Impairment Component

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Introduction

There are three elements to the impairment component:

1. Personal care - for people who need some assistance with their own care
2. Mobility - for people who have difficulty in getting around
3. Clinical cost - where there is evidence that someone has a chronic health problem and needs additional levels of visits to their general practitioner

There is also a separate component known as Flexible Personal Care, which functions differently in that the assessment for this component is carried out by a care professional employed by the Health & Social Services Department. It replaces any personal care award, but a person can continue to get mobility and clinical cost where appropriate.

Persons who are eligible to apply for the impairment component

A claim may be made for any element of the impairment component in respect of any member of a household that meets the residency criteria and is a participant of a valid Income Support claim.

If a valid income support claim exists, then the DO can consider the qualifying criteria for the impairment component. These criteria apply to the member of the household who is claiming the impairment component. It may be an adult or a child and:

1. their illness or disability must have lasted, or be expected to last for at least 6 months, or
2. they are not expected to live more than 12 months

In the case of a terminal illness a person can also meet the criteria for Personal Care level 3 if a relevant clinician provides evidence to say that they have a health condition which might be terminal within the next 12 months. This is handled by a special process and evidence form (Special Rules for End of Life For SR1), and doesn't require a full impairment assessment.

If either of the above conditions is satisfied, then the relevant qualifying conditions for each of the 3 individual elements of the impairment component can be applied.

Flexible Personal Care

If a household member needs a formal package of care, a flexible personal care component is available. Unlike the fixed level personal care components, this component does not have a fixed value but is set at the value of an agreed care package, up to a maximum level set equal to the lowest level of care supported through

the Long Term Care scheme. This component is awarded after an assessment by a social care professional and paid direct to the care provider.

If a household member needs formal care package to provide ongoing help with activities that are an essential part of daily living then the first step is to request a care needs assessment. They should contact the Single Point of Referral (SPOR) at the Health & Community Services Department.

A social care professional will carry out the assessment and discuss the person's care needs with them. This will determine whether they should get help with the cost through flexible personal care or through the separate Long Term Care benefit.

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Personal Care Element

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Component

The personal care element is intended to help people with the cost of their care. To establish the level of care, a test of functional assessment is applied. The test is in the legislation in Schedule 2 of the Income Support (Jersey) Regulations 2007 and is called the personal care test (see below). The test has statements which apply to physical, sensory and mental function. Each statement carries a score.

Applicants will furnish details about their condition, from themselves, their doctor or another person closely involved in their care for example their carer. From this information, the DO will select which are the most appropriate statements from the test that apply to the claimant. The scores from the statements are added together to give a total score which is used to determine the level of payment.

The test applies to all adult and young people aged 12 years or more. The test also applies to children under the age of 12 years although there are some restrictions due to the age of the child. For more information on the children's test see the separate section below.

A person can also meet the criteria for Personal Care level 3 if a relevant clinician provides evidence to say that they have a health condition which might be terminal within the next 12 months. This is handled by a special process and evidence form (Special Rules for End of Life For SR1), and doesn't require a full impairment assessment.

The personal care test

This assesses a person's loss of function using specified activities.

Twelve in the area of physical and sensory function:

1. sitting
2. standing
3. rising from sitting
4. walking
5. bending and kneeling
6. reaching
7. lifting and carrying
8. manual dexterity
9. vision
10. hearing
11. speech
12. seizures resulting in unconsciousness or altered consciousness

Six in the area of mental health and cognitive function:

13. management of personal finance
14. maintaining appearance and hygiene
15. management of daily routine
16. awareness of danger and consequences of behaviour
17. getting around outdoor
18. coping with change

Two that apply only to children under the age of 12 years whether they have a physical and/or mental health condition:

19. need help from another person to ensure developmental milestones
20. need help from another person due to a medical condition

In the personal care test the statements about:

- physical and sensory function (1 – 12) can only apply to someone who has a physical disease or disablement.
- mental health and cognitive function (13 – 18) can only apply to someone who has a mental disease or disablement.

This is to avoid a doubling-up effect of the scoring.

