

Training and Development Unit

Guidance for Examining Medical Practitioners

MED/S2/EMP~0010

Version: 5 Final
2 November 2004

Copyright of Atos Origin UK Ltd 2003.

The copyright in this work is vested in Atos Origin UK Ltd and the information contained herein is confidential. This work (either in whole or in part) must not be modified, reproduced, disclosed or disseminated to others or used for purposes other than that for which it is supplied, without the prior written permission of Atos Origin UK Ltd. If this work or any part hereof is furnished to a third party by virtue of a contract with that party, use of this work by such party shall be governed by the express contractual terms between the Atos Origin UK Ltd company which is a party to that contract and the said party.

Document control

Superseded documents

Version history

Version	Date	Comments
5 Final	2 November 2004	Signed off by MP&CT
5c	28 September 2004	Update following Train The Trainer
5b	8 September 2004	Formatting
5a	1 July 2004	Updates by Dr Steve Forman
4	27 February 2004	Update to Atos Origin Template
3d	22 February 2000	Return from IMPACT – amendments incorporated.
3c	December 1999	Input from Client Liaison Group, Adrian Roberts, Processes and Procedures, Dr Peter Dewis (DSS Medical Policy Group), Sharon Miller (DCBD)
3b	September 1999	Return from QA - amendments
3a	March 1999	Amendments by S Smith

Changes since last version

Outstanding issues and omissions

Issue control

Author: Medical Training and Development Team

Owner and approver: Dr J Wintle

Signature: _____ **Date:** _____

Distribution:

Contents

<i>Section</i>	<i>Page</i>
Document control	2
Contents	3
1. Abbreviations	9
2. About this Guide	10
3. The Department for Work and Pensions (DWP)	11
3.1 Introduction	11
3.2 Structure of the DWP	11
4. Medical Services	13
4.1 Introduction	13
4.2 Role of Medical Services	13
4.3 Conditions of work	14
4.4 Professional Standards	14
5. The Role of the Examining Medical Practitioner	15
5.1 Introduction	15
5.2 Training and approval	15
5.3 Ongoing training	16
5.4 Auditing of reports	17
6. Main features of Disability Living Allowance and Attendance Allowance	18
6.1 Disability Living Allowance (DLA)	18
6.2 Attendance Allowance (AA)	18
6.3 Decision making	18
6.4 Self Reporting	19
6.5 Disability criteria	20

6.6	Personal care	20
6.7	Three rates of the care component	20
6.8	Mobility Problems	21
6.9	Attendance Allowance	22
6.10	Qualifying periods	23
6.11	Terminal illness cases	23
6.12	Children under the age of 16	24
7.	Factors considered by the Decision Maker - Care	25
7.1	Severe disability	25
7.2	Attention	25
7.3	Supervision/watching over	26
7.4	The main meal test	26
7.5	Are the needs reasonable?	27
7.6	Age	28
7.7	Aids to help the disabled	28
7.8	Day or night supervision/attention	28
7.9	Children	28
7.10	Variable needs	29
8.	Factors considered by the Decision Maker- Mobility	30
8.1	Unable or virtually unable to walk	30
8.2	Exertion	31
8.3	Amputations	31
8.4	Walking aids	31
8.5	Deafness and blindness	31
8.6	Severe mental impairment	32
8.7	Guidance and supervision	33
8.8	Intermittent problems	33

8.9	Children	33
8.10	Benefits of getting out and about	33
9.	Equal Opportunities and other legislation	34
9.1	Equal Opportunities Policy	34
9.2	Race Relations Act 1976	34
9.3	The Sex Discrimination Act 1975	34
9.4	The Rehabilitation of Offenders Act 1974	35
9.5	The Disability Discrimination Act 1995	36
10.	Reports from Examining Medical Practitioners	38
10.1	Administrative Arrangements	38
10.2	Telephone contacts with Claimants	39
10.3	Identification of the Claimant at the Assessment	41
10.4	Abortive Visits	42
10.5	The Claimant Refuses You Entry	42
11.	Recommended approach to Disability Assessment	43
11.1	Comparison of role of Clinicians and Disability Medical Analysts	43
11.2	Disability Analysis in DLA/AA	44
11.3	Definitions of Disability and Impairment	45
11.4	Mental state	45
11.5	Availability of a carer or chaperone	45
11.6	Access to the EMP report	45
11.7	Unexpected findings (see Appendix E)	45
11.8	Additional information	46
11.9	Audio or video taping of examinations	46
12.	Risk management of problem situations	47
13.	The nature of the reports	49

13.1	Introduction	49
13.2	General reports	49
13.3	Specific reports	49
14.	Completion of reports	50
14.1	Introduction	50
14.2	Harmful, embarrassing and confidential information – General	50
14.3	The EMP report form	52
14.4	Aborted Visit (No report provided)	53
14.5	Non Aborted Visit (Report Incomplete)	54
14.6	Special Need Requirement	54
14.7	Taking and writing the claimant's statement	55
14.8	EMP Reports Completed by a Third Party	56
14.9	General reports	57
14.10	Good assessment techniques	57
14.11	Personal descriptions in medical reports	60
14.12	Examination	63
14.13	Physical Examination in EMP Assessments	63
14.14	Your opinion	64
14.15	The Assessment of Mobility	65
14.16	Duration of mobility need	67
14.17	The Assessment of Care Needs	67
14.18	Duration of care needs and prognosis	69
14.19	The Assessment of Chronic Fatigue Syndrome (CFS)	69
14.20	Variability of Conditions	71
15.	Assessing Quality of Service	74
15.1	Claimant satisfaction	74
15.2	Integrated Quality Audit System (IQAS)	74

16. Complaints	77
16.1 Definition of a complaint	77
16.2 Why are complaints important?	77
16.3 The complaints procedure	77
16.4 Customer Relations Team (CRT)	79
16.5 Complaints and the Examining Doctor	79
16.6 Escalation of a complaint	82
16.7 Independent Tier	82
16.8 Serious Complaint Investigation Team (SCIT)	83
Appendix A - Medical Services Professional Standards	84
1) Personal Conduct	84
Appendix B -Professional Standards - Disability Living Allowance and Attendance Allowance	87
Appendix C - Attributes for examinations in DLA/AA	88
1) Definition and interpretation of generic attributes	88
2) Presentation and Process Attributes	90
Appendix D - Abortive visits - AV1/AV2 forms	92
Appendix E -Unexpected Findings – Disclosure of clinical information by Medical Advisors to Claimants’ General Practitioners	97
1) Introduction	97
2) General Medical Council Guidance	97
3) Procedures for dealing with unexpected findings when the claimant provides written informed consent	98
4) Guidance for contacting the claimant’s doctor	98
5) Procedures for dealing with unexpected findings when the claimant refuses consent to release information	99
6) General Procedural Guidance	100

7) Customer Service Desk (CSD)	101
8) Unexpected findings arising during the course of file work	101
Appendix F - UE1 (Rev), POID 1 & UE 2	103
Acceptable Forms of Identification	105
Appendix G - Process Map	107
Observation Form	109

1. Abbreviations

AA	Attendance Allowance
CMA	Chief Medical Adviser
CMO	Chief Medical Officer
CMS	Complaints Management System
CRT	Customer Relations Team
DBC	Disability Benefits Centre
DBU	Disability Benefits Unit
DCS	Disability and Carer Service
DLA	Disability Living Allowance
DLAAB	Disability Living Allowance Advisory Board
DM	Decision Maker
DWP	Department for Work and Pensions
EMP	Examining Medical Practitioner
GP	General Practitioner
ICA	Invalid Care Allowance
MM	Medical Manager
MSEC	Medical Services examination centre
MEC	Medical Examination Centre
NDA	Nestor Disability Analysts
NINO	National Insurance Number

2. About this Guide

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

This Guide provides information on the following topics:

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

3. The Department for Work and Pensions (DWP)

3.1 Introduction

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

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

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

Attendance Allowance still continues for people over 65.

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

3.2 Structure of the DWP

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

- Jobcentre Plus** – helps people of working age to find work and receive the benefits to which they are entitled
- Appeals Service** – An independent tribunal body and its administrative function
- Disability and Carers Service**

3.2.1 Disability and Carers Service (DCS)

The DCS was formed in April 2002 from the Disability and Carer Benefits Directorate. It is divided into:

- 11 Disability Benefit Centres (DBC's)** (Birmingham, Bootle, Bristol, Cardiff, Edinburgh, Glasgow, Leeds, Manchester, Newcastle, Sutton and Wembley)
- Disability Benefit Unit** (Blackpool)

- Invalid Care Allowance Unit** (Preston)
- Vaccine Damage Payment Unit** (Preston)
- Disability Modernisation Programme** with other directorate support services (Fylde Coast and Preston Area)

3.2.2 Benefits Administered by the DCS

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

- Disability Living Allowance (DLA)
- Attendance Allowance (AA)
- Invalid Care Allowance (ICA)
- Vaccine Damage Payment Scheme

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

Regarding themselves: "The Disability and Carers Service is committed to providing financial support to disabled people and their carers through a service that is: personal and responsive; consistent and reliable; controlled and professional..."

4. Medical Services

4.1 Introduction

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

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

- Incapacity Benefit (IB)
- Industrial Injuries Scheme Benefits (IISB)
- Disability Living Allowance and Attendance Allowance (DLA and AA).

Nestor Disability Analysts (NDA) is the company responsible for the initial aspects of recruitment, payment and contract management of Examining Medical Practitioners (EMPs) on behalf of Medical Services. Medical Services itself is responsible for training and ongoing support of EMPs. Medical Services and NDA keep accurate updated lists of these doctors, their availability and the range of work that they can perform.

4.2 Role of Medical Services

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

- Disability Assessment Advice
- Interpretation of medical evidence.

In addition we are responsible for interviewing and advising NDA on the suitability of applicants, and subsequently for the training and monitoring of fee-paid medical staff.

Medical Services doctors have specialised expertise as Disability Analysts. The doctors make an assessment of a person's restrictions and limitations caused by the disability, and advise the Decision-Maker in accordance with the relevant legislation. For DLA this advice is formulated around the care and mobility needs likely to arise in the course of a person's daily life.

