of examinations

The DWP never requires that a medical assessment for advising on entitlement to state sickness or disability benefits be recorded on audio or videotape. 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.

Claimants may request that their interview and assessment by an EHCP in respect of a benefit claim be recorded either on audio or videotape.

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Such a request can only be agreed with the prior consent of the EHCP, 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 a rescheduled assessment in the presence of a companion or other witness. If the claimant refuses to avail him/her self of this opportunity and refuses to proceed with the assessment, the EHCP should return the file to the DWP with a note explaining the situation.

13.2.1 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 EHCP, or without ensuring that the safeguards defined above are in place.

13.3 Taking of notes during an examination by the claimant or their 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 warning below should also be given and the fact documented in the report. LiMA offers the phrases as an optional addition. For any handwritten report, on the rare occasions when this is necessary, the report should be annotated on the front cover.

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

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- 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 Health Care Professional, 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. “

This wording will be available in MECs as a desk aid. Examining Health Care Professionals who carry out DVs should carry a copy of Annex H with them for use should the occasion arise.

14. Assessing quality of service

14.1 Claimant satisfaction

Atos Healthcare carries out periodic surveys assessing the satisfaction of claimants. Claimant reactions are evaluated in all aspects of the service including:

- Arrangements for the visits.
- The personal conduct and manner of the EHCP.

The results from the surveys carried out show an overall high level of satisfaction with the service, but also help to identify areas where guidance, training or indeed the process, needs to be enhanced. Analysis of these areas has been considered when drawing up these guidelines.

14.2 Integrated Quality Audit System (IQAS)

Our Integrated Quality Audit System (IQAS) forms a vital part of our overall business and quality system, aimed at supporting the delivery of a professional service, which provides consistent, impartial medical advice. It is linked to the organisational processes for complaints, assessing customer perceptions, training and recruitment of staff.

The IQAS system is based upon:

- A standard process that allows suitably trained and experienced doctors to audit completed work against defined standards of professional practice.
- Systematic feedback of results and trends linked to the need for ongoing training and guidance.
- A mentoring system with each EHCP having a nominated experienced professional colleague responsible for giving advice and for providing feedback including positive support.

14.2.1 The audit system addresses four areas of each product:

1. **Presentation and process** - This area relates to matters such as legibility, completeness and clarity. It includes no medical issues and may be assessed by a non-medical person.
2. **Medical examination** – This embraces all aspects of the medical examination, including history taking, formal clinical examination and the expression of clinical findings.

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3. **Medical reasoning** – This concept includes all the step-by-step reasoning and deduction after consideration of the available evidence, and/or performance of a medical examination, and the formulation of advice to the DM.
4. **Professional Issues** – This encompasses the general principles of medical good practice that underpin all Atos Healthcare's work.

14.2.2 Key requirements

The customer requirements, or Key Requirements, as expressed in the contract, form the basis of any decision on the quality of a product, and form subdivisions of the areas above.

AREAS	KEY REQUIREMENTS
PRESENTATION AND PROCESS	LEGIBLE
	IN PLAIN ENGLISH
	CONSISTENT
	PROCEDURALLY CORRECT
	ALL KEY QUESTIONS ADDRESSED
	FULLY JUSTIFIED
	MEDICAL ISSUES EXPLAINED FULLY
	NON-PRESCRIPTIVE
MEDICAL EXAMINATION	APPROPRIATE MEDICAL EXAMINATION
MEDICAL REASONING	ALL MEDICAL ISSUES ADDRESSED
	MEDICALLY REASONABLE AND LOGICAL
	IN ACCORD WITH ATOS HEALTHCARE GUIDELINES
	IN KEEPING WITH CONSENSUS OF MEDICAL OPINION
PROFESSIONAL ISSUES	IN KEEPING WITH ATOS HEALTHCARE GUIDELINES
	CORRECT PROFESSIONAL HANDLING

14.2.3 Attributes

There are a number of factors to be taken into account when considering a **Key Requirement** and these are termed **attributes**.

Some of these are benefit specific and are easily apparent to anyone with an appropriate level of technical benefit skills; others are specific medical factors, the correctness, or otherwise, of which will not necessarily be visible to our customer.

All the attributes are based on requirements that are specified in training or other guidance material, e.g. EHCP handbooks, Guidance Notes for EHCPs etc.

Some attributes carry more weight than others do. Some are merely “desirables” in that they are not essential to good quality but enhance the product without being vital to its acceptability. Others are defined as **key attributes** in that they are a prerequisite for quality and if unsatisfied will render the product unacceptable. These key attributes carry an asterisk in the table.

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All the attributes are coded which allows for easier collection and analysis both at an individual, unit, and national level. The information from these analyses are used to feed back to individuals, to work towards a consistent standard across all units, and to feed back into training to support the maintenance and improvement of quality at a national level.

A list of attributes for EHCP work is shown at Appendix C

14.2.4 Audit and feedback processes

A limited number of employed doctors working for Atos Healthcare are appointed as auditors, using specific selection criteria. They undergo a training and accreditation process. Only after successful completion of this process are they allowed to carry out audit. Their work is subject to ongoing monitoring by an Internal Validation Group (IVG), which looks to maintain a consistent standard between auditors. Auditors are reaccredited annually subject to satisfactory monitoring of their work.

All EHCPs should expect to receive feedback on their performance from their Medical Manager or mentor. This feedback should provide an overall assessment of performance focusing upon what went well along with any areas where improvements could be expected.

The results of audit where any training needs or additional support are identified, are fed back to the individuals concerned by their mentors. The delivery of this feedback is itself monitored by the same system that collects and analyses the data from the audit. The system prompts action where the feedback has not been given and the outcome recorded.

15. Complaints

15.1 Definition of a complaint

The current definition of a complaint is a clear expression of dissatisfaction about the services that we provide that originates 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. Written complaints may be by letter, fax, e-mail or using the customer service leaflet.

15.2 Why are complaints important?

Complaints are important since they provide information to reduce dissatisfaction and to improve the service that we offer. They give the chance to resolve any dissatisfaction and prevent escalation of the complaint. They also identify training needs and problem areas.