For each of the activities, there is a set of ranked statements, known as descriptors, which illustrate different levels of functional limitation. For each descriptor a set number of points are awarded;

The maximum points available for a descriptor in an activity in the physical and/or sensory areas is 15 points

The maximum points available for a descriptor in an activity in the mental function area is 20 points

The statements for mental function carry a higher score because there are fewer statements in this section and the higher score is simply to weight the statements to make sure that applicants achieve the appropriate subsidy level.

The personal care level is determined by the choice of the descriptors which most accurately reflect the person's level of functional limitation across all relevant specified activities. Using activity 1 `sitting' the descriptors are as follows together with the points they attract;

(a) cannot sit without severe discomfort - 15 points

(b) cannot sit without severe discomfort for more than 10 minutes - 15 points

(c) cannot sit without severe discomfort for more than 30 minutes - 6 points

(d) cannot sit without severe discomfort for more than 1 hour - 3 points

(e) none of the above - 0 points

Descriptors (a) and (b) represent the highest degrees of functional restriction and hence carry the maximum scores of 15 points but descriptors (c), (d) and (e) represent lesser degrees of functional restriction, and hence these score fewer than 15 points. However these points do count towards the overall points scored.

More detail about the scope of each part of the test and how to apply them is contained within the guide for approved doctors and determining officers.

Prosthesis, aids and appliances

In assessing the extent of a persons capability to perform any of the physical and sensory activities (1 - 12) they should be assessed using the following rules:

- Where a member of a household is normally fitted with or normally wears a prosthesis, he or she shall be assessed as if he or she was fitted with or wearing that prosthesis
- Where a member of a household normally wears or normally uses any aid or appliance, or could reasonably be expected to normally wear or normally use any aid or appliance, he or she shall be assessed as if he or she was wearing or using that aid or appliance

Guide for approved doctors and determining officers

The guide for approved doctors and determining officers has been drafted to give DO's a greater understanding of the scope of the test statements. It should therefore be referred to when reviewing applications.

The guide also explains that DO's need to consider the ability of the applicant to undertake the relevant action. The DO has to consider whether the applicant can do the action:

1. in a reasonable time
2. repeatedly
3. without undue pain and
4. in a safe manner

Therefore if by doing something the applicant cannot do anything else afterwards, then the DO should consider that they cannot really do that test.

See Example 28.3

The guide is not in legislation, it is essentially a document to show how the department will interpret the statements of the test which are in the law.

Rates of personal care element

The payment of the personal care element is to help towards the cost of a person's care and it does not necessarily cover all individual costs. There are three levels of payment and claimants must have a minimum score of 15 points to qualify for any payment. The scoring bands are:

Level 1 - at least 15 points, but less than 36 points

Level 2 - at least 36 points, but less than 56 points

Level 3 - at least 56 points, where the person is not receiving long-term care

For the current rates applicable to each band see Components.

Children

The children's test applies to claimants aged under 12 years. The principles of the test are identical to the adult test using the activities and descriptors. This test considers the problems a disabled child has with the activities and descriptors over and above a child without a disability. Children age 12 years and above are considered able to perform all the activities and descriptors in the adult test and so that test is applied to them.

The children's test is divided into 6 age ranges:

Less than 1 year

1 year to under 3 years

3 years to under 5 years

5 years to under 8 years

8 years to under 12 years

The children's test considers the same activities as the adult test. For some activities a child without a disability of a certain age would be unable to perform the activity due to normal development. For similar reasons some descriptors within an activity will not apply to children of certain age ranges. Therefore for each age range some activities and descriptors will not be considered where a 'normal' child in that age range cannot undertake that activity/descriptor.

The children's test recognise that children develop both physically and mentally as they get older and so if development improves their condition, the care award may reduce.

Children only descriptors

For children aged between birth and 12 years the test contains two additional functional aspects. For children aged under 1 year, these are the only two activities that apply. They cover

Need for the help of another person as stipulated by a health care professional to ensure that developmental milestones are achieved as fully as possible. The help may be for example speech, physiotherapy or play therapy but must be part of treatment prescribed by a health care professional. See Example 28.5.

Help prescribed by a health care professional with management of medical conditions. See Example 28.4.

Inapplicable descriptors due to age

Certain descriptors relevant to children are further restricted depending on the age of the child. These are detailed in the guide for approved doctors and determining officers.