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

4.3 Conditions of work

Medical Services Examination Centre (MSEC) allocates work when it becomes available. EMPs are self-employed and there can be no guarantee of case numbers. EMPs are required to return the completed casework within the agreed number of working days (15) from the date of issue of the request.

Nestor Disability Analysts (NDA) is responsible for the payment of fees for the examination and report and expenses for mileage, postage, and telephone costs. Queries on payment due should be made to NDA or allocations sections, according to local practice.

The allocations sections in the MSEC send cases to the EMP nearest to the claimant when practicable, taking into consideration travelling costs and the availability of EMPs. The allocations sections are also responsible for:

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

Any complaints about the standard of the EMP service are referred by the DCS or directly from the claimant to Medical Services for investigation. The complaints procedures are covered in more detail in section 16 of the guidance.

4.4 Professional Standards

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

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

5. The Role of the Examining Medical Practitioner

5.1 Introduction

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

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

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

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

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

5.2 Training and approval

Experienced full-time Medical Advisers train EMPs. This may be supplemented with additional input from DMs.

Training is given on:

- The ethos of the Department of Work and Pensions.
- Equal opportunities policy and relevant legislation.
- Medical Services Professional Standards.
- Customer service.
- Disability awareness.
- Benefit awareness.
- Decision making awareness.
- Examination technique and report completion.
- Approval.

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

5.2.1 Initial Training

This consists of six steps:

1. Pre-course reading: Disability Analysis for New Entrants
2. Trainer-led training day: Disability Analysis for New Entrants
3. Pre-course reading: Directed reading of the Guide for Examining Medical Practitioners
4. Trainer-led training day. This is a participative event that is followed by a Multiple Choice Questionnaire (MCQ) examination. Candidates must attend this event and obtain a pass mark in the examination.
5. The candidates will then be required to complete a minimum of 5 cases and the mentor will subject these to 100% targeted audit, and 100% feedback (positive as well as negative). Further cases may be selected at the discretion of the Medical Manager. Standard Integrated Quality Audit protocols will be applied and the method of delivery of the feedback will be at the discretion of the mentor: either by telephone, letter or in person.
6. After completion of these cases, the candidates will have a formal review with their mentor. This interview will be structured according to certain advisory guidelines. On satisfactory completion of this process the doctor's name is submitted to the CMA for approval.

5.3 Ongoing training

When procedural or legislative changes occur, updated information will be circulated to EMPs. Medical Services will provide details of ongoing training. The details of updating training and feedback will be logged.

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

5.4 Auditing of reports

EMP reports will be subject to periodic monitoring by employed Medical Services doctors. DMs may also refer reports for monitoring if they contain weaknesses.

EMPs will be informed of the outcome of this monitoring. If the standard of reports is unsatisfactory, and this includes illegible writing, a decision on remedial training will be made before any more work is offered. More information on the quality systems will be provided later in the guide (section 15.2 and Appendix C).

6. Main features of Disability Living Allowance and Attendance Allowance

6.1 Disability Living Allowance (DLA)

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

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

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

A DLA claim consists of both components. Entitlement to the care component can be considered from birth. The mobility component for the higher rate cannot be awarded before the age of three years.

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

6.2 Attendance Allowance (AA)

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

6.3 Decision making

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

- A speedy reconsideration of a decision usually by a different DM
- Appeals against the original and reconsideration decisions organised by the Appeals Service

- Appeals against the Appeals Service decisions on a point of law to the Social Security Commissioners and then, with leave, to the Court of Appeal (matters of fact cannot be the subject of appeal to Commissioners or to the Courts).

A tribunal for DLA/AA consists of a:

- Legal chairperson
- Medical member or a person experienced in dealing with the needs of people with disabilities.

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

Appeals on non-disability issues will be directed to the Appeals Service who will determine the appropriate constitution of tribunal to review the situation.

6.4 Self Reporting

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

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

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

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

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

6.5 Disability criteria

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

6.6 Personal care

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

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

The above two criteria relate to entitlement to the *lowest* rate, the following to the *middle* and *highest* rates:

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

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

6.7 Three rates of the care component

The three rates of the care component are:

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

6.8 Mobility Problems

6.8.1 Criteria for the higher rate mobility component

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

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

This includes people:

- Unable to walk.
- Virtually unable to walk i.e. those individuals whose ability to walk out of doors is so limited having regard to the distance, speed, length of time or manner in which they can make progress on foot without severe discomfort.
- For whom the exertion required to walk would constitute a danger to their life, or would be likely to lead to a serious deterioration in their health.
- Who have had both legs amputated at levels through or above the ankle, or who have one leg amputated and are without the other leg, or who are for any reason without both legs to the same extent as if they had been amputated either through or above the ankle.
- Who are deaf and blind to the prescribed degree and, because of the combined disabilities, they need help from another person to reach their desired destination out of doors.
- Who are severely mentally impaired and suffer from severe behavioural problems and satisfy the conditions for the highest rate of the care component as described in paragraph 7.6.

6.8.2 Criteria for the lower rate mobility

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

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

6.8.3 Summary of the mobility rates

The two rates of the mobility component are:

MOBILITY COMPONENT RATE	QUALIFYING CONDITIONS
Higher	Payable if a person: <ol style="list-style-type: none"> 1. Is unable to walk, or 2. Is virtually unable to walk, or 3. For whom the exertion required to walk would lead to a serious deterioration in their health, or 4. Has had both legs amputated at or above the ankle, or 5. Is both deaf and blind, or 6. Is severely mentally impaired, displays severe behavioural problems and is entitled to the highest rate of the care component.
Lower	Payable if a person can walk but cannot take advantage of this faculty outdoors in unfamiliar routes without guidance or supervision most of the time

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

6.9 Attendance Allowance

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

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

6.9.1 The two rates of AA:

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

6.10 Qualifying periods

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

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

6.11 Terminal illness cases

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

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

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

Disability Living Allowance

A person claiming DLA on the grounds of terminal illness does not have to satisfy the qualifying period or the prospective test for either component. To qualify for the mobility component, they must satisfy one of the relevant criteria (see Para 6.8).

Attendance Allowance

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

6.12 Children under the age of 16

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

- For the care component, the child must require substantially more care from another person than a child their age would normally require.
- For the lower rate of mobility component, a child (over 5 years of age) must need substantially more guidance or supervision from another person than a child of the same age in normal physical and mental health would require.
- The higher rate of mobility components can be considered from the age of 3.

7. Factors considered by the Decision Maker - Care

7.1 Severe disability

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

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

7.2 Attention

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

Examples of bodily functions

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

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

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

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

7.3 Supervision/watching over

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

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

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

7.4 The main meal test

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

Key points on the main meal test

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

Factors to consider are:

<input type="checkbox"/> Planning a meal.	}	
<input type="checkbox"/> Peeling and chopping vegetables safely.	}	
<input type="checkbox"/> Using the taps safely.	}	All using appropriate simple equipment and readily available aids.
<input type="checkbox"/> Using a cooker safely.	}	
<input type="checkbox"/> Coping with hot pans.	}	
<input type="checkbox"/> Undertaking the process in a hygienic manner.	}	

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

Key point:

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

7.5 Are the needs reasonable?

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

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

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

7.6 Age

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

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

7.7 Aids to help the disabled

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

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

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

7.8 Day or night supervision/attention

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

7.9 Children

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

7.10 Variable needs

In many conditions the level of disability varies over time. Multiple sclerosis is a good example of this. Asthma, particularly in children, is another. These conditions are characterised by periods of remission and relapse during which the need for help can change greatly. Other conditions can vary markedly from day to day, e.g. chronic fatigue syndrome, whilst others, such as rheumatoid arthritis with its morning stiffness may vary throughout the day. What is important to the DM is the overall level of disability for the majority of the time, not the actual level on a particular day, or the needs during an acute exacerbation or period of remission.

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

8. Factors considered by the Decision Maker- Mobility

8.1 Unable or virtually unable to walk

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

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

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

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

Factors that are taken into account are:

- Distance }
- Speed } of walking on even terrain out of
- Length of time } doors without severe discomfort.
- Manner }

No one factor is decisive.

8.2 Exertion

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

- The effort required to walk would endanger his/her life; or
- It would be likely to have an adverse effect on his/her health.

8.3 Amputations

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

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

8.4 Walking aids

When assessing a person's walking ability with walking aids, take the following factors into account:

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

8.5 Deafness and blindness

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

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

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

8.6 Severe mental impairment

A small number of people with severe mental impairment (SMI) who are physically able to walk also have behavioural problems. These may be extreme and so unpredictable that they need someone to be present watching over them whenever they are awake and that person regularly needs to intervene and physically restrain them to prevent injury or damage. This group has been described in regulations as those who have arrested or incomplete physical development of the brain to the extent that they have severe behaviour problems and qualify for the highest care component. If all these conditions are satisfied, they will qualify for the higher rate of the mobility component.

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

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

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

8.7 Guidance and supervision

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

- Have impaired vision and cannot find their way.
- Do not recognise danger.
- May injure themselves or others.
- May get lost or forget where they are going.
- Need active encouragement or persuasion to continue walking.

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

8.8 Intermittent problems

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

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

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

8.9 Children

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

8.10 Benefits of getting out and about

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

9. Equal Opportunities and other legislation

9.1 Equal Opportunities Policy

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

9.2 Race Relations Act 1976

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

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

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

It is our practice to inform claimants that if they have difficulty understanding English then an interpreter may accompany them. An interpreter should be present if language difficulties would make it difficult for you to make a proper assessment of a claimant's condition. If you arrive at a house and it is evident that an interpreter is required you should explain matters as best you can to the claimant, and telephone the MSC. Arrangements will be made for you to perform the visit at a later date, when an interpreter will be provided.

9.3 The Sex Discrimination Act 1975

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

If a justified complaint is received that an individual has been discriminated against on the grounds of race or gender, no more cases will be referred to that doctor for examination. This action may be in addition to any civil proceedings that the claimant may wish to bring.

9.4 The Rehabilitation of Offenders Act 1974

9.4.1 Background

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

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

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

9.4.2 Implications for Medical Services Doctors

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

If a report submitted to the DWP or Medical Services by a third party makes reference to a criminal conviction, the author will not contravene the Act unless they have access to the person's criminal records. In the case of a factual report from a GP or hospital, this risk would be so unlikely that it can reasonably be disregarded. The information in such a report is likely to have come from the claimant.

