

COVID Clinical Telephone Assessment & Related Filework Guidance for Work Capability Assessments

(MED-COVCTA&FWGWCA ~001)

10th March 2021

Foreword

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

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

This Handbook should be read with the understanding that, as experienced practitioners, the Healthcare Professionals will have detailed knowledge of the principles and practice of relevant diagnostic techniques, and therefore such information is not included.

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

Thus, although the Handbook 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 Healthcare Professionals.

Document control

Superseded documents

Version history

Version	Date	Comments
1a draft	9 th February 2021	Initial Draft – combining various COVID 19 Guidance TA documents
1b draft	16 th February 2021	Formatting
1c draft	18 th February 2021	Further Update following Ops comment on secure phones
1d draft	25 th February 2021	Updated with wider CST comments
1 Final	10 th March 2021	Signed off by DWP

Superseded/Incorporated Documents

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

COVID-19 Filework Process

COVID 19 WCA Telephone Assessments Scripts draft

COVID-19- Sift of Cases Suitable for Telephone Assessments by Clinical Staff not Trained in Filework

Removal of LD and Mental health with Impaired Insight Telephone Assessment (TA) exclusion criteria

COVID TA Appointee Guidance

UTS 14/20 Incomplete Assessment – Face to Face Required - REVISED

Temporary Guidance Note - Face coverings and claimants relying on lip reading

Excluded Information

CHDA Administration Processes

Changes since last version

Outstanding issues and omissions

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Issue control

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1. Introduction

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

CHDA have been working with the DWP throughout the Covid-19 pandemic and the new process of conducting Work Capability Assessments by telephone has been a continuous and evolving process

Initially, advice was limited to identification of the most vulnerable clients and a process of “LCWRA – Yes/No advice” was commenced. At all stages, the guidance and processes were subject to careful scrutiny and strict quality assurance measures by DWP/CHDA and the views and experiences of other stakeholders were also sought throughout. This careful evaluation and quality assurance process has allowed the expansion to WCA advice to the present position.

HCPs have been provided with appropriate training and feedback throughout each stage of the Telephone Assessment process to ensure a quality service can be assured.

This document summarises the current DWP agreed guidance and processes for HCPs when providing WCA advice via a telephone assessment. The guidance also supports HCPs in considering evidence gathering and evaluation through a telephone consultation.

The following Telephone Assessment areas will be covered in this document:

- General Guidance/Processes in WCA Telephone Assessments
- LCWRA “Yes or LCWRA No” Telephone Assessments (Including Risk LCWRA where appropriate). Guidance is also provided in this document on the Clerical ESA/UC 85 completion in these limited advice Telephone Assessments.
- LCW/LCWRA Telephone Assessments (or “Full Telephone Assessments”)
- Related Filework Processes and Guidance

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

2.1 Health and Safety

HCPs must comply with all current UK Government COVID (and devolved authority guidance).

HCPs must also comply with all current CHDA Guidance when working in Assessment Centres or when Home working.

HCPs should refer to current CHDA Health and Safety Guidance.

2.2 Technology

HCPs must ensure that when conducting Telephone Assessments, they only use a specific COVID TA phone supplied by CHDA. These phones meet DWP security specifications for Telephone Assessments. **Under no circumstances should HCPs use their personal phone or another work phone that has not been specifically issued for conducting telephone assessments.**

2.3 Proof of Identity Procedures

In both LCWRA TA and LCW/LCWRA TA standard telephone identification processes should be followed as covered in the Proof of Identity Procedures guide. These procedures also apply if there is a requirement to contact a claimant during the course of Filework activities.

2.3.1 When telephoning claimants

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

It is essential you establish the identity of the person to whom you are talking to at the outset. This process should be followed whether contact is made with the claimant or their appointee.

The following script should be used:

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

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

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

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

Having established the identity of the claimant, there is then a need to explain why the telephone call is being made.

2.3.2 Answering machine received when attempting to contact a claimant

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

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

- NINos
- Current or previous addresses
- Information about health conditions
- Their full name
- Dates of birth
- Family details
- Benefit details
- where it is clear that leaving a message would be inappropriate (e.g. clarify certain details about the claimant)

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

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

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

commence this appointment please contact our Help Desk on (local tel number)

2.4 Claimant Groups who are not suitable for a telephone consultation

Through experience of Telephone Assessments and the quality assurance processes in place, it has been determined by the DWP that the majority of claimants can have a Telephone Assessment conducted.

During the Filework Process, the HCP will screen out cases who meet the below criteria.

- Claimants without a phone
- Claimants requiring BSL Interpreters
- Claimants with hearing difficulties unable to use a phone
- Claimants with speech difficulties

This list is not exhaustive and HCP's must use their clinical judgement based upon information held, as to the appropriateness of a telephone consultation.

HCPs should have a low threshold for discussion with colleagues. This may be of particular importance in those with impaired insight.

No claimant with Learning Difficulties or a Mental Health condition with impaired insight should automatically be excluded from having a Telephone Assessment if this is required to provide advice. However; it is important that the following points are considered:

- Filework – Could adequate information be gathered at the Filework stage to allow WCA advice? It is important that appropriate gathering of evidence takes place during Filework, including clarification calls to claimants, in order to appropriately advise where possible at the Filework stage.
- Companion – HCPs should ensure they actively encourage anyone with learning difficulties or impaired insight to invite a companion to join the call. If the claimant asks for the appointment to be rescheduled so a companion can join this should be accommodated. (The appointment letter already encourages companions but this additional step should be taken)
- Where a claimant has an appointee, an assessment must not take place unless the appointee or other suitable nominated person is present.
- HCPs must use their judgement during a TA, as they would have at a face to face assessment, about the ability of the claimant to engage appropriately. In claimants with learning difficulties or impaired insight the HCP should maintain

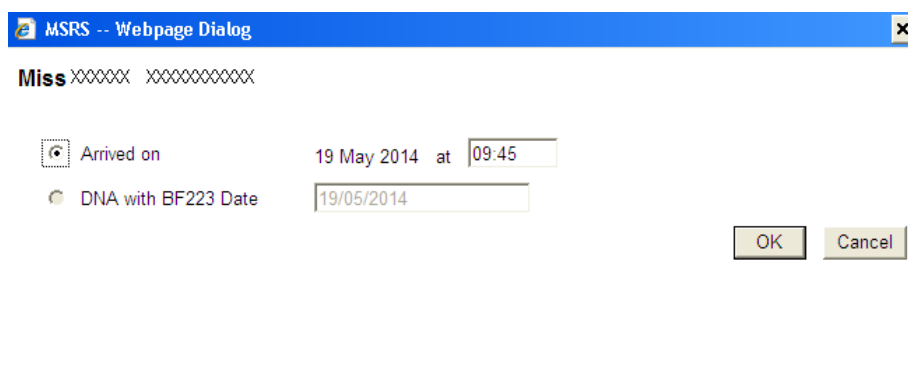
a low threshold to abandon any cases if it is inappropriate to continue. This is a clinical decision. If unsure the HCP should discuss with a CSL or QAL. If an assessment has to be abandoned then the offer of rescheduling with a companion should be made by the HCP. It is likely the numbers of abandoned cases will be low and it is appropriate that the rate is quality assured by the CSLs and QAL.

