

Health, Work and Well-being Directorate

Reforming the Medical Statement

Consultation on Draft Regulations
May 2009

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Executive summary

1. The process used by General Practitioners (GPs) to document their advice on fitness for work to patients with a health condition and the forms they use have remained largely unchanged since the foundation of the NHS. However, the environment in which GPs give their advice has changed:

- In general, work has become safer and much less physically demanding, and less rigid allowing more people with physical conditions to work through their illness rather than take time off work.
- Employers are more flexible and, given the right information about what an individual could be capable of, simple low-cost changes can be made to facilitate an individual's return to work. They are also now obliged to take account of disability rights legislation to help disabled people back into work and retain their jobs.
- Leaders of the healthcare professions have recognised the positive health benefits of being in work, even for those who have to limit their activities,¹ and their role in assisting patients to work;
- The right of patients to be involved in and consulted on all decisions about their care and treatment is fully recognised, for example in the NHS constitution for England.² This includes being enabled to make informed decisions about refraining from work.
- Stigma is increasingly recognised as a major barrier for those with mental health problems,³ and this can be overcome by appropriate advice to employers on working capacity.

2. Despite evidence that, in general, work has a positive effect on health while inactivity can worsen physical and mental well-being,⁴ every year it is estimated that around 350,000 people leave work to claim health-related benefits;⁵ and around 172 million working days are lost in Britain each year due to sickness absence.⁶ With early work-focused healthcare and workplace management many of these people could be helped to stay in work, making them, their families and communities in which they live, all better off.

3. GPs are, in the vast majority of cases, the primary source of advice and guidance for individuals who develop a health condition.⁷ Evidence shows that the advice and guidance they can provide is pivotal to an individual's decisions about whether or not they should return to work. However, while the medical profession is committed to better tackling health and work issues, there is broad recognition that medical practitioners, and in particular GPs, need better support in giving back to work advice to their patients.

¹ *Health Professionals' Consensus Statement: Statement of Health and Work* (2008)

² *The NHS Constitution for England*. Department of Health publications (2009)

³ See for example Thornicroft, G. (2006) *Actions speak louder: Tackling discrimination against people with mental health*, Mental Health Foundation.

⁴ See for example Waddell, G. and Burton A.K. (2006) *Is work good for your health and well-being?* London: TSO.

⁵ Black, C. (2008) *Working for a healthier tomorrow: Review of the Health of Britain's working age population*, London: TSO.

⁶ CBI (2008) *At work and working well? CBI/AXA absence and labour turnover survey 2008*, CBI.

⁷ A proportion of medical statements are supplied by hospital doctors both to out-patients and to in-patients leaving hospital but not fit to return to work. The principles of issuing medical statements are the same for these doctors and the same forms are and will be used.

4. Dame Carol Black, National Director for Health and Work, considered these factors when making her recommendations in *Working for a healthier tomorrow; Review of the health of Britain's working age population*.⁸ Among other measures, she recommended replacing the current 'sick note' with a 'fit note'. The Government accepted her recommendation and, after discussions with stakeholders and a trial of a new statement with over 500 GPs,⁹ is proposing changes to the current medical statement.

5. Medical statements are prescribed in regulations. The purpose of this document is to consult on amending these regulations in order to implement the proposed changes. The Government is seeking views on the draft regulations. The Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) Amendment Regulations 2010 will bring about the following changes. They will:

- change the format of the medical statement to allow doctors to record whether a patient is fit or not fit for work but also include a new option to allow a doctor to indicate where someone "May be fit for some work now".
- update the rules relating to completing statements;
- make provision to rationalise the current set of medical statements, by removing of forms med 4 and 5 to simplify the process for GPs and employers, and reflect recent changes to the welfare system arising from the introduction of Employment and Support Allowance (ESA); and,
- permit GPs to issue statements printed by their practice's computer systems as opposed to handwriting on a statement pad.

6. Specific consultation questions appear throughout this document. These are also listed at page 19.

⁸ Black, C. (2008) *Working for a healthier tomorrow: Review of the Health of Britain's working age population*, London: TSO.

⁹ If you would like full details of the research please write to Office of the Chief Psychologist, c/o Anna Sallis, DWP, HWWD, 2nd floor, Caxton House, 6-12 Tothill Street, London, SW1H 9NA.

Consultation arrangements

Who this consultation is aimed at?

7. In developing the revised medical statement, the Government has consulted widely with GPs, employers and their representatives, health professionals (including experts and advisers), trade unions and other employee stakeholders. We welcome the views of these groups and others with an interest in health and work issues.

Scope of Consultation

8. This consultation and the draft regulations apply to England, Scotland and Wales.

Duration of the Consultation

9. In line with Cabinet Office guidelines, the consultation on these Regulations will run for twelve weeks, beginning on 28 May 2009 and ending on 19 August 2009.

How to Respond

10. We would be grateful if you could send your comments on any aspect of the draft regulations to:

Shelley Fuller
Medical Statement Consultation
Department for Work and Pensions
Health, Work and Well-being Directorate
2nd Floor
Caxton House
Tothill Street
London
SW1H 9DA

Tel: 020 7449 5586

Fax: 020 7340 4340

Email: reforming-medicalstatement.consultation@dwp.gsi.gov.uk

This document is available on the Department's website at:

<http://www.dwp.gov.uk/consultations/2009/>.

11. When responding please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation please state which group(s) the organisation represents and, where applicable, how the views of members were assembled.

Queries about the content of this document

12. Any queries about the subject matter of this consultation should be made to Shelley Fuller at the address above.

Alternative ways of being involved in the consultation

13. We want to ensure that we get views from as broad a range of people as possible about this issue. As well as written responses to the questions we ask in this document, and any other points you would like to make, we intend to continue to engage with interested groups during the consultation period.

14. Copies of the consultation document can be found in the consultations section of our website here <http://www.dwp.gov.uk/consultations/2009/>. This document is available on request in alternative formats or on request from: Angela Morris: Department for Work and Pensions, Health, Work and Well-being Directorate, 2nd Floor, Caxton House, Tothill Street, London. SW1H 9DA. Tel 020 7449 5588. Fax 020 7340 4340.
Email: reforming-medicalstatement.consultation@dwp.gsi.gov.uk

15. We have sent this consultation document to a large number of people and organisations who have already been involved in this work or who have expressed an interest. Please do share this document with, or tell us about, anyone you think will want to be involved in this consultation.

Freedom of information

16. The information you send us may need to be passed to colleagues within the Department for Work and Pensions and published in a summary of responses received, and referred to in the published consultation report.

17. All information contained in your response, including personal information, may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for the purposes of the public consultation exercise, it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information which is provided, or remove it completely. If you want the information in your response to the consultation to be kept confidential, you should explain why as part of your response, although we cannot guarantee to do this. We cannot guarantee confidentiality of electronic responses even if your IT system claims it automatically.

18. If you want to find out more about the general principles of Freedom of Information and how it is applied within the Department for Work and Pensions please contact: Charles Cushing, Department for Work and Pensions, Information Policy Division, Central Freedom of Information Team, Adelphi 1-11 John Adam Street, London, WC2N 6HT (charles.cushing@dwp.gsi.gov.uk or carol.smith4@dwp.gsi.gov.uk). Please note that Charles and Carol cannot advise on this particular consultation exercise, only on Freedom of Information issues.

19. More information about the Freedom of Information Act can be found on the website of the Ministry of Justice¹⁰.

The consultation criteria

20. The consultation is being conducted in line with the Government Code of Practice on Consultation - www.berr.gov.uk/files/file47158.pdf - and its seven consultation criteria, which are as follows:

When to consult. Formal consultation should take place at a stage when there is scope to influence the outcome.

¹⁰ <http://www.justice.gov.uk/a-z/freedom-of-information.htm>

Duration of consultation exercises. Consultations should normally last for at least 12 weeks, with consideration given to longer timescales where feasible and sensible.

Clarity of scope and impact. Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals.

Accessibility of consultation exercises. Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is designed to reach.

The burden of consultation. Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Responsiveness of consultation exercises. Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Capacity to consult. Officials running consultation exercises should seek guidance in how to run an effective consultation exercise, and share what they have learned from the experience.

Feedback on this consultation

21. We value your feedback on how well we consult. If you have any comments on the process of this consultation (as opposed to the issues raised) please contact our consultation coordinator:

Roger Pugh

DWP Consultation Coordinator,

Room 4F,

Britannia House,

2 Ferensway,

Hull

HU2 8NF

Phone: 01482 609571

Fax: 01482 609658

Email: roger.pugh@dwp.gsi.gov.uk

In particular, please tell us if you feel that the consultation does not satisfy the consultation criteria. Please also make any suggestions as to how the process of consultation could be improved further. If you have any requirements that we need to meet to enable you to comment, please let us know.

What will we do after the consultation?

22. The responses to the consultation will be published in a report on our consultation website when we lay the final regulations before Parliament. It will summarise the responses and the action that we will take as a result of them.

Impact Assessment

23. Our initial Impact Assessment for the regulations, which is attached at Appendix 5, sets out our cost/benefits analysis for the proposals contained in this consultation. In determining the broad range of costs and benefits, we have drawn on research findings and some anecdotal evidence. We would be grateful for further information, which would improve the quality of this analysis.

Consultation Question 1: Do you have any further information, data or analysis which would be useful for improving the quality of the analysis in the attached Impact Assessment?

Section One – Policy Background

24. The medical statement, used by General Practitioners (GPs) and other doctors to provide advice to patients who develop a health condition, or who have a condition that worsens, has remained largely unchanged since the foundation of the NHS. This is despite the fact that in the intervening years the environment in which GPs give their advice has changed:

- In general, work has become safer and much less physically demanding, and less rigid, allowing more people with physical conditions to work through their illness rather than take time off work.
- Employers are more flexible and, given the right information about what an individual could be capable of, simple low-cost changes can be made to facilitate an individual's return to work. They are also now obliged to take account of disability rights legislation to help disabled people back into work and retain their jobs.
- Leaders of healthcare professions have recognised the positive health benefits of being in work, even for those who have to limit their activities, and their role in assisting patients to work.
- The right of patients to be involved in and consulted on all decisions about their care and treatment is fully recognised, for example in the NHS constitution for England. This includes being enabled to make informed decisions about refraining from work.
- Stigma is increasingly recognised as a major barrier for those with mental health conditions,¹¹ and this can be overcome by appropriate advice to employers on working capacity.

25. Evidence shows that, in general, being in work is good for health and that being out of work leads to poor physical and mental health.¹² It also increases the likelihood of an individual experiencing poverty and social exclusion. Evidence also suggests that, with appropriate support, over 90 per cent of people with common health conditions can be helped to work and that the numbers leaving work to claim incapacity benefits could be reduced by 20-60 per cent.¹³

26. Despite this evidence and the changes described above, the belief that we should refrain from work when we have a health condition persists. As a result of this, around 172 million working days are lost each year across Britain through sickness absence, costing business around £13 billion.¹⁴ While the vast majority of the individuals affected will return to the workplace, it is estimated that each year around 350,000 will go on to leave work and make a claim to health-related benefit.¹⁵

27. The Government is committed to reducing sickness absence and supporting people with health conditions to stay in or return to work. Such an approach requires better support for

¹¹ See for example Thornicroft, G. (2006) *Actions speak louder: Tackling discrimination against people with mental health*, Mental Health Foundation.

¹² See for example Waddell, G. and Burton A.K. (2006) *Is work good for your health and well-being?* London: TSO.

¹³ Waddell, G., Burton, A.K. and Kendall, N. (2008) *Vocational rehabilitation: what works, for whom, and when?* London: TSO.

¹⁴ CBI (2008) *At work and working well? CBI/AXA absence and labour turnover survey 2008*, CBI.

¹⁵ Black, C. (2008) *Working for a healthier tomorrow: Review of the Health of Britain's working age population*, London: TSO.

employers and individuals. The role of healthcare professionals and GPs, in particular, is critical to this process. In the vast majority of cases they are the primary source of advice and guidance for individuals who develop health conditions and it has been shown that their advice is pivotal when those individuals are making a decision about whether or not to return to work. However, while the medical profession is committed to tackling health and work issues, there is broad recognition that medical practitioners, especially GPs, could be better supported in giving back-to-work advice to their patients.

28. Against this backdrop, Dame Carol Black recommended a number of measures including the replacement of the current 'sick note' with a 'fit note'. The Government accepted this recommendation in November 2008¹⁶ and is now consulting on the detailed changes to the current medical statement after extensive discussions with stakeholders and a trial of a new medical statement by over 500 GPs.