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

Similarly, since neither the DWP nor Medical Services will normally have access to a person's criminal record, any information about convictions will have come from the claimant. Hence if there is good reason for the examining doctor to record such information – i.e. it is materially relevant to the claim – then he or she may do so, in good faith, without fear of contravening the legislation. If a claimant wishes to have mention of a conviction recorded on the medical report, the doctor should:

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

9.5 The Disability Discrimination Act 1995

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

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

The Act covers:

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

9.5.1 Definition of Disability within the DDA

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

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

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

Impairment may be physical or mental, due to illness, accident or congenital abnormality. Mental impairment includes mental illness but only if it is clinically well recognised and learning difficulties. It excludes certain conditions such as a tendency to criminal or sexual acts.

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

- Mobility
- Manual dexterity
- Physical co-ordination

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

Substantial is defined as more than minor or trivial. For example a pianist who loses part of their little finger would not fall within the meaning of the Act since this would not cause a substantial effect on their ability to perform the activities of day-to-day living.

Long Term includes the following:

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

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

10. Reports from Examining Medical Practitioners

10.1 Administrative Arrangements

Key points:

- The arrangements for making appointments are one of the major sources of complaints made by claimants against examining doctors particularly about insufficient notice of the visit.
- It is very important to follow the recommend practice as described below.

EMPs are asked to note the following points when undertaking examinations:

- Contact the claimant and offer an appointment for a visit as soon as possible after receiving a file. This appointment can either be made by a telephone and / or a letter. It is vital to offer sufficient (7 days) notice to allow:
 - The claimant and relatives or carers time to prepare for the examination.
 - To ensure the presence of an interpreter if needed.
 - A parent or legal guardian to be present when examining a claimant below the age of 16 years.
 - When an appointment has been made by telephone, it is good practice to confirm the appointment by letter.
- When contacting the claimant by telephone the procedures outlined in section 10.2 should be followed. Ensure telephone calls are made at reasonable times.
- When notifying a claimant of an appointment time, a maximum of a 1-hour window should be given. Every reasonable effort should be made to attend within that time. If you are running late or are unable to keep the appointment it is important that you contact the claimant to keep them informed.
- When an appointment is discussed on the telephone and a date less than 7 days in advance is agreed as being mutually convenient the EMP should record this fact on the report. Although there is no specific box for entering this, inclusion above the declaration and signature would be appropriate.
- Please Note: Some claimants allege that they were pressurised by the Doctor into accepting such appointments therefore recording the facts on the report can be important. It is very important to be aware of the sensitivities surrounding ensuring that the appointment time is mutually convenient.

- Do not discuss the possible outcome of the claim.
- Make no comments to imply criticism of the diagnosis of the claimant's condition or of their medical care and treatment.
- Avoid writing any embarrassing or confidential comments in the file and be sure you understand the nature of harmful information.
- Take note of Equal Opportunities and other relevant legislation.
- Follow Medical Services Professional Standards.
- Provide proof of identification for the claimant/carer as issued via your Medical Manager.
- Ensure that the person being interviewed and assessed is the person claiming benefit (see section 10.3).
- Return reports promptly within the agreed period, and make contact by telephone with the MSC if this is not possible.

10.2 Telephone contacts with Claimants

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

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

10.2.1 Establishing the identity of the Claimant

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

The following script or something very similar should be used:

"I'm Dr X from Medical Services and I would like to speak to Mr/Mrs/Miss/Ms (Use Full Name of Claimant)". No further details should be given until the claimant has been positively identified.

A positive identification of the claimant should be sought and this would normally be the date of birth or NINO.

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

If the claimant is unavailable, make arrangements to call back, without revealing any further details appertaining to the nature of the telephone call. If the claimant cannot be contacted via the telephone then an appropriate letter should be used.

10.2.2 Informing the Claimant of the reason for the telephone call

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

10.2.3 Exceptional Circumstances

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

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

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

10.3 Identification of the Claimant at the Assessment

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

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

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

- The doctor should identify themselves, who they visiting and the reason for the visit.
- Ask the claimant to provide identification such as a passport or driving licence.
- Circle the evidence provided on the form.
- Ask the claimant to sign the POID1.
- As an additional cross check, compare the signature to the claim form (e.g. IB50 etc., if available) or the proof of identity offered, if signed
- Complete Part 2A of POID1 by ticking 'N/A'. Then complete 2 B.
- Place the POID1 into the claimant's file.

If the claimant's signature does not match the claim form but the claimant has produced an acceptable form of identification the doctor should ask the claimant more in depth questions relating to case history, to establish correct identity and determine whether the examination should continue. If the examining doctor is 100% certain that the individual is not the true claimant, they should contact a FTMA or Medical Manager to authorise suspension of the examination. This should be done by telephone, either mobile or pay phone if necessary.

An individual **must not** be refused an examination unless the examining doctor is 100% certain that the individual who has presented him or herself for examination is not the true claimant.

10.4 Abortive Visits

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

- Complete form AV1 (Appendix D) and leave that at the claimant's address. This form allows you to input the new details of when you will call again. You should arrange the second appointment within the specified target time (usually 15 days from the time the papers were dispatched from the MSC, unless otherwise stated). As 7 day's notice will have previously been give for the first appointment it is not a contractual requirement to do so again. You should ensure that the claimant is given reasonable notice for the second appointment in the event that they wish to arrange for a representative to be present. If you are unable to complete the report within the specified timescales contact the MSC for advice.
- In some special situations cases will be marked by the DBC with a red star. In such situations use form AV2 (Appendix D).
- Fill in **Part 3 – about the visit** (see section 15) of the EMP report form giving reasons for the aborted visit.
- If the property looks uninhabited or you feel that the address may not be correct, telephone the MSC for advice, so they can confirm the address with the DBC.
- If, when you visit again, the claimant is still not at home, fill in the appropriate part of Part 3 - about the visit and return the file to the MSC.
- Please record details of time and date of telephone conversations in the space provided at the bottom of Part 3.
- Please Note: only two attempts should be made to examine the claimant.

10.5 The Claimant Refuses You Entry

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

If the claimant refuses to agree a further appointment, you should inform them that you are obliged to attempt 2 visits to complete the report and provide a date and time on which you will return.

If on the second visit the claimant is either not at home or refuses you entry complete Part 3 of the EMP report form – about the visit and provide the dates of the aborted visits.

11. Recommended approach to Disability Assessment

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

11.1 Comparison of role of Clinicians and Disability Medical Analysts

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

11.2 Disability Analysis in DLA/AA

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

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

11.3 Definitions of Disability and Impairment

Disability analysts should understand the concepts of impairment and disability.

Key points

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

11.4 Mental state

It is important to provide information to the DM about the claimant's mental state even if it is purely to confirm that the individual's mental state is normal. If the claimant appears to be confused or has an altered perception of their condition it is strongly advised you seek additional information from a relative or carer. Where this additional information is not available in the examination setting then you should provide as much detailed information as you can to the DM.

11.5 Availability of a carer or chaperone

Claimants may wish to invite a relative or carer to be present to provide support during their interview and assessment. Many individuals find the prospect of such an interview daunting and stressful. This factor must not be overlooked. You must remain sensitive to the specific situation and comply with the individual's wishes

11.6 Access to the EMP report

It should be borne in mind that the claimant may subsequently see the EMP report, and care should be taken with harmful, embarrassing or confidential information.

11.7 Unexpected findings (see Appendix E)

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

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

11.8 Additional information

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

11.9 Audio or video taping of examinations

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

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

Such a request can only be agreed with the prior consent of the examining doctor, and then only if stringent safeguards are in place to ensure that the recording is complete, accurate, and that the facility is available for simultaneous copies to be made available to all parties present. The recording must be made by a professional operator, on equipment of a high standard, properly calibrated by a qualified engineer immediately prior to the recording being made. The equipment must have facility for reproduction so that a copy of the tape can be retained by all parties

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

Any request by a claimant for an assessment to be audio or videotaped must be declined unless the above safeguards are in place. The claimant must instead be offered the opportunity of a rescheduled assessment in the presence of a companion or other witness. If the claimant refuses to avail him/her self of this opportunity and refuses to proceed with the assessment, the doctor should return the file to the DWP with a note explaining the situation.

11.9.1 Unauthorised Taping

It is for Medical Services, in conjunction with their legal advisers, to determine the action to be taken in the event of a claimant making an audio or video recording without the prior knowledge and consent of the examining doctor, or without ensuring that the safeguards defined above are in place.

12. Risk management of problem situations

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

The most important factors are the doctor's own:

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

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

The following are some points to remember:

- Always treat everyone impartially and sympathetically, and be seen to do so.
- Some claimants use bad language and gestures as a normal means of communication. Nobody, however, is expected to suffer severe abuse, especially if it is sexual or racial in nature. If you suffer such verbal abuse, tell the claimant that the assessment will be terminated if the abuse does not cease immediately and record the information on form PV1.
- Spend time explaining and reassuring the claimant and exploring potential areas of concerns and anxieties.
- Be friendly but firm.
- Be seen to be in control of the situation, in a pleasant manner.
- Never retaliate by word or deed even if provoked, and remain calm.
- Do not continue in the face of persistent abuse or aggression.
- Observe exits as you arrive, and remain between the exit and the claimant.

Good practice points will be dealt with in more detail in the section on assessment technique.

Key Points to minimise the risk.

EMPs should:

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

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

Such incidents include:

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

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

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

If you are ever subjected to abuse or violence then you should report the incident as soon as possible to Medical Services. Form PV1 should be completed for every incident. It may also be advisable to inform the police. If you need help or advice about such incidents and to obtain the forms then your local Medical Services contact will be pleased to assist.

13. The nature of the reports

13.1 Introduction

DLA and AA have two types of report:

- General
- Specific.

For DLA, each type of report may be specific to either the care or the mobility component or to both.

13.2 General reports

General reports are requested in the following circumstances:

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

They include sections for recording:

- The claimant's statement of their care and mobility needs.
- Results of the medical examination.
- Help needed by the claimant from another person to help with social activities, activities connected with religious beliefs and hobbies.
- Your opinion on the effects of the claimant's disabilities on their everyday life.