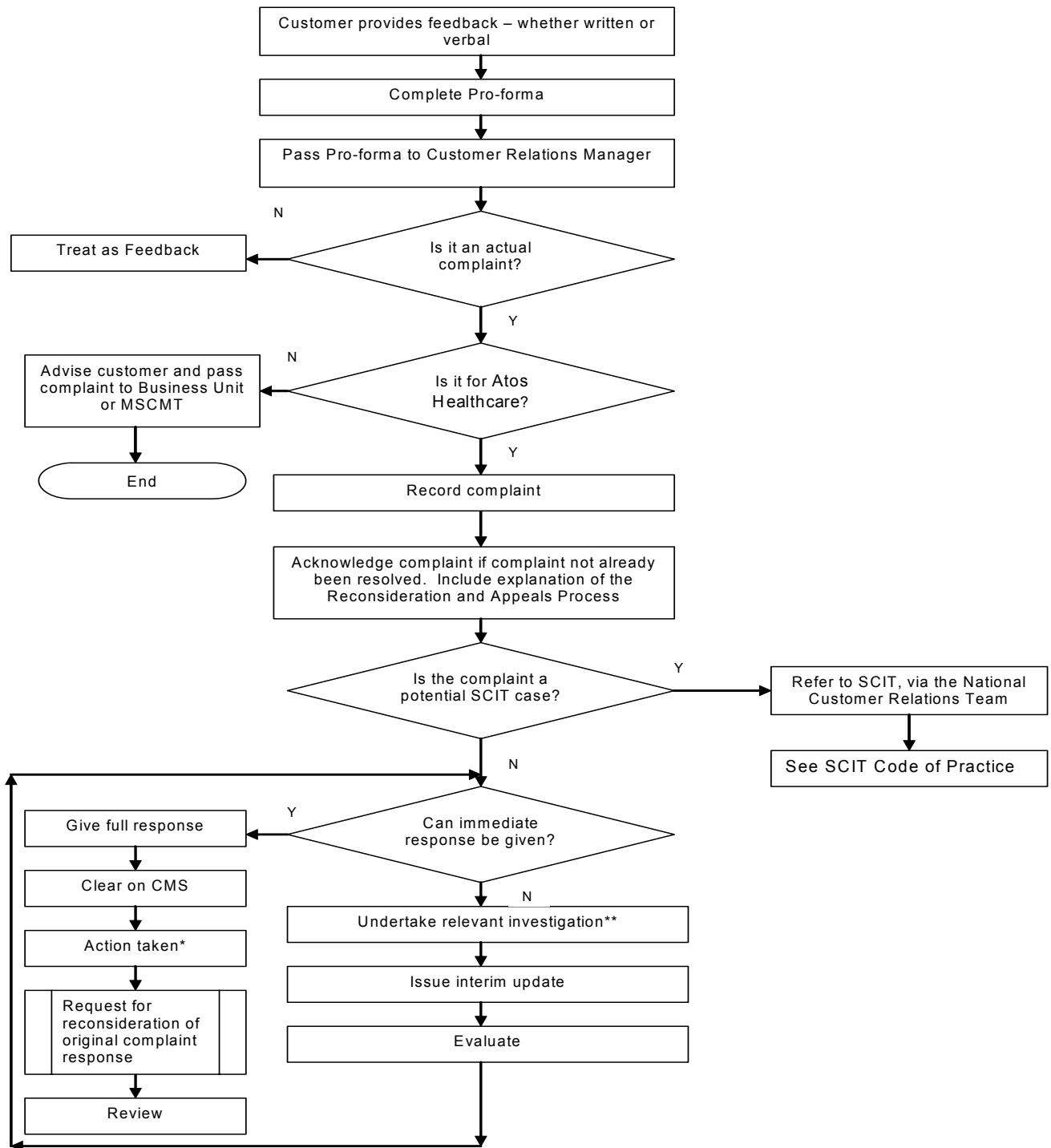
Atos Healthcare values the information gathered from claimants who feel they have cause for complaint. Statistics gathered on the volumes and types of complaint received are passed to the DWP as a requirement of the contract with them. This information is also summarised, along with information from claimant surveys and other enquiries and feedback, into 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.

15.3 The complaints procedure

When someone is dissatisfied with the service received from Atos Healthcare the formal complaint procedure is followed. Some complaints are received directly from the claimant or their representative. Other complaints about Atos Healthcare are referred from the DWP to the Customer Relations Team (CRT) in Atos Healthcare, for investigation and response. A Customer Service leaflet is available on request to explain further 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. The procedure is outlined in the following flow diagrams.

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15.3.1 The Complaint Procedure



* Examples of action include: feedback, remedial action, information forwarded to Dept, apology

** Options include: Examining doctor/MM/MEA/Admin staff/Business Unit/National Customer Relations Team/Witnesses/ Customer – Rep -Carer

15.4 Customer Relations Team (CRT)

The CRT is responsible for ensuring that all complaints are handled in accordance with the guidelines. It is centrally based and is made up of Customer Relations Managers (CRMs). The role of the CRM includes receiving complaints and then investigating, responding to and reporting on them. The team provides advice and support in handling complaints.

A Customer Relations Medical Advisor (CRMA) is also based with the CRT. Their role includes providing medical input on behalf of the Medical Manager at the individual MSECs, to inform the first full response to the complaint.

The CRT provides advice as to whether a complaint should be referred to the Serious Complaints Investigation Team (SCIT) (see below). It also co-ordinates SCIT investigations. They also make recommendations on minimising complaints or the risk of them, and provide responses to, for example, parliamentary questions and ministerial correspondence. The CRT also acts as convenor to the Independent Tier (see below).

15.5 Complaints and the EHCP

The EHCP may become involved in this process whilst in face-to-face contact with the claimant, should the person indicate that they wish to provide feedback. At a later stage, the EHCP may be asked to provide specific comments in response to a complaint received about an examination.

As an EHCP, the claimant may choose to approach you regarding feedback they may have relating to how their medical assessment has been handled. If you receive a complaint during the examination, you are asked to do everything possible to rectify the situation to the satisfaction of the claimant.

When performing an examination in the claimant's home, make sure that you have a copy of the Customer Care leaflet with you.

If the claimant wishes to provide feedback, explain the different options available to them for sending their feedback to Atos Healthcare. If the claimant wishes for their verbal feedback to be recorded in writing, you should record the feedback and give the claimant a copy of the Customer Care leaflet.

15.5.1 What do claimants complain about?

Complaints are categorised according to their nature:

- EHCP's manner or conduct – examples include allegations that EHCPs were “rude, arrogant, did not listen, did not write down everything said, did not give their name, inappropriate examination, inappropriate comments etc”.
- Content of examination – disagreement about whether or not certain clinical tests should have been used e.g. whether blood pressure should have been taken, whether chest should be examined under or over clothing etc.

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- Length of examination – e.g. too long or too short.
- Clinical findings – e.g. what the EHCP has written on the medical report as their opinion or conclusions about the claimant's level of care and/or mobility requirements.
- Administrative issues – e.g. lack of warning regarding date of visit, not sufficient time to arrange for a carer or relative to be present.
- Other – complaints about administrative staff and about issues not directly the concern of Atos Healthcare, which may require comment.

15.5.2 Complaints about EHCPs

The majority of complaints concern the circumstances of the actual medical assessment by the EHCP.

32.1% of all complaints refer to the doctor's manner.
28.9% refer to the content of the examination.
12.1% refer to the clinical findings.

The figures above (for 2007) are based on an analysis of complaints arising from all types of benefit assessments including DLA/AA.