- There will be a process of ongoing DM and HCP feedback to highlight any issues. Ongoing quality assurance measures will also highlight any issues.

2.5 Commencing the Assessment on LiMA

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

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



The screenshot shows a 'MSRS -- Webpage Dialog' window. At the top, it says 'Miss XXXXXX XXXXXXXXXXXX'. Below this, there are two input fields. The first is labeled 'Arrived on' and contains the text '19 May 2014 at 09:45'. The second is labeled 'DNA with BF223 Date' and contains the text '19/05/2014'. At the bottom right of the dialog, there are two buttons: 'OK' and 'Cancel'.

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

2.6 LiMA Considerations

LiMA does mandate certain sections in the report.

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

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

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

2.7 Neurological Conditions List by Practitioner Type

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

HCPs will continue to only assess conditions they are trained to assess in the current guidelines, i.e. Non neuro, Peripheral neuro or complex neuro. Although there will be no physical examination performed in telephone assessments, the restrictions on conditions the HCP is trained to assess still stand. Where a condition is identified during the course of the assessment that requires a complex neuro HCP, this case will have to be transferred to a complex neuro trained HCP, unless LCWRA advice can be provided for a non neurological condition present.

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

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

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

2.8 Prognosis or re-referral advice

Although we give advice on the balance of probability, in most cases the normal full body of evidence will not be available (observations, examination findings, further evidence) and therefore a 6 month prognosis should be given in cases where evidence is felt to be lacking to some degree but deferral for face to face assessment is not considered appropriate. If however; there is strong evidence that a longer prognosis should apply, for example, previous report confirmed a chronic deteriorating condition

and all evidence gathered in the telephone assessment continue to suggest ongoing deterioration, prognosis advice should be given in line with the evidence. This applies to conditions that have not improved as well as those that have deteriorated.

2.9 Opening Script for Telephone Assessments

A script to use to position Telephone Assessments has been agreed by DWP. This script should be used in both LCWRA only and LCW/LCWRA Assessments.

This script can be found in **Appendix A**.

2.10 The role of a Companion

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

2.11 Appointees

As in Face to Face assessments, any claimant who has an appointee registered on the system cannot be assessed unless the appointee or an authorised suitable alternative person is present. Further details can be found in the WCA Handbook.

2.11.1 TA Appointee Guidance where the claimant is unable to engage with a telephone call.

This guidance applies only where the claimant has an appointee, but the claimant cannot engage with a telephone call even to the minimal level required to simply identify themselves.

At Assessment – it may only become apparent that the claimant cannot engage with a telephone call at the assessment. HCPs should proceed with a TA where -

- the evidence suggests the claimed difficulty with using a telephone is medically reasonable and
- the appointee or a suitable person is able to provide the information.

The report should be annotated with – “TA conducted with (insert name of

appointee or appointee nominated appropriate person) only as (insert name of claimant) is unable to talk on the telephone”

You do not need to see permission from the appointee if you are reasonably satisfied that the person you are talking to, is an appropriate person and they assure you the appointee is aware.

2.12 Face coverings and claimants relying on lip reading

While claimants relying on lip reading may be unable to participate in telephone assessments due to reduced hearing, there may be instances they can participate with the help of a companion/appointee or through telephone equipment they own. They may still however experience significant difficulties in face to face communication with others as a result of the use of face coverings. The following guidance has been agreed by the DWP for those who rely on lip reading.

The following guidance should be read and implemented in conjunction with section 3.3.9 (activity 7) of the Revised WCA Handbook. The handbook guidance is not reproduced here.

1. Given the impacts of COVID-19, and the ongoing government guidance to wear face masks in multiple settings, there are concerns that this will adversely affect those individuals with a hearing impairment who rely upon lip reading as a form of communication.
2. Prior to COVID-19, a claimant who was able to lip read would not meet the scoring descriptor for this activity. However due consideration currently needs to be given to those individuals who report problems with communication due to the fact they can no longer reliably lip read because of the general population wearing facemasks.
3. When addressing activity 7, HCPs must consider whether a claimant who relies on lip reading is impeded in such a way by the use of face masks that they, for the majority of the time, have significant difficulty understanding a simple message from a stranger due to sensory impairment. Given government guidance and the widespread use of masks in line with this guidance, a claimant who relies upon lip reading is currently likely to meet descriptor Hb and have Limited Capability for Work.
4. When completing filework the DWP have defined that due to lack of a previous assessment this only applies to rereferral filework and not initial referrals.

5. Prognosis will need to be considered in line with current and proposed restrictions around the use of face masks and how long the HCP considers the claimant likely to be affected in this area. Assuming no other factors supporting a longer prognosis and given the fact that any change to government guidance cannot be sensibly predicted months in advance, a prognosis period of 6 months is most likely to be appropriate.

2.13 Further Evidence on the Day of Assessment

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

2.14 Unexpected Findings Process Guide

If during the course of the customer contact it is felt that a UE 1 is required, HCPs must ensure that they have explained this to the customer and obtained consent, where possible. HCPs should refer to the UE1 guidance located on the intranet for full details.

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

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

complete a hard copy and return to the BSC where a colleague will post the relevant copies to the GP, customer and retain a copy on file.

2.15 Safeguarding Policy

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

2.16 Follow Up/Welfare Calls

2.16.1 General Claimant Welfare

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

2.16.2 Claimant expresses thoughts of self harm or suicide

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

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

conversation with the claimant and any other actions taken. Ensure that the report includes the claimant's NINO.

2.16.3 DWP Welfare Checks

If a claimant reveals details such as extreme financial difficulties where the DWP may be able to assist, please notify DWP through the procedures outlined in the “Protocol for Illness VCC” within “The Virtual Contact Centre Procedural Guide MED-VCCPG01” available on the knowledge library.

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

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

2.18 Finishing a call

A script to use to end the Telephone Assessment has been agreed by DWP. This script should be used in both LCWRA only and LCW/LCWRA Assessments.

This script can be found in **Appendix B**.

3. Evidence Gathering and Evaluation in the WCA (General principles)

3.1 Overview

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

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

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

You may wish to review the self directed learning document 'Effective Report Writing', available on the internal online knowledge portal, which highlights the principles of good practice in medical report completion.

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

3.2 Key Principles of Critical Evaluation of Evidence

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

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

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

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

Remember there are 5 key types of evidence:

- I. **Medical Knowledge**
- II. **Independent Medical Evidence (IME)**
- III. **Independent Medical Opinion (IMO)**
- IV. **Verifiable Medical Information (VMI) – verifiable medical fact**
- V. **Claimant Provided Opinion (CPO)**