13.3 Specific reports

Specific reports are requested when the DM or the Appeals Service needs clarification of a particular aspect of a claim. They differ from general reports because they include:

- A section that sets out the DMs particular area of concern.
- Specific questions the DM would like to be answered in the report.

The claimant's statement is also different, as it should be directed towards the DMs area of concern. If the main body of a report does not cover a specific aspect of a claim, the DM will list any additional questions that need to be answered. These should be answered in addition to completing the main report, not instead of it.

14. Completion of reports

14.1 Introduction

Key Points

- The report form must be completed legibly and must be in black ink as this makes it easier to photocopy.
- The report must be understandable to non-medical DMs and should not include complex medical terms or abbreviations without a clear explanation of meaning.
- Questions with Yes/No boxes must be ticked.
- Comments boxes must be completed whenever possible.
- The statement must be read back and signed /dated by the claimant and / or carer.
- Record time of arrival and departure.
- Record those present during the assessment and their relationship to the claimant.

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

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

14.2 Harmful, embarrassing and confidential information – General

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

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

14.2.1 Harmful Information

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

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

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

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

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

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

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

14.2.2 Embarrassing information

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

- Criticism of the claimant's medical treatment.
- Criticism of a doctor who examined the claimant on a previous occasion.

It is especially important to be aware of mentioning convictions or prison sentences with regard to the Rehabilitation of Offenders Act, 1974 (see section 10.4).

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

14.2.3 Confidential information

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

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

14.3 The EMP report form

The initial section of the EMP report form is divided into three parts.

Part 1 - About the Visit - Medical Services administrative staff completes this.

Part 2 - About the Visit - This section is completed by the DM and gives general information about the claimant such as their disabling conditions and the diagnosis from their medical professional.

Part 2 - Submission to the EMP & Questions for the EMP - The DM may set out the area(s) of concern and points that need clarification. The statement you take in these cases should be directed toward these particular points.

Sometimes the main body of the report may not cover a specific aspect of a claim on which the DM requires information. In these cases the DM will list any additional questions that need to be answered. These should be answered in addition to completing the main report form, not instead of it.

Should your opinion on the care or mobility needs differ from any information provided in part 2, you will need to provide the DM with sufficient information in your report to understand why they should prefer your opinion.

Part 3 – About the Visit – This section should be completed in all instances when you are unable to fully complete the report form. This situation will apply in the following circumstances:

- Aborted Visit (No report provided).
- Non Aborted Visit (Report Incomplete).

14.4 Aborted Visit (No report provided)

Circumstances where this situation might apply would include:

- The claimant is not in on 2 occasions.
- The claimant has refused you entry on two occasions.

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

Examples of good practice in completing this section would be:

“I was unable to complete the EMP report form because on the first occasion the claimant, who was profoundly deaf and who understood sign language, did not have a signer available. He offered to arrange for someone to be present at the second visit but the signer was again not present due to transport problems”

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

The following would not be sufficient:

“The claimant advised that he would not be examined”

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

For example:

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

However:

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

14.5 Non Aborted Visit (Report Incomplete)

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

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

Under clinical findings in the report, please record your informal observations so that the Decision-Maker has some information on which to assess care and mobility needs and wherever possible give your opinion, explaining that this is based upon informal observations only, at Part 11 of the form, in the box entitled “Please use this part of the form to add anything further you think would aid the decision maker or to expand any of your answers”.

In the above circumstances please provide full details of the reasons why you were unable to complete the form in part 3 of the report form.

14.6 Special Need Requirement

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

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

In the first instance the Allocation Section will select an appropriate EMP in the area. This may be all that is required, e.g. in the case of the claimant who requests a female EMP or if there is a suitably qualified EMP that speaks the required language.

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

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

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

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

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

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

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

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

- It is essential that EMPs remain aware of the constraints imposed by targets and make every effort on their part to ensure that the medical arrangements are put in place as efficiently as possible and with the minimum of delay.

The Allocation Section **must** be kept up to date with all developments.

14.7 Taking and writing the claimant's statement

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

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

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

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

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

One of the commonest allegations made by claimants in their complaints is that the EMP did not read back the statement but simply asked them to sign the blank form. Please ensure that you adhere to the recommended procedures set out in these guidance notes.

14.8 EMP Reports Completed by a Third Party

No report for Medical Services can be hand-written by anyone other than you as an EMP.

A typewritten report, typed by a third party, is acceptable because it can be understood that the doctor would have dictated that part of the report to their secretary before checking and signing the typed and completed form.

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

The Legal Advice is that a secretary, being a person who provides or is employed in the provision of a service (typing reports) to persons who are carrying out the administrative work of the Department (i.e. a doctor when acting as an EMP) would fall within the provisions of the Act. They would therefore be susceptible to any prosecution for any breach of confidentiality. This applies irrespective of whether or not the typist is an employee, or has signed a separate confidentiality agreement for other employed work, or is a spouse, partner, or friend of the Examining Medical Practitioner.

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

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

- You should arrange for signature and retention of copies of the EMP report by both parties. Appropriate confidentiality undertakings by those you engage with for the purpose of processing information should also be arranged.

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

14.9 General reports

On general report forms the statement is divided by a number of sub-headings. The claimant's needs in all these areas must be recorded. In addition, needs in connection with a reasonable level of social and recreational activities, together with the frequency and type of activity in these respects must be recorded in the statement. If no help is needed in a particular section please record "no help needed". Do not leave the section blank as this can cause confusion.

When the statement has been completed, read the report back to the claimant and the relative or carer so that any correction or additions can be made, before asking the claimant to sign and hence endorse the statement.

The person giving the information must sign all statements. Those given by people other than the claimant must state that person's relationship to the claimant. It therefore logically follows that the statement must be in the first person if provided by the claimant, and the third person if provided by a parent, guardian (claimant under 16) or by a carer.

14.10 Good assessment techniques

This section provides a practical six-step approach to promote consistent good practice in assessing individuals particularly in their own home environment.

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

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

Step 2: Structuring the interview - Introductions

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

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

1. Explain that your aim is to:

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

2. Explain that you wish to:

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

Step 4: Clarification

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

Step 5: Conducting the assessment – Communication

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

Step 6: Ending the assessment - Closure

- Ask if the claimant or carer has any further questions and respond to them appropriately.
- Explain what happens next i.e. that the report and any other relevant information will go to DM.
- Inform them that if they wish to check on the progress of their claim that they should contact the number provided in the appointment letter.

14.11 Personal descriptions in medical reports

14.11.1 General Principles

The following general principles must always be observed:

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

14.11.2 Descriptions of Race or Ethnic Origin

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

Consequently, in the context of the examinations that are conducted on behalf of customers of Medical Services, references to racial origin are almost universally unnecessary, and the inappropriate use of such descriptions is liable to cause offence. In addition, the use of inappropriate descriptions may, in certain circumstances, lead to an action being brought against the author under the Race Relations Act 1976 or the Sex Discrimination Act 1975. It follows that a description of race or ethnic origin should only be incorporated in a report where there are overriding and compelling medical reasons for including such information. If you consider that a description of race or ethnic origin is essential, the reason for its inclusion should be made explicit and the description used should be factual and expressed as categorised in the Census, as follows:

White

Black – African

Black – Caribbean

Black – Other (please specify)

Indian

Pakistani

Bangladeshi

Chinese

Other (please specify).

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

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

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

14.11.3 Descriptions of Personal Appearance

References to personal appearance are not infrequently made in reports prepared for the DWP. You should appreciate that there is no place for gratuitous comments. Personal appearance should not be described unless there is a clear and unambiguous reason for doing so. The linkage between any reference to personal appearance and the functional assessment must be made explicit. Information that adds no value to the report should be omitted altogether e.g. comments concerning simple obesity with no related disability, length of hair, tattoos, body piercing etc.

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

You must avoid drawing unwarranted inferences from a person's clothing, style of dress, make-up, jewellery or general appearance, and you should avoid commenting on such matters unless the observations form an integral part of the medical evidence. For example, a description of a person as 'untidy and unkempt' may provide useful information to support an assessment of someone with cognitive impairment, learning disability, etc., or it may illustrate a particular degree of functional limitation.

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

Exercise caution in drawing inferences from isolated observations. Adhere to the principles of disability analysis and consider any information derived from the person's personal appearance in conjunction with all other relevant evidence before drawing any conclusions.

The circumstances of the case will often dictate whether or not the inclusion of certain information is relevant. For example, a comment on the fact that a claimant was wearing nail varnish on her toenails would not normally be merited. However, this situation would be altered if the claimant's disability was related to a back condition. In such a case it would be appropriate to include this information as justification of the advice given in relation to activities that require bending, provided that it was ascertained and recorded that she had applied the varnish without assistance from another person.

14.11.4 Descriptions of attitude and mood

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

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

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

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

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

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

14.11.5 Practical application for EMP assessments

Any relevant descriptions of the claimant should be recorded with the clinical findings in the medical examination section. Descriptions can give the DM a mental picture of the claimant and makes it easier for them to interpret the rest of your report. Some examples include:

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

Or

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

14.12 Examination

Examination must be relevant to the claimant's condition and must contain sufficient detail including measurements in metric units (imperial units can be used as supplementary indications).

Vision:

- If the claimant wears spectacles, they must be worn when testing vision. With visual acuity, it is important to assess vision for its usefulness outdoors and to consider the acuity over the whole visual field. If possible a Snellen's chart or similar should be used rather than counting fingers.

Hearing:

- If the claimant wears a hearing aid, it must be worn when assessing hearing. It is important to test the claimant's understanding, not just their ability to react to sound. The test should take the form of a simple instruction or question, shouted if necessary, from one metre behind the claimant.
- Background noises need to be taken into account when assessing the usefulness of the hearing out of doors.
- If there is any indication of deafness the ears must be examined and any pathology or obstruction noted.

Proceed to carry out a relevant examination depending on the individual situation. Record the relevant findings of your assessment. In some situations it will be important to note normal findings e.g. normal reflexes and muscle tone. In others recording inappropriate findings may be required.