Specific complaints relating to EHCPs are pursued based on the seriousness or complexity of the complaint.

15.5.3 Feedback you should not respond to

Sometimes the claimant may wish to complain on matters that do not relate to our services. You must not become involved in explaining such matters.

Complaints or feedback regarding the following (non-exhaustive) list of examples should be referred to a CRM:

- Rules of entitlement to a benefit
- Benefits process itself
- Actual design or nature of any policy
- Complaints about the policy
- Service provided by the Business Unit
- Appeals or decisions to disallow benefit

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15.5.4 Assisting in an Investigation

From time to time, you may receive an enquiry or request for input from the Medical Manager or CRT as part of their investigation into a complaint. In these circumstances, you are expected to provide a written response within five working days. You will be supplied with a copy of the claimant's letter of complaint and other relevant documents, such as a copy of your examination report, as dictated by the circumstances of the complaint.

Your contribution is vital to the successful conclusion of the complaint, as without it, the response given to the claimant by Atos Healthcare will be incomplete and unsatisfactory.

You should ensure that you supply a comprehensive and relevant response that addresses all of the issues raised in relation to your interaction with the claimant. Lack of detail will hamper the CRM or Medical Manager when explaining your position to the claimant.

If any clarification or additional information is required, the CRM or Medical Manager may choose to contact you for further details. During the course of the investigation of a SCIT complaint, it is normal practice to ask you to attend for an interview to give oral evidence. On some occasions, an interview with an Atos Healthcare manager may be arranged during the investigation of a sensitive complaint.

If you are unable to respond within five working days of receipt, you should contact the CRT to explain the position and provide a likely date as to when you will be able to supply a reply.

Depending on the content of the complaint, you may consider it appropriate to contact your defence society to discuss your response before dispatching it to Atos Healthcare.

Under the Data Protection Act, your response to Atos Healthcare may be copied to the claimant if they request sight of it.

For your information, you will be sent a copy of the reply that Atos Healthcare sends to the claimant. This will be provided by the CRT or by your Medical Manager if further action is appropriate.

15.5.5 Follow-up action

Following completion of a complaint action, the file is passed to the Medical Manager of the area in which the EHCP is based. They will review the complaint and decide what follow-up action is required. The Medical Manager will also consider the EHCP's previous complaint record. The categories of action are listed below.

- **No action:** No issues have arisen from the complaint that require communication with the EHCP (the EHCP is provided with a copy of the response letter for information only)

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- **Proactive feedback:** Evidence may be conflicting or irreconcilable. However, while emphasising that it has not been possible to draw conclusions from the complaint, it is appropriate to state that the events that have been alleged by the claimant to have taken place would not be compatible with Atos Healthcare standards. Proactive feedback consists of sending the EHCP a copy of the response to the complaint, in which this view is expressed.
- **Remedial action:** Specific action to be taken in consultation with the EHCP. For example, interview / discussion followed by additional training or monitoring.
- **Formal action:** Formal Personnel action will be instigated. This includes the revocation of approval, capability or disciplinary procedures.

15.6 Escalation of a complaint

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

15.7 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 Atos Healthcare, DWP or Welfare Rights Groups.

The Independent Tier has no legal authority or executive responsibility in relation to Atos Healthcare. It will consider whether Atos Healthcare has adhered to the approved complaints process for handling of the complaint.

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.

A parallel independent medical quality review will be conducted by a qualified and approved medical practitioner. This will be undertaken when there are issues within the complaint that relate to the medical quality of the medical report in question.

The Independent Medical Practitioner will consider whether the relevant medical report considered as part of the complaint investigation has been completed in accordance with Atos Healthcare's quality and professional standards. The medical practitioner will specifically comment on whether the advice provided was:

- Fair and impartial, in accordance with the Department for Work and Pension's Equal Opportunities policy

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- Medically correct
- Complete, justified, and consistent
- Expressed in terms readily understood by the District Office customer
- Legible, where given in writing
- Within the consensus of current medical opinion.

The Independent Tier will not provide views or judgements to any person outside Atos Healthcare on policy issues or decisions of the decision-making authorities.

It is not part of the role of the Independent Tier to enter into discussions about the merit of a complaint with the claimant or any other party to the complaint. However, when carrying out its review, the Independent Tier, or Independent Medical Practitioner, may contact the claimant, or any party to the complaint to seek clarification, or seek expert advice to resolve issues requiring additional guidance. They will do this via the Convenor to the Independent Tier (CRT) who will arrange any contact or obtain additional guidance for the Independent Tier.

The Authority, or representatives of a recognised Welfare Groups, may observe the Independent Tier review. This will be agreed with Atos Healthcare and arranged by the Convenor who will also obtain consent from the claimant or customers concerned.

The Independent Tier, or Independent Medical Practitioner, will determine the appropriate method for reviewing any particular complaint referred to them. However, the findings of the Independent Tier will be communicated in an approved format.

When a referral is to be made, a nominated Customer Relations Manager will act as Convenor to the Independent Tier. The Convenor will assemble all paper from the complaint file, with a schedule of events, and forward these to the Independent Tier, including a set of papers to the Independent Medical Practitioner. Following the review the Convenor will notify the Customer Relations Team Leader of the outcome. The Team Leader will determine the nature of any remedial action appropriate in any case after consultation with senior operational managers.

The Convenor will forward the findings of the Independent Tier to the claimant with information about any remedial action taken by Atos Healthcare because of the findings of the Independent Tier. This will also be provided to the Authority as agreed.

15.8 Serious Complaint Investigation Team (SCIT)

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

- Assault as a consequence of examination

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- 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
- Criminal activities

The Medical Manager will recommend to the CMO whether a complaint is categorised as a SCIT matter. The CMO decides whether a complaint should be investigated as a SCIT and also advises on initial action before the SCIT investigation (including EHCP suspension) and remedial action following it.

The CRT is responsible for facilitating the process, liaising with the Medical Manager and the SCIT.

Atos Healthcare deals with SCIT cases urgently. These cases are processed with particular regard to confidentiality. The importance of considering the rights of both the claimant and the individual against whom the complaint has been made in these cases is paramount.

Once it is established that a complaint is to be investigated by the SCIT, the CRT takes over responsibility for the complaint investigation. The SCIT comprises a non-medical member, who is a senior manager from Atos Healthcare Operations, and a doctor from the pool of experienced Atos Healthcare SCIT doctors. The doctor will have no connection with the area where the complaint has arisen. If the practitioner is an employee, the non-medical member will be from Atos Healthcare HR.

The SCIT will conduct a detailed investigation that involves notification to the EHCP of the complaint and subsequently interviewing the EHCP, claimant and any appropriate witnesses.

On conclusion of the investigation, appropriate action will be taken in consultation with the Medical Manager and with Atos Healthcare HR.

The need for disciplinary or other remedial action will be considered. In the case of a substantiated serious complaint made against a contracted doctor, the VPPC will be informed that no further work will be offered to that doctor.