29. The medical statement is the normal method by which employees provide evidence of sickness to employers during absence. It may also be used to support claims to health-related benefits. The Government believes the current format does not provide sufficient focus on how or whether an individual's condition could be accommodated at work. To improve the flow of such valuable information the Government is seeking to change the emphasis of the medical statement to help employers and employees focus more on what an individual with a health condition can do. Such a change will help ensure patients receive the best possible advice about the benefits of returning to work, and employers have the information they need to make changes to workplaces or work patterns to help facilitate an earlier return to work.

30. Medical statements are prescribed in regulations. There are two sets of regulations those which relate to Statutory Sick Pay paid by an employer, and those relating to state benefits paid by Jobcentre Plus. Identical changes are proposed to both. This consultation is focused on the one set of amending regulations the Government proposes to make to alter those two sets of regulations. They aim to create a medical statement better focused on helping people to return to work (these changes are described in Section 2 below). They also make provision to update the rules relating to completion of medical statements and reduce the different types of medical statements currently in use. The latter will simplify the process for GPs and employers and reflect changes to the benefits system, in particular the introduction of the Employment and Support Allowance (ESA). Changes to the regulations to ensure that computer-generated medical statements are valid in law are also proposed.

31. Section 2 discusses the proposals and how they affect:

- patients who are employed;
- patients already on benefits because they are not working;
- GPs who might print medical statements in their surgeries; and
- the changes which describe the status of those issuing medical statements and the advice they may consider from others.

32. Details of the current set of medical statements are attached at **Appendix 2**. The proposed new medical statement is at **Appendix 3**.

¹⁶ *Improving health and work: changing lives. The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population (2008)* TSO.

Section Two - Proposed Changes

Supporting employed patients to return to work

May be fit for some work now

33. The Government intends to change the format and content of the medical statements so that, as well as indicating whether a patient is fit or not fit for work for benefit and sick pay purposes, the form will allow doctors to record information to help inform discussions between individuals and their employers about whether there are any changes to the employee's work environment or job role which could help in achieving an early/earlier return to work. Specifically, the medical statement will include a new option to allow a doctor to provide an assessment of an individual's fitness for work. Doctors will be able to indicate where someone "May be fit for some work now".

34. The employer will not be bound to implement suggestions by a doctor for workplace changes which would facilitate a return to work. Changes will be provided at the discretion of employers and with the agreement of the employee.¹⁷ The Government recognises that there will be circumstances when an appropriate change cannot be agreed between the two parties or made available in the workplace. Should this happen, a statement which was issued as assessing an individual as 'May be fit for some work now' should be considered as constituting evidence that the patient should refrain from work for sick pay purposes. As now, it will be up to employers to consider all the circumstances in order to determine if they accept that their employee is incapable of work under the terms of their contract.

35. If a doctor opts to classify a patient as "may be fit for some work now", he/she will be required to provide general details of the functional effect of that individual's condition. For example, where an individual has moderate lower back pain, a doctor may suggest that they will be unable to lift heavy objects and should be given the opportunity to change position or take breaks regularly. It is recognised that most of the medical professionals who issue statements on a regular basis are not experts in occupational health. Therefore no more than generic advice such as the example given above would be the expected norm.

36. In a trial of this approach, 583 volunteer GPs considered how they would have completed either the current or a new style medical statement for three modelled patient scenarios ('vignettes'). Using the new form some patients who would have been classified as "fit" moved to 'may be fit for some work now', but a far larger group moved from "unfit" to "may be fit for some work now". This suggested that using the new form could increase the numbers of patients discussing returning to modified work with their employers.

Suggesting changes to the workplace or job role

37. To further assist back-to-work discussions between individuals and their employers, the Government proposes providing doctors with the opportunity to indicate where their patient may

¹⁷ Employers must, however, continue to meet their obligations under the Disability Discrimination Act. An employer must not discriminate against a disabled employee for a reason related to the individual's disability and to consider reasonable adjustments to any provision, criteria or practice, or any physical feature of premises occupied by the employer if these would otherwise put a disabled person at a substantial disadvantage compared to a non-disabled person. Reasonable adjustments must also be considered during the recruitment process.

benefit from common types of workplace or job role changes with their employer's agreement. It suggests:

- a phased return to work;
- altered hours;
- amended duties; and
- workplace adaptations.

38. However, discussions with stakeholders on the design of the new form identified other options for action that may assist an individual's return to work. In particular, many stakeholders felt that an option to suggest an occupational health referral should be added to the list above. Others argued that occupational health provision by employers remains the exception rather than the norm, so that it is likely that in most circumstances employers would not be able to act upon any such advice. Human resource professionals have also suggested that where occupational health services are available employers often have their own referral criteria which may conflict with any advice offered by the doctor.

Consultation Question 2: The Government welcomes views on whether listing common types of changes is helpful; whether those listed are sufficient; and on whether 'Occupational Health assessment' should be added to the revised statement.

Reducing the paperwork: merging the functionality of the Med 5 into the Med 3 and abolition of the Med4

39. Following representations by GPs and their representatives, and to reflect changes to the benefit system resulting from the introduction of Employment and Support Allowance, the Government intends to reduce the different types of medical statements used by doctors.

40. Two changes are proposed. First, the current form Med 5 provides for doctors to issue a medical statement based on an assessment of a report from another doctor. It also enables a doctor to issue a statement more than 24 hours after an examination. These functions will be incorporated into the standard medical statement (revised form Med 3). To achieve this, the following changes will be made to the form Med 3:

- rules will be added to the Schedules to allow a doctor to issue a medical statement following their consideration of a report from another doctor or other healthcare professional provided the report was written no more than a month previously; and
- rules will be adapted to allow doctors to use the Med 3 to certify an individual's fitness or otherwise for work retrospectively, where there has been a prior medical assessment (i.e. one more than 24 hours prior to the statement being issued).

As a result of these changes regulations relating to the Med 5 will be revoked.

Consultation Question 3: Will the changes described in paragraph 40 ensure that the current functions of the special statement - form Med 5 - are accurately incorporated in the revised form Med 3 and associated rules for its completion?

41. The second change results from the introduction of Employment and Support Allowance and alignment of Incapacity Benefit procedures. The form Med 4, which was used in relation to gathering evidence to support the first Personal Capability Assessment referral, is no longer required. Therefore, we propose removing all references to this form from regulations.

Empowering an individual to return to work

42. For many common health conditions or, for example, following routine surgery, doctors will be able to judge with reasonable certainty a point in the near future when their patient should be able to return to the workplace. Generally, therefore, there is no need for an individual or their employer to seek confirmation from their doctor that they are, in fact, fit to return to work either on the expiry of a medical statement or before that date if an individual feels able and it is within advice given by the doctor who issued the medical statement.

43. The Government therefore intends to change the medical statement to allow doctors to specify if they would need to see an individual again when their current statement expires. This change will help individuals to make their own informed decisions about when to return to work; reduce unnecessary burdens on doctors; and reduce uncertainty for employers about when an individual can be expected to return to work.

44. To reinforce this approach, the Government is considering whether to remove the option for doctors to issue a medical statement when an individual is fit for work. This would end the practice, which has no basis in law relating to medical statements, of employers seeking medical evidence of fitness for work before allowing an individual to return to work. This will free up time for GPs to treat patients who require treatment. It will also help individuals make their own decisions about when they should return to work on the basis of the information supplied to them by their doctor.

Consultation Question 4: The Government welcomes views on whether medical statements should only be issued when a patient is assessed as “not fit for work” or ‘may be fit for some work’.

Impacts on the benefits system

45. The Government intends that individuals with health conditions who require the support of the benefit system to return to work will not be disadvantaged by the proposed changes. Therefore, for the purposes of a claim for Employment and Support Allowance, a statement issued by a doctor assessing an individual as “may be fit for some work now” will be taken as evidence of limited capability for work for the purposes of the assessment period. Similar arrangements will apply to those customers who continue to claim Incapacity Benefit.

46. Where an individual is claiming Jobseekers Allowance, the discretion of the Jobcentre Plus personal adviser will be unaffected by the introduction of the new statement. As now, if an individual obtains a medical statement from their GP the individual could, where appropriate, be required to make a claim for Employment and Support Allowance. Alternatively, they could be treated as capable of work for up to 2 weeks: a jobseeker can remain on JSA and be treated as capable of work (when he or she is not) for a maximum period of up to 2 weeks, twice in any job-seeking period of 12 months. However, the new option 'may be fit for some work' could inform a discussion about restricted availability on an ongoing basis. Customers will continue to be able to seek to restrict their availability in agreement with their personal adviser. The personal adviser may, as now, ask for supporting medical evidence in some cases.

47. In all cases where individuals are assessed as not fit for work the system will work as now.

A computer-generated medical statement

48. Subject to the results of a pilot currently nearing completion in Wales¹⁸, the Government has decided to move from a paper-based medical statement to a computer generated format which can be printed in the GP's surgery and saved to the patient's records.

49. Changes to regulations are therefore being made to reflect such computer-generated statements. The Government will announce its plans for computer-generated statements later this year.

50. Medical statements will nonetheless continue to be available in paper format should they be required.

Guidance for doctors, employers and patients

51. The Government will provide guidance for doctors, patients and employers to ensure they are fully aware of how to complete and/or interpret the new medical statement in order to ensure it meets the stated objectives. The Government will work closely with the representatives of medical professions, employer and employees to develop this guidance.

Date of introduction of the new statement of fitness for work

52. The new medical statement will be introduced in April 2010, subject to Parliamentary approval.

¹⁸ See <http://www.hmrc.gov.uk/employers/med-cert-pilot.htm>

Section Three – Commentary on the draft Regulations

Commentary on the draft regulations

53. The following summary explains the purpose of each of the provisions:

Regulation 1 contains the citation and commencement arrangements.

Regulation 2 amends the Social Security (Medical Evidence) Regulations 1976(S.I.1976/615)

- Paragraph (2) (1) substitutes a new regulation 2 (1) and a new paragraph 1(A) for the present regulations. It retains the requirement for a person claiming social security benefits allowances and advantages depending upon incapacity for work or limited capability for work to provide a doctor's statement in accordance with the rules and format set out in Schedule 1 as amended. It removes the requirement :
 - for a doctor to issue a special statement (med 5) in those cases where the doctor has not given a statement since the patient was examined and wishes to give such a statement, but more than one day has passed since the examination; or where the doctor wants to advise the patient that they should refrain from work on the basis of a written report from another doctor. These functions have now been incorporated into the revised doctor's statement as set out in rule 4, 5 and 10 below; and
 - for doctors to provide a statement (med 4) for benefit purposes i.e. where the question of whether a person is capable or incapable for work relates to the personal capability assessment for Incapacity Benefit, or whether the person has or does not have limited capability for work in relation to the work capability assessment for Employment and Support Allowance.
- Paragraph (1A) is a new paragraph and adopts the wording of the existing paragraph (d) and removes reference to paragraph (a) to (c).
- Paragraph (2) (b) amends regulation 2 (2) to reflect changes to numbering of the existing rules.
- Paragraph (2) substitutes a revised Schedule for the current Schedule 1. The schedule contains the rules which a doctor must take account of when issuing a doctor's statement and the form of the statement to be used. The revised schedule carries forward a number of the existing rules and updates others.
- Paragraph (3) removes Schedules 1A and 1B which set out the rules and format of form med 5 and form med 4.

Schedule 1 Part 1 Rules

Schedule 1 Part 1 Rules (note: the revised schedule is the same for both the amended Social Security (Medical Evidence) Regulations 1976 and the Statutory Sick Pay (Medical Evidence) regulations 1985 and hence is described here only once.)

Rule 1:

Introduces new definitions:

- **“assessment”**- is defined as a consultation between the patient and a doctor either in person or by telephone; or where a doctor considers a written report by another doctor or other health care professional.
- **“condition”** - is defined as either a disease or bodily or mental disability .
- **“other health care professional”** is defined as a person other than a registered medical practitioner not being the patient who is either a registered nurse, an occupational therapist or a physiotherapist registered with a regulatory body established under the relevant Health Act.. This definition relates to the issuing of statements by doctors based on written reports described in Rule 5.

The definition of **“claimant”** is being amended to **“patient”** in the Social Security (Medical Evidence) Regulations 1976, to align this with rule 1 of the current Statutory Sick Pay (Medical Evidence) Regulations 1985 as this is to whom the statement is being issued.

There is no change to the definition of **“doctor”**.

Rule 2 the wording has been amended from that of existing rule 2 and 3 of the Social Security (Medical Evidence) Regulations 1976 and rule 2 and 3 (a) of the Statutory Sick Pay (Medical Evidence) Regulations 1985 . This means that existing rule 2, 3 and 3(a) will now be given effect by this new rule 2. The new rule will continue to provide for the doctor’s statement to be issued by National Health Service (NHS) GPs to their NHS patients in the form set out in the Part 2 of this schedule. It is also being amended to take account of amendments to National Health Service Acts in England, Scotland and Wales.

