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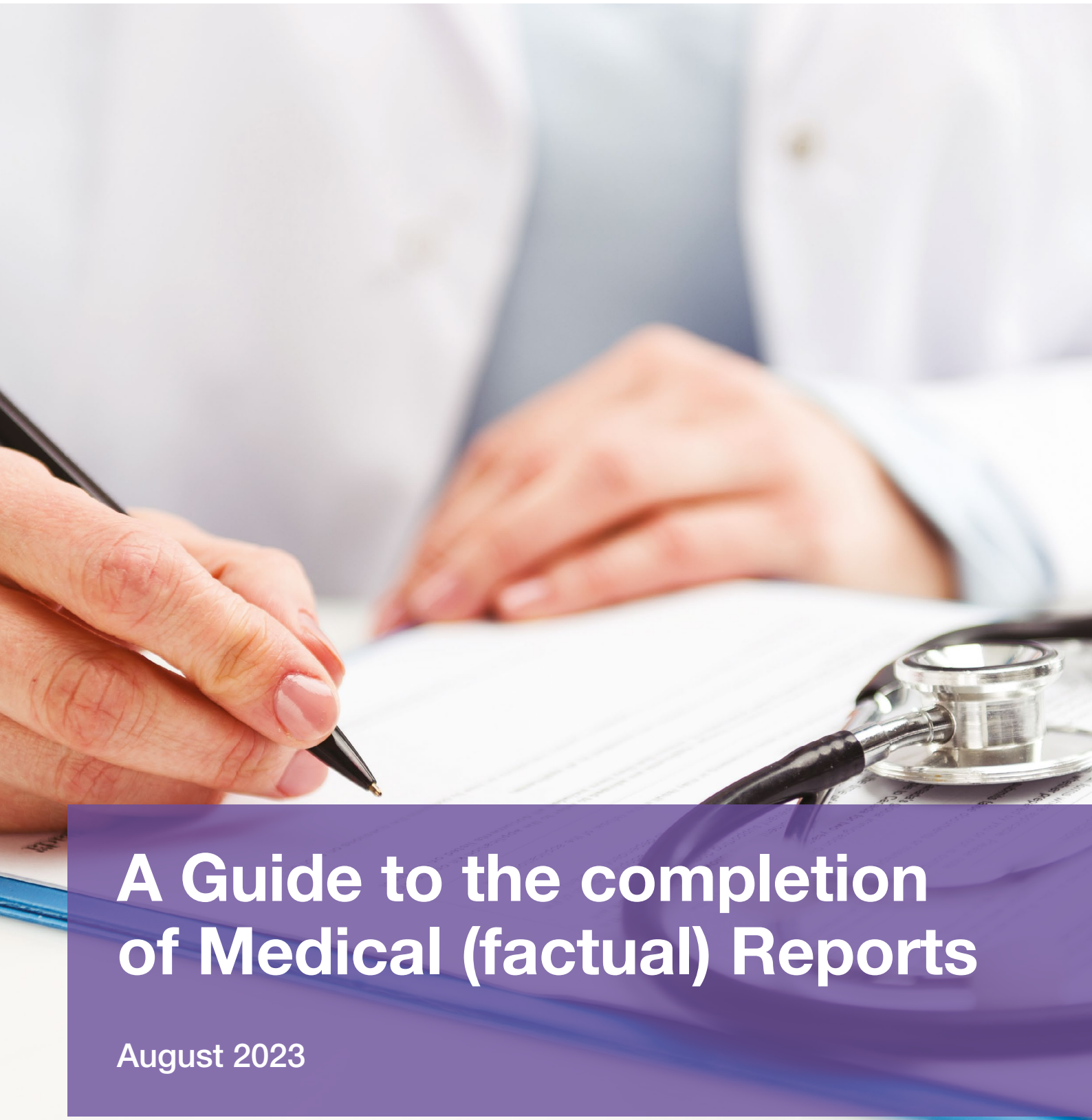

A Guide to the completion of Medical (factual) Reports

August 2023

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. 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 the advice of an experienced healthcare professional trained in disability assessment to review and interpret the report where needed. Your report may also be used if your patient appeals against a benefit decision.

1.1.3 Will the information be used?

Absolutely. 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 considered when producing an assessment report. Departmental Decision Makers are required to consider all the available evidence before deciding on benefit entitlement.

1.1.4 Relevant forms

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

2. Essential Details

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

2.1 Contractual Obligations

2.1.1 Healthcare Professionals

There is a contractual obligation for any Healthcare Professional (GP, Nurse, Physiotherapist, Occupational Therapist and Pharmacist) who has issued a Med3 (fit note) to provide medical reports, free of charge, in relation to Employment and Support Allowance on an ESA113 or FRR2, or for Universal Credit on a UC113 or FRR2.