Appendix A - Atos Healthcare Professional Standards

Personal Conduct

1. All work will be carried out in a manner that recognises the right of everyone to be treated with respect whatever his or her gender, sexual orientation, race, religion, nationality, culture, age, health, (dis)ability, marital status and physical characteristics or appearance.
2. In dealings with claimants and their representatives, Atos Healthcare employed staff and self-employed Contract Medical Assessors will be:
 - Accessible
 - Punctual
 - Reliable
 - Presentable
 - Approachable
 - Courteous
 - Friendly.
3. When carrying out an examination of a claimant, to support the advice giving process, staff will:
 - Introduce himself or herself to the claimant and wear a name badge or offer other official identification.
 - Make the claimant welcome and feel at ease.
 - Be polite at all times.
 - Encourage a person accompanying the claimant to be present during the examination if so desired by the claimant.
 - Explain the purpose of the examination.
 - Explain what the examination entails.
 - Allow the claimant time to give their history, asking questions in a non-adversarial manner and following the relevant guidance (such as this handbook)

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- Carry out a relevant examination to provide the information necessary to give and justify medically reasonable advice.
- Carry out the examination gently to avoid any unnecessary discomfort. Virtually always, only active (and not passive) movements of the limbs are appropriate.

4. When giving Advice:

- Atos Healthcare advice will be objective, independent, fair and impartial, ethical, and given in accordance with our contractual obligations.
- It will conform to the consensus of medical opinion and the balance of probability.
- It 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.

5. The following clarify these terms, concepts and definitions:

Objective	Based on evidence.
Independent	Without the influence of carer responsibility, or involvement in any other aspect of the claim.
Fair and Impartial	<p>With no personal interest, of any sort, in the outcome of the claim under consideration.</p> <p>Everyone has the right to work without fear of harassment. The company is committed to eliminating such behaviour and creating a productive working environment where everyone is treated with dignity and respect whatever their gender, sexual orientation, race, religion, nationality, culture, age, health, (dis)ability, marital status and physical characteristics or appearance. Every employee and person acting on behalf of the company has a duty to protect and respect this right.</p> <p>(Harassment being a generic term that encompasses bullying and victimisation).</p>
Ethical	Conforming to the code of Professional Ethics as laid down by the General Medical Council / Nursing and Midwifery Council
Appropriate Depth	Sufficient factual detail obtained to support the advice.

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Scope	<p>Addressing all the questions asked.</p> <p>Covering all relevant issues, including details of an appropriate medical examination when required.</p> <p>Without reference to entitlement.</p> <p>Answering questions posed by the customer without compromising any subsequent decision making process.</p>
Focus	<p>Relevant.</p> <p>Medically logical.</p> <p>In accordance with contractual obligations.</p> <p>Further Medical Evidence should be appropriate, and obtained by the most economical method.</p> <p>Given in good time, taking account of any targets or deadlines.</p>
Clarity	<p>Concise.</p> <p>In terms understood by the customer.</p> <p>Legible when written.</p> <p>It will be clear in its account of Further Medical Evidence usage.</p> <p>Free of contradictions or conflicts.</p>

The standards are measured by a combination of customer and claimant surveys, peer group audit, direct observations etc.

Appendix B - Professional Standards - Disability Living Allowance and Attendance Allowance

Atos Healthcare function	Standard
EHCP must be:	<ul style="list-style-type: none"> • Presentable in appearance • Courteous in approach • Punctual
Reports must:	<ul style="list-style-type: none"> • Be legible • Be comprehensive • Be consistent within themselves • Be impartial • Be clearly understandable • Be medically correct • Not make any reference to entitlement • Contain non-prescriptive advice in accordance with the relevant legislation • Be free of embarrassing, confidential and harmful information
Measured by <ol style="list-style-type: none"> 1. Review by Registered Medical Practitioner. 2. Comments from DM – assessing legibility, consistency, clarity, helpfulness. 3. External claimant questionnaire - assessing appearance and manner. 4. Level of substantiated complaints. 	

Appendix C - Attributes for examinations in DLA/AA

Definition and interpretation of generic attributes

ATTRIBUTE	CODE
“*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.	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.	G10
“Free from medical abbreviations” - Medical abbreviations should not be used. Although certain shorthand medical terms may be known to most readers it is nevertheless good practice to avoid their use wherever there is any possibility of confusion.	G12
“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”.	G13
“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.	G15
“*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.	G03
“*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 EHCPs.	G04
“*In accordance with legislation” - While the EHCP’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.	G05

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“Appropriate response to incorrect documentation” - The EHCP should be able to recognise the fact that incorrect documentation has been provided. The practitioner’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.	G08
“*FME consideration recorded” - It is important that the customer is made clearly aware of the evidence which the EHCP has considered in giving advice. Further medical evidence is of particular importance in this context.	G11
“*Complete answers to all questions raised” - No area of a report should be left incomplete. If specific questions are raised by the customer they should all be addressed.	G02
“*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 gives a clear explanation of the reasons for giving certain advice and the underlying evidence by which he was guided.	G16
“*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 are avoided, merely that they, and the underlying medical reasoning, are clearly explained for the benefit of the non-medical reader.	G01
“Appropriately detailed” - Excessive detail compromises clarity. Equally, failure to provide adequate information may compromise decision-making. Skilled report-writing avoids these extremes.	G09
“*Full clarification of contradictions and/or conflicts” - Conflicts of evidence should be addressed. Even where the EHCP is unable to provide an explanation for such a conflict, he should demonstrate that the difficulty has been recognised.	G14
“*Not compromising decision-making” - The EHCP’s report should contain no allusion to entitlement to benefit, or express any view regarding the outcome of a case.	G07

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Presentation and process attributes

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

Key Requirements	Professional Issues Attributes	Attribute Code
In keeping with Atos Healthcare Professional Standards	*Standards independent, impartial, ethical, honest and fair	P01
Correct Professional Procedures	Appropriate action taken on harmful, confidential, and embarrassing information	P102
	Appropriate action taken on unexpected clinical findings	P03