The existing rule 3(b) is to be removed from the Statutory Sick Pay (Medical Evidence) Regulations 1985 as the pilot scheme to which it refers no longer applies.

Rule 3 the wording has been slightly amended but it continues to allow other doctors, not covered by rule 2 who provide medical services under the NHS or outside the NHS, to issue a statement as described in rule 2 or on a form substantially similar to it.

Rule 4 is a new rule which ensures that the doctor who gives the statement is the doctor who has made the assessment.

Rule 5 is a new rule to incorporate part of the function of the special statement (Med 5) into the revised statement of fitness for work (Med 3). Where the doctor issues a statement to their patient that is based on the consideration of a written report by another doctor or healthcare professional, it requires that the statement must only be given on a date not later than one month after the date of the written report. To simplify matters we are also removing the current provision that restricts the period for which a statement based on a written report to one month.

Rule 6 amends the existing rule 5 which sets out the information that must be contained in the statement. This means that rule 5 will now be rule 6 with few amendments. Paragraphs (a) to (c) are amended and new paragraphs (d) and (e) are inserted to reflect the new statement of

fitness for work. The wording relating to completion of the statement in ink or other indelible substance has not been amended. This will however allow for the statement to be completed in writing or in a computer generated format.

- Paragraph (a) replaces the reference to ‘claimant’ with ‘patient’ in the Social Security (Medical Evidence) Regulations 1976.
- Paragraph (b) requires the doctor issuing the statement to insert a date on which they assessed the patient’s case.
- Paragraph (c) will require the doctor to state the condition in respect of which they are advising the patient on fitness for work.
- Paragraph (d) is a new paragraph. It requires the doctor to indicate on the statement when he/she considers the patient “may be fit for some work”.
- Paragraph (e) is a new paragraph. It will require the doctor to state whether or not they need to assess the patient’s fitness for work again.
- Paragraphs (f) and (g) adopt the wording of existing paragraphs (d) and (e) with no amendments.

Rule 7 adopts the wording of existing rule 6 with limited amendments. This means that rule 6 will now be rule 7. It amends the reference to ‘rules 7 and 8’ because of renumbering. It replaces ‘diagnosis of disorder’ with ‘condition’ and ‘claimant’ with ‘patient’. It also replaces ‘refrain from work’ with ‘not fit for work’. This reflects the changes being made to the statement. The rule, otherwise, remains as it is; the doctor must state as precisely as possible the condition which has caused the patient’s absence from work.

Rule 8 is a new rule. Where the doctor considers the patient “may be fit for some work”, it will require the doctor to provide their reasons, including details of the functional effects of the condition. If appropriate, the doctor may suggest additional arrangements the patient may make with their employer, if available, to support a return to work.

Rule 9 adopts the wording of existing rule 7. This means that rule 7 will now be rule 9 with limited amendments. For the Social Security (Medical Evidence) Regulations 1976, it aligns the wording to that of the Statutory Sick Pay (Medical Evidence) Regulations 1985. For both regulations it also replaces the word ‘diagnosis’ with ‘condition’ to reflect the changes to the statement. The rule otherwise remains as it is, in that it allows the doctor to state less precisely the condition in cases where disclosure of the precise condition would influence the patient’s well-being or the patient’s position with their employer.

The existing rule 8 has been omitted. It enabled doctors’ to state an “unspecified” diagnosis in those cases where the doctor, from an initial examination, cannot find any clinical signs of a condition stated by the patient that prevents the patient to return to work. Our policy intention is that the new statement must state what a person can or cannot do to enable an early return to work, and this rule does not help to achieve this.

Rule 10 adopts the wording of existing rule 9 with limited amendments. This means that rule 9 will now be rule 10. It replaces the word ‘*examination*’ with ‘*assessment*’. The rule incorporates the functionality of the med 3 and med 5 by allowing the issue of a statement on the date of the

assessment, as well as on a date after the date of the assessment. The rule otherwise remains unchanged, in that, only one statement can be issued for each assessment. A replacement statement can only be issued for the same assessment if the original statement is lost, mislaid or destroyed, but if so it must be clearly marked as 'duplicate'.

Rule 11 adopts the wording of existing rule 10 with limited amendments. This means that rule 10 will now be rule 11. The word 'examination' is replaced with 'assessment'. The rule otherwise remains as it was in that it enables a doctor to provide an end date on the statement, where in the doctor's opinion a patient will be fit to return to work within two weeks of the date of assessment.

Rule 12 adopts the wording of existing rule 11 with limited amendments. This means that rule 11 will now be rule 12. The words 'claimant' are replaced with 'patient'; 'disorder' with 'condition' and 'refrain from work' with 'not be fit for work' and 'may be fit for some work' in order to reflect the changes in the new statement. The rule otherwise remains as it was, in that, it requires the doctor to specify the minimum period that a patient is likely to be unfit for work, but it now also includes the may be fit for some work category.

Rule 13 adopts the wording of existing rule 12 with limited amendments. This means that rule 12 will now be rule 13. We will be replacing the reference to 'rules 12 and 13' because of renumbering; the words 'claimant' are replaced with 'patient', and 'examination' with 'assessment'. The rule otherwise remains as it was in that a statement may only be issued for a maximum period of 6 months unless the patient has already refrained from work in at least the 6 months immediately preceding the date of assessment.

Rule 14 adopts the wording of existing rule 13 with limited amendments. This means that rule 13 will now be rule 14. The reference to 'claimant' is replaced with 'patient'; 'refrain from work' with 'not be fit for work' and 'examination' with 'assessment'; 'until further notice' is replaced with 'an indefinite period' in order to reflect the new statement. Otherwise the rule remains as it was and enables a doctor to issue a statement for an indefinite period when that patient has been off work for more than 6 months and they are likely to remain unfit for work for the foreseeable future.

The present rule 14 has been omitted as there will be no notes accompanying this statement. Detailed information on completion of the statement for fitness for work will be provided in guidance for doctors.

Existing rule 15 has been omitted from the Social Security (Medical Evidence) Regulations 1976 as there will be no reference to vocational rehabilitation which is not used for benefit purposes.

Regulation 3 amends the Statutory Sick Pay (Medical Evidence) Regulations 1985:

- Paragraph (2) amends regulation 1(2) by updating the reference to the Social Security Housing and Benefits Act 1982 to the Social Security Administration Act 1992.
- Paragraph (3) amends regulation 2 (1) and 2(2) by:
 - retaining the requirement for a doctor to provide a doctor's statement in accordance with rules and format set out in Schedule 1 as amended;

- removing the requirement for a doctor to issue a special statement (med 5) in those cases where the doctor has not given a statement since the patient was examined and wishes to give such a statement, but more than one day has passed since the examination; or wants to advise the patient that they should refrain from work on the basis of a written report from another doctor. These functions have now been incorporated into the revised doctor's statement set out in rule 4, 5 and 10 above;
- adopting the wording of existing paragraph (c) which allows for medical information to be provided by other means as may be sufficient in the circumstance of a particular case; and
- updating a reference to the '1982 Act' to the '1992 Act'
- Paragraph (4) substitutes a revised Schedule for the current Schedule 1 which contains the rules a doctor must take into account of when issuing a statement for fitness for work, and the form of the statement to be used. The revised schedule also carries forward a number of rules and updates others in light of the changes. Details of the changes are given above.
- Paragraph (5) removes Schedule 1A which set out the rules and format of form med 5.

Consultation Question 5:

The Government welcomes views on whether the draft regulations, including the rules, achieve the intentions expressed in the commentary. In particular, bearing in mind the Government's aim of reducing sickness absence and supporting people with health conditions to return to work at the earliest opportunity, should the maximum duration of a medical statement be less than 6 months? (See Rule13.)

The Consultation Questions

Consultation Question 1: Do you have any further information, data or analysis which would be useful for improving the quality of the analysis in the attached impact Assessment?

Consultation Question 2: The Government welcomes views on whether listing common types of changes is helpful; whether those listed are sufficient; and on whether 'Occupational Health assessment' should be added to the revised statement.

Consultation Question 3: Will the changes described in paragraph 40 ensure that the current functions of the special statement - form Med 5 - are accurately incorporated in the revised form Med 3?

Consultation Question 4: The Government welcomes views on whether medical statements should only be issued when a patient is assessed as 'not fit for work' or 'may be fit for some work'.

Consultation Question 5: The Government welcomes views on whether the draft regulations, including the rules, achieve the intentions expressed in the commentary. In particular, bearing in mind the Government's aim of reducing sickness absence and supporting people with health conditions to return to work at the earliest opportunity, should the maximum duration of a medical statement be less than 6 months? (See Rule 13.)

Appendix 1

List of organisations which this consultation is copied to

British Medical Association (GPC), England, Scotland and Wales
Chartered Institute of Personnel and Development
Chief Medical Officer, Department of Health, England
Chief Medical Officer, Scotland
Chief Medical Officer, Wales
Citizen's Advice
Confederation of British Industry
Dame Carol Black
Disability Alliance
EEF, the manufacturers' organisation
Faculty of Occupational Medicine
Fast Forward
Federation of Small Businesses
Forum of Private Business
Health Rights Information Scotland
Institute of Payroll Professionals
Local Health Board, Wales
National Health Service Employers
Nursing and Midwifery Council
Royal College of General Practitioners
Royal College of Nursing
Scotland Patient's Association
Scottish Council for Development and Industry
Scottish Financial Enterprise
Scottish Government
Scottish Independent Advocacy Alliance
Scottish Trade Union Congress
Stonewall Scotland
Trade Union Congress
Transport for London
Welsh office
Welsh Trade Union Congress

Appendix 2 – The Current Medical Statements

i) Current form Med 3.

FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY

NOTES TO PATIENT ABOUT USING THIS FORM

You can use this form either:

1. For Statutory Sick Pay (SSP) purposes - fill in Part A overleaf. Also fill in Part B if the doctor has given you a date to resume work. Give or send the completed form to your employer.
2. For Social Security purposes - To continue a claim for state benefit fill in Parts A and C of the form overleaf. Also fill in Part B if the doctor has given you a date to resume work. Sign and date the form and give or send it your Local Social Security Office QUICKLY to avoid losing benefit.

NOTE: To start your claim for State benefit you must use form SC1 if you are self-employed, unemployed or non-employed OR form SSP1 if you are an employee. For further details get leaflet IB202 (from Social Security Local Offices).

Doctor's Statement

In confidence to
Mr/Mrs/Miss/Ms

I examined you today/yesterday and advised you that

(a) You need not refrain from work
(b) you should refrain from work for*†
OR until

Diagnosis of your disorder causing absence from work

Doctor's remarks

Doctor's signature Date of signing

Form Med 3

NOTE TO DOCTOR*† See inside front cover for notes on completion

The medical statement Form Med 3 which is sometimes called a certificate or a sick note, is issued by a doctor attending a patient when he has examined the patient on that day or the previous day. It is used by patients as evidence (or not) of fitness for work and is given to an employer in support of entitlement to Statutory Sick Pay or to Jobcentre Plus in support a claim for Employment and Support Allowance or other benefits on grounds of incapacity.

ii) Current form Med 4.

Doctor's statement

Do not use this form for people claiming Statutory Sick Pay

To the doctor We are assessing your patient's eligibility for Incapacity Benefit and other state benefits under the all work test. Please fill in the following statements.

In confidence to Mr/Mrs/Miss/Ms _____

Main diagnosis
(be as precise as possible)

Other diagnoses

Doctor's remarks
(Including comments on the disabling effects of the condition, treatment and progress. Accuracy and detail will avoid requests for completion of a medical report)

SPECIMEN

To the doctor While the all work test is carried out, we need some evidence that your patient should refrain from their usual occupation. The information you give here will not be part of the all work test.

I am issuing the following statement based upon the current guidance to certifying medical practitioners. I examined you today / yesterday and advise you

that you need not refrain from your usual occupation.

that you should refrain from your usual occupation

for _____ (period).

or until _____ .

Doctor's signature _____ Date / / .

Stamp

Med 4

Printed for BA OSD/PCMG by PADS 008832P 5/99

The Med 4 form was required under the Incapacity Benefit regime to support medical information supplied by the patients GP on the form IB 113. The IB 113 forms were issued by Jobcentre Plus Incapacity Benefit processors in relation to the personal capability assessments (PCA). The IB 113 has been replaced by a form ESA 113 and the Med 4 form is no longer required. Therefore this form is now obsolete and these proposals will remove it from the catalogue of medical statement forms.

iii) Current form Med 5

FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY		Special Statement by the Doctor
In confidence to Mr/Mrs/Miss/Ms		
(A) I examined you on the following dates	(B) I have not examined you but, on the basis of a recent written report from -	
.....	Doctor (name if known)	
.....	of	
and advised you that you should refrain from work (Address)	
.....	I have advised you that you should refrain from work for/until	
from.....to.....	
Diagnosis of your disorder causing absence from work	
Doctor's remarks.		
Doctor's signature	Date of signing	
<i>The special circumstances in which this form may be used are described in the handbook "A guide for medical practitioners."</i>		
		Form Med 5
PATIENT TO COMPLETE PARTICULARS ON REVERSE		
<small>Med 5 001137 07/01 SPSL</small>		

The medical statement Form Med 5 which is sometimes called “the backdating certificate” has two functions. It is used when a doctor needs to issue a medical statement for a past period and he cannot issue a Med 3 because the examination was carried out earlier than the previous day.

