Engaging physicians, benefiting patients: a qualitative study

Julia Hiscock, Paula Hodgson, Sarah Peters, Debra Westlake and Mark Gabbay

A report of research carried out by the Fit for Work Research Group, University of Liverpool on behalf of the Department for Work and Pensions
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Mark Gabbay is the Director of Fit for Work Research Group and the Mersey Primary Care Research and Development Consortium. He is a senior lecturer in General Practice and Head of Division of Primary Care at the University of Liverpool where he also works as a GP. His particular interests in health services research include Mental Health and studies of innovation.

Julia Hiscock has worked as a qualitative researcher for fifteen years, most of which has been in the health and employment sectors. Her research experience spans academic and independent sectors as well as international organisations and includes directing a health research unit and teaching qualitative research methods. She is the qualitative researcher in the Mersey Primary Care Consortium and a member of the University of Liverpool Fit for Work Research Group.

Paula Hodgson lectures on the Sociology of Health and Illness within the Medical School, University of Liverpool and undertakes qualitative research. Her research is primarily in the field of primary care and includes a number of studies looking at GP and patient interactions, including attitudes and behaviour.

Sarah Peters is a lecturer in the department of Psychiatry, University of Liverpool who has over five years experience as a qualitative researcher. Her research includes studies on GP – patient communication and medically unexplained symptoms.

Debra Westlake is a freelance qualitative researcher with over four years experience of conducting qualitative research. She has worked on qualitative studies funded by the Department of Health and the Children’s Society. Her research includes studies of the impact of health policy on the management of family health.
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AA</td>
<td>Attendance Allowance</td>
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<tr>
<td>DLA</td>
<td>Disability Living Allowance</td>
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<tr>
<td>DVLA</td>
<td>Driver and Vehicle Licensing Agency</td>
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<tr>
<td>DWP</td>
<td>Department for Work and Pensions</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GP</td>
<td>General Practitioners</td>
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<tr>
<td>MREC</td>
<td>Multi-centre Research Ethics Committee</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal Capability Assessment</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PM</td>
<td>Practice Manager</td>
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Summary

Introduction

The study aimed both to evaluate the Engaging Physicians, Benefiting Patients pilot, focusing particularly on the reported impact of the pilot communications strategy, and to contribute to the knowledge about General Practitioner (GP) attitudes towards their role in provision of medical evidence in general and the IB113 (and IB113A) in particular, including consideration of broader aspects of culture, attitudes and relationships. Qualitative methods were used. Interviews were conducted with 25 GPs and 18 Practice Managers in the pilot area (Section 1.3).

Practice systems for the IB113

Respondents described a range of practice processes for handling such forms varying from ‘no set procedure’ to ‘meticulous method’ (Section 2.1). Efficient practices were proud of this, citing professionalism and teamwork. Staff used a variety of methods for ‘chasing up’ forms, including electronic or paper-based form tracking. Forms might be redirected to GPs with the most recent or longstanding familiarity with the claimant, or occasionally according to workload distribution needs, particularly during holiday periods. There is some evidence that these processes impact on both the promptness and quality of IB113 completion (Sections 2.2 – 2.4).

GP strategies to complete the IB113

Respondents described different ways to manage IB113 completion within the context of competing clinical and administrative demands. Tasks are prioritised according to: their direct impact on patient care and clinical work; professional or personal satisfaction; professional development; financial reward, and the time and complexity of completing the task (Section 3.1). IB113 prioritisation within this environment varied. GPs usually described them as ‘a chore’, ‘very tedious or ‘a pain’. GPs were unlikely to spend more than 15 minutes completing an IB113, depending on both the complexity of, and their familiarity with the claimant’s case.
(Section 3.2). Workload delegation included administrative staff extracting relevant information from the record for the GP; and Practice Nurses completing forms if they were the main clinical contact (Section 3.3).

Managing the information required in the IB113

Unlike most fitness for work forms (Med 3, 4 and 5), the patient is absent when the IB113 is completed. GPs therefore use paper and computer records or memory. Whilst many rely on memory alone when familiar with the patient, others were concerned about the risk of missing new or forgotten information if records weren’t checked.

Searching records was described as ‘time-consuming’ and ‘trawling’. Views on whether IT records made this easier were mixed. Even though some practices downloaded all recent paper-based information onto the electronic record, as IT records may be incomplete, paper records were sometimes used as well. Some GPs print off letters or IT record extracts and enclose them with the IB113 (Section 4.1).

What is required by the Department for Work and Pensions – fact or opinion?

Many GPs described difficulties matching the information they held, from whatever source, and gauging what was actually required, as they were unclear about what was expected (Section 4.2). This was influenced by who they believed would see the form, for example whether it would be another doctor or a clerk. GPs felt they had little information on the claimant’s capacity for coping with living and working. They relied on the patient report for this information, and how it was interpreted and recorded in the notes or their memory. Some GPs were unclear whether fact or opinion were required. Many considered that questions about prognosis and functional assessment in particular called for opinion, not fact. This widespread dilemma may reflect a lack of clarity in the IB113 itself. The strategies employed by GPs regarding ‘sticking to facts’ or ‘giving opinions’ seemed to relate to the individual cases and, for example, their complexity, or how clear-cut they believed the case to be, as well as practitioners having fixed approaches (Section 4.2.3).

Coding a response

GPs were concerned about situations where their opinion of fitness for work differed from the claimant’s. ‘Codes’ might be used to communicate this on the form, and some even wished there was a covert way of indicating their differing opinion, either through an agreed code or the equivalent of the RM71.

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1 RM7 forms are included with the Med 3 pads to request a patient undergoes independent assessment by the DWP earlier than it might have occurred under normal procedures.
Codes fell into three categories: particular medical language (to avoid stigmatising), key phrases (such as ‘improved’ or ‘genuine’), as an indication that the information provided was that requested by the claimant (‘patient reports that’). Another common strategy was to skimp or miss out certain sections of the form. This ‘coding’ may explain many of the apparent communication problems between practices and the Department for Work and Pensions (DWP) in respect of the ‘quality’ of information provided on the IB113 (Section 4.3).