2.1.2 Hospital Trusts

Health and Social Care Trusts are required to provide hospital case notes, X rays and medical reports without charge and within 10 working days of receipt of the request. For the provision of hospital case notes and X rays, photocopies should be supplied unless otherwise specified. If original hospital case notes or X rays are provided, DfC aims to return them to the Health Trust who sent them within 10 working days of receipt from the Trust.

2.2 Information Provision

2.2.1 Consent

Any information that we ask you for is necessary to enable DfC to carry out its official duties. The legal basis for the request is GDPR Article 6(1)(e) and Article 9(2)(b) for special category information.

2.2.2 Release of Information

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

2.2.3 Harmful Information

Harmful information is anything that would be considered harmful to a patient's health, if they were to become aware of it, (for example, 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.

2.2.4 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.

2.2.5 Letters and reports from other healthcare professionals

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

2.2.6 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 patient's condition or disability.

2.2.7 Delegation of completion of reports

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

No fee is payable to NHS doctors working in hospital for completion of PIP or DLA/AA factual reports.

MacMillan nurses, Nurse specialists and practice nurses can complete the SR1 Form, but only GPs and GMC registered consultants may claim a fee.

3. Report Completion

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

3.1 General Points

3.1.1 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**.

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 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 assessment.

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 assessment.

Question 6 - Public transportation

A small number of patients are unable to travel to an assessment centre, and may be offered a taxi or assessment in their own home if required. Patients who travel to an assessment 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 seizures they have had in the last three years?"

Healthcare professionals can also use the form to request information about patients who are being treated for cancer. This is because, under certain circumstances, patients receiving, about to receive or recovering from chemotherapy or radiotherapy for cancer can be placed in the Support Group of Employment and Support Allowance without having to undergo a face to face assessment and

the information can be helpful to the decision maker in making that decision. The questions relate to:

- diagnoses and clinical features
- treatment, likely duration and estimated recovery time
- whether the claimant is likely to be able to work – please answer this question only if you feel confident to do so

Please return the form within seven days from the date of receipt.

5. Universal Credit (UC) form

5.1 UC form 113

5.1.1 Background

Most information requests regarding Universal Credit claims will be on the UC113.

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 to be sure.

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

5.1.2 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.

5.1.3 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 assessment.

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 assessment.

Question 6 - Public transportation

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

5.2 UC form FRR2

5.2.1 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 seizures they have had in the last three years?"

Healthcare professionals can also use the form to request information about patients who are being treated for cancer. This is because, under certain circumstances, patients receiving, about to receive or recovering from chemotherapy or radiotherapy for cancer can be placed in the Limited Capability for Work Related Activity Group without having to undergo a face to

face assessment and the information can be helpful to the decision maker in making that decision. The questions relate to:

- diagnoses and clinical features
- treatment, likely duration and estimated recovery time
- whether the claimant is likely to be able to work – please answer this question only if you feel confident to do so

Please return the form within seven days from the date of receipt.

6. Personal Independence Payment (PIP) factual report

6.1 Background

Factual reports for patients claiming Personal Independence Payment (PIP) may be requested where the Assessment Provider believes that further evidence will help inform their advice to the department.

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

- preparing food
- taking nutrition
- managing therapy or monitoring a health condition
- washing and bathing
- managing toilet needs or incontinence
- dressing and undressing
- communicating verbally
- reading and understanding signs, symbols and words
- engaging with other people face to face
- making budgeting decisions
- planning and following journeys
- moving around

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

6.2 Specific Questions

Date when last seen

If your patient has not been seen recently by you, please tell us when and where 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 patient's 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, epilepsy 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 patient's 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 diagnosis

Information could include details of drug and non drug treatment, aids and appliances used (prescribed or, if known, non prescribed), specify frequency of 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 6.1 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 healthcare professional if invited to a face to face assessment.

Question 8 - Patient travel to an assessment centre

A small number of patients are unable to travel to an assessment centre, and may have the PIP assessment carried out in their own home. Patients who travel to an assessment 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.

7. Disability Living Allowance (DLA) & Attendance Allowance (AA)

7.1 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.

There is no requirement to provide statements for other benefit claims such as PIP as those forms do not include a statement section.

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.

NHS hospitals and Trusts are obliged to provide the information free of charge.

7.2 DLA/AA factual report

7.2.1 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 10 working days from the date of receipt.

7.2.2 Specific Questions - Page 1

- Contains information about the medical condition claimed by the patient and a specific question or questions that the DfC decision maker would like you to answer in the report.
- Date when last seen.
  If your patent 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 Part 7 further details).

Question 2 - Details of conditions
Details of the past 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, epilepsy 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.

Question 4 - Relevant clinical findings
Main 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"

Question 7 - Further Details

Again, this section is 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.

8. SR1 form

8.1 Background

The purpose of the SR1 form is to tell the Department for Communities (DfC) about a patient who meets the special rules criteria. It is not used to make a claim for benefit.

You should complete the form promptly if you believe that your patient meets the special rules criteria, namely:

- they have a progressive disease and, as a consequence of that disease you would not be surprised if your patient were to die within 12 months

The special rules criteria do not just apply to patients with cancer.