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

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

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

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

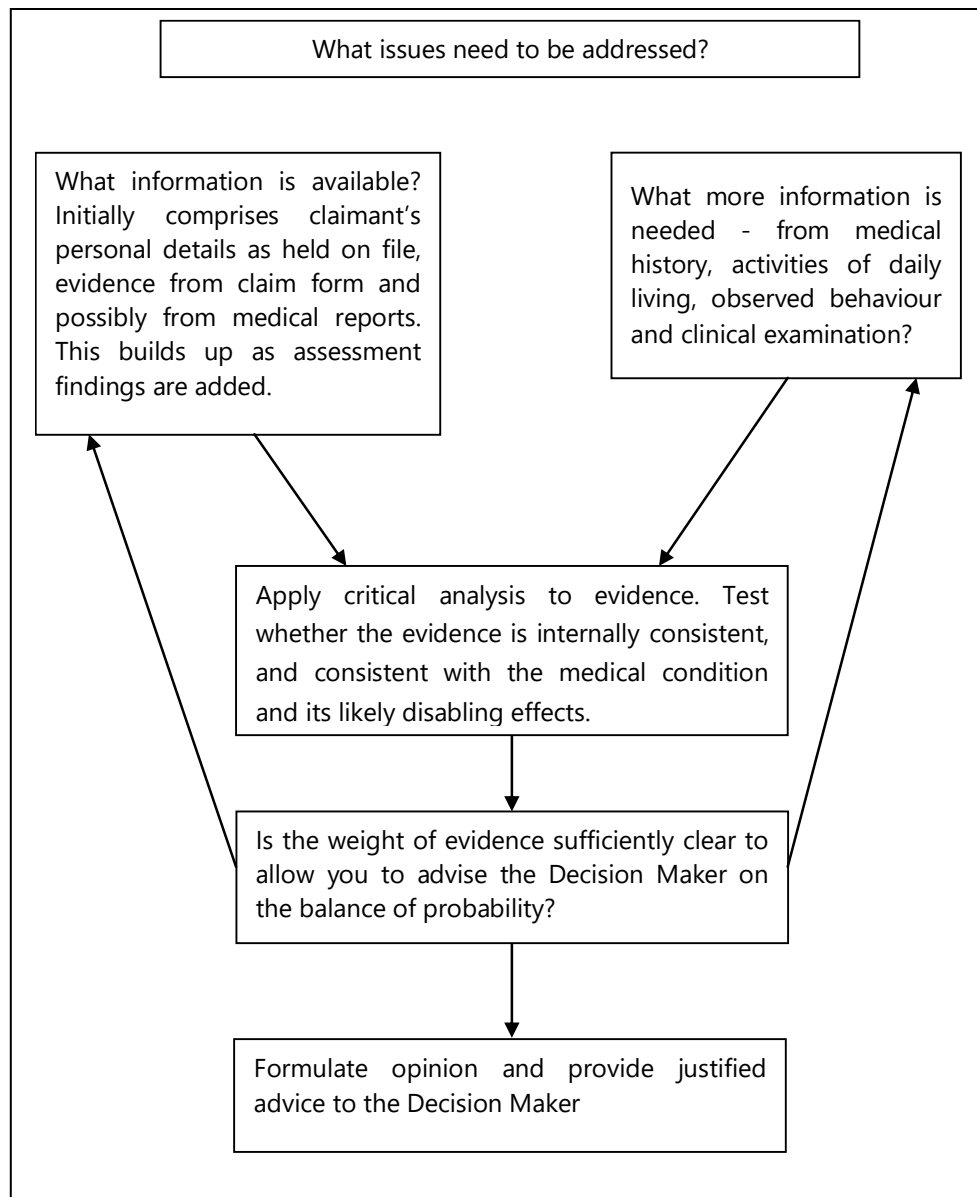
In terms of CPO, VMI and coverage, you and your history taking skills are essential to ensure you have obtained adequate information from the claimant/appointee/companion to allow you to provide advice to the Decision Maker.

Remember that some of the normal evidence you gather such as observations and examination will not be available, so it is essential that you gain as much information as possible and address any inconsistencies in the evidence obtained.

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

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

The Evidence Cycle



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

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

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

3.3 Reminder of Best Practice in exploring the Clinical History

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

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

3.3.1 Customer Care issues

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

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

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

3.3.2 Clinical History Taking (Physical)

You must ensure you obtain details of:

- ☐ Duration and Progression of condition
- ☐ Symptoms
- ☐ Exacerbating or relieving factors

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

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

Other Key points to note in Clinical History:

- **All** conditions stated by the claimant in the questionnaire (ESA50 / UC50), included in the file (WCA55) and during the assessment must be mentioned. There may also be evidence such as previous reports or a MED3 available on the computer programme MSRS, these must also be scrutinised carefully for a note of any conditions not already stated.

NB. If there is a record on MSRS of a questionnaire being returned but it is not included in the WCA55, the assessment should not proceed unless a full search has been completed in accordance with the Misplaced and Missing Files Process Guide (MED – MMFPG01)

- The condition history is one of the key sources of evidence, and should contain sufficient detail to enable the HCP to proceed with the assessment with a broad idea about the likely significance of the condition in relation to the stated disability
- You must take a clear history of each condition, particularly when it is likely to be a source of significant disability. Where there has been improvement, this must be made clear to the DM. A history that is too brief, such as “had bowel surgery 1 year ago” with no further elaboration is unlikely to be helpful to the DM
- In unilateral conditions, the side affected must be specified
- Variability must be addressed fully, not just “2 good days/5 bad”. Variation within the day and what the claimant can and cannot manage during good and bad spells should be explored. The frequency of exacerbations must be discussed and taken into account when providing advice to the DM

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

3.3.3 Clinical History (Mental Function) – Key points

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

You must ensure you obtain details of:

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

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

Key points to note in the Mental Function Clinical History:

- **All conditions stated by the claimant in the questionnaire (ESA50 / UC50), included in the file (WCA55) and during the assessment must be mentioned. There may also be evidence such as previous reports or a MED3 available on the computer programme MSRS, these must also be scrutinised carefully for a note of any conditions not already stated**
NB. If there is a record on MSRS of a questionnaire being returned but it is not included in the WCA55, the assessment should not proceed unless a full search has been completed in accordance with the Misplaced and Missing Files Process Guide (MED – MMFPG01)
- The condition history is one of the key sources of evidence, and should contain sufficient detail to enable the HCP to proceed with the assessment with a broad idea about the likely significance of the condition in relation to the stated disability
- The HCP must take a clear history of each condition, particularly when it is likely to be a source of significant disability. Where there has been improvement, this must be made clear to the DM. A history that is too brief, such as “had psychosis 2 years ago, now fine” with no further elaboration is unlikely to be helpful to the DM
- Self harm / suicide history must be explored in detail – with details including any past history, need for hospitalisation or specialist input, any ongoing self harm, any ongoing suicidal thoughts / plans /intent. This must always be done in a sensitive manner. By telephone, this is extremely important. You must actively listen to what is being said, bearing in mind you will not have the usual non verbal clues to judge their reactions when discussing this. Carefully consider a welfare follow up call or whether the unexpected findings processes must be applied.
- Variability must be addressed fully, not just “2 good days/5 bad”. Variation within the day and what the claimant can and cannot manage during good and bad spells should be explored. The frequency of exacerbations must be discussed and taken into account when providing advice to the DM. This is particularly important in conditions with substantial variability such as Bipolar Illness
- Any exacerbating features or activities which cause a bad spell and any relieving features or activities which cause a good spell must be explored
- Current symptoms and their effect on function should be explored to determine whether activities can be performed safely, reliably, repeatedly, to an acceptable standard and in a reasonable time
- When documenting the diagnosis the most appropriate option on the computer programme (LiMA) should be used. Where conditions are unrelated it is not appropriate to group them together, as an example, it would not be appropriate to group along history of depression and a new diagnosis of dementia.
- When the diagnosis is confirmed, such as Bipolar disorder it is preferable to

record this as 'Bipolar disorder' rather than 'Mental Health problem'

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

3.4 Reminder of Best Practice in exploring the Typical Day History

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

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

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

The typical day history is an integral part of the very important functional history step in disability analysis. By using effective communication techniques, a well-focussed history is vital in the evidence gathering process to assist in completing the WCA

report. The typical day provides an account of how the claimant manages activities on a day to day basis and is personalised for that individual. The focus is on what that individual can and cannot do and how they manage with various activities.