14.13 Physical Examination in EMP Assessments

You should seek the claimant's express permission before proceeding to carry out any physical examination that you deem to be necessary. It is vitally important that all doctors should understand that they must not assume consent. Explicit consent to the examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report. A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

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

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

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

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

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

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

When carrying out a physical examination, you should use your professional judgement to decide when it is appropriate to offer a chaperon, or to invite the claimant to have a relative or friend present. In this context, the duty of the chaperon is to protect you from any possible complaints about unethical conduct, and the chaperon's role is merely to remain in the room whilst you examine the claimant, unless you ask the chaperon for assistance. This guidance assumes particular significance when the doctor and claimant are of the opposite gender.

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

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

14.14 Your opinion

Only ask claimants to demonstrate activities within their own limits. You must form your own opinion in the light of the medical history and examination and any other evidence available on whether these limitations are reasonable.

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

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

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

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

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

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

Key point

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

14.15 The Assessment of Mobility

Your opinion on the claimant's walking ability must be consistent with your clinical findings, informal observations and your assessment of the stage of their illness. This takes into account the level of investigation and treatment and the likely effects of the condition on a person of that age, but need not be based on a formal walking test. You may be offered the opportunity to observe the person walking out of doors and going upstairs. If not, your assessment of outdoor walking ability will have to be made on the basis of:

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

Do not take account of the terrain when giving your opinion on how far the claimant can walk out of doors without severe discomfort. People can often tell you for what length of time they can walk, but tend to be inaccurate. This is even more marked when estimating distance. However they can usually tell you where they walk to e.g. the local shops, bus stop etc. You will then be able to interpret the distance during your visit.

Key points on the practical guide for assessing walking ability

- Someone walking at an average speed manages about 90 metres in one minute (i.e. the length of a football field).
- Walking at a slow speed equates to 60 metres in one minute.
- Walking at a very slow speed equates to 30 metres a minute

In some circumstances it may not be possible to give an opinion on the limit of walking ability on the basis of clinical information and observation. In these circumstances it is in order to ask the person to undertake a walking test. This should be adapted to meet the individual circumstances but ideally should involve asking the person to walk outdoors, on level ground at their normal pace, for 2 minutes. The accuracy of observations recorded during the test is important and special note should be taken of a deviation from the normal.

Data should include the distance walked, the time taken, and any change in pulse rate during the test. These factors should be accompanied by qualitative observations on gait, balance, manner of progress, along with an estimate of the level of pain or discomfort experienced. The number, duration and nature of any pauses should also be recorded.

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

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

If a person's walking ability varies, take account of the overall ability over a period of time not just their ability on the day of the examination. When the walking of a person is interrupted by sudden stops, describe the nature and frequency of the interruptions. It is important to differentiate between stops that are of the person's own making and stops that are due to a physical condition for which a rest is justifiable.

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

14.16 Duration of mobility need

This is the date on which the present mobility problems arose, not the date the disability started. For some people the two develop at the same time, e.g. when a person suffers a stroke. For others a slow deterioration in their medical condition leads to increasing disability.

The important date is the one on which the claimant reached their present level of need for the mobility aspect. This may not be the same date as that on which care needs reached their present state.

14.17 The Assessment of Care Needs

Please answer all questions and complete the comment boxes if you have said the claimant needs help with a particular activity or if there is a need for supervision in some way. Your professional opinion is required, bearing in mind:

- What is said by the claimant.
- What you have found when examining them, and
- Any other information that may be on file.

The use of aids needs to be considered. Examples that may be appropriate are:

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

The above list is not comprehensive.

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

14.17.1 Care at Night

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

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

Always elaborate when you think the needs are different from those described by the claimant, either in type or amount.

When elderly people give their statements, needs are often understated rather than exaggerated.

The DM needs a definite indication of the **average** amount of attention needed at night.

Key Points on assessing night needs

- On each occasion assistance is required for bodily functions (only) give an accurate estimate of the duration in minutes.
- The above should not include time spent on providing comfort or companionship.
- Whether attention is needed on average:
 - more than once each night
 - once each night, or
 - less than once each night, and if so:
- Whether attention is needed on a nightly basis on the majority of nights, i.e. four or more nights a week, or less.

14.17.2 Supervision Needs

When giving your opinion on the need for supervision, consider whether or not reasonable, common sense precautions could be taken to prevent danger arising. Such precautions should be:

- Practicable
- Available, and
- Affordable.

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

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

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

14.18 Duration of care needs and prognosis

The date on which the need for attention/supervision arose is required, not the date the disability started.

For example, a relative or carer who brings a disabled parent to live with them usually does so because of a slow deterioration in their condition. In this case, the need did not arise on the date the person went to live with their relative but some time before. This could also be said of people in nursing homes.

Only when a person suffers from acute illness can the date of admission to hospital be the date on which the needs arose.

It is very helpful to the DM to provide wherever possible an indication of the prognosis and likely changes to the disabling effects of the condition(s) present. This should include, where relevant, the likely impact of any known planned treatment.

Provide as much information of the nature and extent of the variation in disabling effects.

14.19 The Assessment of Chronic Fatigue Syndrome (CFS)

14.19.1 CFS – clinical features

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

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

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

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

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

14.19.2 Medical assessment for benefit purposes

Despite clear recognition by both the Department of Health and the DWP that CFS is a real and disabling condition, some doctors still display varying degrees of scepticism. Such scepticism is not in keeping with Medical Services' professional standards, and it is not acceptable when doctors are carrying out assessments on behalf of the DWP.

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

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

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

14.20 Variability of Conditions

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

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

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

When completing the report form, you are usually asked to record the claimant's own statement of the frequency of good and bad days, as well as if the assessment was carried out on a good or a bad day.

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

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

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

And

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

It is important to appreciate that, **in addition** to recording the claimant's own statement about variability, you are being asked to express **your opinion** about the level of variation that you would expect to take place, given the circumstances of the case under consideration. In so doing, it is important to recognise that the variation that a claimant reports in their **level of symptoms** will not necessarily translate into a significant variability in their **level of function**. Your advice must be based on what is medically reasonable in that case, and must be adequately justified. This last statement is, of course, true for all the advice that you give in all your reports.

You should record your opinion about variability of function at Part 8 of the report.

Examples

The following examples illustrate the salient points

- 1) A claimant with mechanical back pain states that the symptoms are worse on 1 to 2 days every 1 to 2 weeks. The EMP would usually conclude that the level of function should not vary significantly even though the pain may be worse on some days. The medical basis for this opinion is that mechanical back pain does not cause substantial fluctuations in function over this type of time scale. The EMP might possibly also refer to the general advice that people with back pain should usually try to keep mobile.
- 2) A claimant with mechanical back pain tells the EMP that in addition to the level of pain and functional problems that they usually experience, there are occasional exacerbations of back pain when mobility is severely limited for three or four days. These episodes occur irregularly and infrequently; there have been two of these episodes in the last one and a half years. The EMP would mention this in the account and state that this is consistent with the natural history of back pain. However, in this situation, the EMP would not need to describe in detail the level of functional problems during these exacerbations, as the claimed variability is irregular and infrequent.
- 3) A claimant with multiple diagnoses e.g. ischaemic heart disease, type 2 diabetes mellitus and generalised joint disease may be seen on an average day. However they may claim that they need more help getting out of bed and with self care on a bad day. They may also state that they do not go out on bad days because of joint pains. If observation and musculoskeletal examination by the EMP are all normal, or if they only demonstrate minor functional deficit, the EMP should say that significant variation in function is unlikely in the absence of physical signs indicating significant joint disease.
- 4) A claimant with proven ischaemic heart disease might say that their angina is worse when walking outdoors when the weather is cold or windy. The EMP may well agree that this would be an aggravating factor. However the frequency is quite unpredictable, as it is weather related.

- 5) A claimant with episodes of migraine states they have acute episodes once or twice a week during which they are prostrated for a short period of time. There is supportive evidence for this statement, in that the claimant is taking prophylactic treatment in addition to treatment for acute attacks. They are also attending their GP regularly as well as a neurology outpatient clinic. In such circumstances, the EMP may conclude that the claimed variability in function is reasonable, as it follows a medically recognisable pattern with the condition and is consistent with the medical management being provided. However, a different conclusion may have been drawn if the collateral evidence, indicative of more severe disability, had been absent i.e. if medical management had been less active.

15. Assessing Quality of Service

15.1 Claimant satisfaction

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

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

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

15.2 Integrated Quality Audit System (IQAS)

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

The IQAS system is based upon:

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

15.2.1 The audit system addresses 4 areas of each product:

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

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

15.2.2 Key requirements

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

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

15.2.3 Attributes

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

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

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

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

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

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

15.2.4 Audit and Feedback Processes

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

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

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

16. Complaints

16.1 Definition of a complaint

The current definition of a complaint is **a clear expression of dissatisfaction about the services that we provide which originates from a claimant.** A complaint can be made:

- By the claimant or their authorised representative, including MPs.
- Verbally or in writing. Verbal complaints can be made in person or by telephone. Written complaints may be by letter, fax, e-mail or using the customer service leaflet.