Influences on completing the IB113

Strength of conviction

Confidence about diagnosis and fitness for work was a key factor in the time and effort invested in completing IB113s. Cases at either end of the fitness for work spectrum were easiest to process, and prioritised (Section 5.1).

GP perceptions about the patients

A number of key perceptions about patients influenced GPs’ effective completion of IB113 and IB113A (Section 5.2). The first of these was GPs’ belief about the nature of the condition, incorporating features of complexity, chronicity, stability, severity and whether discrete or multiple problems (Section 5.2.1). Mental health problems and medically unexplained symptoms were considered particularly problematic. In both these areas GPs were concerned that evidence was largely self-report with little objective information to assist diagnosis or prognosis. These cases were considered less sympathetically by some GPs (Sections 5.2.2 and 5.2.3).

Many GPs distinguished between ‘genuine’ and ‘fake’ claims, based upon their perceptions of patients’ culpability for the onset or progress of their illness or their motivation to get better. This differentiation was a source of tension for GPs (Section 5.2.4). Many feared that challenging such patients would lead to conflict damaging the therapeutic relationship. Patient motivation to return to work and their personal circumstances, in particular financial situation, were also reported as important influences (Sections 5.2.5 and 5.2.6).

GP perceptions about Jobcentre Plus

GPs had contrasting opinions about the effectiveness of the system and the quality of Medical Services Doctors working within it. Whilst some perceived it as fair and effective, most did not. Reports of patient experiences led many to doubt medical officers’ expertise. There were concerns about trust. Some GPs wanted to protect vulnerable patients from unknown doctors, or described patient reported occurrences of poor care or confidentiality lapses (Section 5.3).
GP perceptions about their role

Three key GP roles were identified: clinician, advocate and adjudicator. Most described balancing these as a key source of tension. Whilst some saw their primary role as clinicians, others strongly endorsed their patient advocacy role, particularly for vulnerable patients. Sometimes they were prepared to write their report to secure the outcome they felt their patient deserved. This highlighted a tension about who had responsibility for work capacity decisions. Some believed that the GP was best placed, with their wider patient context and knowledge, but it was an unwelcome role and others felt that the decision should be made by a governmental body.

GP personal perspectives

Some GPs described a strong personal work ethic, being influenced by their lifecourse and family experiences. Most acknowledged the importance of work for health, but some also recognised that in certain situations the health-benefits of not working, at least in the short-term, were greater. Many considered that honesty and fairness to themselves, the patient and society, was important (Section 5.5).

GP perceptions about interfaces

GPs were uncomfortable about being at the interface between the priorities of the patient and the benefits system. The GP-patient relationship was considered central, and potentially threatened by fitness for work related claims. GPs employed strategies such as withholding opinions and assessment of functioning, providing instead, only minimal ‘factual’ details, as strategies to protect the relationship. There were fears that a negative outcome, particularly when relationships were already strained, could cause conflict. Some expressed relief that the responsibility for the decision could be deflected to the ‘Ministry’.

Relationships with the DWP were generally described as poor, an opinion based on patient report or constructed from inconsistent decisions and lack of feedback. In contrast to Medical Certificates (Med 3 and 5), GPs had little control over IB113 outcome and some considered that the evidence they provided was not valued (Section 5.6).

Providing information and guidance to practices

Understanding of the IB113

Whilst most GPs and Practice Managers were aware that completing the form was part of their contractual obligations, a few expressed considerable surprise when informed during the interview that no additional fee was linked to the IB113. Even if completing the form was a low personal priority, GPs recognised its importance to their patients’ welfare. However, there was quite widespread misunderstanding about Benefit systems and processes, including confusion about who saw the forms
and the decision-making process. In addition to uncertainty about the sequence and timing of the IB113 and Med 4. Practice Managers tended to consider IB113s within the generality of benefits system forms (Section 6.1).

**DWP guidance about the IB113**

There was little awareness of DWP information for Primary Care. Whilst some GPs had explored the website, others were unaware, unlikely to use it or unfamiliar with the internet. There was even less familiarity with any of the paper-based information, which was rarely prioritised and thus submerged within general incoming mail (Section 6.2).

**Desire for further knowledge**

Whilst some GPs thought that more information about the forms and their relationship with each other would be useful, most GPs and Practice Managers considered the task straightforward. Whilst there was more interest in the benefits system, this was still low on most GP educational priorities. Our findings indicate that brief information on the purpose of the form would be the best approach (Section 6.3).

**The Engaging Physicians Benefiting Patients pilot communications input**

**Pilot mailing**

Few GPs recalled seeing this. This may be due to problems with distribution to or within practices. If GPs did receive the mail, most only glanced at, and then forgot, ignored, shredded or put it aside to read later. There was no clear link between reading the mailing and interest in the topic.

Those who remembered the mailing recalled information about a website. Those shown it again at the interview regarded it as confirming prior knowledge and unlikely to have much impact on their attitudes or behaviour. Some noted that it indicated that forms were read by a doctor. No post-mailing behaviour changes were reported. The mailing was thought by some to lack visual appeal and to be indistinguishable from the plethora of mailings. The paper-based format was seen as a distinct disadvantage by paperless/light practices, preferring electronic, readily disseminated formats. There were mixed views about the prominence of the Atos Origin logo (Section 6.4.1).