It is also used when a doctor has not carried out an examination but is using a report from another doctor or medical profession to provide a medical statement.

This form is used in the same way as the Form Med 3. It is proposed that this form is amalgamated into the revised Med 3.

Appendix 3 - The new Form Med 3 (Including the Med 5 facility).

Statement of fitness for work

Med3 04/09

For social security or Statutory Sick Pay

Patient's name

I assessed your case on

and, because of these condition(s):

- I advise that
- you are fit for work.
 - you are not fit for work.
 - you may be fit for some work now.

Comments, including functional effects of your condition(s): <div style="font-size: 4em; color: red; opacity: 0.5; transform: rotate(-15deg); position: absolute; top: 50%; left: 50%; pointer-events: none;">DRAFT</div>	If available, and with your employer's agreement, you may benefit from: <input type="checkbox"/> a phased return to work. <input type="checkbox"/> altered hours. <input type="checkbox"/> amended duties. <input type="checkbox"/> workplace adaptations.
--	--

This will be the case for
 or from to

I will/will not need to assess your fitness for work again at the end of this period.
 (Please delete as applicable)

Doctor's signature

Date of statement

Doctor's address

The revised form Med 3 has an additional option for doctors – May be fit form some work. This option should be used where the doctor considers that the patient could return to work if some aspects of his work changed either temporarily or permanently. Where this option is used the doctor must provide additional information about the condition or his advice for a return to work in the free text “comments” box.

This form also enables a doctor to provide information based on: an examination today; an earlier examination; another doctor's or healthcare professional's report. The reverse of this form (not shown) will provide space for the patient or employee to complete identifying details similar to those provided on the existing Forms Med 3 & Med 5.

**Appendix 4: The Social Security (Medical Evidence) and Statutory Sick Pay
(Medical Evidence) Amendment Regulations 2010**

 STATUTORY INSTRUMENTS

2010 No. [000]

SOCIAL SECURITY

TERMS AND CONDITIONS OF EMPLOYMENT

The Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010

Made - - - - 2010

Laid before Parliament 2010

Coming into force -- []

The Secretary of State for Work and Pensions, in exercise of powers conferred by sections 5(1)(h) and 14(2) of the Social Security Administration Act 1992⁽¹⁹⁾ with the concurrence of Her Majesty's Revenue and Customs insofar as this is required and after reference to the Social Security Advisory Committee makes the following Regulations.

Citation, commencement and interpretation

1.—1. These Regulations may be cited as the Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010.

(1) These Regulations shall come into force on [].

(2) In these Regulations:—

“the 1976 Regulations” means the Social Security (Medical Evidence) Regulations 1976⁽²⁰⁾;

“the 1985 Regulations” means the Statutory Sick Pay (Medical Evidence) Regulations 1985(c).

Amendment of the 1976 Regulations

2.—2. The 1976 Regulations are amended as follows.

(1) In regulation 2 (evidence of incapacity for work, limited capability for work and confinement) for paragraph (1) substitute the following—

“2.—(1) Subject to regulation 5 and paragraph (1A) below, where a person claims to be entitled to any benefit, allowance or advantage (other than industrial injuries benefit or statutory sick pay) and entitlement to that benefit, allowance or advantage depends on that person being incapable of work or having limited capability for work, then in respect of each day until that person has been assessed for the purposes of the personal capability assessment or the limited capability for work assessment they shall provide evidence of such incapacity or limited capability by means of a statement given by a doctor in accordance with the rules set out in Part 1 of Schedule 1 to these Regulations.

(1A) Where it would be unreasonable to require a person to provide a statement in accordance with paragraph (1) above that person shall provide such other evidence as may be sufficient to show that they are incapable of work or have limited capability for work so that they should refrain (or should have refrained) from work by reason of some specific disease or bodily or mental disability.”

⁽¹⁹⁾ 1992 c.5.

⁽²⁰⁾ S.I. 1976/615.

(c) S.I. 1985/1604

(b) in sub-paragraph (2) for “rule 10” substitute “rule 11”.

(2) For Schedule 1 (rules) substitute—

“SCHEDULE 1

Regulation 2(1)

PART 1

RULES

1. In these rules—

“assessment” means either a consultation between a patient and a doctor which takes place in person or by telephone or a consideration by a doctor of a written report by another doctor or other health care professional;

“condition” means a specific disease or bodily or mental disability;

“doctor” means a registered medical practitioner not being the patient;

“other health care professional” means a person other than a registered medical practitioner and not being the patient who is a registered nurse, an occupational therapist, or a physiotherapist registered with a regulatory body established by an order in council under section 60 of the Health Act 1999⁽²¹⁾;

“patient” means the person in respect of whom a statement is given in accordance with these rules.

2. Where a doctor issues a statement to a patient in accordance with an obligation arising under a contract, agreement or arrangement under Part 4 of the National Health Service Act 2006⁽²²⁾ or Part 4 of the National Health Service (Wales) Act 2006⁽²³⁾ or Part 1 of the National Health Service (Scotland) Act 1978⁽²⁴⁾ the doctor’s statement shall be in a form set out at Part 2 of this Schedule and shall be signed by that doctor.

3. Where a doctor issues a statement in any case other than in accordance with rule 2, the doctor’s statement shall be in the form set out in Part 2 of this schedule or in a form to like effect and shall be signed by the doctor attending the patient.

4. A doctor’s statement must be based on an assessment made by that doctor.

5. Where a doctor’s statement is based on the consideration of a written report by another doctor or other health care professional that statement may only be given on a date not more than one month after the date of such written report.

6. A doctor’s statement shall be completed in ink or other indelible substance and shall contain the following particulars:

- (a) the patient’s name;
- (b) the date of the assessment on which the doctor’s statement is based;
- (c) the condition in respect of which the doctor advises the patient whether or not they are fit for work;
- (d) a statement, where the doctor considers it appropriate, that the patient may be fit for some work now;
- (e) a statement that the doctor will or, as the case may be will not, need to assess the patient’s fitness for work again;
- (f) the date on which the doctor’s statement is given;
- (g) the address of the doctor,

and shall bear, opposite the words “Doctor’s signature”, the signature in ink of the doctor making the statement.

7. Subject to rule 9, the condition in respect of which the doctor is advising the patient is not fit for work or, as the case may be, which has caused the patient’s absence from work shall be specified as precisely as the doctor’s knowledge of the patient’s condition at the time of the assessment permits.

⁽²¹⁾ 1999 c.8.

⁽²²⁾ 2006 c.41.

⁽²³⁾ 2006 c. 42.

⁽²⁴⁾ 1978 c.29.

8. Where a doctor considers that a patient may be fit for some work the doctor shall state the reasons for that advice and where this is considered appropriate, the arrangements which the patient might make, with their employer’s agreement, to return to work.

9. The condition may be specified less precisely where, in the doctor’s opinion, disclosure of the precise condition would be prejudicial to the patient’s well-being, or to the patient’s position with their employer.

10. A doctor’s statement may be given on a date after the date of the assessment on which it is based, however no further statement shall be furnished in respect of that assessment other than a doctor’s statement by way of replacement of an original which has been lost, in which case it shall be clearly marked “duplicate”.

11. Where, in the doctor’s opinion, the patient will become fit for work on a day not later than 14 days after the date of the assessment on which the doctor’s statement is based, the doctor’s statement shall specify that day.

12. Subject to rules 13 and 14, the doctor’s statement shall specify the minimum period for which, in the doctor’s opinion, the patient will not be fit for work or as the case may be may be fit for some work now.

13. The period specified shall begin on the date of the assessment on which the doctor’s statement is based and shall not exceed 6 months unless the patient has, on the advice of a doctor, refrained from work for at least 6 months immediately preceding that date.

14. Where—

- (a) the patient has been advised by a doctor that they are not fit for work and, in consequence, has refrained from work for at least 6 months immediately preceding the date of the assessment on which the doctor’s statement is based, and
- (b) in the doctor’s opinion, the patient will not be fit for work for the foreseeable future,

instead of specifying a period, the doctor may, having regard to the circumstances of the particular case, enter, after the words “case for”, the words “an indefinite period”.

PART 2

FORM OF DOCTOR’S STATEMENT

DOCTOR’S STATEMENT

Statement of fitness for work
For social security or statutory sick pay

Patient’s name

Mr, Mrs, Miss, Ms

I assessed your case on:—

/ /

and, because of these condition(s):—

I advise that

- you are fit for work.
- you are not fit for work
- you may be fit for some work now

Comments, including functional effects of your condition(s):

If available, and with your employer’s agreement, you may benefit from:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations.

This will be the case for

or from

/ /

to

/ /

I will/will not need to assess your fitness for work again at the end of this period. *(Please delete as applicable)*

Doctor’s signature

Date of statement

 / /

Doctor’s address

(3) Schedules 1A and 1B are omitted.

Amendment of the 1985 Regulations

3.—(1) The 1985 Regulations are amended as follows.

(2) In regulation 1(2) (citation, commencement and interpretation) for “the 1982 Act” means the Social Security Housing and Benefits Act 1982” substitute ”“the 1992 Act” means the Social Security Administration Act 1992;”.

(3) In regulation 2 (medical information) for paragraph(1) substitute-

“(1) Medical information required under section 14(1) of the 1992 Act relating to incapacity for work shall be provided either—

- (a) in the form of a statement given by a doctor in accordance with the rules set out in Part 1 of Schedule 1 to these Regulations; or
- (b) by such other means as may be sufficient in the circumstances of any particular case.”.

(4) For Schedule 1 substitute—

“SCHEDULE 1

Regulation 1(3)

PART 1
RULES

1. In these rules—

“assessment” means either a consultation between a patient and a doctor which takes place in person or by telephone or a consideration by a doctor of a written report by another doctor or other health care professional;

“condition” means a specific disease or bodily or mental disability;

“doctor” means a registered medical practitioner not being the patient;

“other health care professional” means a person other than a registered medical practitioner and not being the patient who is a registered nurse, an occupational therapist, or a physiotherapist registered with a regulatory body established by an order in council under section 60 of the Health Act 1999⁽²⁵⁾;

“patient” means the person in respect of whom a statement is given in accordance with these rules.

2. Where a doctor issues a statement to a patient in accordance with an obligation arising under a contract, agreement or arrangement under Part 4 of the National Health Service Act 2006⁽²⁶⁾ or Part 4 of the National Health Service (Wales) Act 2006⁽²⁷⁾ or Part 1 of the National Health Service (Scotland) Act 1978⁽²⁸⁾ the doctor’s statement shall be in a form set out at Part 2 of this Schedule and shall be signed by that doctor.

⁽²⁵⁾ 1999 c.8.

⁽²⁶⁾ 2006 c.41.

⁽²⁷⁾ 2006 c. 42.

⁽²⁸⁾ 1978 c.29.

3. Where a doctor issues a statement in any case other than in accordance with rule 2, the doctor's statement shall be in the form set out in Part 2 of this schedule or in a form to like effect and shall be signed by the doctor attending the patient.

4. A doctor's statement must be based on an assessment made by that doctor.

5. Where a doctor's statement is based on the consideration of a written report by another doctor or other health care professional that statement may only be given on a date not more than one month after the date of such written report.

6. A doctor's statement shall be completed in ink or other indelible substance and shall contain the following particulars:

- (a) the patient's name;
- (b) the date of the assessment on which the doctor's statement is based;
- (c) the condition in respect of which the doctor advises the patient whether or not they are fit for work;
- (d) a statement, where the doctor considers it appropriate, that the patient may be fit for some work now;
- (e) a statement that the doctor will or, as the case may be will not, need to assess the patient's fitness for work again;
- (f) the date on which the doctor's statement is given;
- (g) the address of the doctor,

and shall bear, opposite the words "Doctor's signature", the signature in ink of the doctor making the statement.

7. Subject to rule 9, the condition in respect of which the doctor is advising the patient is not fit for work or, as the case may be, which has caused the patient's absence from work shall be specified as precisely as the doctor's knowledge of the patient's condition at the time of the assessment permits.

8. Where a doctor considers that a patient may be fit for some work the doctor shall state the reasons for that advice and where this is considered appropriate, the arrangements which the patient might make, with their employer's agreement, to return to work.