16.2 Why are complaints important?

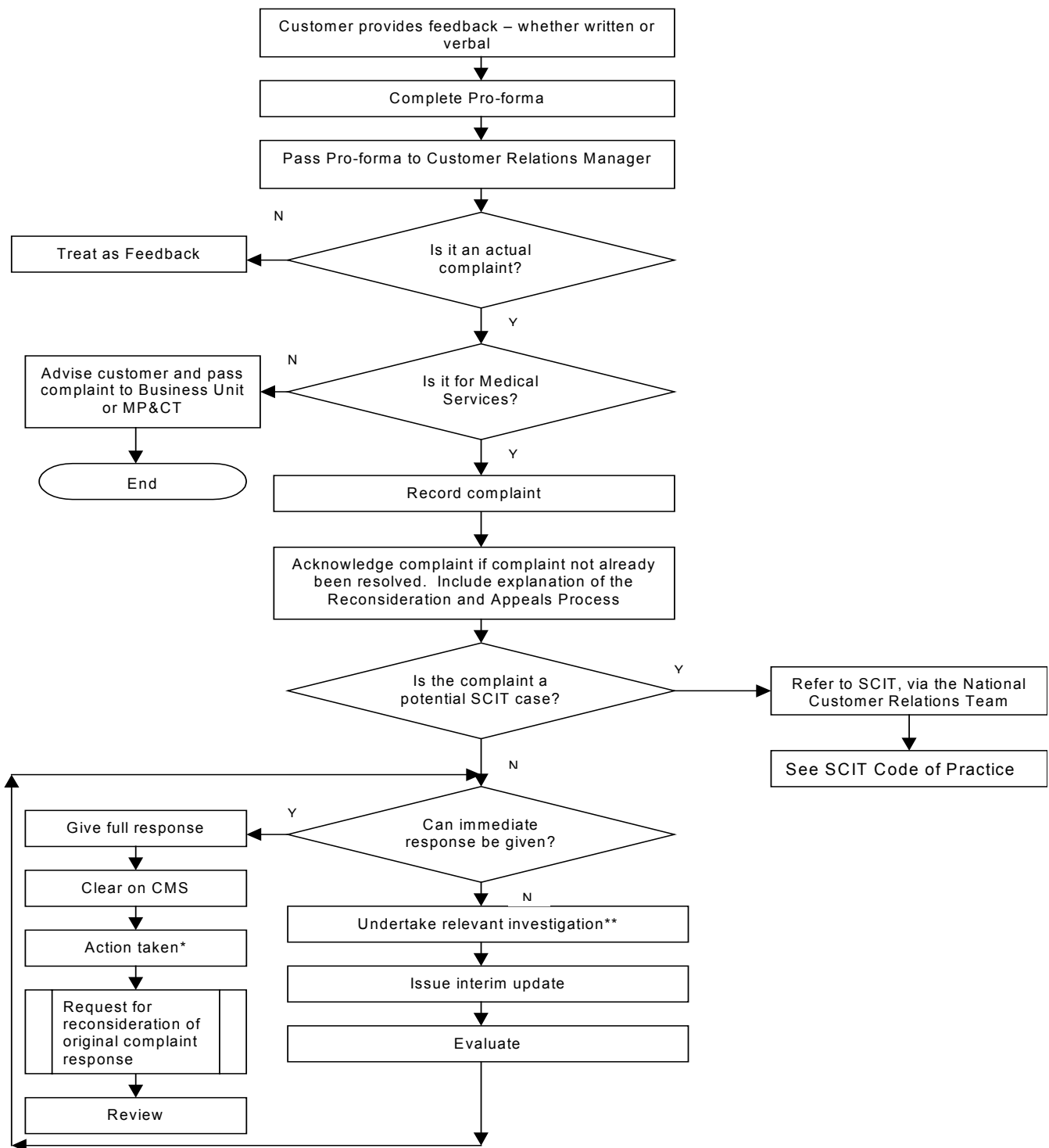
Complaints are important since they provide information to reduce dissatisfaction and to improve the service that we offer. They give the chance to resolve any dissatisfaction and prevent escalation of the complaint. They also identify training needs and problem areas.

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

16.3 The complaints procedure

When someone is dissatisfied with the service received from Medical Services the formal complaint procedure is followed. Some complaints are received directly from the claimant or their representative. Other complaints about Medical Services are referred from the DWP to the Customer Relations Team (CRT) in Medical Services, for investigation and response. A Customer Service leaflet is available on request to further explain the formal process. The leaflet is issued to callers who wish to lodge a complaint in person, and the leaflet is issued with an acknowledgement letter on receipt of a written or telephoned complaint. The procedure is outlined in the following flow diagrams.

16.3.1 The Complaint Procedure



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

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

16.4 Customer Relations Team (CRT)

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

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

The CRT provides advice as to whether a complaint should be referred to the Serious Complaints Investigation Team (SCIT) (see section 16.8) and co-ordinates SCIT investigations. They also make recommendations on minimising complaints or the risk of them, and provide responses to, for example, parliamentary questions and ministerial correspondence. The CRT also acts as convenor to the Independent Tier (see section 16.7).

16.5 Complaints and the Examining Doctor

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

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

When performing an examination make sure that you have a copy of the Customer Care leaflet with you.

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

16.5.1 What do claimants complain about?

Complaints are categorised according to their nature:

- Doctors manner or conduct – examples include allegations that doctors were “rude, arrogant, did not listen, did not write down everything said, did not give name, inappropriate examination, did not read back report before requesting signature of claimant, inappropriate comments etc”.

- Content of examination – disagreement about whether or not certain clinical tests should have been used e.g. whether blood pressure should have been taken, whether chest should be examined under or over clothing etc.
- Length of examination – e.g. too long or too short.
- Clinical findings – e.g. what the doctor has written on the medical report as his opinion or conclusions about the claimant’s level of care and/or mobility requirements.
- Administrative issues – e.g. lack of warning regarding date of visit, not sufficient time to arrange for a carer or relative to be present.
- Other – complaints about administrative staff and about issues not directly the concern of Atos Origin Medical Services which may require comment.

16.5.2 Complaints about doctors

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

36.7% of all complaints refer to the doctor's manner.
 27.5% to the content of the examination.
 12.4% to the clinical findings.

The figures above (from 2004) are based on an analysis of complaints arising from all types of benefit assessments including DLA/AA.

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

16.5.3 Feedback you should not respond to

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

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

- the rules of entitlement to a benefit
- the benefits process itself
- the actual design or nature of any policy
- complaints about the policy
- the service provided by the Business Unit
- appeals or decisions to disallow benefit

16.5.4 Assisting in an Investigation

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

Your contribution is vital to the successful conclusion of the complaint, as without it, the response given to the customer by Medical Services will be incomplete and unsatisfactory.

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

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

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

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

Under the Data Protection Act your response to Medical Services may be copied to the claimant if they request sight of it.

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

16.5.5 Follow-up Action

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

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

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

16.6 Escalation of a complaint

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

16.7 Independent Tier

If the complainant continues to be dissatisfied, although all issues have been addressed, the complaint can be referred to the Independent Tier of the complaint process. The Independent Tier is made up of people who are not part of Atos Origin or the DWP.

The Independent Tier has no legal authority or executive responsibility in relation to Medical Services. They are responsible only for reviewing Medical Services' adherence to the process for handling the complaint.

They will look at the complaint and decide if it has been handled correctly. This will include looking at whether or not all issues have been identified and addressed, whether the complaint was dealt with promptly and efficiently, whether sufficient investigation was undertaken and the appropriate individuals asked to comment.

The Independent Tier cannot decide whether or not the responses given to the complainant were adequate or correct, nor can it comment on the decision of the DWP on the benefit claim, or the opinions expressed by an examining doctor in the medical report.

As part of Customer Relations, there is a convenor (previously the Medical Services Client Liaison Group) to the Independent Tier who liaises with them making sure all relevant papers are referred. They also have a responsibility to the customer to ensure they are aware of the status of the referral and are also notified of the outcome.

16.8 Serious Complaint Investigation Team (SCIT)

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

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

The CMO decides whether a complaint is categorised as a SCIT matter. They also advise on initial action before the SCIT investigation (including doctor suspension) and remedial action following it.

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

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

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

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

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

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

Appendix A - Medical Services Professional Standards

1) Personal Conduct

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

- Carry out a relevant examination to provide the information necessary to give and justify medically reasonable advice.
- Carry out the examination gently to avoid any unnecessary discomfort, where possible assessing active movement of limbs before embarking on any passive movement.

4. When giving Advice

- Medical Services advice will be objective, independent, fair and impartial, ethical, and given in accordance with our contractual obligations.
- It will conform to the consensus of medical opinion and the balance of probability.
- It will be of an appropriate depth, scope and focus, and presented with a clarity that will permit the DM to give reasonable consideration to the medical issues.

The following clarify these terms, concepts and definitions.

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

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

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

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

Medical Services function

Standard

EMP must be:

- Presentable in appearance
- Courteous in approach
- Punctual.

Reports must:

- Be legible
- Be comprehensive
- Be consistent within themselves
- Be impartial
- Be clearly understandable
- Be medically correct
- Not make any reference to entitlement
- Contain non-prescriptive advice in accordance with the relevant legislation
- Be free of embarrassing, confidential and harmful information.

Measured by

1. Review by Medical Advisers.
2. Comments from DM – assessing legibility, consistency, clarity, helpfulness.
3. External claimant questionnaire - assessing appearance and manner.
4. Level of substantiated complaints.

Appendix C - Attributes for examinations in DLA/AA

1) Definition and interpretation of generic attributes

ATTRIBUTE	CODE
<p>“Legible” – The evaluation of legibility is inevitably a subjective task. However, some measure of the ease with which a product may be read is necessary in our business. A passage may be regarded as legible if it can be read at not less than half the average speed of printed text, and no key words or phrases are indecipherable.</p>	G06
<p>“Clearly presented” - Good presentation is an important component of clarity. Faced with a lengthy passage of free text it is often difficult for the reader to efficiently identify its components and structure. Underlined headings and logical sectioning of text greatly aid communication between author and reader.</p>	G10
<p>“Free from medical abbreviations” - Medical abbreviations should not be used. Although certain shorthand medical terms may be known to most readers it is nevertheless good practice to avoid their use wherever there is any possibility of confusion.</p>	G12
<p>“Free from medical jargon” - The use of medical jargon, which includes medical abbreviations, can lead to misunderstandings. The term “medical jargon” is distinguished from technical medical language (see “Clear explanation of medical issues”). Examples of medical jargon would be “Oedema ° cyanosis °....” or “Nodes neck ↑↑ R>L”.</p>	G13
<p>“In plain English” - The use of uncommon or long words where everyday, commonly used terms would be equally effective is not good practice. Sentences should be brief, clear and to the point.</p>	G15
<p>“*Consistent” - A report should be consistent in that it must contain no internal contradictions. A fact or opinion given in one part of a document should be in accord with all other components of the product.</p>	G03
<p>“*In accordance with defined procedures and current advice” - This attribute requires that a report must be procedurally correct. It should be prepared in accordance with current usage as defined in reference publications for medical advisers.</p>	G04