**Pilot presentation**

GPs attended the presentations having identified the learning need, through ‘happenstance’, or within a timetabled training programme. Participants particularly valued role-plays, case studies, and the opportunity to meet a Medical Services Doctor. Knowledge acquired included: IB113 process and decision-making, clarification of the DWP ‘rationale’ for IB113s, that clinicians read the completed
IB113s. These learning points were linked to behaviour change by GPs who attended, namely: including more detail on forms and increased use of medical terminology. Attitudes were particularly influenced amongst ‘happenstance’ attendees, including greater motivation to fill the form well (as it is read by a doctor), and a reassurance that they were actually read at all. Face-to-face learning was thought far more effective than the mailings in promoting change, whether at the pilot presentations, practice meetings or through discussions with ‘expert colleagues’ (Section 6.4.2).

Suggestions made by GPs

Suggestions for changes to the IB113 form

Many wanted an electronic form. Two formats were proposed, an electronic form to be filled on the computer manually, or a semi-automatic one that would link to sections of the record and download the relevant READ coded information. There were also a number of suggestions for improving the layout. These included smaller boxes and more tick-boxes (as in the IB113A). Others suggested that information currently held by the DWP could be already on the form for confirmation or amendment, which would save record trawling. A clearer indication of the information requested for each question was also suggested, to reduce confusion and misunderstanding (Section 7.1).

Suggestions for systems to support the completion of the IB113

Some Practice Managers suggested they play a greater role in processing and tracking IB113s. They also suggested that reminders could be given for overdue forms, to support the occasional telephone ones already undertaken in some areas (Section 7.3).

Suggestions for guidance, training and feedback

Whilst GPs with little interest in the IB113 were unenthusiastic about further information, others wanted electronic guidance and training materials (with the URL address included on the form itself), as these were thought easier to distribute and refer to later. Other suggestions included; more face-to-face meetings with DWP medical services, particularly in practices; guidance for Practice Managers that could be used for training and practice manuals; and feedback, on claim outcome, quality of form completion and area statistics on incapacity claims and outcomes (Section 7.4).

2 READ codes are the current coding system for IT records systems, due to be replaced by SNOMED.
Conclusions

The process of completing IB113s is more complex than the DWP anticipated or probably requires. Rather than simply listing key items from the record GPs, filter, translate and interpret data before completing the form and employ a variety of strategies to communicate with the DWP that are not necessarily correctly decoded by the Medical Services Doctor (Section 8.1).

The GP-held data available in most cases are not suitable for commenting on functionality, as this either is not explored specifically during consultations nor consistently recorded (Section 8.2). Future IB113 developments need to take account of increasing electronic records (Section 8.4.1).

We identified a range of effective practice processes for monitoring, tracking and chasing-up IB113s. These could be usefully collected and disseminated to those practices experiencing difficulties completing the forms on time, in the form of suggestions that may help them resolve their problems (Section 8.4).

Among the most effective aspects of the pilot were the face-to-face training sessions, and where guidance and education about benefits and forms was succinct and of high quality. While electronic formats may become increasingly popular, the potential value of timely training interventions (face-to-face and convenient for practice staff) was also recognised in the pilot assessment (Section 8.6 and 8.7).

The IB113A was almost universally welcomed and is seen as a significant improvement. Its success should inform future development of both paper and electronic forms.
1 Introduction

This report presents the findings of a qualitative study to evaluate the Engaging Physicians, Benefiting Patients pilot. It was funded by the Department for Work and Pensions (DWP) and was carried out by the Fit for Work Research Group at the University of Liverpool.

1.1 Study aims

The research which is presented here aims to explore the effects of the DWP Engaging Physicians, Benefiting Patients pilot project on GPs’ understanding of, and compliance with, the medical evidence gathering process.

Specifically, the study had two objectives:

• To evaluate the impact of the pilot arrangements, particularly: the communication strategy – including changes in understanding (both of the systems and of the potential benefits to patients); attitudes about the role of Primary Care in providing medical evidence, in general, and specifically via the IB113 (and IB113A); awareness of sources of information and guidance; and relationships with the DWP, focusing mainly on Jobcentre Plus and Medical Services.

• To contribute to the knowledge about GP attitudes towards their role in provision of medical evidence in general and IB113 (and IB113A) in particular, including consideration of broader aspects of culture, attitudes and relationships.

1.2 Background

Incapacity Benefit is the main long-term state contributory benefit for people who are unable to work due to their health or disability. People in employment will usually be eligible for Incapacity Benefit after 28 weeks of sickness absence, prior to which they will receive Statutory Sick Pay. People who are unemployed or self-employed will receive Incapacity Benefit earlier than 28 weeks.
Eligibility for Incapacity Benefit is assessed through the Personal Capability Assessment (PCA). This has three main components: a self-assessment questionnaire completed by the claimant, medical advice from a DWP-employed Medical Services Doctor (which may or may not be based on a medical examination) and medical evidence from the claimant’s GP. It is the latter which is the particular concern of this study.

1.2.1 Medical evidence gathering for Incapacity Benefit

This report focuses on the information that GPs provide as part of the process of a claimant’s assessment for Incapacity Benefit. For Jobcentre Plus, the role played by GPs is an important part of the assessment process as it helps them to deal with claimants’ applications more promptly and effectively.

There are a range of ways in which GPs support this process. Remuneration for this work is included in GPs NHS Terms of Service. There is no separate fee paid for the work. For claimants in the first 28 weeks of their sickness absence, GPs provide medical statements on forms such as Med 3 and Med 4, (often referred to as ‘sickness certificates’ or ‘sick notes’). In addition, for claimants normally beyond 28 weeks of sickness absence, GPs provide information about the claimants condition for Jobcentre Plus on the form IB113. It is this evidence which is the subject of this report. The IB113 is discussed in the next section.

1.2.2 The IB113

The form IB113 (see Appendix D) is a four sided form which is sent to GPs by Jobcentre Plus requesting medical information on a particular claimant who is being assessed for Incapacity Benefit. The purpose of the IB113 is to obtain factual evidence from claimants’ GPs about conditions that would potentially exempt the claimant from parts of the Personal Capability Assessment (PCA), and to provide information on the claimant’s medical condition, which can be used to inform the PCA process.