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Key Requirements	EHCP Report Attributes	Attribute Code
Appropriate Medical Examination	*Appropriate clinical and past history recorded	S10
	Client's description of variability recorded	S13
	Current medical treatment described	S18
	Current symptoms described	S19
	Hospital treatment and appointments recorded	S30
	Medication recorded	S37
	Side effects recorded and explained	S66
	Diagnosis recorded and explained if necessary	S67
	Clear record of customer's reported impairments and restrictions	C28
	Appropriate pen picture present	C10
	Account of average day activities present	C18
	Account of average daily activities functionally focussed and relevant	C19
	Social / cultural issues addressed	R71
	*Clear record of a careful structured examination of all relevant areas	C01
	*Clinical findings expressed clearly and concisely	C03
	*Examination covers all known conditions	C04
	*Inappropriate signs clearly described	C06
	*Record of appropriate mental health assessment, if indicated	C08
	Appropriate examples of observed behaviour recorded	C12
	Clinical tests appropriate to specific conditions applied and recorded	C13
	Measurements recorded properly and appropriately	C14
	Style of recording permits future comparison	C15
	Date and mode of development of symptoms recorded adequately	C17
	Epilepsy questionnaire completed if required	C29
Medically Reasonable and Logical	*Mobility opinion consistent with clinical findings	R26
	*Opinion on safe mobility supported and consistent with clinical findings/observed behaviour/anecdotal evidence	R35
	*Day attention needs are medically justified and consistent with clinical findings	R79
	*Main meal opinion: Opinion justified and consistent with clinical findings	R67
	*Day supervision: expressed needs medically justifiable	R11
	*Night attention: needs are medically justified and consistent with clinical findings	R27
	*Night supervision: expressed needs medically justifiable	R28
	*Opinion based on clinical findings and observation and not on clients claimed needs	R33
	*Medically reasonable and logical	R25
All Medical Issues Addressed	*Inconsistencies dealt with clearly	R20
	Attention opinion checklist; all tick boxes justified if help needed	R48
	Clear categorisation (attention vs. supervision) of help required in maintaining personal hygiene	R49
	* FME clarified and interpreted when required	R63
	Variability issues clarified	R103
	Clear link between observations and claimed disability	R106
	Appropriate justification given for advice on prognosis	R104
In Keeping With Consensus of Medical opinion	*Advice conforms to consensus of medical opinion and balance of probabilities	R01

Appendix D - Abortive Visits – Form AV1

Form AV1

Medical Services

PROVIDED BY ATOS ORIGIN ON BEHALF OF THE DWP

Office Address

To

From

Date

As arranged, I called to examine you regarding your claim for

- | | |
|--|---|
| <input type="checkbox"/> Incapacity Benefit | <input type="checkbox"/> War Pension |
| <input type="checkbox"/> Disability Living Allowance | <input type="checkbox"/> Industrial Injuries Scheme Benefit |
| <input type="checkbox"/> Attendance Allowance | <input type="checkbox"/> Severe Disablement Allowance |

on / / but you were not available when I visited.

What happens next

I will visit you on / / at

While I will use my reasonable endeavours to meet the specified appointment time I may be held up by delays incurred during previous examinations and journeys.

Should you feel that this appointment is unsuitable please contact the visiting practitioner on the number below:

Practitioner's Name

Phone Number

Appendix E - Unexpected Findings – disclosure of clinical information by Health Care Professionals to claimants' General Practitioners

Introduction

Situations arise when EHCPs carrying out disability assessments may come across information that they feel should be reported to the claimant's General Practitioner. The following section gives details of what to do in these cases.

1) GMC / NMC Guidance

Guidance regarding confidentiality is published regularly by the GMC and NMC. It sets out the duties and obligations that EHCPs have in terms of maintaining patient confidentiality. It is made explicit that consent must be obtained from the patient (claimant) before any information is released about them, unless there are exceptional circumstances. It is clearly stated that the purpose of the disclosure and its content must be made clear to the patient prior to its release. In DLA/AA work it would most likely mean releasing information to their General Practitioner.

There may be rare occasions when despite the patient's inability or refusal to give informed consent, the EHCP may in their professional judgement feel it is appropriate to disclose information about that individual. Discretion must be exercised within the GMC / NMC guidelines, and EHCPs must be prepared to justify fully their decision to take such action. The types of circumstances when unauthorised disclosure by EHCPs would be justified include:

- When the release of that information is necessary to protect others from risk of death or serious harm;
- When the patient requires urgent medical treatment, but cannot be contacted within a suitably rapid period of time.
- When the individual is not competent to give consent.

All practitioners are strongly advised to read the appropriate guidance notes from the GMC or NMC.

If any doctor does not have a copy, then they should contact the GMC at 178 Great Portland St, London W1W 5JE (Tel: 020 7580 7642) or visit www.gmc-uk.org. There will be updates of the frequently asked questions on the website.

If any nurses do not have a copy, then they should contact the NMC at 23 Portland Place, London W1B 1PZ (Tel: 020 7637 7181) or visit www.nmc-uk.org.

2) Procedures for dealing with unexpected findings when the claimant provides written informed consent

When an EHCP identifies a need to pass information about a claimant to the GP then they must provide an explanation to them why this is the case. The discussion should include:

- The information to be disclosed.
- Reasons for the disclosure of this information.
- A request for consent to release of the information.

The EHCP should record relevant details of their discussion with the claimant on form UE1 (Rev), both in respect of the information that they have 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. An example of this form is in Appendix F.

The claimant should be given a copy at the time of the examination.

The findings must be communicated to the claimant's General Practitioner within 24 hours, provided that the claimant gives consent for this release.

3) Guidance for contacting the claimant's doctor

a) Contact by telephone and letter:

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 EHCP to report any unexpected findings to the claimant's GP by telephone and record details of the conversation on form UE1 (Rev). This is outlined below:

- A copy of the UE1 (Rev) form must be handed to the claimant.
- For this purpose, each EHCP will have been issued with three spare copies of form UE1 (Rev) along with a piece of carbon copy paper.
- If carbon paper is not available, the EHCP must make an exact copy on a separate UE1 (Rev).

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

Telephone contact must be made in all cases with the claimant's medical attendant, 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 to 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, where the administration clerk will issue the completed UE1 (Rev) to the GP or Medical Carer, after taking copies for CSD (retained for 3 months), the claimant's file and the EHCP's personal file (to be retained for a minimum of 10 years).

For cases examined in MECs, similar general principles are used.

b) Claimant does not have a GP:

If the claimant does not have a GP, advise them to seek medical attention, and provide them with an additional copy of the UE1 (Rev) detailing the clinical findings.

4) Procedures for dealing with unexpected findings when the claimant refuses consent to release information

If the claimant refuses to give consent, the EHCP 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 EHCP should only complete the form partially, 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 compendium file and the EHCP's personal file, in accordance with current guidance.

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

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

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

Medical Services

b) When the claimant refuses consent to release information but in your professional judgement you consider that the release of that information is essential

Whenever the claimant refuses to provide consent (written or verbal) despite the EHCP's best endeavours to explain why this is necessary, the EHCP must respect their views but also must determine whether disclosure is still essential (see earlier). If the release is considered essential then the EHCP must complete all relevant sections in the UE1 (Rev), providing a justification for the disclosure despite the claimant's refusal to provide oral/ 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 where appropriate, and copies are filed as stipulated.

5) General procedural guidance

a) Harmful information

See section 12

b) Referral to hospital

Circumstances may occur when you may consider 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 or Medical Carer and confirmed in writing using a UE1 (Rev) form, which should be fully completed to include the claimant's signed agreement wherever practical. If a signed agreement is not practical, for example the claimant is unconscious or is in such dire straits that it would be insensitive to request a signature (e.g. experiencing a myocardial infarction), the EHCP should briefly describe the situation on form UE1 (Rev).