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

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

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

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

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

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

Points to consider when taking a typical day history:

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

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

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

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

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

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

happen if they had to get to an urgent appointment, etc.

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

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

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

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

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

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

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

In Mental Function, someone may have had kitchen accidents and therefore no longer makes meals due to significant problems with concentration. Do they remember not to cook, do they have to leave a message to remind them not to cook or do they completely forget and keep cooking resulting in more accidents?

- If someone has stopped an activity, it is not sufficient to simply state "no longer cooks meals". This does not provide enough information to robustly justify your

advice on function. For example, a person may choose not to cook due to motivation problems, domestic circumstances, cognitive issues, or a number of different physical restrictions.

- Sufficient detail needs to be obtained to avoid making inaccurate inferences about the claimant's functional ability.

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

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

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

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

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

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

- The information obtained from the claimant must be documented as accurately as possible, and extreme care must be taken not to misinterpret or misrepresent what is said by the claimant.
- When documenting the typical day, spelling and grammar must be of a standard that the intent of the message is clear and keeping in mind that what is required is a professional report.
- Concise, spaced paragraphs make it easier to read the report and identify the important details used to justify your opinion on the claimant's function.

- Enquiry into the typical day should be performed in a sensitive manner, probing and exploring activities as necessary, while avoiding irrelevant or third party information. The most effective way to obtain a typical day is to start with open questions and then use more closed questions to obtain further detail and clarification.
- During the typical day it may also become apparent that the claimant has a thought disorder or lacks insight. This needs to be carefully explored and documented to include the effect this has on function.
- Some mental health symptoms are associated with distress. Enquiry into the typical day should be done in a sensitive manner, probing and exploring activities as necessary, while avoiding irrelevant or third party information, and not be so intrusive as to cause distress.

Further information on history taking is detailed later in this document.

4. LCWRA “Yes/No” Telephone Assessments - Specific Clinical Considerations

This section contains information that you may find useful to assist you in conducting “LCWRA Yes/No” telephone assessments.

Remember that in this type of Telephone Assessment, the aim is to identify the most vulnerable claimant who meet LCWRA functional criteria (including eating and drinking) or those who meet “Treat as LCWRA” criteria. (TI/Pregnancy Risk/Cancer treatment/LCWRA Risk).

In this type of Telephone Assessment, all claimants will remain at least on the assessment rate, therefore LCW advice or below threshold advice is not being given in this process.

No fit for work decisions will be made by DWP as a result of a “LCWRA Yes/No” telephone assessment.

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

In LCWRA Yes/No assessments, the information gathered at interview is not initially completed on LiMA. **This information is gathered on an electronic ESA or UC 85 form. (Clerical completion).**

Where the HCP feels they have enough information to advise on LCWRA, they would then transfer the information and complete the report using the LiMA application.

Full details on completion of the “Clerical” WCA 85 are contained in the Document Telephone Assessments – Clerical WCA MED-COVID19TAC~001. A copy of this document is available in **Appendix C**

4.1 General Issues

4.1.1 Clinical Support

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

Remember in this type of assessment – you are considering whether you have adequate information to advise on the LCWRA threshold, i.e. is it met or not. You are not providing specific advice above or below LCW threshold.

The following information is supplied to help you consider areas to explore when conducting a LCWRA Yes/No Telephone Assessment

4.2 Lower Limb Activities

The following information should provide you with brief prompts and issues to consider specifically during a “LCWRA Yes/No” telephone interview.

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

LCWRA Criteria

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

Cannot either

- (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion or*
- (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion*

4.2.1.1 Overview

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

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

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

Walking speed reminder

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

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

4.2.1.2 Areas to consider in history taking:

- ☐ General considerations of condition history and typical day history

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Remember, throughout the pandemic, normal activity has been restricted to varying degrees, so you will have to ensure you cover what an average typical day represents rather than restrict this to the strictest periods of UK Government isolation and social distancing measures.

☐ Musculoskeletal / neurological problems

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

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

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

Example: Generalised arthritis. On regular analgesia. Had right knee replacement 2 years ago, now waiting for left knee replacement (no date for surgery yet). Right knee no longer painful since surgery but still has residual stiffness – cannot bend it more than a right angle, although can straighten it fully. Left knee constantly painful, cannot straighten it fully and cannot even make a right angle when bending it, knee is swollen and tender to touch. It looks twice the size of the right knee. Also has problems with most finger joints – index, middle fingers on left hand; and middle and ring fingers on right hand – joints of fingers themselves are swollen and cannot bend

fingers fully to make a fist. Problem with right elbow – constant pain and stillness, cannot bend and straighten elbow fully without pain, movements restricted to half of what able to complete with left elbow.

☐ Cardiorespiratory problems

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

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

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

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

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

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

How long can the claimant perform an activity for?

How often / how soon can they repeat an activity?

How long do they need to rest after an activity?

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

4.2.2 Standing and sitting - Activity 2

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

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

LCWRA Criteria

Transferring from one seated position to another

Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person

4.2.2.1 Areas to consider in history taking:

- General considerations of condition history and typical day history

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

Ability to toilet independently

Ability to get in/out of car / public transport

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

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

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

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

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

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

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

☐ Musculoskeletal / neurological problems

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

Can they sit for the duration of the telephone assessment?

Remember upper and lower limbs

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

☐ Pressure sores

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

☐ Abdominal / pelvic problems

Any surgery, other treatment

Description of type and site of pain or other symptoms

Relieving or exacerbating factors

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

4.3 Upper Limb

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

4.3.1 Reaching – Activity 3

LCWRA Criteria

Reaching

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

Remember this activity area reflects a bilateral problem and relates to shoulder function and/or elbow function. (WCA Handbook)
Reduced function in the activity may be encountered in a number of musculoskeletal conditions including: frozen shoulder; arthritis; cervical

spondylosis; impingement syndrome; rotator cuff tears; instability and dislocations etc.

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

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

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

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

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

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

- Dressing and undressing (including reaching for clothes on shelves/in wardrobes)
- Hair washing and brushing
- Shaving
- Household activities such as reaching up to shelves; putting shopping away at home; household chores such as dusting; hanging laundry on a washing line
- Leisure activities such as aerobics, golf, painting and decorating

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

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

LCWRA Criteria

Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this Schedule)

Cannot pick up and move a 0.5 litre carton full of liquid

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

(WCA Handbook)

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

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

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

Make sure exploration covers if it is a unilateral or bilateral problem.

Pain may be in one particular joint or more generalised in the limb.

Ask the person to describe in some detail their symptoms. Ask them to describe any weakness in as much detail as possible. If required, ask them to describe any other neurological features such as poor coordination (may describe as clumsiness, tendency to drop things), tremor (shaking and can't pick things up) or loss of sensation etc.