In February 2004, a new version of the IB113 was introduced for re-referral cases, where a claimant is being reassessed after a period on Incapacity Benefit, to ascertain whether there has been any change in their condition. This is a shorter and more structured form, called the IB113A. (A copy of form IB113A can be found in Appendix D). The IB113A is, at the time of writing, in temporary abeyance. The reason for this is that the IB113A requests GPs to provide information only on any change since the last IB113. It is therefore necessary for Jobcentre Plus to have backfiles in order to provide the full information required. However, it is currently not possible to access backfiles and thus the form IB113A is not being used until the backfile issue is resolved.

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3 Med 3 is a medical certificate (or ‘sick note’) issued by the GP, as a statement of incapacity for work. It is used in the first 28 weeks of sickness absence. Med 4 is a medical statement normally issued at 28 weeks, for claimants undergoing the Personal Capability Assessment (PCA).
IB113 forms have the potential for generating useful information for the decision on eligibility to Incapacity Benefit. Frequently, however, they are either not returned at all, or contain insufficient information to be of use. This may impact negatively on claimants who may be called in for what turns out to be an unnecessary medical examination. It can also lead to systemic frustrations and inefficiencies.

Recent studies (Hiscock and Ritchie, 2001; Sainsbury et al., 2003) have highlighted a range of different GP attitudes and consequent behaviour towards the completion of medical evidence and IB113s in particular. While some GPs take the forms very seriously and complete them with care, others feel irritated, alienated, or place a low priority on their completion.

A number of initiatives have been introduced to explore and improve the access to medical evidence from GPs, including a Better Medical Evidence Gathering pilot (Sainsbury et al., 2003) that examined alternative arrangements for medical evidence to be obtained from the claimant’s GP. It concluded that, where well completed, an IB113 from a GP can provide more useful evidence than information gleaned from the patient’s medical records.

1.2.3 The Engaging Physicians Benefiting Patients pilot

The Engaging Physicians Benefiting Patients pilot was a further attempt to improve the medical evidence provided by GPs on the form IB113 and to improve the efficiency of the process. It aimed to engage and educate GPs on the importance of the information they provide on the IB113 and in turn increase the numbers of focused and complete IB113s which are returned to Jobcentre Plus.

The pilot, which was run for five months during the summer of 2004, in North East England, had two components. Firstly, Medical Services took over the administration process for the IB113, from Jobcentre Plus. This component of the pilot was evaluated separately and is not covered in this report. Secondly, a new communications strategy was introduced. This comprised of a mailing and presentations to GPs. It is the reported impact of this communications strategy which the research reported here explores (see in particular, 6.4).
1.3 Methodology

1.3.1 Research design

A qualitative approach was used in order to obtain the depth of data required to explore knowledge, attitudes and behaviour of the GPs and Practice Managers.

At the outset of the project, ethical approval was obtained from a Multi-centre Research Ethics Committee (MREC) and approval was also obtained from the relevant Primary Care Trust Research Management and Governance Groups.

1.3.2 The sample

Purposive sampling was used to identify a range of GP and Practice Manager respondents to provide a spread of characteristics which were of relevance to the objectives of this study.

The main strategy for sampling was to obtain a range in terms of the way GPs filled out the IB113. Data was available on whether or not GPs returned the IB113s which they had been sent, and where they had, the extent to which the DWP had found the evidence provided useful. This data is not routinely collected, but was collected specifically for the quantitative component of the Engaging Physicians Benefiting Patients pilot evaluation which complemented the findings of this study. However, during the fieldwork stage, it transpired that GPs did not always personally complete the IB113s they were sent, but would often pass them to a colleague. This meant that the prime sampling criteria was no longer of use. However, the sample selection was also based on ensuring a range of Primary Care Trust and Jobcentre Plus districts, a range of practice types in terms of catchment area and practice size, and a range of GP and Practice Manager characteristics. See Appendix A for further details of the sampling frame.

GPs and Practice Managers from the same practice were invited to participate, and interviewed separately.

1.3.3 Data gathering

Twenty-five in-depth interviews were conducted with GPs and eighteen with Practice Managers, during September and October 2004. Interviews with GPs lasted between 45 and 60 minutes. As less issues of depth were covered in the interviews with Practice Managers, they typically lasted about 30 minutes. Separate topic guides, with a similar core structure to allow comparison in the analysis, were used flexibly to guide the GP and Practice Manager interviews (copies of the topic guides can be found in Appendix C). Interviews were taped, with consent, and transcribed verbatim. An honorarium of £75 was paid to participating practices, in recognition of their time commitment.
1.3.4 Analysis

The transcribed data was summarised and organised to make it manageable for interpretation. This was done using the manual, matrix method, known as ‘Framework’, which facilitates both thematic and case-by-case analysis. The second stage of analysis was to interpret the data and to extract patterns, associations and explanatory accounts. All the research team were involved in this process, meeting regularly to discuss, review and revise theme development.

1.4 Outline of the report

Our qualitative approach made it possible to gather rich, in-depth data on the range of attitudes and behaviours of the GPs and Practice Managers interviewed. However, it is important to note that our research design cannot provide quantitative data on prevalence, and whilst the findings may be generalisable, further quantitative research would be required to explore the limits to this.

Quotations are used throughout the report to illustrate the issues being described. To ensure the protection of anonymity, at times some details in the quote have been changed. Where this has been done, square brackets have been used to indicate this.