<p>“*In accordance with legislation” - While the medical adviser’s role is wholly advisory and not statutory, the work is nevertheless carried out within the framework of current legislation. It is therefore a required attribute that advice is given in accordance with the law.</p>	<p>G05</p>
<p>“Appropriate response to incorrect documentation” - The medical adviser should be able to recognise the fact that incorrect documentation has been provided. The doctor’s response will vary according to circumstances, but above all should not compound the error. It should reflect the needs of the business and the requirements of the customer.</p>	<p>G08</p>
<p>“FME consideration recorded” - It is important that the customer is made clearly aware of the evidence which the medical adviser has considered in giving advice. Further medical evidence is of particular importance in this context.</p>	<p>G11</p>
<p>“*Complete answers to all questions raised” - No area of a report should be left incomplete. If specific questions are raised by the customer they should all be addressed.</p>	<p>G02</p>
<p>“Advice adequately justified” - Advice which is not accompanied by justification is no more than a gratuitous opinion. This attribute requires that the author of a report gives a clear explanation of the reasons for giving certain advice and the underlying evidence by which he was guided.</p>	<p>G16</p>
<p>“*Clear explanation of medical issues” - A report written solely in technical medical terms is valueless to the non-medical customer. This attribute does not require that such terms are avoided, merely that they, and the underlying medical reasoning, are clearly explained for the benefit of the non-medical reader.</p>	<p>G01</p>
<p>“Appropriately detailed” - Excessive detail compromises clarity. Equally, failure to provide adequate information may compromise decision-making. Skilled report-writing avoids these extremes.</p>	<p>G09</p>
<p>“Full clarification of contradictions and/or conflicts” - Conflicts of evidence should be addressed. Even where the medical adviser is unable to provide an explanation for such a conflict, he should demonstrate that the difficulty has been recognised.</p>	<p>G14</p>
<p>“*Not compromising decision-making” - The medical adviser’s report should contain no allusion to entitlement to benefit, or express any view regarding the outcome of a case.</p>	<p>G07</p>

2) Presentation and Process Attributes

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

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

Key Requirements	EMP Report Attributes	Attribute Code	
Appropriate Medical Examination	All claimed needs covered by the statement	S07	
	*Appropriate clinical and past history recorded	S10	
	Current medical treatment described	S18	
	Current symptoms described	S19	
	Current work situation described	S20	
	Statement covers all claimed needs in relation to the DBD146	S55	
	Statement written in first person	S61	
	Statement signed by client [or carer/representative]	S54	
	Appropriate pen picture present	C10	
	Current symptoms described	C16	
	*Clear record of a careful structured examination of all relevant areas	C01	
	*Clinical findings expressed clearly and concisely	C03	
	*Examination covers all known conditions	C04	
	*Inappropriate signs clearly described	C06	
	*Record of appropriate mental health assessment, if indicated	C08	
	Medically Reasonable and Logical	*Mobility opinion consistent with clinical findings	R26
		*Opinion on safe mobility supported and consistent with clinical findings/observed behaviour/anecdotal evidence	R35
	*Day attention needs are medically justified and consistent with clinical findings	R79	
	Main meal opinion: Opinion justified and consistent with clinical findings	R67	
	*Day supervision: expressed needs medically justifiable	R11	
	*Night attention: needs are medically justified and consistent with clinical findings	R27	
	*Night supervision: expressed needs medically justifiable	R28	
	*Opinion based on clinical findings and observation and not on clients claimed needs	R33	
	*Medically reasonable and logical	R25	
	*Inconsistencies dealt with clearly	R20	
All Medical Issues Addressed	Attention opinion checklist; all tick boxes justified if help needed	R48	
	Clear categorisation (attention vs. supervision) of help required in maintaining personal hygiene	R49	
	FME clarified and interpreted when required	R63	
	Social/cultural issues addressed if requested in DBD146	R71	
	Summary/prognosis present if requested on DBD146	R73	
In Keeping With Consensus of Medical opinion	*Advice conforms to consensus of medical opinion and balance of probabilities	R01	

Appendix D - Abortive visits - AV1/AV2 forms

Office Address

MEDICAL SERVICES

To

From

Date

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

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

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

What happens next

I will visit you on / / at

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

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

Doctor's Name

Phone Number

AV1

MEDICAL SERVICES

If you get in touch with us please tell us this reference number

If you need to ask us anything you can ring us on

Monday – Friday

Date

About your claim for

Disability Living Allowance

Attendance Allowance

This letter is about

We arranged for you to be examined by a doctor on / / but you were not available when the doctor visited.

If you do not make yourself available for a visit we may not be able to continue paying your benefit.

What happens next

The doctor will visit you again on / /

In the morning at

In the afternoon at

If you have made a claim/receive payment for somebody else the doctor will visit them at this address:

The name and address for the doctor is on page 2 of this letter.

Please read the notes on pages 2 and 3 of this letter. They tell you more about the examination, and what to do if you need to change the appointment.

Please turn over>

Form AV2

MEDICAL SERVICES

About the doctor

The name and address of the doctor who will visit is:-

Name

Address

Phone number

If you live in a nursing home or residential care home

Please tell the matron or person in charge of the home about the visit.
They will need to know when the doctor will visit

If you cannot be at home

If you have to change the time of the visit please let the visiting doctor know straightaway. Please try not to change the date of the visit unless you have to. This could delay your claim or affect your payment.

If you go into hospital

If you expect to go into hospital or you are admitted to hospital please tell the visiting doctor straightaway. You should tell the doctor which hospital you will be in and the name of the ward. If you know when you expect to leave the hospital you should tell the doctor.

MEDICAL SERVICES

What will happen with the doctor visits you

The doctor will need to discuss with you the effects of your disability on your daily life and may need to examine you.

It may help if someone who knows how much help you need can be with you when the doctor visits.

You can also have someone else with you if you think it would make you feel more comfortable. This could be a carer, a friend or a relative.

Please tell the doctor

- how much help you normally need during the day
- how much help you normally need during the night
- what problems you have with getting around
- if they have visited you on a day when your illness or disability is better or worse

What happens after the doctor visits you

The doctor will send their report back to us. A doctor cannot make a decision about payment of your allowance

A Decision Maker will look at this report and make a decision about your allowance. We will write to you as soon as we can to tell you about the decision the Decision Maker has made.

What is a Decision Maker

Decision Makers are people who decide whether you are entitled to benefit or not, based on the law. They also decide how much benefit you can get.

If you do not want to be medically examined

If you do not want to be medically examined please tell us the reason why on page 4. Then send this letter back to us. Our address is at the top of the front page of this letter.

Please turn over>

MEDICAL SERVICES

If you do not want to be medically examined

Please give us the information we ask for and tell us why you do not want to be medically examined.

Surname

Other names

National Insurance (NI) number
This is at the top of the front page of this letter

I do not want to be medically examined because

Signature

Date / /

Appendix E - Unexpected Findings – Disclosure of clinical information by Medical Advisors to Claimants’ General Practitioners

1) Introduction

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

2) General Medical Council Guidance

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

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

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

All doctors are strongly advised to read these guidance notes from the GMC. If any doctor does not have a copy then they should contact the GMC at 178 Great Portland St, London W1W 5JE (tel. 020 7580 7642) or visit www.gmc-uk.org. There will be updates of the frequently asked questions on the website.

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

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

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

The doctor should record relevant details of their discussion with the claimant on form UE1 (Rev), both in respect of the information that they have given to the claimant and the claimant's response.

For example **"I advised your patient that he should report the symptom of coughing up blood to you and he said that he would arrange an appointment as soon as possible"**.

These details should be recorded on form UE1 (Rev) in the section **"I have examined your patient/reviewed your patient's file* in connection with their claim to benefit. I believe that you will wish to be aware...."**

Informed written consent from the claimant should be obtained on the UE1 (Rev) form and the procedural guidance must be followed in full. An example of this form is in Appendix F.

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

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

4) Guidance for contacting the claimant's doctor

a) Contact by telephone and letter:

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

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

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

Telephone contact must be made in all cases with the claimant's medical attendant, to ensure compliance with the 24-hour deadline.

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

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

b) Claimant does not have a GP:

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

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

If the claimant refuses to give consent, the examining doctor should not normally make any attempt to contact the GP by telephone or by letter. The claimant should be asked to sign the relevant section of the UE1 (Rev) to indicate this refusal.

In these circumstances, the doctor should only complete the form partially, so as to provide the claimant's name and NINO for identification purposes, and details of the clinical condition that raised concern. There is no need to complete the GP contact details, as the form is not intended for despatch. Nevertheless, copies of the partially completed UE1 (Rev) should be retained on the claimant's file, the CSD compendium file and the doctor's personal file, in accordance with current guidance.

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

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

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

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

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

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

6) General Procedural Guidance

a) Harmful Information

See section 14.2.1

b) Referral to hospital

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

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

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

c) Advising the claimant

In all instances of unexpected findings the claimant must be advised to consult their GP/Medical Carer in the near future, and the degree of urgency communicated to the claimant will depend upon the clinical judgement of the examining doctor. Due sensitivity must be observed when advising the claimant to attend their GP and you must ensure that your manner does not give rise to undue concern.

d) Undiagnosed mental health conditions

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

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

If in any circumstances there is doubt on the correct way to proceed, doctors should consult CSD for advice.

7) Customer Service Desk (CSD)

Role of CSD

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

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

CSD will be able to call upon the services of an experienced MA if any difficulty is encountered.

8) Unexpected findings arising during the course of file work

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

The Medical Adviser should write to the claimant and request the claimant's written consent for disclosure. A first-class reply paid envelope for reply should be enclosed. The letter to the claimant must include an indication of the nature of the information that is intended for communication to the GP, although this must of course be done in such a way as to avoid engendering undue alarm.

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

If a positive response to the request for consent is received, it should be linked to the file and passed to an MA immediately. The MA should then contact the GP by telephone on the same day – this is important to reduce the likelihood of a situation developing where the claimant contacts the GP before Medical Services has had an opportunity to pass on the relevant information. In addition to telephoning the GP, the MA must complete form UE1 (Rev) with the relevant details. This form should be handed to the administration clerk, who will issue the completed UE1 (Rev) to the GP or Medical Carer, after taking copies for CSD (retained for 3 months), the claimant's file and the doctor's personal file (to be retained for a minimum of 10 years). In file work cases only it is not necessary to issue a copy of the UE1 (Rev) to the claimant, as they will already have been provided with relevant details in the earlier letter seeking their consent.