They also apply to severe, life limiting conditions, chronic progressive illness and frailty (this is not an exhaustive list).

Benefits that can be claimed under special rules

Special rules claims can be made in the following benefits:

- Universal Credit
- Employment and Support Allowance
- Personal Independence Payment
- Disability Living Allowance
- Attendance Allowance

If your patient meets the special rules criteria for Universal Credit they will be paid a higher rate of benefit and will not be expected or required to carry out any work related activity in order to receive their benefit.

For all other benefits, claims will be processed as a priority and in the majority of cases they will receive the highest rate of benefit.

8.2 When you should complete the SR1 form

You should complete the SR1 form if you would like to encourage your patient to see which benefits they may be entitled to as part of a discussion about future care planning or if requested by your patient or their representative.

Who can make claims on behalf of patients?

For Disability Living Allowance, Attendance Allowance and Personal Independence Payment only, any person representing the patient can make a third party claim on their behalf, even if the patient is unaware that a claim is being made. In this circumstance the form should be issued on request to the representative.

For UC and ESA only an appointee or person with power of attorney can make a third-party claim on the patient's behalf.

Your patient's prognosis

Determining life expectancy in these circumstances is challenging. The form asks for factual information and does not require you to give a specific prognosis. Please use language that you would normally use when communicating with other clinicians.
You will not face any negative consequences from the factual information you supply, for example if your patient lives longer than 12 months.

Patients who may not know the true nature of their illness

When a patient asks you for an SR1 form, please do not assume that they understand the special rules criteria or that these apply in certain circumstances to people with progressive, life-limiting disease.

How this form will be used by DfC

The SR1 form allows you to provide further evidence to enable us to make a decision on your patient's claim. It is not a claim form, as you cannot claim on behalf of your patients. It will not normally be necessary for you to examine the patient. You may use your own knowledge and the patient's records to get the information you need. This form can be completed by a registered clinician such as a:

- General Practitioner (GP)
- hospital or hospice doctor
- registered nurse

The registered nurse needs to have acquired the expert knowledge and clinical competencies to undertake the assessment. They may be working in a role such as an advanced nurse practitioner, a Macmillan nurse, a clinical specialist nurse or a practice nurse with expertise in long term conditions management.

8.3 What we will do if we need to clarify any information

DfC relies on the judgement of clinicians when they complete an SR1 form. You may be contacted by a healthcare professional working for one of our clinical assessment providers:

- if we need clarification of some of the information on the SR1 form to help with our decision about the claim, or
- if the patient has made a claim under the special rules procedures but has not submitted an SR1 form and we need clinical information to support the claim

Because we need to deal with these claims urgently, the healthcare professional will usually contact you by phone.

8.4 What to do with the completed form

- give the SR1 form to the person who asked you to complete it and return the fee form separately to us – see Claiming a fee section below, or
- send the completed SR1 form and fee form to us.

When returning SR1 forms, please ensure a separate envelope is used for each individual patient. Please do not staple documents together.

8.5 Claiming a fee

You can claim a fee if you are a GP or GMC registered consultant, but only if you have authorised this form by signing it at the end. To claim your fee, please complete the fee form. We will pay your fee into your bank or building society account. Only original copies of the form will be accepted.

Please send the completed form to:

Disability & Carers Service
Castle Court
Royal Avenue
Belfast
BT1 1HR

8.6 Obtaining Blank SR1 Forms

GP Practices can place an order for the Blank SR1 form via the online ordering service from the Business Service Organisation Procurement and Logistics Service (PaLS).

Should you have any queries concerning this service, please contact the PaLS Customer Helpline Team on 028 9536 1301

8.7 Specific Questions

SR1 form – parts 1 to 3

The SR1 form asks for factual information and should contain details of:

- diagnosis and other relevant conditions
- date your patient was first thought to meet the special rules criteria
- whether the patient is aware of their condition and/or prognosis
- 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 or interventions that may significantly alter the prognosis

9. Industrial Injuries

9.1 BI205

9.1.1 Background

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

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

9.1.2 Specific Questions

Question 2 (BI205) - History of the condition at first attendance

This should include any reference to industrial causation if known.

9.2 BI127

9.2.1 Background

This form is sent to Hospital Medical Record Departments. 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 10 working days.

9.3 MR3 IIDB

9.3.1 Background

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

Appendix A

- ESA113 - Factual report in connection with Employment and Support Allowance (ESA)
- UC113 - Factual report in connection with Universal Credit (UC)
- FRR2 - Factual report in connection with UC or 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
- SR1 Form - Factual report in connection with DLA/AA/ESA/UC/PIP for people with an estimated prognosis of less than 12 months to live
- 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 Disablement 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 seizure, type of warning and duration? Frequency of seizures as recorded in notes or hospital letters. Injuries recorded after seizures, history of attendance at A&E after seizures and resultant falls. Date of last seizures 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.

Available in alternative formats.

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