For example:

- Currently having a flare up of rheumatoid arthritis. Describes pain and swelling in hands, wrists and forearms most days. They use wrist splints prescribed by the OT. Fingers swollen at the joints – describes knuckles swollen and the finger joints warm with the ones below the knuckles are swollen big and round. (This is consistent with proximal interphalangeal joint swelling in rheumatoid arthritis). They also describe trigger finger with the finger flexed in position and suddenly snapping back into place. The wrist is also warm too touch and hurts

when moving. Unable to open bottles and jars even with the aids provided by OT. Manages to lift light items like the tea cup and a small pint bottle of milk but daughter leaves the cap off. Describes having to use the speaker phone to take call now as unable to hold the handset for long.

- Previous arm fracture and elbow dislocation (left) with nerve damage. Describes loss of strength in the left forearm since accident. Describes muscle wasting – forearm very small in size compared to the right forearm. Describes the fingers are like a claw as unable to form a fist or move fingers freely. Not much feeling in the in the left hand. In addition unable to straighten elbow out. No problems with the right arm.

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

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

4.3.3 Manual Dexterity – Activity 5

LCWRA Criteria

Manual dexterity

Cannot either:

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

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

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

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

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

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

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

- Filling in forms (e.g. ESA50/UC50, national lottery ticket)
- Use of phones, mobile phones, setting house alarms, light switches
- Paying for things with either cards or cash (Carefully clarify if able to manage contactless payments? Enter PIN? Pick up coins - using pincer grip or has to scoop coin up by pushing off

the edge of counter etc?)

- Coping with buttons, zips, and hooks on clothing
- Cooking (opening jars and bottles; washing and peeling vegetables)
- Leisure activities such as reading books and newspapers; doing crosswords; knitting; Do-It-Yourself jobs
- Driving, including manipulating the fuel cap to refuel a car, using keys to open locks etc.
- Cooking (lifting and carrying saucepans, crockery)

4.4 Sensory Activities

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

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

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

LCWRA Criteria

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

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

Understanding Communication by

- i) *verbal means (such as hearing or lip reading) alone, or*
- ii) *non-verbal means (such as reading 16 point print or Braille) alone, or*
- iii) *any combination of (i) and (ii), using any aid that is normally, or could reasonably be, used, unaided by another person*

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

4.4.1 Overview of key points of the activity areas

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

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

Activity 7: Understanding communication by:

- i) verbal means (such as hearing or lip reading) alone,
- ii) non-verbal means (such as reading 16 point print or Braille) alone, or
- iii) a combination of i) and ii),

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

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

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

- Descriptor considers the ability of an individual to get safely around familiar and unfamiliar locations
- Duration and speed of visual loss is likely to impact on a person's ability to adapt.
- Does the claimant report having a certificate of visual impairment

- Use of aids – glasses, magnifying glasses, hearing books, white or red/white sticks, guide dog

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

4.4.2 Areas to consider exploring

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

- Who completed the questionnaire and why it was not completed by the claimant if completed by another person (For example was the writing on the form too small?)
- Aids – what do they use, are they helpful? Any aids they are not able to use and why? If using aids such as a magnifying glass, how much or how long can they read with this.
- Do they use sign language, Braille or assisted technology? If not why not – have they ever considered it?
- Do they have a CVI? Can they or a companion provide details of any acuity/visual field deficit recorded there?
- Ability to move around indoors – do they trip over things, has the house been adapted. Do they bump into doorways they cannot see to the side of them?
- Ability to self administer medication – taking correct medication, reading dose, taking small tablets, adjusting dose of medication such as insulin
- Ability to drive
- Ability to care for others / pets
- Ability to use public transport (in normal circumstances) – identify public transport vehicles, read bus numbers / information boards / timetables, use ticket machines, ask for ticket, listen for announcements, give destination
- Ability to go out alone - making their way on the street, cross the road safely, navigate around obstacles / people / kerbs

- Socialising with family, friends, neighbours (Under normal circumstances)
- Social events – ability to order at a bar / restaurant, read menu, order a take away
- Hobbies - reading, television, art work, craft work, sports. If reading – do they know what text size is used on phone/kindle/tablet etc

RNIB guidance indicates the following

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

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

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

4.4.3 Some conditions to consider

Glaucoma / cataracts

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

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

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

Traumatic Brain injury (complex neuro)

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

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

4.5 Continence

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

LCWRA Criteria

At least once a week experiences (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device; sufficient to require the individual to clean themselves and change clothing

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

4.5.1 General Points

- Problems with incontinence to be taken into account only whilst the person is conscious / awake.
- Risk of incontinence – has to be high for majority of the time
- Mobility issues may be taken into account, but only when there is a bladder / bowel problem, not simply the mobility problem alone
- Sensitive and careful exploration is required
- Clarification is required for any issues mentioned by claimant to determine whether this is a longstanding issue, whether it is related to their medical condition, or whether the issue relates to current restrictions (for example need for self isolation, stay at home advice, etc.)

4.5.2 Areas to consider in history taking:

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

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

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

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

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

Are there any aggravating or relieving factors?

How often is it happening?

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

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

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

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

Have they spoken to their GP about this?

Have they been given a formal diagnosis?

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

Have they been referred for any specialist advice?

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

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

Have they required any hospital inpatient or outpatient treatment?

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

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

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

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

4.6 Consciousness during Waking Moments

4.6.1 General Points

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

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

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

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

4.6.2 History – Key points

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

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

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

- If any recent hospital /clinic letters ask for if willing to share (read out) and record details
- How does the condition affect day to day function? – Any problems washing, cooking, going out alone, participating in any hobbies or sports, caring responsibilities, etc
- Do they wear any medical alert jewellery or cards?
- Have they been advised not to drive or work at heights / close to machinery / etc?

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

4.7 Mental Function

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

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

Key points for Mental Function Activity Areas

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

Activity 11 – learning tasks

- Completion of a simple, moderate or complex task
- Learn and retain information

- Consider how long taken to learn a task

LCWRA Criteria

Learning tasks

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

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

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

LCWRA Criteria

Reduced awareness of everyday hazards leads to a significant risk of:

- (i) *injury to self or others; or*
- (ii) *damage to property or possessions, such that they require supervision for the majority of the time to maintain safety*

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

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

LCWRA Criteria

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

Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions

Activity 14 - Coping with change

- Change to normal routine

- Inability to cope which significantly alters day to day life

LCWRA Criteria

Coping with change

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

Activity 15 – Getting about

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

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

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

LCWRA Criteria

Coping with social engagement, due to cognitive impairment or mental disorder

Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual

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

- Difficulties in social behaviour
- Needs to be evidence of a disorder of mental function

LCWRA Criteria

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

Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited

behaviour that would be unreasonable in any workplace

4.7.1 Areas to consider exploring in the history:

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

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

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

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

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

- Who completed the questionnaire and why it was not completed by the claimant if completed by another person
- Getting washed and dressed – complete independently, appropriate clothing, dressed in correct order
- Ability to self administer medication – taking correct medication, reading dose, taking small tablets, adjusting dose of medication such as insulin
- Ability to learn new tasks – what, complexity, time span, how often need to be

shown and length of recall, repeat the action

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

Self harm / suicide history –

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

4.7.2 Some scenarios to consider:

Severe depression (personal action)

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

Anxiety (difficulties going out)

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

Psychosis (appropriateness of behaviour)

Remember it is possible that a person may have psychosis that was not evident at the Filework stage and you may find yourself on a call with a person experiencing psychotic symptoms. Carefully consider whether if this is uncovered during a telephone assessment whether continuing is appropriate. In all cases, ensure only enough information to advise on LCWRA is gathered to minimise the duration of the call thus reducing any stress on the claimant. Always consider whether a UE1 is required or a welfare check.