9. The condition may be specified less precisely where, in the doctor's opinion, disclosure of the precise condition would be prejudicial to the patient's well-being, or to the patient's position with their employer.

10. A doctor's statement may be given on a date after the date of the assessment on which it is based, however no further statement shall be furnished in respect of that assessment other than a doctor's statement by way of replacement of an original which has been lost, in which case it shall be clearly marked "duplicate".

11. Where, in the doctor's opinion, the patient will become fit for work on a day not later than 14 days after the date of the assessment on which the doctor's statement is based, the doctor's statement shall specify that day.

12. Subject to rules 13 and 14, the doctor's statement shall specify the minimum period for which, in the doctor's opinion, the patient will not be fit for work or as the case may be may be fit for some work now.

13. The period specified shall begin on the date of the assessment on which the doctor's statement is based and shall not exceed 6 months unless the patient has, on the advice of a doctor, refrained from work for at least 6 months immediately preceding that date.

14. Where—

- (a) the patient has been advised by a doctor that they are not fit for work and, in consequence, has refrained from work for at least 6 months immediately preceding the date of the assessment on which the doctor's statement is based, and
- (b) in the doctor's opinion, the patient will not be fit for work for the foreseeable future,

instead of specifying a period, the doctor may, having regard to the circumstances of the particular case, enter, after the words "case for", the words "an indefinite period".

PART 2
FORM OF DOCTOR'S STATEMENT
DOCTOR'S STATEMENT

Statement of fitness for work
For social security or statutory sick pay

Patient's name

Mr, Mrs, Miss, Ms

I assessed your case on:—

/ /

and, because of these condition(s):—

I advise that

- you are fit for work.
- you are not fit for work
- you may be fit for some work now

Comments, including functional effects of your condition(s):

<p>Comments, including functional effects of your condition(s):</p>	<p>If available, and with your employer's agreement, you may benefit from:</p> <ul style="list-style-type: none"> <input type="checkbox"/> a phased return to work <input type="checkbox"/> altered hours <input type="checkbox"/> amended duties <input type="checkbox"/> workplace adaptations.
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This will be the case for

or from

/ /

to

/ /

I will/will not need to assess your fitness for work again at the end of this period. *(Please delete as applicable)*

Doctor's signature

Date of statement

/ /

Doctor's address

(5) Schedule 1A is omitted.

Signed by authority of the Secretary of State for Work and Pensions

Date
 Work and Pensions

Name
 Minister of State
 Department for

We concur

Names

Two of the Lords Commissioners of Her Majesty's Revenue and Customs

EXPLANATORY NOTE

(This note is not part of the Regulations)

(To be inserted.)

Appendix 5 –Impact Assessment of the Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) Amendment Regulations 2010

Summary: Intervention & Options

Department /Agency: Department for Work and Pensions	Title: Impact Assessment of the Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) Amendment Regulations 2010	
Stage: Consultation	Version: One	Date: 28 May 2009
Related Publications: Dame Carol Black's Review 'Working for a healthier tomorrow'; the response 'Improving health & work';		

Available to view or download at: <http://www.workingforhealth.gov.uk> & www.dwp.gov.uk

Contact for enquiries: Ann-Maria Loughman

Telephone: 020 7449 5587

What is the problem under consideration? Why is government intervention necessary?

Dame Carol Black's review of the health of Great Britain's working-age population estimated that sickness absence and associated worklessness costs the economy about £100bn p.a. It highlighted the importance of early intervention to prevent longer-term or repeated absences and a need to encourage medical professionals to explore options which could lead to an earlier return to work.

A medical professional's earliest intervention is usually when a medical statement or 'sick-note' is requested. The current statement limits doctor's abilities to discuss or advise patients about fitness for work. Reforming the statement to address fitness for work would redress this problem. Regulations prescribe the format and rules for completion of medical statements.

What are the policy objectives and the intended effects?

This proposal is an important part of the Government's wider objective of keeping people well and in work. Evidence suggests that work is good for an individual's health. Improving the information provided on a revised medical statement would help individuals who have developed a health condition or have an existing impairment that has worsened return to appropriate work as early as possible. This allows them to profit from the well-being factors of being in work. Similarly, it would reduce the numbers of people leaving work to claim health-related benefits such as the Employment and Support Allowance.

What policy options have been considered? Please justify any preferred option.

1. Do nothing: retain the current statement Form Med 3. The information provided by healthcare professionals to individuals or employers would remain imperfect, thereby potentially hindering an early return to work and risking longer-term absence or worklessness and reduced productivity.

2: Legislative change: amend the current statement to shift focus onto what individuals can do rather than what they cannot do.

Option 2 is the preferred option as this meets the policy objectives.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? A monitoring and evaluation plan is under development. This would include a review of current sickness absence certified by general practitioners (baseline) and an assessment of the impact of the proposed policy change.

Ministerial Sign-off For CONSULTATION STAGE Impact Assessment:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:



.....Date: 28 / 05 / 2009

Summary: Analysis & Evidence

Policy Option: 2	Description: Amend the current medical statement to shift focus onto what individuals can do rather than what they cannot do.
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by ‘main affected groups’ The key one-off costs are (i) communication and IT costs for central government (£0.5m); (ii) training costs for GPs (£2.4m), (iii) increase in printing costs for central government (£0.7m); and (iv) increase in administrative costs for GPs to order new Form Med 3 statements (£0.1m PV). The average annual cost is from an increase in printing costs for GPs (£1.6m)
	One-off (Transition) Yrs	
	£ 3.7m 10	
	Average Annual Cost (excluding one-off)	
£ 1.6m	Total Cost (PV)	£15.0m – 15.7m
Other key non-monetised costs by ‘main affected groups’		

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by ‘main affected groups’ The key expected benefit is an increase in output from early return to work (£45.3m-£151.0m p.a.). These benefits will accrue to different groups (i) increase in earnings for individuals (£9.0m-£30.1m p.a.) (ii) fiscal benefit to taxpayer/ Government (£5.7m-£19.1m p.a.). GPs will also benefit from time savings as a result of fewer consultations and admin. savings (£5.1m-£16.8m p.a.). Central Government will save on printing costs (£1.4m p.a.).
	One-off Yrs	
	£ 10	
	Average Annual Benefit (excluding one-off)	
£ 51.8m – 169.1m	Total Benefit (PV)	£ 380.6m – 1,243.1m
Other key non-monetised benefits by ‘main affected groups’. In addition to the immediate increase in output, early return to work has a number of long-term benefits. Emerging evidence suggests that for many people, an early return to work helps to prevent short-term sickness absence from progressing to long-term absence and ultimately worklessness.		

Key Assumptions/Sensitivities/Risks Key monetised benefits are based on three scenarios - for medical statements issued to individuals with 2 or more statements p.a., it was assumed an additional 3%, 5% and 10% of cases return to work early. It is further assumed that output increases by 50% of the assumed wage for one extra week (minimum wage) (NB: output is usually taken to be 100% of the assumed wage).

Price Base Year 08/09	Time Period Years 10	Net Benefit Range (NPV) £ 365.0m – 1,228.1m	NET BENEFIT (NPV Best estimate) £ 611.6m
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What is the geographic coverage of the policy/option?	Great Britain			
On what date will the policy be implemented?	April 2010			
Which organisation(s) will enforce the policy?	N/A			
What is the total annual cost of enforcement for these organisations?	£ 0			
Does enforcement comply with Hampton principles?	N/A			
Will implementation go beyond minimum EU requirements?	N/A			
What is the value of the proposed offsetting measure per year?	£ 0			
What is the value of changes in greenhouse gas emissions?	£ 0			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)
Increase of £	Decrease of £	Net Impact £ N/A

Key:	Annual costs and benefits: Constant Prices	(Net) Present Value
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Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

This impact assessment has been produced for the purposes of a consultation exercise. It is not final - the views of stakeholders and the general public are invited. All costs and benefits in this impact assessment must therefore be treated as indicative. The impact assessment will be updated as further information becomes available.

Introduction

1. In her review of the health of Great Britain's working-age population, Dame Carol Black²⁹ estimated the annual economic cost of health related worklessness and sickness absence to be around £100bn per year. Employers, communities and the tax payer all bear these costs. As part of a number of recommendations to reduce them, Dame Carol highlighted the importance of the role of early intervention and the need for the medical certification process to better support GPs in providing their best advice to patients, and ultimately their employers on fitness for work. This together with evidence³⁰ that work is good for an individual's health, and requests from business for better information on medical statements, has led to this review of the format and completion of medical statements .

Consultation

2. The Government has engaged with a range of stakeholders, including representatives from health professions, employer organisations and trades unions to seek their views on the current medical statement. In addition, a draft of the revised statement has been tested with over 500 GPs. This has led to the development of a new medical statement as described in this impact assessment.
3. This impact assessment (IA) has been produced for the purposes of a consultation exercise. The purpose of the consultation is to ascertain the views of stakeholders and the general public of these proposals. All costs and benefits in this impact assessment are based on a number of assumptions. The estimates will be examined as further information becomes available and this assessment revised as necessary.

Medical Statements : background

4. Medical statements (more commonly known as a medical certificate or 'sick note') are issued by GPs and other healthcare professionals as evidence of an individual's fitness for work. Patients may be required to provide their employers with a medical statement to support a claim for Statutory Sick Pay³¹ if a spell of sickness lasts

²⁹ Dame Carol Black's review of the Health of Britain's working age population - Working for a healthier tomorrow –(2009)

³⁰ Waddel, G. and Burton A.K. (2006) Is work good for your health and well-being? The Stationery Office.

³¹ Employers have a statutory liability to pay SSP to any employee who is sick and unable to work under their contract of employment for 4 or more consecutive day and who meet the qualifying conditions. SSP is paid at a flat weekly rate of £79.15 to people who are classified as

more than 7 days. Similarly, a medical statement is required by Jobcentre Plus to support a claim to benefits such as Employment and Support Allowance.

5. The medical statement, Form Med 3, is issued by the doctor treating the patient and is based on an examination that has been carried out either that day or the day before. Form Med 4 is a separate statement that supplements information supplied by GPs to assist with personal capability assessments (PCAs) under the Incapacity Benefit regime. Form Med 5 has two functions. It is issued by a patient's GP where a statement of incapacity for work is required for a past period and is based on a previous examination. It is also used when a statement is based on a written report from another doctor who has carried out an examination.
6. The Social Security Administration Act 1992 provides the legislative base for medical statements. This provides for regulations to prescribe what evidence may be provided in support of any claim to benefit. It makes a similar provision for the evidence that may be required by employers for Statutory Sick Pay purposes. Doctors are contractually required to provide this evidence to their patients and to do so, on forms set out in the Social Security (Medical Evidence) Regulations 1976 and in the Statutory Sick Pay (Medical Evidence) Regulations 1985.

Improving the medical certification process: Details of the proposed change

7. In its present format of the medical statement requires a doctor to describe in brief terms an individual's condition and indicate whether they are or are not fit for work. The statement focuses on what people cannot do rather than what they can and provides little opportunity for healthcare professionals to provide basic advice about what steps if any individuals and their employers could take to help facilitate an early return to work. The existing form also reflects an age when an employee had a specific job rather than today's more flexible workplace.
8. The proposed changes are intended to allow medical professionals to record information that is more positive and more pertinent to subsequent discussions patients may have with their employers when considering whether a return to work is appropriate or possible.
9. The Government also proposes taking this opportunity to streamline the certification process for GPs and reduce the number of forms used. Two forms (Form Med 3 and Form Med 5) would be combined and a further form (Med 4) would be abolished.

Med 3 and Med 5

10. Amending regulations would introduce a new style medical statement Form Med 3 (See copy in Annex D of consultation document). This would incorporate the function of the current Form Med 3 and the function currently provided for by Form Med 5. During the stakeholder consultation it was agreed that it was no longer necessary to use separate forms to denote the type of examination or information used to provide the medical statement.

11. Based on their professional opinion GPs would be able to indicate to their patient that they are;
 - fit for work; or
 - unfit for work; or
 - may be fit for some work now.

This third option is designed to be used when the GP considers that some permanent or temporary change to a patient's work duties or environment could allow them to return to work. Where used there would be a mandatory requirement to provide additional information about the condition or further advice to support decisions about a return to work in a free text comment box. Whether the patient returns to work on the basis of this advice would be a matter for discussion between him and his employer as to the feasibility of making the necessary adjustments. If an employer is unable to accommodate such adaptations the employee would then be considered to be unfit for work for benefit and statutory sick pay purposes, for the period indicated on the form.

Med 4

12. GPs are asked to complete a form Med 4 to help Jobcentre Plus determine a person's incapacity for work and eligibility for benefits, such as Incapacity Benefit. Employment and Support Allowance (ESA) has replaced Incapacity Benefit for all new customers. This new benefit has fewer requirements for medical information from GPs. The Med 4 is now obsolete and GPs would no longer be asked to complete these forms or provide this information in another format. (A revised form ESA 113 has replaced the form IB 113).