Using activity 7 `lifting and carrying' the descriptors are as follows together with the aged below which the descriptor does not apply:

(a) cannot pick up and transfer a full glass of water of 200ml capacity with either arm - 3 years

(b) cannot pick up and pour from a full saucepan or kettle of 1.5 litre capacity with either arm - 8 years

(c) cannot pick up and transfer a 2.5 kg bag of potatoes with either arm - 8 years

(d) can only pick up and transfer a full glass of water of 200ml capacity with one arm - 3 years

(e) none of the above - 3 years

Children under 8 years would not be able to lift the equivalent of full saucepan or a bag of potatoes.

The same principles apply to the mental health disablement statements.

GP's report

When a member of a household has indicated that they wish to claim the impairment component (or any element of it), they will be asked to give the name of their treating practitioner and give consent to contact that practitioner.

In most cases this will be their GP and so the GP will be asked to provide a report. The questions included in this report have been agreed with representatives of the local medical profession.

The report generally follows the same format as that used by the Disability and Carers Service (DCS) in the UK, which was formally agreed by the British Medical Association.

The report asks for factual clinical information which a GP can reasonably be expected to answer from the case notes and his knowledge of the patient. Questions about daily living activities can only be answered if these are known to the GP.

A service level agreement is in place with the GPs to ensure that the reports meet a certain standard and that the department is diligent in obtaining permission from their patients for disclosure of confidential medical facts.

GPs are paid for the completion of these reports but will not be paid for reports that do not meet the required standards.

The GPs have been given broad guidelines about what general information to provide and the completion of the form. The form will contain permitted technical language (i.e. language referenced in a medical dictionary) and will avoid jargon. The GPs will also state which specific Clinical guidelines about certain conditions they are following to treat the patient.

Harmful information

Where the GP has completed the section at the back of the report entitled harmful information, the DO should use this information in the assessment, but must be aware that it may not be divulged to the applicant consent and harmful medical evidence.

No GP's report and DO's right to request information

If a GP report is not available, the DO should determine if there is sufficient evidence available without it to enable them to make an assessment of the persons loss of function.

If not then the DO should contact the GP and ascertain whether the request was received and if so has a report been completed and returned. If the GP has declined to complete the report, the DO should establish the reasons for this.

Should a GP report then not be received the applicant will need to be informed that report has not been completed by their GP and advised of other options available to them. This may for instance be whether a report can be provided by another doctor (the DO should confirm that consent is available from the applicant to contact this doctor), e.g. a consultant who has treated them recently, or from their carer.

The DO should then determine if there is sufficient information provided or whether they wish to exercise the power to request information. This can include the right to refer an applicant for a medical assessment by one of the department's approved doctors, but also allows the DO to request certificates and other documents, or that the person submits to a medical assessment with a healthcare professional that they arranged themselves.

Applicant's self report

The self report also acts as the claim form for the impairment component either as a whole or any of the three elements separately. The applicant is required to sign a declaration at the end of the report and to give consent for their medical practitioner to be contacted. The request for a Practitioner's Report will only be sent out after receipt of a correctly completed self report.

Everyone claiming the impairment component (or any element of it) will be asked to complete a self-report form. This differs from a self-assessment in that it is simply asking the applicant to provide information about the way their illness or disability affects them and not asking them to judge whether they actually qualify for a benefit.

The report follows the format of the activity statements in Schedule 1 of the Income Support (Jersey) Regulations 2008. This is important because changing the wording in any way leads to a change in the test.

It should also be noted that the language used in the statements is often in the negative as the test is determining what the claimant cannot do. Establishing what they are capable of doing does not identify the level at which they need assistance.

If the applicant is not able to complete the form themselves, then they can get someone else to complete it. The applicant (or the person who completes the form of their behalf) must sign the declaration.

The applicant can also ask anyone who participates in their care on a professional basis to complete section 6 of the report. This could be (for example) an occupational therapist, community psychiatric nurse or social worker. If this part is completed, then the health care professional must also sign a declaration.

Often someone in these professions will have more direct knowledge about the effects on the functional aspects than the GP. This may be particularly important should the GP not complete a report.