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

4.8 Treat as LCW/LCWRA Criteria

4.8.1 Treat as LCW

Not applicable in “LCWRA Yes/No” Telephone Assessments

4.8.2 Treat as LCWRA

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

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

Some specific considerations are detailed below:

Terminal Illness

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

Questions regarding terminal illness must be asked sensitively and if a

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

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

Chemotherapy/ Radiotherapy

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

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

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

Pregnancy Risk

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

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

Mental/Physical Risk LCWRA

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

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

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

Eating and drinking

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

5. LCW/LCWRA Telephone Assessments -Specific Clinical Considerations

5.1 Background

In addition to the “LCWRA Yes/No” telephone assessments that were initially introduced during the COVID 19 pandemic, the DWP agreed to extend the use of Telephone Assessments to include advice on all levels of disability.

Therefore in LCW/LCWRA Telephone Assessments advice can be provided on:

- Evidence suggests LCWRA threshold is met
- Evidence suggests LCW threshold is met
- Evidence suggests LCW threshold is not met (below threshold)

Through extensive review, feedback and audit, DWP has determined that “all outcomes” advice can be provided on the balance of probability in the majority of cases. It is however acknowledged that in some cases advice cannot be provided without additional evidence such as a clinical examination. Advice on this situation is detailed in Section 5.3 below.

5.2 Evidence Gathering in “All Outcome” WCA Telephone Assessments

The key factor in the provision of quality advice is a detailed history that carefully explores and clarifies levels of function in all areas.

Evidence gathering as detailed in section 3 of this document remains critical to the provision of advice and HCPs must ensure the level of detail of information gathered is sufficient to provide robust advice in the absence of other strands of evidence such as physical examination and visual observations that would be available in a face to face setting.

Details of prompts for evidence gathering through history taking are contained in Appendix D

An Aide Memoire for History taking to assess Substantial Risk is provided in Appendix E

A copy of the Mental State Examination in Telephone Assessments can be found in Appendix F.

You should regularly refresh your knowledge of the content of Appendices D-F.

5.3 Situations where WCA Advice cannot be provided following a Telephone Assessment

It is acknowledged by DWP and CHDA that there may be some unusual situations where advice cannot be provided without recourse to a face to face assessment to allow further evidence gathering.

To accommodate these situations guidance has been issued and changes to LiMA have been made to allow certain reports to be held on the system, awaiting a face to face assessment. These are detailed below.

5.3.1 LiMA Considerations

When you reach the 'authorise and accept' page you will see a question asking if the exam is complete.

When conducting a Telephone assessment:

- TICK YES if you are content that you can provide advice to the Decision Maker that the evidence suggests:
 - they meet LCWRA criteria (including risk)
 - they are over threshold for LCW (including risk and any treat as LCW category)
 - if they are below threshold and you are confident that you can provide advice on the balance of probability to the Decision Maker that the client does not meet the LCW threshold.
- TICK NO for any case that the evidence suggests below threshold advice may be possible, **but you do not feel the evidence is robust enough to advise that a face to face assessment is required.** (You must follow the guidance in the next section before you can indicate advice is incomplete and a face to face assessment is required).
- When conducting a face to face assessment you will ALWAYS tick YES

The screenshot shows a web browser window titled 'WCA Exam - Internet Explorer'. The address bar shows 'UC: 2013 Regulations'. The page has a blue header with the 'LiMA' logo. Below the header is a navigation bar with 'Goto', 'Exam', 'Session', and 'Help' tabs. The main content area is titled 'Review and Confirm' and contains a list of links on the left: 'Client / Examination Information', 'Medical Condition & Treatment', 'Description of Functional Ability', 'Medical Opinion - Physical', 'Medical Opinion - Mental Health', 'Exceptional Circumstances', 'LCWRA', 'Assessment Summary', 'Prognosis', 'Medical Examination Findings', 'Harmful Information', and 'Authorise & Accept'. The 'Authorise & Accept' link is selected. The right side of the page shows the 'Medical Report' section, which includes 'Authorise and Accept' and 'Timing' information. The 'Timing' section shows 'Report started: 11:48:11 - 2/11/2020', 'Examination started: 11:48:20 - 2/11/2020', 'Examination ended: 11:49:15 - 2/11/2020', 'Report completed: 11:51:01', and 'Report duration: 00:02:44'. Below this is a section for 'Is the exam complete?' with radio buttons for 'Yes' and 'No'. There are also checkboxes for 'Spelling' and 'Grammar'. A 'Complete' button is at the bottom right. The browser's status bar at the bottom shows the time as 11:51 and the date as 02/11/2020.

5.3.2 Process for advising a Face to Face Assessment is required in below threshold cases

- You may not be able to make a recommendation which requires further advice if you're not confident in a below threshold outcome if there is contradictory evidence and it cannot be reconciled without the addition of observation and examination. Remember, the level of evidence required is always balance of probability, and all cases where F2F is being considered must be discussed with a CSL or QAL. It is expected that cases where observation and/or examination are required to advise below threshold would be rare.
- As a result, a HCP must contact a CSL for CSD advice on all cases where they want to advise the customer requires a F2F assessment.
- You must not select the 'requires F2F' option without CSD advice from your CSL.
- For audit purposes, the HCP must write in block capitals the name of the CSL who provided the advice and the date the advice was given on the proforma below the outcome section.

- Each day a report will be produced and sent to the QALs listing those cases that have been selected by the HCP as requiring a further F2F assessment. The list will indicate whether CSD advice has been provided.
- A full audit must be completed if the case is not indicated as having CSD advice, and feedback will be provided to either the HCP or CSL.
- It is important the CSL completes the CSD advice manager for each case.

5.3.3 Audit Process

- All HCPs who have completed the areas of support scheduled in January/February can complete the below threshold recommendation on all cases.
- These HCPs will be on 100% audit collection to enable audit of the below threshold recommendations.
- The HCPs can only be removed from audit once the HCP/ACM/CSL/QAL are confident that the HCP is confident with completion and quality of the assessment. The final approval is made by the QAL.
 - What a QAL/CSL/ACM will be looking for when quality assuring a HCP:
 - Pattern of Audit – not necessarily a run of A grades but a C in a batch would prevent approval.
 - Is the HCP confident in the process?
 - Are they approaching CSD for regular advice?
 - How often is the HCP recommending that a customer requires a F2F assessment, as these should be minimal.
- Further audit with DWP through the Quality Gateway will also be in place to ensure a comprehensive quality assurance process is in place.

6. WCA Telephone Assessment -Specific Filework Considerations

6.1 Introduction

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

This section outlines the filework process to follow during this period.

The process is designed to work with both office based and home working.

There is a requirement at filework to identify those suitable for a telephone assessment if the filework output is call to exam. That process is covered here.

This guidance cannot cover every eventuality. It is important that at any point the HCP is unsure they discuss with their support colleagues. In the first instance discussions should be with the CSL or QAL. If the situation remains unresolved then they can escalate to CALs.