Once again all telephone conversations between the EHCP and the claimant's GP or Medical Carer must be recorded on the UE1 (Rev).

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

c) 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 EHCP. Due sensitivity must be observed when advising the claimant to attend their GP and you must ensure that your manner does not give rise to undue concern.

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d) 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/Medical Carer 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, EHCPs should consult CSD for advice.

6) Customer Service Desk (CSD)

Role of CSD

CSD will be an initial point of contact for EHCPs who have queries regarding the action to take and from claimant's GPs or Medical Carers on receipt of a completed UE1 (Rev) from Atos Healthcare.

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 MA if any difficulty is encountered.

7) Unexpected findings arising during the course of file work

If a EHCP wishes to pass on information uncovered in the documentary evidence that they feel the GP may be unaware of, the consent of the claimant must be obtained first.

The EHCP 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 to the claimant must include an indication of the nature of the information that is intended for communication to the GP, although this must of course be done in such a way as to avoid engendering undue alarm.

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 review period.

If a positive response to the request for consent is received, it should be linked to the file and passed to an MA immediately. The MA should then contact the GP by telephone on the same day – this is important to reduce the likelihood of a situation developing where the claimant contacts the GP before Atos Healthcare has had an opportunity to pass on the relevant information.

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In addition to telephoning the GP, the MA must complete form UE1 (Rev) with the relevant details. This form should be handed to the administration clerk, who will issue the completed UE1 (Rev) to the GP or Medical Carer, after taking copies for CSD (retained for 3 months), the claimant's file and the EHCP's personal file (to be retained for a minimum of 10 years). 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.

If after five working days the consent has not been returned, the CSD Team Leader should pass the photocopy to a EHCP who 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 the photocopy. Following the telephone conversation:

- If the claimant informs the MA 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 MA should consider if release of information without the claimant's consent is justified.

Copies of the letter requesting consent, results of any telephone conversations, and consent/refusal to consent should be held in the CSD file, the EHCP's file and the claimant's referral file. An example of the letter that can be used is in Appendix F.

Medical Services

Appendix F - UE1 (Rev), POID 1 & UE 2

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

REPORT OF UNEXPECTED FINDINGS FOLLOWING MEDICAL EXAMINATION

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):	Initials/date/location	Copy (tick):	Initials/date/location
Faxed to GP: <input type="checkbox"/>	<div></div>	CSD <input type="checkbox"/>	<div></div>
Sent to GP: <input type="checkbox"/>		Claimant's File <input type="checkbox"/>	
Claimant copy: <input type="checkbox"/>		Doctor's File <input type="checkbox"/>	

Do Not Weed (DWP Purposes Only)

UE1 (Rev) 10/01

Medical Services

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

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

PP	ECID	SAL	HOLD
DP	CGC	BC	HODOC
WS	BANK	MC	TU
BSOC	TP	PRV	AC
BILLS	GV3	DVLC	HMFC
LARC	LAP	CB	CRED

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 ☐

POID1/Version 1
Feb 2002

Medical Services

Acceptable Forms of Identification

Atos Healthcare will accept as evidence of identity one of the following:

<u>Type of Identity</u>	<u>Code</u>
<input type="checkbox"/> Claimant's own passport	PP
<input type="checkbox"/> European Community identity card	ECID
<input type="checkbox"/> Standard Acknowledgement (for those seeking asylum in UK)	SAL

Alternatively, Atos Healthcare will accept any three of the following documents as proof of identity:

<input type="checkbox"/> Birth certificate	BC
<input type="checkbox"/> Marriage certificate	MC
<input type="checkbox"/> Travel pass	TP
<input type="checkbox"/> Form GV3 (one way travel document issued by UK embassies abroad)	GV3
<input type="checkbox"/> Local Authority rent card	LARC
<input type="checkbox"/> Certificate of identity issued by the Home Office to the claimant	HOID
<input type="checkbox"/> Forms issued by the Home Office to the claimant	HODOC
<input type="checkbox"/> Police registration certificate	PRC
<input type="checkbox"/> Full driving licence	DVLC
<input type="checkbox"/> Life assurance policy	LAP
<input type="checkbox"/> Divorce/annulment papers	DP
<input type="checkbox"/> Recent wage slip	WS
<input type="checkbox"/> Trade union membership card	TU
<input type="checkbox"/> Adoption certificate	AC
<input type="checkbox"/> Cheque book	CB
<input type="checkbox"/> Cheque guarantee card	CGC
<input type="checkbox"/> Bank statements	BANK
<input type="checkbox"/> Building society pass book	BSOCY
<input type="checkbox"/> Paid household bills in the name of the claimant	BILLS
<input type="checkbox"/> Certificate of employment in Her Majesty's Forces	HMFC
<input type="checkbox"/> Store or credit cards	CRED

Medical Services

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

[Title] [Claimant Name]

[Address 1]

[Address 2]

[Address 3]

[Postcode]

Reference: **AB 123456 C**

Telephone: (####) ### ####

[Date]

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)