The report begins with an account and analysis of the systems used at practice level to respond to requests for the IB113 (Chapter 2). Chapter 3 analyses the strategies and tactics that GPs use to complete the IB113. In Chapter 4, GP strategies to manage the information required for the IB113 are described. These ideas are developed further in Chapter 5, which explores the range of influences on GPs that effect their completion of the IB113. In Chapter 6, GPs’ and Practice Managers’ knowledge and awareness of the IB113 and the reported impact of the ‘Engaging Physicians Benefiting Patients’ pilot communications input are explored. Chapter 7 reports on suggestions made by GPs and Practice Managers to improve the IB113 and the systems which surround it. Chapter 8 details the conclusions of the study.
2 Practice systems for the IB113

This chapter describes the process by which practices receive the IB113 and process them: that is, arrange for their completion and dispatch to the DWP. It shows the range of approaches from the relatively informal to highly systematised protocol and includes an explanation of actors involved and their roles.

IB113 forms are processed within the context of a workplace that GPs and practice managers describe as overwhelmed by both clinical and administrative tasks, and where ‘time is precious’ (Male, 25 – 30 years as a GP). This leads practices to develop systems for dealing with requests for information, such as IB113, so that they can be managed. There was a spectrum of approaches to processing the IB113 from arrival to despatch.

2.1 The ‘efficiency’ versus ‘no set procedures’ models

There is a variation in how much the flow of the IB113 through the practice is monitored and controlled. Practices could be placed on a continuum between, at one extreme, the least organised approach to processing the IB113 which could be termed ‘no set procedure’ (Female, 11 – 20 years as a Practice Manager), and at the other extreme, the ‘efficiency model’ or what was described by one practice as their ‘meticulous method’ (Female, 11 – 20 years as a Practice Manager). This use of a common protocol is further explored below. To illustrate the ‘efficiency’ and ‘no set procedure’ models, a case study of a practice from each end of the continuum is included.
Example of a practice where ‘no set procedure’ is used for processing of IB113

This medium sized practice in a small town has a mixture of semi-rural and urban population. The Practice Manager is very experienced and works full-time. The practice is ‘paperless’, but data have not been recorded electronically retrospectively so any predating medical records have to be accessed from paper files.

The Assistant Practice Manager opens the mail and date stamps it. For IB113s they attach the patient’s paper records and put them into the tray of the doctor named on the form. Since patients may see a number of GPs, generally the doctor whose name is on the form feels obliged to complete it (although GPs do not know the rationale of how the form comes to be addressed to them). If the GP feels they do not have knowledge of the patient, ‘in an extreme case’ (Male, 6 to 10 years as a GP) they would check computer records and redirect the form to the doctor whom the patient has seen most regularly. The progress of the form is not tracked. If the doctor is busy the IB113 could be in their tray for a week or so. If less busy, they could be turned around in a couple of days. The arrival of a duplicate form from the DWP serves as a reminder that the form has not been returned. Generally the form is passed back to the secretaries already sealed in the envelope for dispatch. Thus the administration staff have no role in checking the form or copying it. In certain cases the doctor may ask for the IB113 to be scanned into patient records – but this is rare.

The Practice Manager comments that there is ‘no set procedure’ for logging these forms. It is implied that there may be different procedures for forms that attract a fee.
Example of a practice where a ‘model of efficiency’ is adopted for processing IB113s

This medium sized urban practice has a high level of deprivation. The part-time, but experienced, Practice Manager states they put in a lot more than their official hours. Requests for medical evidence are opened by an administrator and logged onto the computer system – patient’s name, date of birth and which GP is to complete the IB113 are recorded. Administration staff will ‘eyeball’ the computer records to see which GP has seen the patient most recently, or direct the IB113 to the GP named on the form. Paper notes are attached, but most patient information is now on computerised records (the practice has recently computerised). GPs who have been in the practice longer, will recognise the patient names and redirect them to the GP whom they know sees the patient most regularly. An audit trail operates, whereby the log is checked each day to check that the form has been completed. Expected turnaround is a couple of days. Doctors are given administration time once a week and secretaries chase the forms if they are not returned promptly. Forms are returned to a designated administration team member who checks that the form has been stamped, signed and dated. They sometimes photocopy the form and file it in the patient records before dispatching it.

The audit trail system for medical evidence requests has been in operation for eight years. The Practice Manager stated emphatically that the same procedure operates for IB113 as for individually remunerated forms. A GP interviewed, reported that they take time over the forms and use social data on patients that they have recorded for purposes of other medical evidence requests such as insurance forms. The Practice Manager reported that the system is ‘just part of our meticulous method.’

2.2 Features of practice administration which facilitated IB113 completion

There were a number of key factors in the administration procedures of ‘efficiency model’ practices that have a significant impact on the completion of form IB113. These are examined in turn here.

2.2.1 Motivated by efficiency

Practice Managers described it as part of their professional role to have an overview of the practice system for processing requests for medical information. The Practice Manager was also more likely than the GP to be aware of timeframes and to be concerned to meet deadlines for forms. The ‘efficiency model’ Practice Managers suggested pride and enthusiasm for working to deadlines, operating in teams or making improvements in systems:
We don’t like things like this hanging around for long, that’s why we like things to be done on a daily basis. We like to do today’s work today – that’s our little code, doing today’s work today.’

(Female, 0 – 5 years as a Practice Manager)

2.2.2 Chasing and tracking the IB113 forms

Administration staff would generally post the IB113 into the GPs’ docket, or in-tray. Less common was for them to put it directly onto the GP’s desk. While in the docket, the form was still visible to the administration staff and somewhat under their control, since they could informally chase the doctors by commenting on the fullness of their in-tray:

‘They [GPs] tend to leave them [IB113s] in their trays; if their trays are filling up, you know they are not dealing with their work…’

(Male, 11 – 20 years as a Practice Manager)

Thereafter the form disappeared into the realms of the GP’s office, from which point it was more difficult for administration staff to track. Although some GPs operated highly efficient systems of turnaround of the IB113, more commonly, GPs were not as aware of timescales as the administration staff and necessarily operated within other frameworks of prioritising and putting clinical work first. In these cases, the influence of the Practice Manager and other administration staff on the GP was critical. This influence may operate either formally or informally, through gentle ‘nudges’, hints or more explicit chasing. These two types of approaches are illustrated in the two quotes below:

‘If a couple of days have passed and the GP hasn’t filled it in we say ‘have you got a time when you are going to do your administration work?’