Ailment Guide, Decision tables and Typical Outcome Tables (TOT's)

To assist DO's an Ailment Guide, Decision tables and Typical Outcome Tables (TOT's) have been produced for the more common diseases or disablements such as back pain and depression. The information supplied by the applicant must first be used to understand the severity of their problem.

The Ailment Guide, Decision tables and Typical Outcome Tables (TOT's) categorise each condition as mild, moderate and severe. The categorisation of severity does not mean that someone has a similar level of requirement for care. For example, severe migraine is less disabling than moderate back pain.

To validate the self report, the information to consider will be primarily the clinical information given by the doctor. Usually this will include medication, but it may refer to specific tests.

See Example 28.9 or Example 28.10

If more information/understanding about a condition and the resulting care needs is required by a DO they can refer to the medical guidance provided by the website NHS Choices. This site is funded by the Department of Health to provide objective and trustworthy information and guidance on all aspects of health and healthcare.

Once the DO has an understanding of the severity of the condition, then they can select the appropriate typical outcome table which are part of the Ailment Guide, Decision tables and Typical Outcome Tables (TOT's) .

The following are the ailments current covered by the Ailment Guide, Decision tables and Typical Outcome Tables (TOT's):

1. Anxiety
2. Asthma
3. Back Pain
4. Depression
5. Osteoarthritis lower
6. Osteoarthritis Upper
7. Ischaemic Heart Disease
8. Learning Difficulties
9. Schizophrenia
10. Stroke - Lower Limb
11. Stroke - Upper Limb
12. Vision

Typical outcome tables (TOT's)

The typical outcome tables have been produced to help DO's understand which test statements are most relevant to a condition and its severity. They are contained as part of the Ailment Guide, Decision tables and Typical Outcome Tables (TOT's).

When the DO has ascertained which statements of the test apply from the information supplied by the applicant, then they can compare these statements to the TOT selected. If they are the same, or reasonably similar, then the DO can be confident of awarding the resulting level of the personal care element.

If the information supplied by the applicant results in differences to the TOT, then the information supplied should be reviewed to understand where the difference lies. If there is medical evidence that supports the selection of a statement, then this should be used. See Example 28.11

Condition not covered in Ailment Guide, Decision tables and Typical Outcome Tables (TOT's)

If the relevant ailment is not covered in the Ailment Guide, Decision tables and Typical Outcome Tables (TOT's) the DO should review the evidence provided to ascertain if any statements apply. The DO may also consult one of the department's approved doctors to see if they can assist in the interpretation.

If the DO is unable to interpret the information provided or reach a decision, then they can approach the applicant for further information asking specific questions. The DO may also approach the applicants GP (or anyone else whom the department has permission to approach the applicant's self report) for further information.

If the DO is not able to make an award from all the information provided, then the applicant should be asked to undertake a medical assessment also known as a medical board. During the medical assessment, an approved doctor will be asked as part of the examination to select the statements that in their opinion apply to the applicant.

More than one condition diagnosed

In many cases, the applicant may have more than one condition diagnosed and there could be a combination of many. For instance, someone with learning difficulties could also have heart disease, or a blind person may develop arthritis.

These cases are more complex, but the same principles apply. Each diagnosis must be assessed separately and then the points added together ensuring that no double scoring occurs.

See Example 28.13

If the points awarded by the DO for the same activity in respect of the separate conditions are the same then that score is used. However if the points awarded for the separate conditions are different then this must be considered more carefully by the DO to establish the reason for the difference. It is not simply a matter of either taking the lower score or giving the applicant the benefit of the doubt and awarding the higher score.

If it is not possible to determine the award from information provided even after further discussion with the applicant, GP or health care professional treating them, then the DO should consider referring the applicant for a medical assessment, also known as a medical board, conducted by one of the department's appointed doctors.

Transient conditions

Conditions other than those resulting in a terminal diagnosis, must have lasted or be expected to last for at least 6 months before a claim to the impairment component can be accepted if they are eligible.

However a DO may need to consider what effects a transient illness/loss of function that is not likely to last 6 months may have on an applicant who already has a chronic disease or physical or mental health disablement.