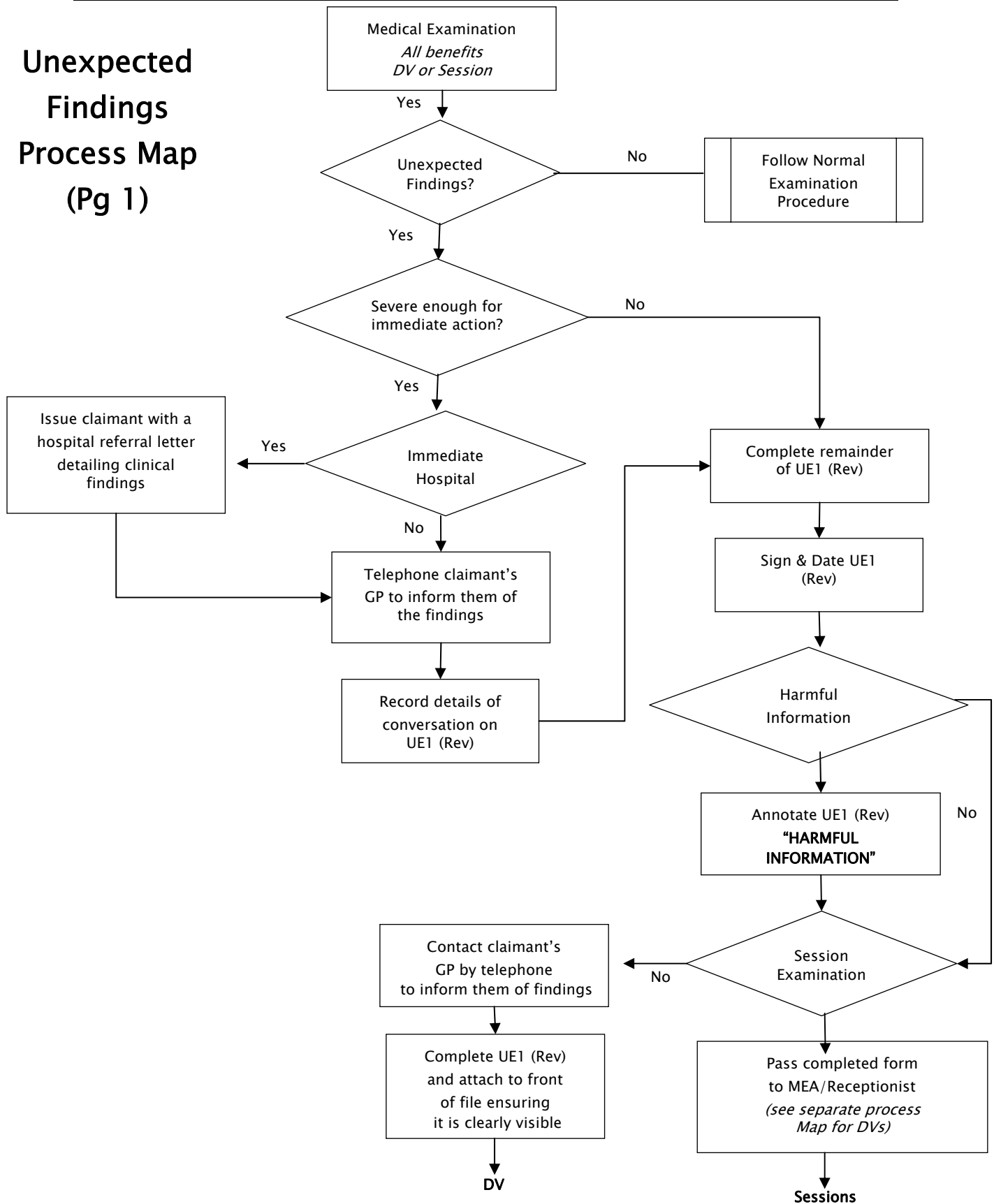
Date: / /

Name: _____

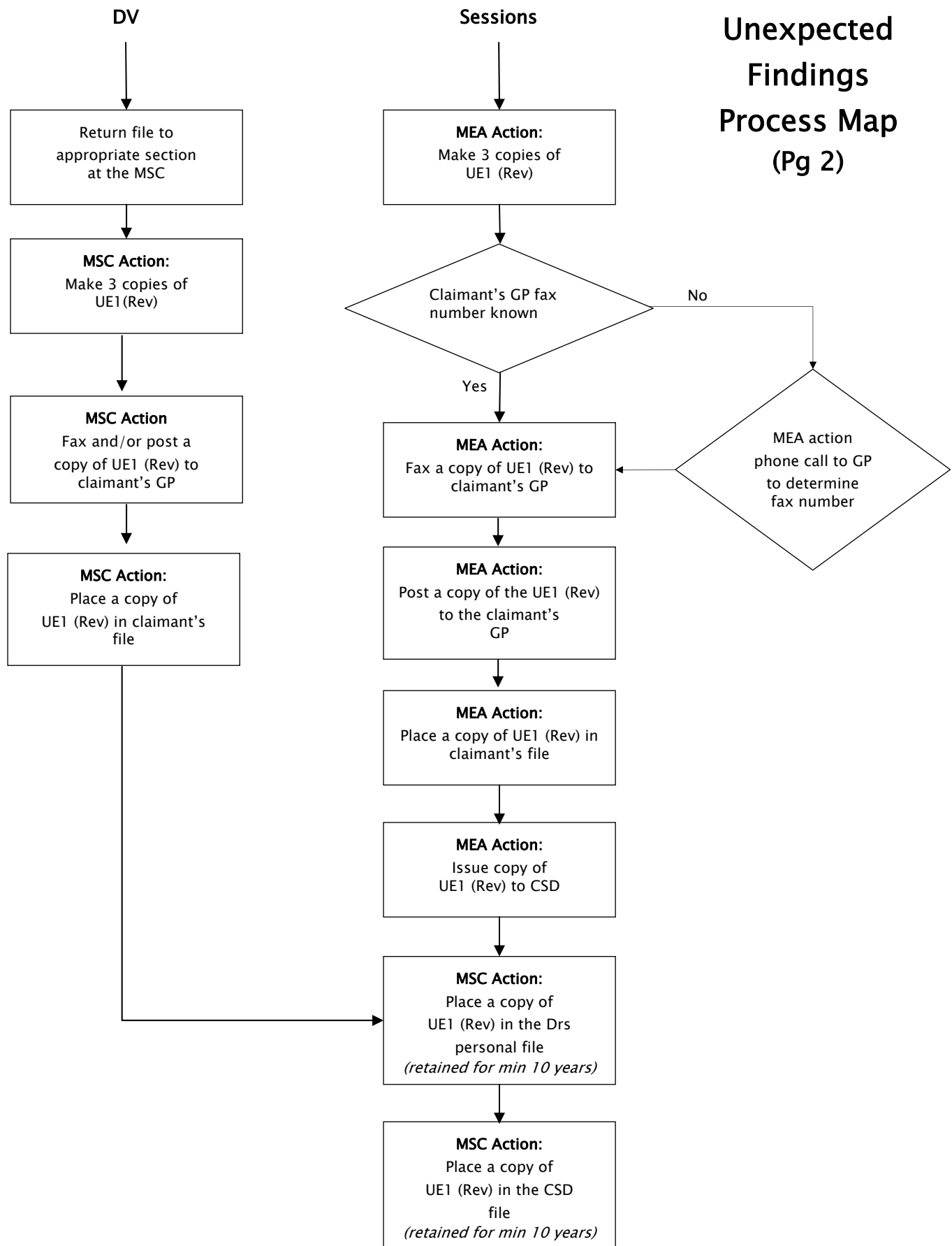
UE2 10/01

Appendix G - Unexpected Findings Process Map

Unexpected Findings Process Map (Pg 1)



Medical Services



Appendix H - Taking of Notes during an Examination by Claimant or Companion

“Where notes are taken by you, we consider it of assistance to both myself, as the Examining Health Care Professional, 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 Health Care Professional, 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. “

Appendix I - DLA in Children

1. Introduction

- 1.1 What follows is a summary of a consultation paper prepared by the Disability Living Allowance Advisory Board, which was commissioned to consider the following issues:
- (i) The way in which children make the transition to independent walking (based on the physical aspects of walking), concentrating on the age at which a normal child will make this transition and describing the range of expectations in terms of the age at which this transition will be made.
 - (ii) The age at which we should expect a child to be independently mobile without guidance and supervision outdoors, and the characteristics of children who fail to achieve this particular milestone (taking account of physical/mental problems).
 - (iii) The characteristics of children who will fail to make either of the transitions, including the prognosis for independent walking for those who fail to make the transition.