(Female, 11 – 20 years as a Practice Manager)

‘We’ll extract them and put them on his [GP’s] desk and tell him to complete it before he goes home – don’t leave the building before you complete it!’

(Female, 21 – 30 years as a Practice Manager)

One Practice Manager even suggested that she would welcome the opportunity to take over the system further to ensure completion within the deadline, and would appreciate external reminders.

2.2.3 Designated IB113 administration staff

Practices where administrative tasks were divided among a number of designated members of staff were more likely to demonstrate an efficiency model of working. For example some practices had designated a part-time administration person to process requests for reports and log their receipt and dispatch. In other practices more senior administration staff initiated the processing of forms, while secretaries received, logged and dispatched them.
While it was recognised that systems do not always work perfectly, in efficiency model practices formalised, designated roles were generally favoured as a method for making sure the practice achieved deadlines since they ensured individuals took responsibility.

### 2.2.4 Common protocols

In practices that prided themselves on efficiency, IB113 was included in an established protocol or formalised audit trail for receiving and tracking the completion of other forms and reports such as Disability Living Allowance (DLA) claims and insurance claims and treated as ‘just another form’:

> ‘We’ve set up a template *in patient records*, within the template there is procedure to follow – not just for this form but for all forms, fee generating or not.’

(Female, 11 – 20 years as a Practice Manager)

In other practices however, there was a conscious discrimination between requests that are independently remunerated and those, like IB113, that are part of contractual obligations:

> ‘We don’t track them, we get them off the desk pretty quickly... we track other things, we track the things we get paid to do. Insurance forms they are tracked, but not these.’

(Male, 6 – 10 years as a GP)

### 2.3 Relationship between efficiency models and other practice factors

Due to the qualitative approach and purposive sampling used in this study, it is difficult to draw any generalisable conclusions about associations between factors that may influence the development of more efficient models of administration. Nevertheless, a logical extension of descriptive analysis about practice efficiency is to interrogate the data for any patterns that could be illuminating.

We explored possible relationships between the practice efficiency models and other factors such as practice list size, special interests of the GP or length of time the practice has been paperlight or paperless, since it was hypothesised that efficiency could be more important in large practices that have more cases to deal with or could be more available to practices that have had fully computerised medical records for some time. The data were examined for patterns however, in this study these factors did not appear to influence the system. Indeed, while all practices sampled were at some stage of computerisation, two practices that prided themselves on their efficiency were only beginning to computerise medical records at the time of interview.
The personality and motivation of Practice Manager and other key people in the administration team, and the willingness of the practice to operate as a team, seem to be key to the development of tracking and monitoring systems, and to the smooth running of the system for completion of all requests for medical evidence. The development of common protocols for all forms was also important since IB113 benefited indirectly from these systems. Possible relationships between efficiency and socio-economic deprivation of the population, or rural-urban status were also explored. It may be that GPs in areas of higher deprivation receive more requests for medical evidence for Incapacity Benefit and therefore need to devise systems to deal with throughput, but again there did not appear to be any patterns to this relationship of factors in this study sample. Another hypothesis could be that a GP who has an interest in occupational health or the benefits system, or who has had experience in working for Medical Services, may have an interest in practice systems for dealing with IB113, but this did not prove to be the case either. While no hard conclusions can be drawn from this analysis, it would be interesting to find out more about what drives practices to efficiency in the processing of IB113.

2.4 Distribution of form IB113

The process by which the decision is made about which GP from the practice will complete the form varied. This is important because quality of information included in form IB113 is highly dependent on a GP’s knowledge of the individual patient and their history. As will be explored in the following chapter, GPs are required to provide ‘factual information’ for the IB113, which they may therefore assume can be completed by any doctor who has access to the medical records. In practice, the information required requires the GP to have knowledge of the patient condition, including information on their functional capacity. While some practices distributed requests for evidence to the GP named on the form and made the best of the information available, other practices tried to make a match based on other criteria. The following methods of allocation were exhibited in the sampled practices, demonstrating the spread of distribution policies. IB113s were distributed to the:

- GP last seen by the patient according to medical records (who may not know them best);
- GP who knew the patient best/sees the patient most frequently (who may not have seen them recently);
- GP named on the instruction from Jobcentre Plus (generally Jobcentre Plus will address the form to the doctor on whose list the claimant appears). However, practices did not routinely operate personal list systems:

  ‘The patient is registered with one doctor but always sees another doctor, it’s no point in that [IB113] going to the registered doctor because they don’t know the patient and can’t necessarily give an accurate report. So it will go to the doctor that knows the patient the best.’

  (Female, 11 – 20 years as a Practice Manager)
The process was not always transparent or consistent, however, since not all GPs were aware of why the forms come to them rather than to a colleague:

‘Not sure why I get the form for certain patients – I think the receptionist tries to stretch the work out evenly to the doctors – it might come to me because I have seen the patient – I was the last GP to see the patient.’

(Male, 0 – 5 years as a GP)

In fact, while Practice Managers gave accounts of allocation of forms based on a certain criteria, in some Practices either administration staff or GPs themselves passed forms around to ease the task as a second stage of allocation – or redistribution. This may have been because the GP for whom the form was intended was on holiday, in which case either administration staff or doctors themselves may pass the form on to another doctor, or because another partner was more familiar with the case:

‘Yes, some of them [GPs] have their own rules. Doctor [name of doctor] for example, if it’s got his/her name on, he will just do it. But others, they would make a balanced decision. They would look at the screen and say, their usual doctor is Doctor A, but actually they have seen Doctor B. The last four times, so it [IB113] would go to Doctor B.’