This process is based upon current government advice and is subject to change.

6.2 Key Principles

Contacting claimants by telephone is allowed within current guidelines. This guidance introduces a process to gather clarification direct from the claimant.

Standard telephone identification processes to be followed as covered in Proof of identity procedures guide.

Unexpected findings, unacceptable behaviour and safeguarding policies are unchanged.

If uncertain – the situation should be discussed with an appropriate colleague.

This guidance will be shared with the DWP and the IA.

DWP require us to request FME where it is appropriate, however this guidance should reduce the amount that is necessary.

It is important to remember in our advice the level of proof is balance of probability not absolute proof.

All filework actions should be completed on LiMA and all telephone calls recorded on the FRR4.

During this period for any advice justification or on an FRR4, COVID should be written at the start of the FRR4 or justification on a filework output.

It is likely to be useful to understand if an output was completed during this pandemic when the claimants benefit comes up for review in future and it is not possible to put in an automated fix quickly.

Whilst we are not carrying out face to face assessments, all filework options remain valid including call for telephone assessment. How assessments are managed is not a practitioner concern during the filework process.

6.3 Filework guidelines

The general principles laid out in the WCA Filework Guidelines document apply.

It is important to remember that absolute proof is never required, we are advising on balance of probability.

Refer to the filework guidance.

Remember the five fundamental areas of documentary evidence and provide advice based upon the strongest evidence. (See section 1 of this document for further information).

All filework options remain available.

- Medical Knowledge: The guidance is unchanged
- Independent Medical Evidence (IME): This may or may not be available in the file.
- Don't forget that IME may also be taken from a previous, well-completed and justified Work Capability Assessment report.
- Independent Medical Opinion (IMO): This may or may not be available in the file.
- Verifiable Medical Information (VMI): This may already exist within the file or on MSRS. You may be able to supplement this with an appropriate call to the claimant.
- Claimant Provided Opinion (CPO): Again this may be supplemented during a call to the claimant.

6.4 Overview of temporary COVID-19 Filework FE process

- HCP reviews claim and using this guidance document to decide if it is suitable to obtain FE from customer.
 - If not suitable, HCP continues to follow normal Filework actions
 - If suitable, HCP checks if a telephone number is available.
- If a telephone number is not available, HCP should annotate case and pass back to Administrator.
 - If telephone number is available, HCP should attempt to call customer to obtain 'verbal FE' using FRR4
 - If customer is not available and requires a call back outside of session parameters, annotate case with details and pass to Administrator
- If customer does not wish to provide detail, HCP should continue with normal Filework actions

6.5 Making calls to claimants

Do not request FME until consideration has been given to whether a call to the claimant could clarify enough to allow advice to the DM.

The aim of any call is to clarify details that may then allow the HCP to advise. It is NOT the intention at this stage to clarify every area nor to complete a telephone assessment.

Any call should be short with a few focused questions.

If it is felt a call is inappropriate or unlikely to yield information allowing advice, then currently the DWP would still expect FME to be requested where appropriate within current guidelines.

Before requesting FME, HCPs must ensure it really is necessary and likely to answer the questions required. It is not acceptable to default to FME where a call may help the HCP advise, or when the correct outcome is call to exam.

6.5.1 When calling claimants

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

proof of identity procedures guide.

It is essential you establish the identity of the person to whom you are talking to at the outset. Details of scripts to be used are detailed in Section 1 of this document.

6.5.2 Suitable Contacts:

- Appointee – only call if appointee is an actual person acting as an appointee and not the council or a lawyer
- Claimant – if appointee in place then the claimant must **NOT** be contacted. Information should be obtained from the appointee

6.5.3 TA Appointee Guidance where the claimant is unable to engage with a telephone call.

This guidance applies only where the claimant has an appointee, but the claimant cannot engage with a telephone call even to the minimal level required to simply identify themselves.

- Where the Filework practitioner is advising call to exam-
- File to be reviewed by CSL or QAL who must agree that it is not possible to advise without a TA.
- If the evidence suggests the claimed difficulty with using a telephone is medically reasonable then a TA with the appointee only can be undertaken.
- The Filework output should be annotated with – “Claimant unable to engage with telephone call, appointee only assessment has been agreed”

6.5.4 Claimant Groups who should not be contacted to clarify information from a brief phone call

This list is not exhaustive and the HCP must use their clinical judgement on information held on the appropriateness of a telephone call to the claimant. It is possible that some of these categories may only become apparent once you have made the call. In these cases you should use your skills as an HCP to politely terminate the call.

- Claimants without a phone by definition are excluded from this process
- Claimants requiring BSL Interpreters
- Claimants with hearing difficulties unable to use a phone

- Claimants with speech difficulties

Please note that in claimants who express suicidal thoughts or self harm, a clarifying call may be more appropriate than a call to assessment. However careful consideration should be made as to the appropriateness of such a call on a case by case basis. If in doubt this should be discussed with a senior colleague.

6.5.5 Recording of Evidence

The FRR4 will be used to record the content of any call. There will be a requirement to that this advice was provided under emergency COVID measures by putting the word “COVID” in the FRR4

Where a 113 is returned the BAU process will be followed.

6.6 Types of Filework referrals

6.6.1 Files currently at workstack (FME already requested)

Consider whether there is there another option to the requested FME?

For example

- 113 requested but client address is a care home – a call could be made to care home manager.
- Clarification on Braille could be achieved with a call to the claimant, where this information could allow LCWRA decision
- Additional key information from claimant/appointee may allow a decision to be made

6.6.2 Initial Referrals

Without a previous report, fully justified advice options may be more limited with less evidence available.

There still may be an opportunity to obtain minor clarifications such as dates of admission, level of care etc. to allow LCWRA/Treat as LCWRA/Treat as LCW advice.

It is essential to consider the diagnosis and any potential vulnerability that may suggest direct contact with the customer would be inappropriate. It may be more appropriate to contact the GP or another healthcare provider noted in the

questionnaire. For example, if the customer has a history of a severe mental illness, such as Schizophrenia, make every effort should be made to obtain further evidence from either their appointee or other appropriate source.

Where there is concern over suicide/ self harm issues it is essential to carefully consider whether a call to the client is appropriate. If there is any doubt, the situation should be discussed with an experienced clinician.

6.6.3 Re-referral Scrutiny

6.6.3.1 Accept ongoing Functional LCW

Areas HCPs may be able to address from a few careful clarification questions include:

Mental Health – previous assessments above threshold e.g. getting about, social engagement - no LCWRA stated on questionnaire – phone call could be made to claimant to confirm static condition. A few questions could clarify that LCWRA is not applicable in conjunction with questionnaire.

Continence – Previously LCW for monthly continence. Clarifications should be made on ongoing frequency, changes to condition/management, use of pads and establishing LCWRA does not apply.

Consciousness – Previously LCW- may have to confirm if continence claimed as a result of seizures. In terms of consciousness the very rare occasions where physical risk may have to be considered could be explored through condition management, recent investigations, level of carer support etc.

6.6.4 Treat as LCW

6.6.4.1 Substantial Risk

Where there is concern over suicide/ self harm issues please carefully consider whether a call to the client is appropriate. If you are in any doubt please discuss with an experienced clinician.

6.6.4.2 Regular Treatment

A call could be made to the claimant to allow information to be gathered on frequency of treatment etc.