2. The Transition to Independent Walking

- 2.1 There are a number of ways in which normal children make the transition from immobility to independent walking. Most children begin to crawl some time before walking. They then begin to pull themselves up and move around, holding on to furniture, or on to an adult's hand, before taking their first independent steps. Once this has occurred there is a very rapid increase in walking ability, as the child first becomes very mobile within the home and then outdoors.

For children who crawl, the range of ages at which they first were able to take 10 steps is around 10 - 18½ months, with a median age at about 13½ months. About 5% of normal children do not crawl before they walk. A few appear to just stand at around 10-11 months, having made no previous effort to move around. Some get around by rolling over and over, while others creep on their tummies in a form of "commando crawl".

- 2.2 A small group of children get around by bottom shuffling, hitching or scooting in which the child sits on the floor and slides along on one or both buttocks, by pulling on the floor with one or both flexed legs. These children have a lower muscle tone and tend to walk at a later age than do children who crawl. There is often a similar history in siblings and other family members. However, there is nothing to suggest that these children are in any way abnormal and some appear to excel in activities where exceptional suppleness is an advantage. In any event, only about 3% of such children are not walking by the age of 30 months, which means that only about 15 children per 10,000 in the general populations (i.e. 0.15%) have failed to reach this milestone by this age.

Medical Services

- 2.3 All these observations are supported by the findings from the 1958 National Childhood Development Study which followed up a cohort of around 15,000 children who were born in April of that year. At 18 months, all but 4.3% of children were walking independently, with the proportion of boys who were not walking being rather greater than girls (4.9% v. 3.6%). Unfortunately, later studies of this type did not collect similar data on walking, but there is no reason to believe that the situation has changed significantly with the passage of time.
- 2.4 By the age of 2½ years, the very great majority of normal children will be walking independently. There is a difference between a child's first few hesitant steps and the development of useful walking ability. However, for most children, once the first steps have been taken there is a very rapid increase in mobility. At this age it is reasonably certain that all children will be able to walk unless they have a disability which affects their walking.

3. The Transition to Independent Mobility (without guidance and supervision)

- 3.1 In many ways, the age at which children can be allowed to go out unsupervised is determined by external and social factors. For example, there is a belief amongst many parents that the world is not such a safe place as when they were growing up. Having said that, parental attitudes do vary considerably on the age at which children are allowed out alone. In addition, a child who lives, for example, on a quiet road in a small housing estate is likely to be allowed out earlier than one who lives on a busy main road.
- 3.2 Children will generally be allowed to play outdoors in a garden from about the age of two years. They will be able to cope with an uneven surface and can go up and down low steps two feet at a time. They will not be safe in the presence of ponds or places where they may fall from heights. Supervision in any event will need to be frequent but not necessarily continual. From the age of about 3 years, most children can run and jump. They might walk around a supermarket, or for a similar distance outdoors, with a parent holding hands, using reins, or supervising very closely. Longer distances outdoors will be travelled in a normal pushchair or buggy.
- 3.3 By the age of 4 years children will normally have dispensed with the use of a pushchair and will walk to the local shops or playgroup (e.g. distances of up to half a mile or so) in the company of an adult. During the primary school years there is a process during which the child's outdoor mobility becomes progressively greater and the level of adult supervision becomes progressively less. The speed and pattern of this progression is clearly influenced by many of the external factors mentioned above. In any event, it is advisable for supervision to be present when crossing main roads in all children up to the age of about 11 years.

4. The Characteristics of Children Who Fail to Make the Transition to Independent Walking or Unsupervised Mobility

- 4.1 There are a large number of groups of children who would fail to walk by the age of 30 months. From these, we can identify three groups who would account for the majority of children within this category. These are:-

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4.2

- Children with severe learning disabilities, with a prevalence of around 1:1000.
- Children with the most severe forms of autism, with a prevalence of around 4:10,000 (although there will be a considerable overlap between this group and those with severe learning disabilities).
- Children with severe cerebral palsy, with a prevalence of about 1:1600.

It should be noted that the prevalences quoted are estimates of the number of children who will have failed to walk by 30 months and not the overall prevalence of the particular condition. It should also be noted that two of the categories relate to mental rather than physical disabilities, but in many of these, a physical cause for the mental disability will be evident. Finally, it is also important that particularly at this end of the severity spectrum there will be an overlap between individuals in each of these groups.

4.2 All other relevant groups are rare and include:-

- Other neurological disorders
 - Duchenne Muscular Dystrophy (although many will be walking by 30 months, only to deteriorate later);
 - Spinal muscular atrophy;
 - Congenital myopathies;
 - Spina bifida;
 - Head injury;
 - Encephalitis/meningitis;
 - Spinal cord injury.
- Limb Defects (some of which can be surgically corrected).
- Brittle bone disease.
- Arthritis.
- Cardiac and respiratory disorders - particularly broncho-pulmonary dysplasia, but also in the most severely affected children with more common cardiorespiratory children e.g. congenital heart disease and asthma.
- Sensory impairments - blindness, deafness and with particular problems with those children who are deaf/blind.

Making precise estimates of numbers is clearly difficult, but there would perhaps be about 4000 children in the groups discussed above who would fail to walk between the age of 30 months and their fifth birthday.

4.3

In considering the question of prognosis it is important to note, that in many such children we are dealing with developmental delay rather than a permanent impairment in walking ability and consequently an improvement should be expected in a high proportion - particularly in those children with severe learning disabilities or autism. The position with those with severe cerebral palsy, where problems of lower limb spasticity remain may be different, so that despite any improvement brought about by the development process, training or therapy, severe difficulties with walking are likely to remain.

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Again making precise estimates of numbers is difficult, but a reasonable assumption would be that 80% of children across all groups are likely to be walking by the age of 4 years.

- 4.4 The question of independent mobility without guidance and supervision in disabled children is not especially relevant to this particular discussion, in that a high level of supervision is required by all children below the age of five years. There will be some children, for example, with learning disabilities and sensory impairments who will fail to walk physically by the age of 30 months, but then, as this ability develops, will require substantially more guidance and supervision than normal throughout the childhood years. Those who would currently qualify for the higher rate mobility component because of severe mental impairment under the current rules need special mention. These are likely to be amongst those with severe learning disabilities mentioned in paragraph 4.1 above. Clearly however they do develop the physical ability to walk, from which point the particularly intense supervision needs which are characteristic of the group become apparent.

Observation Form

Please photocopy this page and use it for any comments and observations on this document, its contents, or layout, or your experience of using it. If you are aware of other standards to which this document should refer, or a better standard, you are requested to indicate this on the form. Your comments will be taken into account at the next scheduled review.

Name of sender: _____ Date: _____

Location and telephone number: _____

Please return this form to:



