A Guide to the completion of Medical (factual) Reports

Department for Communities
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Contents

1 Introduction

This guidance is for all healthcare professionals who complete medical (factual) reports for the Department for Communities (DfC) or their Assessment Providers[1] . It gives advice on how patients can be supported through the sharing of information.

1.1 Background

1.1.1 Why does the Department request Medical (factual) reports?

When deciding benefit entitlement it is essential that the right decision is reached. Up to date relevant information is central to this process. DfC may seek information from a number of sources

- The patient
- Carers, relatives, and friends
- Professionals involved in the patient's care

Wherever possible, information collection is kept to a minimum but at times professional reports to substantiate claims are needed. This information is invaluable to ensure your patients get their correct entitlement with minimum disruption.

1.1.2 Who uses the report?

Decisions on benefit entitlement are made by non medical Decision Makers. Decision Makers will use your report and will seek, when necessary, advice of an experienced trained healthcare professional to review and interpret the report mindful of the benefit under consideration and associated assessment process. Your report may also be used if your patient appeals against a benefit decision.

1.1.3 Will the information be used?

DfC and their Assessment Providers only request a report where it is needed and not in every case. The medical report you provide will then be taken into consideration as part of the assessment process. Departmental Decision Makers are required to consider **all** the available evidence before deciding on benefit entitlement.

1.1.4 Timely completion of reports.

In order to avoid unnecessary delays in determining your patient's entitlement to benefit, prompt completion of these reports would be appreciated.

[1] ATOS Healthcare and Capita Health and Wellbeing

1.1.5 Relevant forms

A list of each form and its purpose can be found in Appendix A.

1.1.6 Further information

Further information about benefits relevant to you and your patient can be found at:

http://www.nidirect.gov.uk/index/information-and-services/money-tax-and-benefits/benefits-and-financial-support/disability-1.htm

2 Report Completion

This section explains the type of information that is useful to us and will help support your patients.

2.1 General Points

2.1.1 All Medical Reports

Please complete the forms as fully as you can from your medical records and your knowledge of the patient. It is not necessary to interview or examine the patient in order to complete the report.

In the reports, we are looking for evidence based on clinical facts. If you would like to offer your opinion, please make sure it is supported by factual evidence.

A summary of any relevant information in hospital letters can be helpful.

Examples of useful information for specific conditions are contained in Appendix B.

3 Essential Details

This section contains important considerations when completing medical reports for DfC.

3.1 Contractual Obligations

3.1.1 General Practitioners

There is a contractual obligation for any GP who has issued a Med3 (fit note) to provide medical reports, free of charge, in relation to Employment and Support Allowance on an ESA113.

3.1.2 Hospital Trusts

Health and Social Care Trusts are required to provide hospital case notes, X rays and medical reports without charge. For the provision of hospital case notes, photocopies should be supplied unless otherwise specified. Requests should be met within ten working days of receipt. If original hospital case notes or X rays are requested, DfC aims to return them to the Health Trust who sent them within ten working days of receipt from the Trust.

3.2 Information Provision

3.2.1 Consent

DfC obtain consent from the patient to approach you for the release of clinical information. Therefore you can rely on an assurance from DfC or a healthcare professional working on their behalf that consent has been provided and there is no requirement for you to ask to see a copy of the patient's consent.

3.2.2 Release of Information

Information (including medical reports) will be made available to patients on request or if they appeal against a benefit entitlement decision. Harmful information (see below) is the only exception.

3.2.3 Harmful Information

Harmful information is anything that would be considered harmful to a patient's health, if they were to become aware of it, (e.g. a diagnosis of a malignancy). This may be legally withheld from a patient and would not be released by DfC. Please put any harmful information either in the relevant section of the report or on a separate sheet of paper.

Please identify any such information clearly in your report.

3.2.4 Embarrassing information

Under data protection legislation, information which would simply embarrass the author, or someone else, cannot be withheld. Any reports which you provide should not contain inappropriate personal remarks or suspicions of malingering which cannot be substantiated and which you would not want your patient to see.

3.2.5 Letters and reports from other healthcare professionals

Please include in your report any relevant information contained in letters or reports from other healthcare professionals.

3.2.6 Rehabilitation of Offenders Order (NI) 1978

To ensure compliance with the Rehabilitation of Offenders (Northern Ireland) Order 1978 your report should not contain any reference to criminal convictions whether spent or not unless the information is directly relevant to the customer's condition or disability.

3.2.7 Delegation of completion of reports

It is acceptable for you to delegate completion of the ESA113, FRR2, or DLA/AA factual report to your practice nurse. However, you must confirm your authorisation by signing at the end.

4 Employment and Support Allowance (ESA) form

4.1 ESA form 113

4.1.1 Background

Most information requests regarding Employment and Support Allowance claims will be on the ESA113.

We ask you to complete this form if we think that the patient may have a severe health condition or disability but do not have enough information already available to be sure.

The forms should be returned within five working days from the date of receipt.

4.1.2 Computer Printouts

You can send us a computer printout of the appropriate part of the patient record if you wish, but you will still have to complete any sections of the form where the answer is not clear from the printout. The printout should contain active problems; current medication with date last prescribed; details of the last three consultations. Please remove third party data or other information not relevant to your patient's benefit claim.

4.1.3 Specific Questions

Question 4 - Functional difficulties

This question is trying to identify patients with the most severe disabilities, for example, those who have difficulty walking short distances, etc. Identification of these patients may avoid the need to bring them to an unnecessary face to face examination.

Question 5 - History of threatening or violent behaviour

The purpose of this section is to identify those patients who may pose a threat to a healthcare professional if invited to a face to face examination.

Question 6 – Public transportation

A small number of patients are unable to travel to an examination centre, and may be offered a taxi or examination in their own home if required. Patients who travel to an examination centre are entitled to claim travelling expenses.

4.2 ESA form FRR2

4.2.1 Background

Form FRR2 allows healthcare professionals to ask one or more specific questions. For example,”This patient is known to have epilepsy, please could you let us know how many recorded fits they have had in the last three years?”

Simply answer the question and return the form within five working days from the date of receipt.

5 Personal Independence Payment (PIP) factual report

5.1 Background

Factual reports for patients claiming Personal Independence Payment (PIP) may be requested where the Assessment Provider (Capita Health and Wellbeing) believes that further evidence will help the Department when deciding eligibility to the benefit.

The assessment for PIP considers the claimant's ability to carry out a series of everyday activities. The relevant activities are:

- Managing their health conditions and treatment
- Communicating
- Walking or moving around
- Getting somewhere on their own
- Making simple decisions
- Preparing, cooking and eating food
- Washing, bathing and using the toilet/managing incontinence
- Dressing and undressing.

5.2 Specific Questions

Date when last seen

If your patient has not been seen recently by you, please tell us when, where and by whom the patient was last seen by another healthcare professional.

Question 1 – Disabling conditions

List all health conditions or impairments which may affect the patient's current functional ability and the dates of when these conditions first presented.

Question 2 – History of condition(s)

Please detail the patients past and present medical history. Details of the past history can be very useful, especially when it demonstrates a change in condition over a period of time, rather than simple statements such as "suffered since xx/xx/xxxx ".

It is helpful to state whether the condition(s) are mild, moderate or severe although it is accepted that this is subject to individual interpretation, and if appropriate, whether they are well controlled or not (diabetes, asthma etc). Include details of any relevant special investigations or tests for each condition and the results.

Question 3 – Symptoms and variability

Information should be based on the patients clinical record and include both day-to-day and longer-term fluctuations. Include the frequency and duration of exacerbations and specify if the condition is well controlled.

Question 4 – Relevant clinical findings

Entitlement to PIP is based on the impact of the individual's impairment or health condition(s) on their everyday life. Please provide details of examination findings related to the severity or impact of any health conditions or impairments.

Question 5 – Treatment – current, planned, response and prognosis

Information could include details of drug and non drug treatment, aids and appliances used (prescribed or, if known, non prescribed), specify frequency or treatment and, for medication, dose as relevant.

Question 6 – Effects of the disabling condition(s) on day to day life

If known, it would be helpful to have information on the patient's ability to carry out the relevant activities as outlined at Para 5.1 above.

We are looking for facts, not opinion, with the date of the observation. If you would like to offer your opinion, please make sure it is supported by factual evidence.

Question 7 – History of threatening or violent behaviour

The purpose of this section is to identify those patients who may pose a threat to a health professional if invited to a face to face consultation.

Question 8 – Patient travel to an assessment centre

A small number of patients are unable to travel to a consultation centre, and may have the PIP consultation carried out in their own home. Patients who travel to a consultation centre are entitled to claim travelling expenses.

Question 9 - Additional information

This section is not asking for opinion but provides space to answer any specific questions raised and an opportunity to add any other relevant information. For example:

- In patients with severe depression, do they have suicidal ideas or psychotic features?
- Planned treatment, for example, hip replacement surgery.

6 Disability Living Allowance (DLA) & Attendance Allowance (AA)

6.1 Claim pack statement

Disability Living Allowance (DLA) and Attendance Allowance (AA) claim forms contain a statement section which patients or their representative may ask you to complete.

The form requires a brief description of your patient's illness and disabilities and how they are affected by them. Patients are advised that the best person to complete this section is the person most involved with their treatment or care, not necessarily their doctor.

This information is provided free of charge.

6.2 DLA/AA factual report

6.2.1 Background

Factual reports for patients claiming DLA or AA may be requested when there is insufficient clinical information to make a decision.

The completed report should be returned within ten working days from the date of receipt.

In addition to a covering letter the factual report:

- Contains information about the patient and the medical condition/disabilities claimed by the patient;
- Requests the date when the patient was last seen. If your patient has not been seen recently by a GP, if relevant, please tell us when and where the patient was seen by another healthcare professional (Include in further details section); and
- Includes specific questions which you are asked to complete.

6.2.2 Specific Questions

Question 1 – Diagnosis of the disabling conditions.

Question 2 - Details of the past medical history can be very helpful, especially when it demonstrates a change in the condition over a period of time, rather than simple statements such as “suffered since xx/xx/xxxx”.

It is helpful to state whether the conditions are mild, moderate or severe, although it is accepted that this is subject to individual interpretation, and, if appropriate, whether they are well controlled or not (diabetes, asthma etc).

Relevant test results for example the result of exercise testing in coronary artery disease (Bruce Protocol).

Question 3 - Variability
For those conditions that vary on a day to day basis, information about how they vary can be very useful to enable the Decision Maker to gauge the likely frequency of any needs.

Question 4 - Relevant clinical findings such as

- Peak flow or spirometry results in asthma or COPD
- Joint examination findings (range of movements, swelling, deformity)

Question 5 - Treatment
The level of medication (dose, frequency and compliance) is very helpful, especially for analgesics and inhalers.

Details of prognosis help the Decision Maker determine how long to award benefit for.

Question 6 - Disabling effects
We are looking for facts, not opinion, with the date of the observation. If you would like to offer your opinion, please make sure it is supported by factual evidence. Good examples of facts might be:

- “Walks slowly with marked right sided limp using walking stick”
- “Not breathless when attends surgery for routine check”
- “Normal balance and gait”

Additional questions and further details
Again, these sections are not asking for opinion but provides opportunity to add any other relevant factual information. For example:

- In patients with severe depression, do they have suicidal ideas or psychotic features?
- Planned treatment, for example hip replacement surgery.

7 Special Rules for terminally ill

7.1 Background

Your patient or their representative may ask you to complete form DS1500 if they think they are terminally ill. The form can be used for ESA, PIP, DLA or AA claims and will ensure that they are dealt with rapidly under special provisions.

The completed report should either be handed to the patient or their representative or it can be sent directly to DfC. Guidance on where it should be sent to is contained within 'Guidance notes on completion of a DS1500 for Medical Practitioners'.

7.2 Specific Questions

The DS1500 asks for factual information and should contain details of:

- Diagnosis and other relevant conditions
- Whether the patient is aware of their condition and/or prognosis.
    - If unaware, the name and address of the patient's representative requesting the DS1500
- Clinical features which indicate a severe progressive condition (examination findings and results of investigations including staging if appropriate)
- Relevant treatment including response and planned treatment/interventions that may significantly alter the prognosis

8 Industrial Injuries

8.1 BI205

8.1.1 Background

This form requests factual information about an individual's medical condition in relation to claims for Industrial Injuries Disability Benefit (IIDB).

8.1.2 Specific Questions

Question 2 (BI205) - History of the condition at first attendance
This should include any reference to industrial causation if known.

8.2 BI127

8.2.1 Background

This form is sent to Hospital Medical Record Departments in relation to claims for Industrial Injuries Disability Benefit (IIDB). The BI127 requests photocopies of the relevant case notes, including any X ray reports.

Under a long standing agreement, NHS hospitals and Trusts are obliged to provide information (factual reports, hospital case notes and X rays) free of charge and within ten working days.

8.3 MR3 IIDB

8.3.1 Background

This form is sent to GPs to request details regarding an accident or incident in relation to claims for Industrial Injuries Disability Benefit (IIDB).

It is requested that a reply be provided within seven days.

Appendix A

- ESA113 – Factual report in connection with Employment and Support Allowance (ESA)
- FRR2 - Factual report in connection with ESA requesting answers to one or more specific questions
- PIP Factual Report – Factual report in connection with PIP
- DLA/AA claim form statement - Statement at back of claim form in connection with Disability Living Allowance (DLA) / Attendance Allowance (AA)
- DLA/AA factual report - Factual report in connection with DLA/AA
- DS1500 - Factual report in connection with DLA/AA/ESA for people who may be terminally ill
- BI205 - Factual report in connection with Industrial Injuries Disability Benefit (IIDB)
- BI127 – Request for photocopies of case notes including X ray reports in connection with IIDB
- MR3 IIDB – Factual report in connection with Industrial Injuries Disability Benefit (IIDB)

Appendix B

Examples of useful information for specific conditions

Respiratory conditions including asthma and COPD

Severity	Mild, moderate or severe?
Symptoms	Breathless at rest or on mild or moderate exertion?
Hospital care	Under hospital care or history of hospitalisation for an acute attack?
Clinical findings	Chest examination, PEFR (expected, most recent, lowest recorded and when), spirometry (if available).
Treatment	Inhalers (which inhalers, are they regularly requested, if not when was the last prescription), nebulisers or oxygen used at home, oral steroids in the last 6 to 12 months?
Effects on day to day activities	If known.