6.6.4.3 Recovery from treatment

A call to the claimant or appointee may help to ascertain extent of surgery, any complications and progress.

6.6.4.4 Exclusion through Public Health Order

COVID itself may bring about an increased frequency of use of this treat as LCW criteria by decision makers. Calls simply to ask if someone has been diagnosed or think they have COVID-19 are unlikely to be helpful.

6.6.4.5 Pregnancy (confinement)

A call may be required to clarify EDD. (ESA only)

6.6.5 Functional LCWRA

Mobilising – where there were severe issues before, medical knowledge of the condition and likely progression or improvement with treatment along with a few pertinent questions over the telephone may allow advice.

Note that observations of being breathless whilst talking on the phone are valuable pieces of evidence to consider alongside the other available evidence. Ensure the nature of the condition and potential for change is fully considered whilst formulating advice.

Previous LCWRA for Upper Limb Function:

If questionnaire is unclear, a few questions may help clarify if any real improvement likely for example at last assessment joint replacement discussed.

Learning Disability- previous LCWRA – No Questionnaire – contact appointee to confirm no change.

Other severe enduring mental health conditions where functional LCWRA previously applied, details from appointee or claimant may confirm ongoing problems or even further deterioration. Care must be taken to sensitively explore any mental health issues.

6.6.6 Treat as LCWRA

6.6.6.1 Pregnancy Risk

Previous reports may indicate pre-existing health problems that may influence Pregnancy risk advice. E.g. Heart disease or MH. Brief clarifications may allow pregnancy risk advice- level of input etc. May also be to clarify the current pregnancy and complications such as placenta praevia/level of care etc.

6.6.6.2 Recovery from Chemo and Radiotherapy

Previously LCWRA – sometimes questionnaire not fully completed. Further detail

may clarify issues ongoing.

6.6.6.3 Eat/Drink

Clarification may confirm level of care in situations such as anorexia where LCWRA applied before or Peg tube feeding etc.

6.6.6.4 TI

Phoning the client in terms of TI claims would be inappropriate. Normal DWP processes should be followed.

6.6.6.5 LCWRA Risk

Where there is concern over suicide/ self harm issues carefully consider whether a call to the client is appropriate. If in any doubt HCPs should discuss with an experienced clinician.

6.7 Screening appropriate cases for a full telephone assessment

Where the filework outcome is call to exam, a process is required to select cases appropriate for a telephone assessment.
This applies to:

- Existing referrals that are currently awaiting an assessment
- New referrals where the filework outcome is call for assessment
- Existing referrals awaiting a face to face assessment will require review.
(Cases will be sorted and allocated by administration colleagues).

HCPs completing filework must ensure their justification explains who is suitable or not suitable and split all call to exam files into a suitable and non suitable bundle, identifying these cases for administration colleagues.

6.7.1 Claimant Groups who are not suitable for a telephone consultation.

Please see Section 2.2 for details of claimant groups who are not suitable for telephone assessments.

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6.8 Filework Sift of Cases for Potential LCWRA

This activity can be conducted by non-Filework trained clinical colleagues to quickly

select cases where LCWRA could potentially be advised following a telephone Assessment.

LCWRA (Risk) cases.

Where the evidence strongly suggests a high-risk mental health diagnosis with self-harm and suicidal ideation these cases should be made available to a Filework practitioner who will attempt to obtain FE in order to correctly advise. The Filework CSL should track these cases and liaise with QAL.

- Personality Disorders
- Eating disorders
- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Dissociation and dissociative identity disorder (DID)

Resources for sift advice

- CSL
- QAL
- CAL
- Experienced Filework practitioner. (Please attempt to contact a CSL in the 1st instance)

6.8.1 Categorisation of Sift Cases

Sift cases can be categorised in to two groups.

Category 1 – Likely LCWRA at telephone assessment

This applies only where all other options have been exhausted and file cannot be dealt with using COVID 19 filework process.

If Further Evidence has not been returned, or contains limited functional information, and previous attempts to contact GP or other care giver has been unsuccessful the HCP carrying out the sift should first identify via MSRS the Previous exam output or Filework output where the advice indicates severe restriction and current questionnaire suggests no improvement or worsening.

In the case of a new claim where there is no previous history of a previous exam or Filework output and severe restriction is indicated in the claim pack, then consideration needs to be given to the diagnosis, medication and level of input (i.e. specialist input/frequent GP input) for condition, needs to be medically consistent. Included within the option would be severe mental health conditions are likely to meet support group criteria.

This list of medical diagnosis is not exhaustive but is focused on those common conditions that are likely to lead to advice of LCWRA.

- Heart disease/Heart Failure/Angina/Chest Pain
- COPD
- Pulmonary Disease
- Huntington's Disease
- Multiple sclerosis
- Parkinson's Disease
- Stroke/CVA
- Cystic Fibrosis
- Brain Injury
- Cerebral Palsy
- Rheumatoid Arthritis/Osteo Arthritis
- Fatigue (Chronic) (Fibromyalgia)
- Motor Neurone Disease.
- Muscular Dystrophy
- Polio
- Spinal Injuries.
- Paraplegia
- Severe Incontinence
- The presence of multiple medical conditions which could severely compound level of function
- Blindness/Partially Sighted
- Profound Learning disability
- Cancer

- Residency i.e. Care Home/Hospital
- Appointee
- Psychotic illness
- Bipolar Affective Disorder
- Severe Depression
- Eating disorders

Category 2 – All other cases i.e. LCWRA advice is unlikely or low probability.

All other options have been exhausted and file cannot be dealt with using COVID 19 filework process.

Previous Risk LCWRA may now fulfil Risk LCW.

Always consider if other 'special circumstances' are suggested in the questionnaire.

Appendix A Opening Script for Telephone Assessments

The following script should be used for LCWRA only and LCWRA/LCW TA

☐ Commencing a call

The following form of words should be used

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

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

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

Today we will undertake a Work Capability Assessment by telephone. We may not be able to get as much information as we could from a face-to-face assessment and we may not get enough to make a recommendation. However, we are doing our best to make recommendations where possible.

If we are unable to make a recommendation following your telephone assessment, your benefit will continue until DWP make a decision or let you know that your benefit is due to end and we will invite you to a face-to-face assessment as soon as we can.

Appendix B Closing Script for Telephone Assessments

The following script should be used for LCWRA only and LCWRA/LCW TA

☐ **Finishing a call**

The following script should be used:

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

When I review your report, I may not be able to make a recommendation about your capability for work without seeing you face-to-face. If this happens, your benefit will continue until DWP make a decision or let you know that your benefit is due to end and we will invite you to a face-to-face assessment as soon as we can.

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

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

Thank you again for the time today.

Appendix C Clerical Completion of ESA 85 reports in “LCWRA Yes/No” cases



Telephone
Assessments - Clerical

Appendix D Best Practice in History Taking in Telephone Assessments



Appendix D - History
taking in TA .docx

Appendix E Mental State Examination in Telephone Assessments



Appendix E - MSE in
TA.docx

Appendix F Substantial Risk History Taking Aide Memoire



Appendix F -
Substantial Risk Histo

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: Centre for Health and Disability Assessments
Clinical Training Team
Room 236 2nd Floor
Five Ways House
Islington Row Middleway
Birmingham
B15 1SL