Computer generated form

13. It is planned for the new style medical statement to be available in a computer generated format. This will allow patients details, diagnosis and dates to be input on the form before printing the document for signature. The design would replicate the paper version and should be available as part of the software used in GP surgeries. Details from the statements would be retained on the GP's patient records system. This would negate the need for transferring data from paper to electronic format or ordering and maintaining stationery stocks securely.

Impact of changes

Groups Affected

14. These amendments affect doctors who issue medical statements, patients and employers.

Costs and Benefits

15. Detailed calculations of the costs and benefits are set out in Annex D. The 'do nothing option' has no additional costs and benefits and is the baseline for comparison. Costs and benefits for the proposed changes to introducing a new

computer generated Form Med 3 form are additional costs and benefits over the do nothing option.

16. In 2008, the Department for Work and Pensions carried out a study comparing the current Form Med 3 statement to a new trial Med 3 statement³². The results (the relevant sections of which are included at Annex A) showed that GPs completing the trial Med 3 were less likely to advise patients to refrain from work. However, it was also found that a smaller proportion of patients were deemed to be ‘fit for work’ under the trial Med 3. Taking the drop in the percentage of people ‘fit for work’ from the decrease in the percentage ‘not fit for work’, there was still a net increase of between 15 to 44 percentage points in individuals considered to be ‘fit for some work’ as opposed to ‘not fit for work’ in the vignette cases. **Based on these findings, it is expected that with a revised Med 3 statement, some patients would return to work more quickly after a period of sickness absence.** This is one of the key expected benefits of the proposed policy change.
17. For the purposes of estimating this benefit in the impact assessment, various scenarios were developed. The proposed policy change is expected to have an impact on all patients with the greatest benefit for individuals with numerous/repeat sickness absence episodes. Analysis of medical statements indicates that 49% of patients were issued with 2 or more medical statements a year and 9% were issued with 5 or more as shown in the table below³³. Although these individuals make up just under half of all patients, they are issued with 76% of all medical statements in a given year. Individuals with numerous/repeat sickness absence are also likely to have an increased risk of long-term incapacity.

Table 1: Analysis of medical statements

	Proportion of all patients	Proportion of all statements issued
Patients issued with 1 statement	50.8%	24.1%
Patients issued with 2 to 4 statements	40.1%	49.2%
Patients issued with 5 to 9 statements	8.7%	24.6%
Patients issued with 10 or more statements	0.4%	2.1%
Total	100%	100%

Source: Analysis produced by Shiels using data collected from nine GP practices. See Shiels C., Gabbay M.B. and Ford F.M. (2004) ‘Patient factors associated with duration of certified sickness absence and transition to long-term incapacity’. British Journal of General Practice, February 2004, 54, 86-91.

Scenarios

18. **For medical statements issued to individuals with 2 or more statements a year, it was assumed an additional 3%, 5% and 10% of cases return to work early. It is further assumed that individuals return to work and that output**

³² Source: Sallis A., Birkin R. and Munir F. (in preparation) A number of papers reporting a comparison of the current Med 3 and trial Med 3 forms. If you would like full details of this research please contact Anna.Sallis@dwp.gsi.gov.uk

³³ Analysis produced by Shiels using data collected from nine GP practices. See Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) ‘Patient factors associated with duration of certified sickness absence and transition to long-term incapacity’. British Journal of General Practice, February 2004, 54, 86-91.

increases by just 50% of the assumed wage for one extra week (National Minimum Wage). It is usually assumed that a person's output equals 100% of his or her wage. Output is assumed to be less than 100% to account for a possible reduction in productivity or reduced hours for example. These assumptions are believed to be conservative. The average period certified on a medical statement for this group is between 1-4 weeks and based on the above research, a greater proportion of employees are expected to return to work early.

19. The results of the scenarios show that even with the conservative estimate of an additional 3% of cases returning to work, the increase in output to the economy is an estimated **£332.9m** over the ten year period 2009/10 – 2018/19 (present value) (£45.3m per annum). This rises to £1,109.6m if 10% of cases return to work early (£151.0m per annum).
20. In addition to the increase in output, early return to work has a number of long-term benefits. Emerging evidence suggests that work is good for health and that for many people an early return to work helps to prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness³⁴. The long term benefits of early return to work have not been monetised in this impact assessment as the exact impact of early return to work on long-term sickness absence is difficult to measure and quantify.
21. The benefits of early return to work and the long-term benefits of good health accrue to different groups in society. These are discussed below for the main affected parties, together with other benefits and costs of the proposed policy option.

Impact on main affected groups

Impact on individuals

22. An early return to work for individuals would result in an increase in earnings (difference between earnings and Statutory Sick Pay/Occupational Sick Pay after tax). Based on the above scenarios, this is estimated at **£66.3m to £221.0m** over the ten year period from 2009/10 – 2018/19 (present value) (£9.0m to £30.1m per annum).
23. As well as the increase in earnings in the short-term, as discussed above, emerging evidence suggests that work is good for health and that for many people an early return to work helps to prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness. So individuals would also benefit from improved health in the long-run.

Impact on employers

24. For employers, an early return to work results in savings. Apart from not paying SSP or occupational sick pay there would be a reduction in other costs of sickness absence such as turnover costs, loss of skills base, re-training costs and poor staff morale. There will also be an increase in revenue and profits that would flow from any additional output produced. There is, however, some potential for additional

⁶ Waddell, G. and Burton, A. K. (2006) Is work good for health and well-being? The Stationery Office.

costs if workplace adjustments are required to facilitate an early return e.g. specialist equipment or adjustments to working time agreements. Some workplace adjustments may not have any costs attached e.g. changes in work patterns. **Overall a net benefit is expected for employers.** As the proposed policy is not compulsory, rational employers would be likely to accept the GPs recommendation only if the benefits of an early return to work outweighed the costs. The impact on firms has not been monetised in this impact assessment as the increase in revenue from the additional output and cost of workplace adjustments is unknown.

Impact on public sector

Central Government/Taxpayer

Benefits

25. For the Government/taxpayer, there is additional tax revenue from individuals being in work as opposed to being off sick. Based on the above scenarios, the fiscal benefit is estimated at **£5.7m to £19.1m per annum**. In the long term, there are NHS savings from reduced use of healthcare resources as work is good for health plus further gains in tax revenue and savings in reduction of benefit payments (Employment and Support Allowance) as more people are in work.
26. A further benefit of the proposed policy is savings in printing costs for central government (from 2010/11). Printing, however, would not cease completely as some GPs may request paper medical statements from time to time. For the purposes of the impact assessment, it is assumed that 10% of Form Med 3 statements would continue to be printed by central government, giving an estimated saving of **£1.4m** per annum.

Costs

27. There is a one-off implementation/set-up cost for central government in communicating the changes to GPs, production of guidance for GPs and employers, and software development for the computer-generated Form Med 3. These are estimated at **£0.5m** and would be incurred in 2009/10 prior to implementation of the new Med 3 statement.
28. An increase in printing costs is expected in the year prior to implementation as GPs may order some paper copies of the new Med 3 as spares or 'back-up' in case of computer failure. It is assumed that printing costs will increase by 50% at **£0.7m** in 2009/10.
29. Where employers and their employees are unable to reach agreement about changes to an individual's working environment or role, this could lead to a dispute over payment of SSP. The SSP scheme has a formal disputes process managed by HMRC to resolve disagreements over decisions relating to SSP. In some cases these disputes relate to issues around fitness for work. Any increase in disputes as a result of the proposed policy is expected to be minimal and temporary as comprehensive guidance will be provided for employers. Over time, employers and employees will become familiar with the new Form Med 3 and disputes will return to

their current levels or lower as fewer medical statements would be issued. This cost is likely to be small and has not been monetised in this impact assessment.

30. The estimated net benefit of the proposed policy change for Central Government is **£50.8m – £149.1m** over the ten year period 2009/10 – 2018/19 (present value).

GPs

Benefits

31. The proposed new computer-generated Form Med 3 statement is expected to result in a time saving for GPs. Although qualitative feedback from the DWP pilot study (discussed above) indicates that GPs expect a longer discussion with patients considered 'fit for some work'³⁵, it is believed that the computer generated aspect of the Form Med 3 statement could be quicker for GPs to complete, especially over time as GPs become more familiar with the system. Currently GPs complete by hand a Form Med 3 statement and transfer some of the details onto their own electronic records. With the computer-generated Form Med 3 statement, GPs would be able to record details electronically onto the Form Med 3 statement straight away and retain a permanent record on their system. Further, early return to work is expected to lead to improved health conditions as work is good for health so fewer GP consultations are expected. Based on the scenarios used above for increase in output and early return to work, it is estimated that for each case of early return to work, one GP consultation is saved. This generates savings of between **£5.0m to £16.7m per annum**. This assumption is tested in the sensitivity analysis.
32. GPs would benefit from administrative savings from no longer having to order medical statements (from 2010/11). This is estimated at one hour of practice staff time per practice per year, a total of **£0.1m per annum**.
33. Abolishing the Form Med 5 as a stand alone form and incorporating its functionality into the new version of the Form Med 3 would make the medical certification process simpler for GPs and potentially increase their efficiency. This benefit is likely to be small and has not been monetised in this impact assessment.
34. A computer generated Form Med 3 statement would provide GPs with a permanent record which they can refer back to during future consultations with the patient. It would help to identify individuals with repeat sickness statements and patterns of illness enabling discussions on what adjustments can facilitate an early and continuous period of return to work. Improved recording and analysis of statements would also allow GPs to compare standards of clinical practice and improve treatment of their patients resulting in better clinical outcomes. In addition, it would facilitate easier identification of regional or health issues, public health surveillance

³⁵ The DWP pilot study found that the trial new Med 3 statement may on average take an extra 1-2 minutes more to complete in a live consultation than the current Med 3 statement. However, there is some uncertainty around this estimate as it is based on speculative estimates only rather than a trial in a live consultation. It is also not possible to determine whether GPs answered the question with specific regard to potentially more complex cases that may require a 'fit for some work' bracket or whether they took an average of the expected cases they would see across the range of fit, fit for some work and not fit for work. Further, it is difficult to determine a precise estimate as there is a potential bias in the sample towards GPs being more willing to engage in discussions about work. Given the uncertainty in the estimate, it is not used in this Impact Assessment.

and service planning. These benefits have not been monetised in the impact assessment.

Costs

35. There is a one-off training cost for each GP to read the new guidance on the Form Med 3 statement and to familiarise themselves with the computer generated version. It is estimated that on average each GP would spend one hour to train costing a total of **£2.4m** in 09/10.
36. An increase in administrative costs is expected in 2009/10 prior to implementation as GPs may order some paper copies of the new Form Med 3 as spares or 'back-up' in case of computer failure. This is estimated to cost **£0.1m** in 2009/10.
37. There would be an increase in printing costs for GPs. This is estimated at **£1.6m** per annum. It is expected that printing costs would fall over time as health conditions improve from early return to work and fewer medical statements would be required.
38. The estimated net benefit of the proposed policy change for GPs is between **£23.3m to £109.7m** over the ten year period 2009/10 – 2018/19 (present value).
39. For the public sector as a whole, the estimated net benefit is between **£74.2m – £258.8m** over the ten year period 2009/10 – 2018/19 (present value).

F. Summary and Recommendations

40. **The analysis indicates that the proposed amendment is likely to generate a net benefit.** Even based on the scenario of an additional 3% of sickness certification cases for individuals with 2 or more statements per year returning to work and producing 50% of previous output for one extra week, there is a net benefit to the economy of **£365.0m** over the ten year period 2009/10 to 2018/19 (present value). The net benefit rises to £1,228.1m if 10% of cases return for an extra week. In reality, the net benefits are likely to be substantially greater due to the long term benefits of early return to work which have not been monetised in this impact assessment (see Annex 2 and 3 for a full summary of the monetised costs and benefits and the sensitivity analysis).

G. Risks

41. One of the key expected impacts of the proposed policy is an early return to work. Research carried out by the DWP (see Annex A) which compared the current Form Med 3 statement to a new trial Form Med 3 statement indicated that an early return to work was likely. The study found a net increase of between 15 to 44 percentage points in individuals being considered to be 'fit for some work' as opposed to 'not fit for work'. As the study was based on vignettes, there is a risk that evidence from the study is not repeated in live consultations after implementation. This risk would be mitigated by working closely with GPs and other stakeholders during and following implementation to ensure they are familiar with available research that demonstrates the health benefits of remaining in work. Guidance is also being developed which would be routinely reviewed and available pre and post implementation.
42. In the impact assessment, to account for the uncertainty in the size of the likely impact, very conservative scenarios were selected - 3%, 5% and 10% of cases for individuals with 2 or more statements per year returning to work and output increases by 50% of the assumed wage for one extra week (minimum wage).