Coronary artery disease

Diagnosis	How was the diagnosis made? Was it only clinical or confirmed by investigations? What investigations? Results of investigations such as ECG, echocardiogram, exercise test (Bruce Protocol).
Severity	Mild, moderate or severe?
Symptoms	Anginal attacks, how frequent, when do they occur ie associated with mild, moderate or severe exertion, does GTN help, is dyspnoea present on mild, moderate or severe exertion?
Hospital care	Under hospital care or is there a history of repeated attendance at A&E or inpatient admissions with chest pain?
Clinical findings	Is there any evidence of heart failure?
Treatment	Medications (dose and frequency), are prescriptions ordered regularly, are they effective, has the patient had any surgical treatment or is any planned in the future? If yes, which procedure?
Effects on day to day activities	If known

Musculoskeletal conditions including back pain and arthritis

Diagnosis	What type of arthritis? If back pain is it simple or specific (disc prolapse etc)? Results of important investigations such as MRI scan.
Symptoms	For arthritis, which joints are affected, severity of affected joints, exacerbations and flare ups, how often and how severe? For back pain, pain, variability, duration of acute exacerbations and severity, radiation of pain.
Hospital care	Any history of falls recorded? Any hospital attendance? Neurology or rheumatology referral?
Clinical findings	For arthritis any deformity, range of joint movements, other clinical findings. For back pain, range of movements of spine and straight leg raising. Is there any neurological deficit or muscle wasting?
Treatment	Any physiotherapy, occupational therapy, aids provided, back pain clinic attendance, counselling/clinical psychologist? Has any of the above helped? Any planned surgical treatment such as awaiting hip or knee surgery. If so when is this due? Medication. What medication, dose, frequency, are regular prescriptions ordered, does medication help?
Effects on day to day activities	If known

Conditions affecting mental function

Diagnosis	Duration of conditions – whether mental illness or cognitive impairments, for example autistic spectrum disorders.
Severity	Mild, moderate or severe?
Symptoms	Day to day variations reported, recorded history of suicidal thoughts/intent/attempts in the past? If yes, when and how? Episodes of self harm? History of self neglect? Awareness of dangers? Insight? Confusion state or disorientation or lack of concentration or motivation? Capable of self medicating?
Hospital care	History of psychiatric hospitalisation, voluntary or compulsory under the Mental Health Act? Under primary or secondary care? Who sees and how often?
Clinical findings	Brief mental state findings and date.
Treatment	Medications, type, dose, frequency, route, side effects, effectiveness. Are regular prescriptions ordered, if not when was last prescription ordered?
Effects on day to day activities	If known

Epilepsy or loss of consciousness

Diagnosis	Type of epilepsy or other causes of loss of consciousness, for example syncope etc? How was diagnosis made, is it confirmed on EEG or history alone? Any other associated conditions, for example mental health?
Symptoms	Warning before fit, type of warning and duration? Frequency of fits as recorded in notes or hospital letters. Injuries recorded after fits, history of attendance at A&E after fits and resultant falls. Date of last fit as recorded in notes or hospital letters.
Hospital care	Under hospital care, which specialist, frequency of review, when last seen? History of hospitalisation, history of status epilepticus?
Treatment	Medications, which ones, frequency, any changes in medication type or dose, if yes any change in control and if so what change? Any future proposed changes in medication planned?
Effects on day to day activities	If known.

Childhood problems (DLA only)

Children's claims are assessed on the need for help above that expected in another child of a similar age (without claimed medical conditions).

Diagnosis	If diagnosis is related to behavioural problems, for example ADHD, autism, Asperger's syndrome, learning difficulties etc then who made the diagnosis? Any other conditions such as incontinence (if dry before)?
School	Normal or special needs school?
Symptons	Any reported Behavioural problems? If yes provide details. Any injuries related to the conditions claimed?
Hospital care	Attending a specialist, if so who and how often? Any hospitalisations?
Treatment	On medication, if so is it effective? Any known night time medications such as creams etc and frequency of dosage or application?
Effects on day to day activities	If known.