DWP Medical (factual) Reports

A guide to completion – April 2022

Department for Work & Pensions

Contents

1 Introduction

This guidance is for all healthcare professionals who complete medical (factual) reports for the Department for Work and Pensions (DWP) or one of 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 DWP request reports?

When deciding benefit entitlement it is essential that the right decision is reached. Up to date and relevant information is central to this process. DWP 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 the minimum of 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. DWP 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 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.

2.2 Universal Credit (UC) and Employment and Support Allowance (ESA) form UC/ESA113

2.2.1 Background

Most information requests regarding Universal Credit (UC) and Employment and Support Allowance (ESA) claims will be on the UC/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 5 working days from the date of receipt.

2.2.2 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.

2.2.3 Specific Questions

Question 4 - Functional difficulties

The 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 examination centre, and may be offered a taxi or assessment in their own home if required. Patients who travel to an examination centre are entitled to claim travelling expenses.

2.2.4 Further Information

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

https://www.gov.uk/government/publications/a-short-guide-to-the-benefit-system-for-general-practitioners

Information can also be found at:

CHDA (for ESA and UC)
Phone: 0800 288 8777
Email: customer-relations@chda.co.uk
Information for GPs:
https://www.chdauk.co.uk/frequently-asked-questions-gps

IAS (for PIP in Scotland, North & South England)
Phone: North of England & Scotland: 0800 188 4880
South of England: 0800 188 4881
Information for GPs:
https://www.mypipassessment.co.uk/supporting-evidence/medical-professionals-guide/

Capita (for PIP in Wales and the Midlands)
Phone: 0808 1788 114
Information for GPs:
http://www.capita-pip.co.uk/

2.3 UC/ESA form FRR2

2.3.1 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 3 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 DWP 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 this if you feel confident to do so

Please return the form within 7 days from the date of receipt.

2.4 Personal Independence Payment (PIP) factual report

2.4.1 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 5 working days from the date of receipt.

2.4.2 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 the 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 conditions

Please detail the patients past and present 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 1999".

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). 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 at 2.4.1.

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 examination centre and may be offered a taxi or assessment in their own home if required. Patients who travel to an examination 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.

2.5 Disability Living Allowance (DLA) & Attendance Allowance (AA) claim pack statement

2.5.1 Background

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.

2.6 DLA/AA factual report

2.6.1 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.

2.6.2 Specific Questions

Page 1

Contains information about the medical condition claimed by the patient and a specific question or questions that the DWP decision maker would like you to answer in the report.

Date when 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 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 1999".

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 information. For example:

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

2.7 DS1500 and SR1 report forms

See The ‘Special Rules’: how the benefit system supports people nearing the end of life for guidance on the DS1500 and SR1 report forms.

2.8 BI205

2.8.1 Background

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

The completed report should be returned within 7 days from the date of receipt.

2.8.2 Specific Questions

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

2.9 BI127

2.9.1 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.

3 Essential Details

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

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 in relation to Universal Credit or Employment and Support Allowance on an ESA113 or FRR2. This should be done free of charge as covered by the contractual arrangements between GPs and the relevant Primary Care Trust.

3.1.2 Hospital Trusts

Under a longstanding agreement[1] NHS 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 or originals, CDs or transfer by portal is acceptable with CD or portal being preferable. If original hospital case notes or X rays are provided, DWP aims to return them to the NHS Trust who sent them within 10 working days of receipt from the Trust.

3.2 Information Provision

3.2.1 Consent

DWP obtain consent[2] from the patient[3] to approach you for the release of clinical information. Therefore you can rely on an assurance from DWP or a healthcare professional working for Atos Healthcare, Centre for Health and Disability Assessments (CHDA) or Capita Health and Wellbeing that consent has been

[1] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004381?PageOperation=email

[2] Consent may be provided either in writing, electronically or verbally. DWP has procedures in place to ensure that consent is valid.

[3] Occasionally consent may be provided by a third party acting on the patient's behalf.

- If the patient is mentally incapable of managing his own affairs, and there is power of attorney or an appointee is acting on behalf of the patient, as permitted in legislation.
- If the patient is potentially terminally ill and the claim to benefit has been made by a third party on the patient's behalf, as permitted in legislation.

provided and there is no requirement for you to ask to see a copy of the patient's consent.

In addition, the Access to Medical Reports Act 1988 does not apply to reports for benefit purposes[4] and you do not have to discuss with or show the information to the patient before you send it.

3.2.2 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.

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 DWP. 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 Act

To ensure compliance with the Rehabilitation of Offenders Act 1974 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.

[4] The Access to Medical Reports Act only applies to reports for insurance and employment purposes.

3.2.7 Delegation of completion of reports

It is acceptable for GPs to delegate completion of the ESA113, FRR2, 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 DS1500 and SR1, but only GPs and GMC registered consultants may claim a fee.

Appendix A

- UC/ESA 113 – Factual report in connection with Universal Credit (UC) or Employment and Support Allowance (ESA)
- FRR2 - Factual report in connection with UC/ESA requesting answers to one or more specific questions
- PIP Factual report – Factual report in connection with Personal Independence Payment (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 for UC, ESA, PIP, DLA and AA patients with an estimated prognosis of less than 6 months to live
- SR1 – Factual report for UC and ESA patients with an estimated prognosis of 6 to 12 months to live
- BI205 - Factual report in connection with Industrial Injuries Disablement Benefit (IIDB)
- BI127 – Request for photocopies of case notes including X ray reports in connection with IIDB
- FAS1500 - Factual report in connection with the Financial Assistance Scheme[5]

[5] Requests for these reports are rare. They are therefore not included in this guidance. Further information can be found at https://www.gov.uk/government/collections/financial-assistance-scheme-guidance-for-pension-scheme-professionals

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 i.e. 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 seizure 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 change 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?
Symptoms	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.