If the change in condition is not likely to last for 6 months, then a full reassessment of the award is not appropriate and the existing award can remain in place. However, it is possible that although function returns it will not be to the same level as before and it would therefore be appropriate to review after a shorter period than previously set.

See Example 28.14

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Mobility Element

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The mobility element is intended to help people who, because of their illness or disability, require specialised transport to get out and about, or who may not be safe going out on their own and so have to have someone with them.

A functional test is applied, using some of the statements in the personal care test. If any of the appropriate statements apply to an individual then the mobility element may be awarded.

The relevant statements in respect of the mobility element of the impairment component are contained in Schedule 2, Part 2 of the Income support (Jersey) Regulations 2007 and are listed below:

A statement in respect of any of the activities numbered 1 to 3 shall be selected having regard only to the member of the household's physical and sensory abilities.

Where a member of a household is normally fitted with or normally wears a prosthesis, he or she shall be assessed as if he or she was fitted with or wearing that prosthesis.

Where a member of a household normally wears or normally uses any aid or appliance, or could reasonably be expected to normally wear or normally use any aid or appliance, he or she shall be assessed as if he or she was wearing or using that aid or appliance.

A statement in respect of any of the activities numbered 4 to 6 shall be selected having regard only to the member of the household's mental and cognitive abilities.

1. Walking:

(a) Cannot walk at all.

(b) Cannot walk more than a few steps on level ground and/or up and down one stair without having to stop or feeling severe discomfort, even with the support of a handrail.

(c) Cannot walk more than 50 metres on level ground and/or walk up and down a flight of 12 stairs without having to stop or feeling severe discomfort.

Note: Statement is not relevant in the case of child under the age of 3 years.

2. Vision, including visual acuity and visual fields, in normal daylight or bright electric light:

(a) Cannot see the shape of furniture in the room.

(b) Cannot see well enough to read 16 point print at a distance of 20 cm.

(c) Cannot see well enough to recognise a friend at a distance of 5 metres.

Note: Statement is not relevant in the case of child under the age of 3 years.

3. Seizures causing loss of consciousness or altered consciousness:

In the past 6 months has had one or more seizures with loss of consciousness or altered consciousness and either –

(a) was awake when the seizure commenced but had no useful warning of the seizure; or

(b) had dangerous post-ictal behaviour.

Note: Statement is not relevant in the case of child under the age of 12 years.

4. Management of personal finance:

Does not understand the value of money.

Note: This statement is not relevant in the case of a child under the age of 8 years.

5. Awareness of danger and consequences of behaviour:

5a. is totally unaware of common dangers or the potentially harmful consequences of his or her behaviour.

5b. Needs to be instructed on at least a daily basis about common dangers or the potentially harmful consequences of his or her behaviour.

Note: Statement (b) is not relevant in the case of a child under the age of 5 years.

6. Getting around outdoors:

6a. Unable to cope with leaving the house unless accompanied by another person.

6b. Unable to find his or her way around even in familiar places.

Note: This statement is not relevant in the case of a child under the age of 8 years.

In 6 "Getting around outdoors", where in the personal care test Activity 17 the most functional loss is described under 17a as "unable to cope with leaving the house even if accompanied by another person", the mobility element is not awarded as the individual does not actually leave the house.

A higher level of subsidy is available to people who work and earn a certain amount.

Children

Children under the age of three years are not eligible for the mobility element. In addition some specific statements do not apply under a certain age and these are detailed in the introduction.

See Example 28.15

Long-term care

A person is not entitled to a mobility component if they are receiving long-term care in an approved care home. If they are receiving long-term care and are residing in their own home then the mobility component can be considered.

Higher subsidy for earners

Income support recognises that people who are working have to travel more often and so will have higher costs. Therefore, a higher rate of subsidy for the mobility element is

available if an applicant is working. However, the applicant must be earning more per week than the higher rate of the mobility component.

The rates of the mobility element of the impairment component can be found in Components.

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Clinical Cost Element

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Introduction

In Jersey, GP's are private businesses and so will charge patients for the services that they provide. This is usually a charge made after each visit. The cost of these visits is subsidised for Jersey residents through the Health Insurance (Jersey) Law 1967. The health scheme subsidises every GP visit by a set amount.