H. Implementation

43. Subject to this consultation & Parliamentary agreement it is proposed to implement these changes from April 2010.

I. Monitoring and Evaluation

44. A monitoring and evaluation plan is under development. This would include a review of current sickness absence certified by GPs (baseline) and an assessment of the impact of the proposed policy change. The study is likely to be a before and after study. It would not be possible to pilot the proposed new Form Med 3 statements because these forms are used primarily as evidence to support claims to benefits. Therefore to introduce different styles of forms in different areas would create unacceptable inequalities in the benefit system. These forms are also required by employers as evidence to support payments of Statutory Sick Pay. Again national consistency is needed to ensure everyone has the same access to entitlement of payments as well as maintaining a system that is straightforward for employers to administer. The limitations of a before and after study would be taken into account in developing the evaluation and in interpreting the results.

Specific Impact Assessments

Competition Assessment

45. The proposals do not affect competitiveness between companies.

Small Firms Impact Test

46. Dame Carol Black's review stemmed from responses to 'Call for Evidence' carried out in October 2007 and supplemented by discussion events held in November 2007. These provided an opportunity for employers, healthcare professionals and other key stakeholders to engage directly with Dame Carol about their views on the factors which affect health and working life in Britain. Small and medium sized enterprises were involved in these discussions. Of those that responded to how people can be helped to remain in or quickly return to work, around half specifically proposed that the medical statement should show what people can do instead of what they cannot.
47. In some cases, work related adjustment that may be needed to keep an individual in work would result in extra costs for the employer. This may be a particular concern for small businesses who typically have lower absence levels but who may be less able to afford the additional costs. It is for each individual employer to consider whether such investments are worthwhile. It is expected that employers behaving rationally would only make the investments only if the benefits of making such adjustments (i.e. increase in profit generated from early return to work of the individual) outweigh the costs of both making the adjustment and of having the individual on long-term sickness absence. Therefore the proposed change is not expected to have a negative or disproportionate impact on small firms.

Legal Aid Impact Test

48. As there are no criminal or new civil penalties related to these proposals therefore there is no impact on Legal Aid.

Sustainable Development

Environmental Impact

Carbon and Greenhouse Gas Assessment

49. It is estimated that there would be a small increase in printing Form Med 3s in 2009/2010 followed by a decrease in subsequent years as fewer Form Med 3s are expected to be issued.

Social Impact

Health Impact Assessment Test

50. An initial screening of the possible impact of the proposed policy change on medical statements showed that there is likely to be a significant impact on human health by virtue of its effect on employment which is a determinant of health. It also showed that a significant impact is likely on primary care. A health impact assessment was therefore undertaken to assess the impact and consider how the policy could be used to have a positive impact.

51. **Are the potential positive and/or negative health and well-being impacts likely to affect specific sub-groups disproportionately compared with the whole proportion?**

The proposed policy is thought likely to impact positively on all people with health problems who require medical statements but could have a greater benefit to those with mental health problems.

A study of medical statements by Shiels, Gabbay and Ford³⁶ found that 28.0% of individuals' first medical statements was issued for a mild mental disorder (including anxiety, stress, depression, 'mixed anxiety and depression', bereavement reaction and addiction), making this the biggest cause of incapacity for work. Mild mental disorder also accounted for the highest proportion of sickness absence days lost (39.7%) and it was more likely to result in long term incapacity. This is supported by evidence from other surveys on all sickness absence. The annual absence management survey conducted by the Chartered Institute of Personnel and Development found stress and mental ill-health (such as clinical depression and anxiety) to be a significant leading cause of both short and long term absence as shown in the table below:

Table 2: Percentage of respondents citing stress and mental ill-health as a leading cause of absence

Cause of absence	Short-term		Long-term	
	Manual workers	Non-manual workers	Manual workers	Non-manual workers
Stress	42.9	53.9	50.9	65.8
Mental ill-health	23.0	26.0	42.6	51.4

Source: CIPD (2008) Absence management: annual survey report 2008.

NB: Long-term absence is defined at four weeks or longer.

Stress is the biggest cause of long-term absence, among non-manual workers followed by acute medical conditions then mental health conditions. Similar results were found by the Confederation of British Industry³⁷.

52. As the above data suggests that the majority of employees are absent with mental health problems it could therefore follow that this group would benefit most from these proposals.

53. **Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates?**

The proposed policy change is expected to result in early return to work. Emerging evidence suggests that work is good for health and that for many people an early return to work helps to improve health conditions and prevent short-term sickness absence from progressing to long-term sickness absence and ultimately

³⁶ Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) 'Patient factors associated with duration of certified sickness absence and transition to long-term incapacity'. British Journal of General Practice, February 2004, 54, 86-91.

³⁷ CBI (2008) At work and working well? CBI/AXA absence and labour turnover survey 2008.

worklessness³⁸. This indicates that individuals would have less contact with health services in the future and would enjoy a better quality of life.

54. **Are there likely to be public or community concerns about potential health impacts of this policy change?**

No public or community concerns about the potential health impact of this policy change have materialised so far which have not been resolved by discussion and compromises during our engagement with stakeholders as this policy was developed and this form redesigned.

However a public consultation is being undertaken to ensure any such concerns are identified and addressed.

³⁸ Waddell, G. and Burton, A. K. (2006) Is work good for health and well-being? *The Stationery Office*.

Equality Impact Assessment

55. There is no reliable routine sickness absence certification data available. The most comprehensive existing data is captured in the previously mentioned study by Shiels, Gabbay and Ford. This is used in the analysis below where possible. General sickness absence figures are also used because of this lack of information. References are provided below.

Gender

56. Absence data by gender shows mixed findings. Although more women are off sick at any one time, their duration of absence appears to be shorter on average.

According to Labour Force Survey (LFS) data, in the period July 2007 to June 2008, sickness absence rates for working age women was 2.9% compared with 2.2% for men³⁹. This means 2.9% of working age women had at least one day's absence from work in the reference week because of sickness or injury, a greater proportion than that for men⁴⁰.

Analysis of medical statement by Shiels, Gabbay and Ford⁴¹ found a greater proportion of medical statements were issued to women - 55.3%. The mean duration of sickness episodes were, however, lower for females with a mean of 9.0 weeks compared with 10.9 weeks for males. A significantly higher proportion of males were also certified sick for more than 28 weeks (11.6% for males and 8.4% for females). This is supported by caseload data on incapacity benefits which shows a higher proportion of males than females.

Based on the above data, it is not possible to draw firm conclusions that would demonstrate any disproportionate impact by gender.

Age

57. This policy is directed at the working age population of the UK. It is likely that the proposed policy will impact differently on different age groups, although again the data does not provide a clear picture. A greater proportion of young people are off sick at any one time but their duration of absence is shorter on average.

LFS data indicates that younger employees have higher sickness absence rates than older employees. In the period July 2007 to June 2008, 2.6% of the 16 to 24 and 25 to 34 age groups were absent from work in the reference week. This is compared with 2.5% for 35 to 49 age group and 2.4% for employees aged 50 to 59/64.

³⁹ Office for National Statistics (2008) "Sickness absence from work in the UK" in Economic & Labour Market Review, Vol 2, No. 11, November 2008.

⁴⁰ LFS data showed that of those who were sick, there was no noticeable difference in proportion of working time lost. LFS data relates to the reference week only so is limited when considering duration of absence. It is used here only in the absence of any other data.

⁴¹ As footnote 1.

Analysis of medical statement by Shiels, Gabbay and Ford⁴², however, found a linear relationship between age and length of sickness episode. For the four age groups, <30, 30-44, 45-49, >=60 years old, mean sickness duration were 7.9, 9.0, 11.5 and 17.0 weeks respectively. Those with long-term sickness absence (>28 weeks) were also significantly older with a mean age of 44.0 compared with 39.6 years for those with absence duration of 28 weeks or less.

Based on the above data, it is not possible to draw firm conclusions that would demonstrate any disproportionate impact by age.

Race

58. Data on medical statements by ethnicity is not available. However, analysis of general sickness absence data using the LFS showed that in the period July 2007 to June 2008, the Black/Black British ethnic group had the highest sickness absence rates at 3.8% in the reference week as shown in the table below. The Asian/Asian British ethnic group has the lowest rates at 2.3% while 2.5% of those in the White ethnic group were absent from work in the reference week. Data on length of absence is unavailable so it is not possible to draw firm conclusions that would demonstrate any disproportionate impact by race.

Table 3: Sickness absence rates of working-age employees by ethnicity, July 2007 to June 2008

Ethnic Group	Sickness absence rate (%)
White	2.5
Mixed	2.4
Asian or Asian British	2.3
Black or Black British	3.8
Chinese or Chinese British	2.4
Other	3.3

Source: Office for National Statistics (2008) "Sickness absence from work in the UK" in Economic & Labour Market Review, Vol 2, No. 11, November 2008.

Disability

59. The proposed policy is thought likely to impact differently, but positively, on people with a disability. Data on medical statements by disability is not available. However, analysis of general sickness absence data using the LFS showed that in the period July 2007 to June 2008, 4.6% of employees who classified themselves as disabled were off work due to sickness compared with 2.3% for employees who did not classify themselves as disabled⁴³. Of those who were sick, the proportion of usual working time lost in the reference week was also higher for disabled than non-disabled employees. This suggests that employees with a disability may disproportionately benefit from the policy change.

⁴² As footnote 1.

⁴³ As footnote 3.

Further Action

60. In light of the Equality Impact Assessment, further data collection and analysis will be undertaken:
- by including additional questions in future quarters of the LFS (to start in the first quarter of 2009) to gain a fuller understanding of general sickness absence, in particular, length and cause of absence; and
 - as part of the evaluation exercise to better assess current sickness absence certified by GPs and impact of the proposed policy change on the different groups discussed above.

Human Rights

61. These proposals will not contravene individuals' human rights. Doctors will provide a more detailed opinion to employers about individuals' condition in some cases. This is reasonable because the information supplied will facilitate a return to work.

Rural Proofing

62. Particular rural circumstances would not be adversely affected by these proposals which are beneficial regardless of locality.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	Yes	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No

Annexes

Annex A

RESULTS OF DWP STUDY ON TRIAL MED 3 STATEMENT

In 2008, the Department for Work and Pensions carried out a study comparing the current Form Med 3 statement to a trial new Form Med 3 statement. The study involved 583 GPs from 9 Primary Care Organisations. GPs were randomly assigned to receive either the trial Med 3 statement (intervention group) or the current Form Med 3 statement (control group). They were then invited to complete and return the Form Med 3 statement for three vignettes or hypothetical sick leave scenarios. Each vignette presented a patient with a different health condition: (i) back pain; (ii) depression and (iii) back pain and depression. The characteristics of the vignette patients were chosen to reflect those known to be associated with an increased risk of long-term incapacity.

The results of the study showed that GPs completing the trial Med 3 were less likely to advise the vignette patient to refrain from work compared to GPs using the current Form Med 3 as shown in table A1 below. For the back pain vignette, 77% of GPs completing the current Form Med 3 statement declared the individual to be ‘not fit for work’ compared with 20% completing the trial new Med 3 statement, a difference of 57 percentage points. However it should also be noted that fewer cases were assessed as ‘fit for work’ using the trial Med 3 form (24% compared to 11%, a difference of 13 percentage points). Taking account of this, there is a difference of 44 percentage points.

For the depression case, 91% and 74% of GPs completing the current and trial new Med 3 respectively, found the individual to be ‘not fit for work’ [a difference of 15 percentage points (accounting for the fewer assessed as ‘fit for work’ using the trial Med 3)]. Finally for the combined vignette, 88% of GPs completing the current Form Med 3 statement declared the individual to be ‘not fit for work’ compared with 58% completing the trial new Med 3 statement [a difference of 22 percentage points (accounting for the fewer assessed as ‘fit for work’ using the trial Med 3)].

Table A1: Fitness for work: results of DWP study

	Current Med 3 (%)	Trial new Med 3 (%)
Back pain		
Fit for work	24	11
Fit for some work	-	70
Not fit for work	77	20
Total	100	100
Depression		
Fit for work	9	7
Fit for some work	-	19

Not fit for work	91	74
Total	100	100
Combined back pain and depression		
Fit for work	12	4
Fit for some work	-	38
Not fit for work	88	58
Total	100	100

Source: Sallis A., Birkin R. and Munir F. (in preparation) A number of papers reporting a comparison of the current Med 3 and trial Med 3 forms. If you would like full details of this research please contact Anna.Sallis@dwp.gsi.gov.uk

Note: Figures may not sum to 100 per cent due to rounding.