(Male, 11 – 20 years as a Practice Manager)

But it was not uncommon for GPs to feel guilty about passing forms on to another partner, even if they did not know the patient well. In instances where they did not want to burden a colleague with a form that had come to them, or where the patient was not well known by any of the partners, they completed the form as best they could with only computer notes to guide them even where they recognised this was not ideal. There appeared to be almost an unspoken code that GPs would take their share of the administration load.

What appears to operate in some practices is a decision-making process by individual GPs within the team about whether to accept the form or not, based on their views of who is most competent to fill the form. This may override a decision made by administration staff.

However, there were two examples of a more formalised and unusual system of distribution operating.

- **Monthly rotation (month on, month off)**

  In one practice a very formalised policy operated whereby the senior receptionist distributed the forms between the two GPs who rotated the task of completing reports or forms on a monthly basis.

- **Paying another partner to do administration**

  In one practice a particular GP had made an arrangement to pay another partner to complete their forms for them to relieve the administrative burden:
‘We’ve got one partner who is very, very laid back about doing his paperwork. And actually one of the other partners has just said ‘right well, you know, I’ll do it but I want to be rewarded for that, you know, if I’m going to take on all the paperwork.’

(Female, 11 – 20 years as a Practice Manager)
3 GP strategies to complete the IB113

The previous chapter dealt with the systems by which the practice, including administrative and medical staff, interact in the processing of form IB113 and IB113A. This chapter describes the methods GPs use to manage the IB113 as part of their workload and explores the practical strategies of prioritisation and delegation.

Both GPs and Practice Managers perceive their working environment to be overwhelmed by the competing priorities of clinical and administrative tasks. They may try to stretch time available by pushing the boundaries of their working hours, multitasking and taking work home, but continual prioritising is necessary:

‘We get a lot of paperwork and I must say I look at IB113 as an evil. Whether its necessary or not, its still an evil and I do them, don’t think too much about them.’

(Male, 11 – 20 years as a GP)

3.1 Prioritisation

While the IB113 itself was viewed by some as more straightforward than other medical evidence requests, its completion was still seen to take time away from more valued tasks.

The provision of medical evidence for form IB113 was generally thought to be a low priority – an onerous task and one which most GPs often attempted to spend as little time on as possible:

‘I fill these forms in a crap way...its just a chore...I get away with the bare minimum.’

(Male, 6 – 10 years as a GP)
As was discussed in Chapter 2 all form filling was generally seen as irritating by GPs. However, some doctors also reported that they may deal with form IB113 before others because they felt it is less complex and therefore quicker to complete:

‘Because it [the IB113] is quite quick you know, if you’ve got five minutes you might say, oh I’ll do that.’

(Male, 6 – 10 years as a GP)

GPs used a range of criteria to judge the value of tasks they undertake and thus to make decisions about allocation of their time. Tasks were judged on whether they were:

- Valuable in terms of patient care.
- Personally/professionally satisfying and developmental.
- Financially rewarding.

3.1.1 Clinical work and patient care

GPs compared the time taken to complete an IB113 with time that could be better spent on clinical work with a patient, which was considered more valuable and satisfying:

‘It’s hard to spend more time on a form than you would in the consultation. So the consultation is ten minutes, and yet a form like that could easily take 15 minutes to fill in.’

(Male, 6 – 10 years as a GP)

Clinical administration such as hospital letters, blood tests and prescriptions came second on GPs priorities, followed by administration for what one GP termed ‘third party reports’:

‘Urgent letter, I would do those first, then the non-urgent later on…An IB113 is non-urgent, in my opinion, I would say. For me, a referral letter, for hospital is very important, and it is very important if it was a prescription, it’s very important if it was for a blood test and all those things are very important. Those are top priorities.’

(Male, 11 – 20 years as a GP)

In general, providing medical evidence for reports was not perceived to hold value for the GP, as it serves no direct purpose for clinical care:

‘It [IB113] is nothing to do with getting the patients better or treating them medically, it’s just kind of administration work really.’

(Male, 11 – 20 years as a GP)
However, some GPs did identify that in some clinical situations, there could be an indirect function of the IB113 for the GP. It was recognised by some GPs that the IB113 can provide the GP with a potential mechanism for them to initiate discussion of fitness for work issues with patients and hence a potential opportunity to address occupational rehabilitation. In one example, a doctor pointed out that sometimes it was when trawling through data for completion of IB113 that they realised that a patient had not been seen for a considerable amount of time and that a review of their condition would be beneficial. However, other GPs viewed the IB113 to be of lesser importance than the insurance questionnaires or applications for benefits such as DLA and Attendance Allowance (AA):

‘Because, if somebody is applying for insurance, and you get a questionnaire from an insurance company, life assurance company, you know that they have a mortgage waiting or something. Life insurance, it needs sorting out quickly, so you fill it in quickly, same with AA if they’re needing, to get money...so it [the IB113] comes lower down.’

(Male, 21 – 30 years as a GP)

3.1.2 Professional satisfaction and development

Clinical work was also seen by GPs as personally and professionally more satisfying than the provision of medical evidence:

‘My enjoyment of the job is seeing patients and talking to them and managing their problems. The paperwork thing is kind of very low on my priorities.’

(Male, 21 – 30 years as a GP)

Other demands competing with IB113 for GPs time included continuing professional development. Administration work of all types was seen as reducing time allowed for study:

‘GPs are inundated with paperwork, many forms of all types. It takes considerable time and encroaches on protected study time.’

(Male, 11 – 20 years as a GP)

3.1.3 Financial reward

The role of financial incentives was stressed by many GPs in this sample and formed an important part of their prioritising of administrative work. Forms which attract fees are given priority by GPs over what were termed by one Practice Manager as ‘free forms’. Most recognise that they have a contractual obligation to complete IB113, but this does not necessarily hold a great deal of weight when they are short of time.