The remainder of the GP charge is known as the co-payment and the patient is responsible for paying this.

The basic adult/child component of income support includes the cost of 4 GP surgery visits over a year.

The clinical cost element is to help members of a household with the costs of their GP surgery visits above the 4 visits in a year and it can be awarded to any member of a household if that member has been diagnosed by a medical practitioner as suffering from a chronic or progressive illness.

This includes children of any age although for children aged under 6 months the DO should ensure that the basic qualification criteria for the impairment component as a whole is satisfied. See Persons who are eligible to apply for the impairment component.

There are two levels of the clinical cost element:

Level 1 - where that member requires at least 5 GP visits to prevent complications or to alleviate symptoms or receive palliative care

Level 2 - where that member requires at least 9 GP visits to prevent complications or to alleviate symptoms or receive palliative care

To help Income Support recipients plan for the ongoing cost of GP co-payments the department has devised a household medical account (HMA) into which money deducted form the household income support entitlement can be saved on a regular basis. For further information on this see HMA.

Medical treatment covered

Only visits to a GP are covered by the clinical costs element.

If the applicant is receiving care from a hospital consultant or through other services provided by Health & Community Services for example the diabetes nurse, then there is no charge for this and so the clinical costs element is not applicable.

Level 2 clinical cost element

Level 2 of the clinical costs element should be considered where, in addition to the requirements for level 1, the GP report indicates that the claimant has significant problems, often this would be co-morbidity i.e. having more than one chronic disease diagnosis or period of exacerbations and fluctuations in one or more condition.

Level 2 should also be considered for claimants over the age of 85 as it is recognised that this age group when presenting with chronic diseases do require higher levels of medical care.

In all cases, but especially in the over 85 age group, the GP may indicate that increased medical care at the primary level (i.e. by the GP in the community and not at the hospital which is the secondary level) is avoiding the claimant having to be admitted to hospital. In the latter circumstance, it would be appropriate to review after a short period as circumstances may change rapidly.

Where the claimant does not require a higher level of medical care, but is unable to attend the surgery and therefore is paying a higher co-payment for home visits, then any (further) subsidy should be considered through special payments. See Medical and associated expenses.

Palliative care

The clinical costs element can be awarded if a person is receiving palliative care. This is also sometimes referred to as comfort care, tender loving care or hospice care.

Palliative care is a comprehensive approach to treating serious illness with a focus on keeping dying patients comfortable through pain control and addressing psychological, social, and spiritual concerns, instead of treating the disease or condition.

The GP will need to confirm the illness and prognosis and indicate palliative care is being given as part of the treatment plan. Palliative care management may require frequent home visits by the GP to ensure the patient is pain free and comfortable, though patients receiving palliative care are also supported by Community nurses.

Depending on the circumstances detailed by the GP, the DO may award Level 2 for a 12 week duration and should keep the claim under review after 10 weeks to consider whether further financial assistance is required through a special payment. See Medical and associated expenses.

However the award of the clinical costs element in these circumstances needs to be handled sensitively. It is therefore likely that each application will be awarded on an individual basis. Therefore the same process detailed in this guide for a general claim to the clinical costs element should be followed by the DO when considering an application for the clinical cost element for palliative care.

Chronic disease

Chronic diseases in the context of the clinical cost element are impairments which are long lasting. They may be progressive i.e. get worse or may improve e.g. childhood asthma or joint replacement surgery for a major leg joint. Often they can be controlled but not cured. Impairments which fall into this definition would include Diabetes or Generalised Osteoarthritis.

See Example 28.16

If more information/understanding about a chronic condition is required by a DO they can refer to the medical guidance provided by the website NHS Choices. This site is funded by the Department of Health to provide objective and trustworthy information and guidance on all aspects of health and healthcare.

Illnesses resulting from infections are treatable and are therefore not considered chronic medical problems for consideration of the clinical cost element. Examples of such conditions would be chest, urine and eye infections.

Physical injuries resulting in loss of function such as a fracture to a limb are also likely to be transient and therefore not chronic medical conditions under the terms of the clinical costs element.

DO's should ensure that the GP confirms the applicants diagnosis and identifies the prognosis. If there is no chronic disease identified by the GP then the clinical costs element cannot be awarded.