If after five working days the consent has not been returned the CSD Team Leader should pass the photocopy to a Medical Adviser who will telephone the claimant and ask if the letter has been received and is being returned. Details of the telephone call and any conversation should be recorded on the back of the photocopy. Following the telephone conversation:

- If the claimant informs the MA that the letter has been/will be returned, wait for a further two days for the letter. If no reply is received after a verbal reminder, then it should be assumed that consent is withheld.
- If claimant refuses to reply to the letter the MA should consider if release of information without the claimant's consent is justified.

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

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

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

REPORT OF UNEXPECTED FINDINGS FOLLOWING MEDICAL EXAMINATION

To:

GPs Fax No:

From:

Tel No:
Our Ref. (NINo):
Date:

Dear Doctor

Information about your patient:

Name:

Date of Birth: / /

Address:

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

Claimant Consent:

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

Signed: _____ (claimant) Date: / /

Please note that:

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

GP notified by telephone Time notified GP : : I have advised your patient to consult you

Yours sincerely,

Signed: _____ (Doctor) Date: / /

Name (Print): _____

Official Use Only

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

Do Not Weed (DWP Purposes Only)

UE1 (Rev) 10/01

MEDICAL SERVICES



PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

PROOF OF IDENTITY SLIP

Please complete part 1 with the claimant's details.

PART 1

Full Name (please print).....

Date of Birth.....

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

PART 2

For office use only

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

A) Has correct identity been established by Receptionist/MEA?

Yes No N/A

If 'No' or 'N/A' complete B

B) Has Examining Doctor been able to establish correct identity?

Yes No

POID1/Version 1
Feb 2002

Acceptable Forms of Identification

Medical services will accept as evidence of identity one of the following:

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

Alternatively, Medical Services will accept any three of the following documents as proof of identity:

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

MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

[Title] [Claimant Name]

[Address 1]

[Address 2]

[Address 3]

[Postcode]

Reference: **AB 123456 C**

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

[Date]

Dear [Title] [Claimant Surname]

Re: Request for disclosure of information to your General Practitioner

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

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

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

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

Please find enclosed a stamped address envelope.

Yours sincerely,

Medical Adviser

Claimant Consent:

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

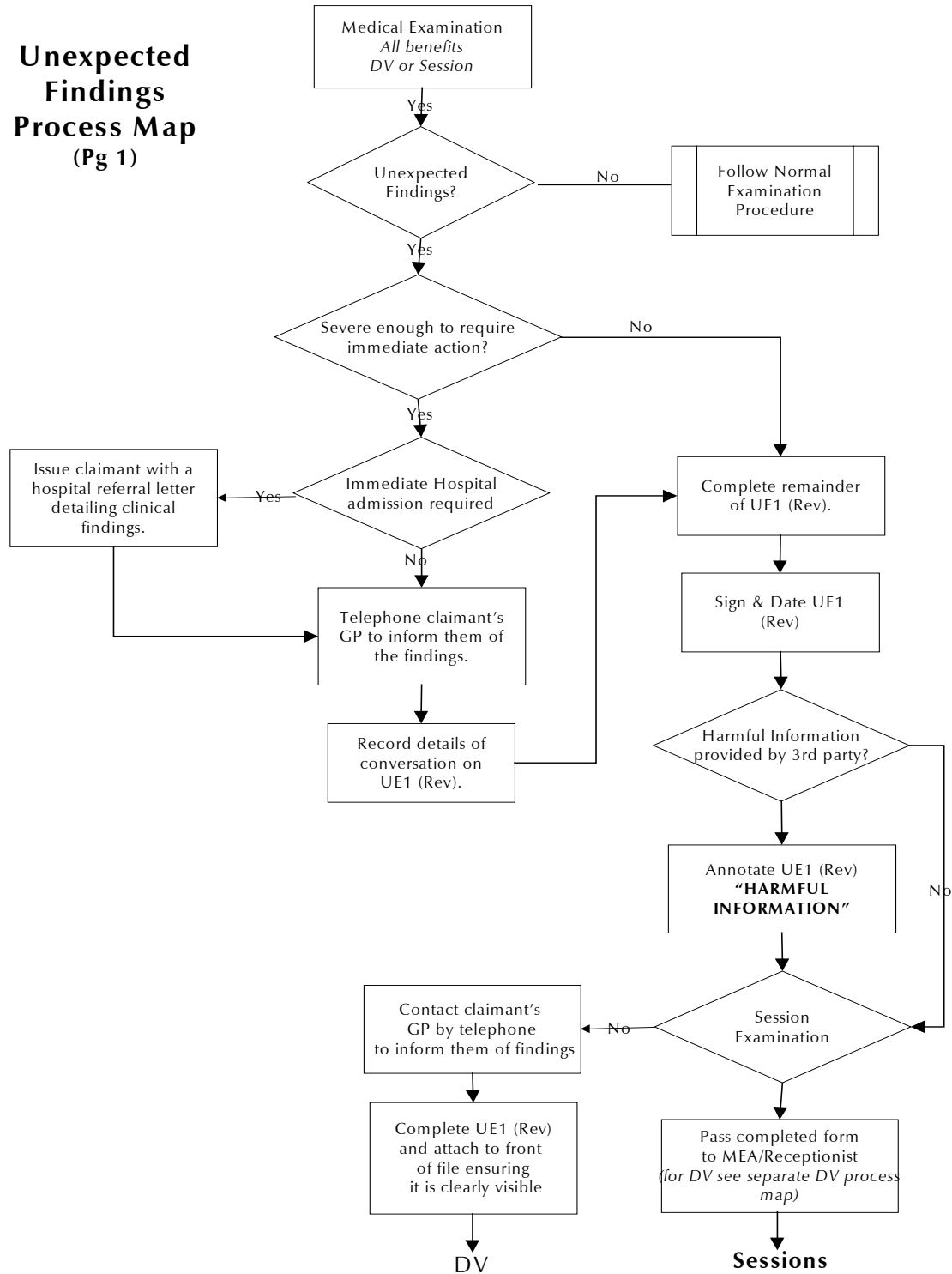
Signed: _____
Name: _____

(*claimant*) Date: / /

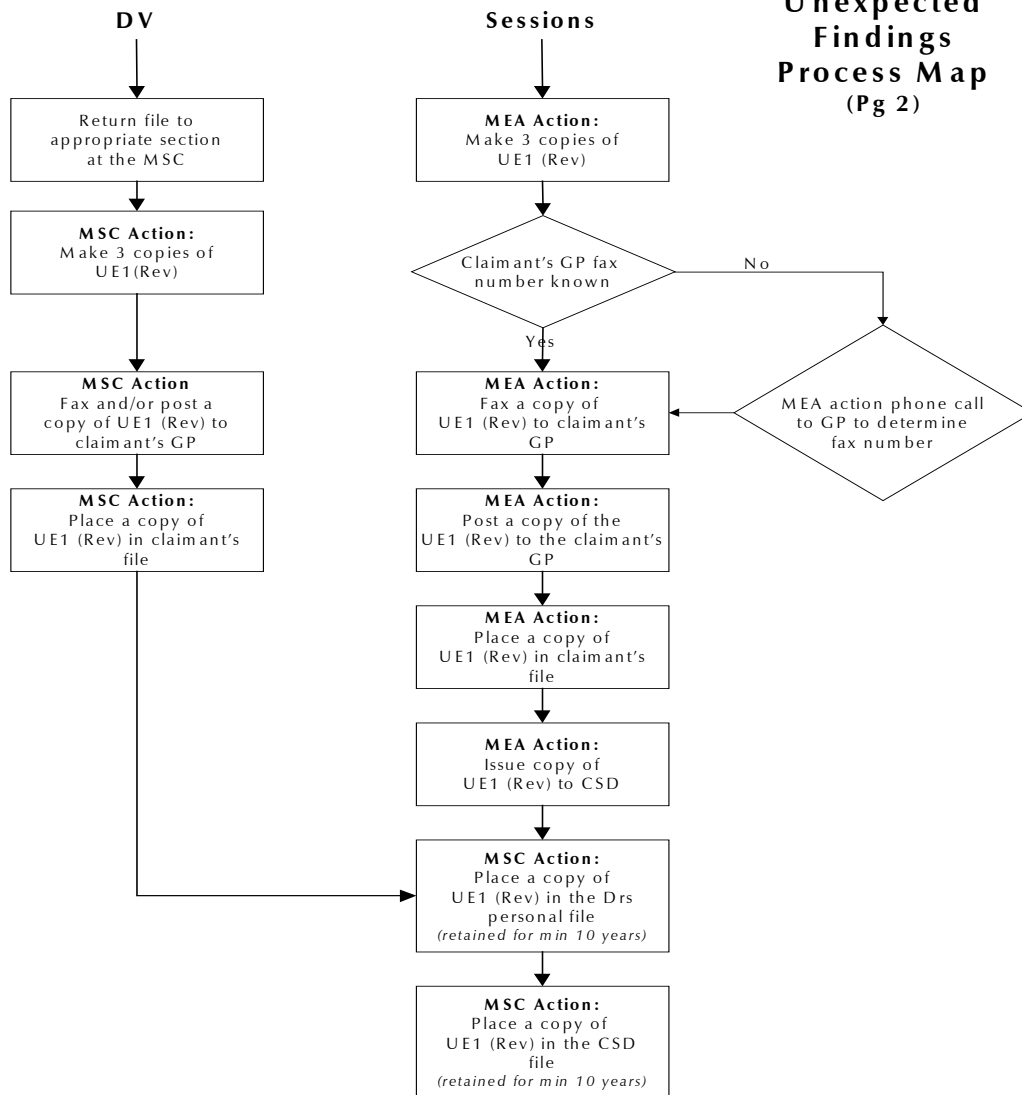
UE2 10/01

Appendix G - Process Map

Unexpected Findings Process Map (Pg 1)



**Unexpected Findings
Process Map
(Pg 2)**



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: Angela Rhodes
Training and Development Co-Ordinator
Atos Origin
3300 Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YQ