Annex B

SUMMARY OF MONETISED COSTS AND BENEFITS FOR THE ECONOMY

Table B1: Scenario 1

(An additional 3% of medical certification cases for individuals with 2 or more medical statements per year returning to work early (£m))

	2009/10	Annual benefit/cost 2010/11-2018/19	Total benefit/cost 2009/10-2018/19	Total benefit/cost 2009/10-2018/19 (PV)*
Benefits				
Increase in output	-	45.3	407.6	332.9
Savings in printing costs (for Central Government)	-	1.4	12.2	9.9
Time saving (for GPs) due to fewer Med 3s	-	5.0	45.0	36.7
Administrative savings (for GPs)	-	0.1	1.3	1.1
Total benefits	-	51.8	466.1	380.6
Costs				
Set-up costs (for Central Government)	0.5	-	0.5	0.5
Increase in printing costs (for Central Government)	0.7	-	0.7	0.7
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in administrative costs (for GPs)	0.1	-	0.1	0.1
Increase in printing costs (for GPs)	-	1.6	14.8	12.1
Total costs	3.7	1.6	18.5	15.7
Net benefits	-3.7	50.1	447.5	365.0

* PV = present value (discounted rate = 3.5%)

Table B2: Scenario 2

(An additional 5% of medical certification cases for individuals with 2 or more medical statements per year returning to work early (£m))

	2009/10	Annual benefit/cost 2010/11-2018/19	Total benefit/cost 2009/10-2018/19	Total benefit/cost 2009/10-2018/19 (PV)*
Benefits				
Increase in output	-	75.5	679.3	554.8
Savings in printing costs (for Central Government)	-	1.4	12.2	10.0
Time saving (for GPs) due to fewer Med 3s	-	8.3	75.0	61.2
Administrative savings (for GPs)	-	0.1	1.3	1.1
Total benefits	-	85.3	767.8	627.1

Costs				
Set-up costs (for Central Government)	0.5	-	0.5	0.5
Increase in printing costs (for Central Government)	0.7	-	0.7	0.7
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in administrative costs (for GPs)	0.1	-	0.1	0.1
Increase in printing costs (for GPs)	-	1.6	14.6	11.9
Total costs	3.7	1.6	18.3	15.5
Net benefits	-3.7	83.7	749.5	611.6

* PV = present value (discounted rate = 3.5%)

Table B3: Scenario 3

(An additional 10% of medical certification cases for individuals with 2 or more medical statements per year returning to work early (£m))

	Annual benefit/cost 2010/11- 2009/10	Annual benefit/cost 2018/19	Total benefit/cost 2009/10- 2018/19	Total benefit/ cost 2009/10- 2018/19 (PV)*
Benefits				
Increase in output	-	151.0	1,358.6	1,109.6
Savings in printing costs (for Central Government)	-	1.4	12.2	10.0
Time saving (for GPs) due to fewer Med 3s	-	16.7	150.0	122.5
Administrative savings (for GPs)	-	0.1	1.3	1.1
Total benefits	-	169.1	1,522.1	1,243.1
Costs				
Set-up costs (for Central Government)	0.5	-	0.5	0.5
Increase in printing costs (for Central Government)	0.7	-	0.7	0.7
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in administrative costs (for GPs)	0.1	-	0.1	0.1
Increase in printing costs (for GPs)	-	1.6	14.0	11.5
Total costs	3.7	1.6	17.7	15.0
Net benefits	-3.7	167.6	1,504.4	1,228.1

* PV = present value (discounted rate = 3.5%)

Annex C

SENSITIVITY ANALYSIS

The key unknown variables in the Impact Assessment are:

- the numbers of medical statements issued per year (Med 3s and 5s)
- time savings to GPs from fewer consultations
- printing costs

The estimates used are tested below to determine if the conclusions of the analysis will alter given the likely range of values that the key variables may take.

Numbers of Med 3s and Med 5s

Currently the sickness certification scheme is paper-based which has resulted in a lack of robust and accurate information on how many sick notes are issued. The central estimate used in the impact assessment is based on an analysis of printing orders giving an estimated figure of 18.7m Form Med 3s and Form Med 5s per year. Other estimates indicate a different numbers of statements:

- A study by Shiels and Gabbay based on reporting by nine GP practices found that GPs issue an average of six Med 3 and Med 5 statements per week, an estimated total of 11.5m per annum⁴⁴.
- A survey by Norwich Union Healthcare estimate GPs issues an average of 11 medical statements per week giving a total of approximately 21.1m⁴⁵.
- Another study report on average, GPs will issue 20 medical statements per week, an estimated total of 38.4m⁴⁶.

An increase on the central estimate of the numbers of Med 3s and 5s would result in (i) a rise in output; (ii) a rise in GP consultation savings; (iii) a reduction in printing cost savings for Central Government; and (iv) an increase in printing costs for GPs. The rise in output and in GP consultation savings dominates the latter two effects, thus generating even higher net benefits. The reverse is true for a decrease in the central estimate. An estimate of 11.5m per annum, however, still generates a net benefit of between £223.4m to £753.4m for the economy over ten years (present value).

⁴⁴ See Shiels, C. and Gabbay, M. (2007) *Patient, clinician and general practice factors in long-term certified sickness*, Scandinavian Journal of Public Health, 35:3,250-256. Number of Med 3 statements = number of Med 3 statements per GP per week x number of GPs in England, Wales and Scotland (WTE/FTE used where available). Calculation: 11.5m = 6 per GP per week x 37,000 GPs.

⁴⁵ Norwich Union Healthcare (2004) *Doctor's orders: The third Health of the Nation Index from Norwich Union Healthcare* (www.healthofthenation.com).

⁴⁶ Sawney, P. (2002) *Current Issues in fitness for Work Certification*. British Journal of General Practice 52, 117-22.

Time savings to GPs from fewer consultations

The impact assessment assumes that for each case of early return to work, one GP consultation is saved. If this saving was halved so that half a GP consultation is saved per case of early return, there would still be a net benefit for GPs [£4.8m to £48.0m over ten year (present value)] and for the economy as a whole (£346.4m - £1,166.4m).

Printing costs

The assumptions used in the impact assessment for printing costs were 10 pence per statement for GPs and a lower cost of 8 pence per statement for Central Government due to economies of scale. A doubling of costs to 20 and 16 pence respectively still do not alter the conclusions of a net benefit for GPs [£11.2m to £98.3m over ten years (present value) and for the economy as a whole (£362.1m to 1,225.9) to over ten years (present value)].

ANNEX D

DETAILED CALCULATIONS FOR COSTS AND BENEFITS

Cost/Benefit/Component	Calculation (08/09 prices)	Source(s)
<p>Increase in output [based on scenarios of 3%, 5% and 10% of statements for individuals with 2 or more statements per year returning to work for an extra week and the output is 50% of assumed wage (NMW)]</p>	<p>Numbers of medical statements for individuals with 2 or more statements per year = proportion of all statement issued to this group x total number of statements</p> <p>14.2m = 0.76 x 18.7m</p> <p>Increase in output = % of cases x number of Med 3 statements for group x NMW x hours worked per week x 0.5</p> <p>£45.3m/£75.5m/£151.0m = 3/5/10% of cases x 14.2m Med 3 statements x £5.73 x 37 hours x 0.5</p> <p>NB: Output is valued at national minimum wage (NMW) rather than average earnings as survey data indicates that sickness absence is higher amongst the low skilled.</p>	<p>Proportion of all statements issued to those with 2 or more statements per year: see table 1.</p> <p>Total number of statements: analysis of printing orders</p> <p>Hours worked per week (median): ONS (2008) 'Annual Survey of Hourly Earnings'. The Stationery Office.</p>
<p>Increase in earnings for individuals [based on scenarios of 3%, 5% and 10% of statements for individuals with 2 or more statements per year returning to work for an extra week and the output is 50% of assumed wage (NMW)]</p>	<p>Total increase in earnings = % of cases x number of Med 3 statements for group x [(0.5 x NMW for one week) – SSP] x (1-tax and NIC rate)]</p> <p>£9.0m/£15.0m/£30.1m = 3/5/10% of cases x 14.2m Med 3 statements x [((0.5 x £212) -£75.4) x (1-0.31)]</p> <p>NB: For simplicity, we have assumed that employees do not receive OSP. Tax and NIC = 31% (11% NI and 20% tax) assuming annual salary at NMW. Rates are assumed to be at 08/09 levels throughout.</p>	
<p>Fiscal benefit [based on scenarios of 3%,</p>	<p>Fiscal benefit = (employee NI/tax rate + employer NI rate) x % of</p>	

<p>5% and 10% of statements for individuals with 2 or more statements per year returning to work for an extra week and the output is 50% of assumed wage (NMW)]</p>	<p>cases x number of Med 3 statements for group x [(0.5 x NMW for one week) – SSP]</p> <p>£5.7m/£9.5m/£19.1m = (31%+12.8%) x 3/5/10% of cases x 14.2m Med 3 statements x [(0.5 x £212) - £75.4]</p> <p>NB: Employee tax and NIC = 31%; employer NIC = 12.8%; Rates are assumed to be at 08/09 levels throughout.</p>	
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Cost/Benefit/Component	Calculation (08/09 prices)	Source(s)
Savings in printing costs for Central Government (number of Med 3s saved due to fewer consultations + 90% of remaining Med 3s)	<p>Printing cost savings = [number of Med 3s saved due to fewer consultations + (number of remaining Med 3s x 0.9)] x printing cost per Med 3</p> <p>$£1.4m = [(3/5/10\% \text{ of cases} \times 14.2m \text{ Med 3 statements}) + ((18.7m - (3/5/10\% \text{ of cases} \times 14.2m \text{ Med 3 statements})) \times 0.9)] \times £0.08$</p>	<p>Printing cost of 8p per statement is an assumption only. This is tested in the sensitivity analysis. Actual printing costs cannot be used due to commercial confidentiality.</p>
Increase in printing cost to Central Government in 09/10 prior to implementation of policy change (50% of existing Med 3s)	<p>Increase in printing cost = number of Med 3s x 0.5 x printing cost</p> <p>$£0.7m = 18.7m \times 0.5 \times £0.08$</p>	<p>As above.</p>
Savings in GP consultation time (one consultations per case of early return to work)	<p>Savings in GP consultation time = % of cases x number of Med 3 statements for group x cost of GP time per consultation</p> <p>$£5.0m/£8.3m/£16.7m = 3/5/10\% \text{ of cases} \times 14.2m \text{ Med 3 statements} \times £11.7$</p>	<p>Cost of GP time = £60 per hour for salaried GP; £80 per hour for contractor GP from data provided by Department of Health. Lower cost used in impact assessment.</p> <p>11.7 minute per consultation: PSSRU (2008) 'Unit Costs of Health and Social Care 2008', University of Kent.</p>
Administrative savings for GPs (from 2010/11 onwards)	<p>Admin. savings = Number of GP practices x cost of one hour of an administrators time</p> <p>$£0.1m = 10,000 \times £15.00$</p> <p>NB: it is assumed that each GP practice orders statements twice a year taking 30 minutes each time.</p>	<p>Number of GP practices: NHS workforce data</p> <p>Cost of administrator per hour: £15 per hour from data provided by the Department of Health.</p>
One-off training cost to GPs (assumed to be one hour per GP)	<p>Training cost = number of GPs in England, Wales and Scotland (headcount) x 1 hour x cost of GP time per hour</p> <p>$£2.4m = 40,000 \text{ GPs} \times 1 \text{ hour} \times £60$</p>	<p>Number of GPs: NHS workforce data of staff numbers</p> <p>Cost of GP time = £60 per hour for salaried GP; £80 per hour for contractor GP from data provided by Department of Health. Lower cost used in impact assessment.</p>

Cost/Benefit/Component	Calculation (08/09 prices)	Source(s)
Increase in administrative costs for GPs (09/10)	<p>Admin. increase = Number of GP practices x 0.5 x cost of one hour of an administrators time</p> <p>£0.1m = 10,000 x 0.5 x £15.00</p> <p>NB: it is assumed that in 09/10 each GP practice orders some new Med 3 statements taking ½ an hour of an administrator's time</p>	<p>Number of GP practices: NHS workforce data</p> <p>Cost of administrator per hour: £15 per hour from data provided by the Department of Health.</p>
Increase in printing costs for GPs (90% of remaining Med 3s)	<p>Increase in printing costs = number of Med 3s remaining x 0.9 x printing cost per Med 3</p> <p>£1.6m = ((18.7m – (3/5/10% of cases x 14.2m Med 3 statements)) x 0.9) x £0.1</p>	<p>Printing cost of 10p per statement is an assumption only. This is tested in the sensitivity analysis. Lower printing costs per statement are used for Central Government as it is likely that they benefit from economies of scale.</p>