If despite having an application for the clinical costs element disallowed an applicant still requires assistance with their GP bills the DO should consider if a special payment is appropriate. See Medical and associated expenses.

Awarding the clinical cost element

Once a chronic diagnosis has been established, the award of the clinical costs element can then be considered.

The applicants GP should state in the GP report if the applicants treatment plan is based on recognised clinical guidelines and if so cite the guidelines used. The GP should also state the number of visits required to maintain the person's well being for the previous 12 month period and within the report, provide information supporting a visit plan for the continued management of the applicant's condition.

However, it should be remembered that medicine is not an exact science and claimants' visit requirements can only be estimated based on the known information.

In considering the award of the clinical costs element, the DO must determine if the GP has demonstrated that the applicant requires ongoing and systematic monitoring to maintain their basic health.

Where a chronic condition has been established, and the claimant is either under the age of 12 years or over 65 years, then the clinical cost level 1 can be considered as an appropriate award as these age groups do require greater levels of monitoring.

For all applicants regardless of age, clinical cost level 1 should be considered where the GP has indicated that their condition is not stabilised. The DO should also look to see if the GP has included anything in the treatment plan to indicate that the condition should be stabilised at a time in the future. For example when starting a course of new tablets the applicants blood levels may need to be monitored regularly for the first six months. In such a case it would be appropriate to review the award of the clinical costs element after the six month period as expired.

Chronic diseases may also fluctuate and the award of clinical costs element should incorporate known fluctuations that result in an increased medical need e.g. people with COPD who invariably get chest and associated infections through the winter.

Reviewing awards

It is likely that when first diagnosed or when new treatments are initiated applicants will require a greater level of medical care. However, once their condition and treatment are stabilised, then their medical need will generally lessen.

Consequently where someone has been awarded the clinical costs element at either level 1 or 2, but at review it is established that they no longer need that level of visiting to maintain their health, then the DO should either reduce the level or disallow the clinical cost element as appropriate.

Clinical Cost Element Guide

The clinical cost element guide is available to DO's to assist with determining if the clinical cost element may be awarded for the following specific medical conditions:

1. Arthritis (OA)
2. Asthma
3. Chronic Obstructive Pulmonary Disease (COPD)
4. Heart Disease
5. Depression
6. Diabetes
7. Older People

It provides assistance with assessing the level of clinical costs element and a flowchart on the claims process.

Clinical guidelines

The legislation defines recognised clinical guidelines as:

"Evidence-based systematically-developed statements originating from a professional medical or scientific organisation that are designed to assist medical practitioners and patients with decisions about appropriate health care for the patient's specific medical circumstances".

Examples of these are:

1. NICE - National Institute of Clinical Excellence – website: www.nice.org.uk
2. Royal College of Physicians - set standards that may be found at: http://www.rcplondon.ac.uk/standards.asp

Within the next few years the Health Minister for will provide similar strategies for primary care services within Jersey.

If there is any doubt as to whether the guideline cited by the GP is acceptable, the Policy Principal should be contacted to confirm if it is appropriate.

Household Medical Account (HMA) (this section to be removed)

The clinical costs element is designed specifically to help people with ongoing illnesses to meet the cost of the co-payment, but not everyone visiting the doctor will have an ongoing illness. It is not easy to budget for the co-payment either on a regular basis or for unexpected bouts of ill health, which is why the Department devised the system of the HMA.

The HMA is a means to help IS recipients save for the cost of visiting a GP. The account works by the claimant "saving" an amount each week, from the IS entitlement of their household.

The DO should advise the claimant how much to save depending on how often they and the other members of their household are likely to visit the doctor and/or whether home visits are required if they or a member of their household cannot attend the GP surgery.

When a visit is made to the GP, the surgery will then make a claim for the medical benefit subsidy (through the Health Insurance Law) and also the co-payment to be paid from the HMA of the claimants household.

It is particularly important that household's containing people with ongoing medical conditions utilise the savings account to help them budget.

Any household that does not have an HMA is responsible for paying the co-payment charge directly to the GP surgery.

Refer to the HMA Section for the Policy on HMA savings.

Last modified at 10/05/2022 11:30 by System Account