GPs recognised that they would spend more time on the form if they were being paid to do them, particularly since some felt the weight of responsibility in the information they were asked to provide, and compared their role to that of a solicitor who would be paid to provide evidence in such cases:
'They're not gleefully done – they're done as a sort of duty. I work most efficiently when driven by an incentive and these don’t have a direct incentive.'

(Male, 6 – 10 years as a GP)

3.2 Allocation of time

This section explores GP’s strategies for allocating time to complete form IB113. This includes the physical time spent on the task as well as the turnaround time, or time taken for GPs to get to the task once they know it needs their attention.

Many GPs dealt with time pressure by allocating a minimal amount of time to the task of form filling in general, and to IB113 in particular. GPs’ estimates of time taken to complete the report ranged from ‘a few minutes’ to ten to 15 minutes. The upper limit mentioned was 15 minutes.

The length of time taken to complete the form would partly depend on whether a patient was known – in which case it would take only minutes to complete, whereas for patients who are not known, the search for information would delay the process.

There were also GPs who described how they would sometimes try to fit the completion of IB113 into a few minutes before surgery begins or ends. So time available was limited by a deadline to begin surgery. In some cases, forms were completed outside the working day. One GP reported frequently taking forms home to complete as he feels there is no time for the task within the working day (Male, 13 years as a GP).

Some GPs gave accounts of their conscious decision to cut down on information provided to economise on time. Doctors would either leave sections blank that take longer to complete or cut down on detail. Some GPs routinely left Sections 4–6 of form IB113 blank since they were felt to require a greater level of GP reflection and therefore time commitment. Sections 4–6 are on the left hand side of the inside of the IB113 form. Question 4 asks what the patient has been told about the likely clinical course of their condition. Question 5 asks for ‘any other information’. It is suggested that this could include whether the patient would be unable to attend an examination by public transport or taxi, or additional information about the effect of the condition on daily living. Question 6 refers only to patients with a psychiatric condition and asks for any history of suicide attempts, self-injury or threatening or violent behaviour:

‘I’ll spend...maybe up to ten minutes, but I wouldn’t spend more time than that on it...yes, so I frequently leave them blank. Generally the left side of the form is OK because it details what they’re suffering from, how long they’ve had it for and what medication they take, but on the right side of the form there’s things like, how the particular problem affects them...that’s not something I would necessarily go into any detail about.’

(Male, 6 – 10 years as a GP)
GPs are instructed on the front of form IB113 that ‘a reply within seven days will be appreciated.’ In practice, turnaround times varied widely. Some GPs adopted a conscious strategy and aimed for a particular turnover time (that may have fitted into a practice system) – such as ‘receipt to send off in three to four days’ (Male, over 30 years as a GP) or ‘I personally don’t keep anything on the desk paperwork wise for more than a week and I would probably try to turn one of these around in two days’ (Male, 6 to 10 years as a GP). Another GP likes to ‘keep on top’ and would turn the form around in ‘a couple of days’ (Female, 21 – 30 years as a GP). At the opposite end of the spectrum were doctors who reported that forms can ‘sit on the desk for a month, maybe six weeks in the summer holidays’ (Male, 6 to 10 years as a GP).

GP holidays were frequently mentioned as a source of delays in forms being completed. In many practices other GPs would take on the task during holidays, but this was not always a reliable method of ensuring efficiency, since other colleagues may not know the patient and therefore not complete the form either:

‘If someone is on holiday today or yesterday, you would not allocate this form to them if they are away for a week or two weeks. We would put it into the system and it might well be that there is a Doctor allocated who can’t do it. They would say ‘can’t do this’ and put it in another Doctors box with a scribble, but we wouldn’t knowingly give it to someone who wasn’t going to be here for two weeks at all so they wouldn’t even know it required doing.’

(Male, 6 – 10 years as a Practice Manager)

GPs and Practice Managers reported a great deal of inconsistency in the speed of IB113 completion between partners in practices, and so turnaround times were difficult to predict at a practice level. There were incidences in which GPs admitted that forms can be lost under piles of paperwork and may not be returned at all.

3.3 Delegation

One particular strategy to economise on the time taken for completion of IB113 stood out as deserving separate consideration since it is a conscious policy organised between GPs and practice staff and represents a fairly infrequent and unusual example of cooperative strategies. Some practices had decided to delegate completion of some sections of form IB113 to other practice personnel. In two of the practices in our sample, administration staff undertake an initial trawl of computerised medical records and provide what were believed to be more clear-cut factual details of cases – for example date of onset and diagnosis. In one practice, the system of delegation to a data entry clerk was initiated by GPs and administration staff together as a way of dealing with a short-term crisis when they were a GP short, but also as a longer-term efficiency strategy:

‘We do it [complete the IB113] as part of our terms of service, so we fill it in, but we find an efficient way of doing it – as we do with a lot of forms – to reduce bureaucracy.’

(Male, 21 – 30 years as a GP)
Generally the data that was extracted was regarded as the more factual, clinical information, available on computer records and was again seen to be part of a drive for efficiency and to cut down on paperwork for GPs:

‘The object of the exercise is that you don’t want the doctors sitting there filling in the forms. Essentially they [administration staff] pull up the computer record and say this patient was last seen on such and such, that is a fact, it’s on there... they wouldn’t fill in medication because they wouldn’t be quite sure which applied to the condition that is being talked about. That’s a clinical matter, so its real factual clerical stuff that they would be expected to fill in – the rest of it is down to the doctor... We’ve pared down the paperwork as much as possible – the admin work getting done by administrators, clinical work getting done by clinicians.’

(Male, 11 – 20 years as a Practice Manager)

In another practice, a data input clerk had been trained specifically for the role of extracting and inputting data from electronic records for the purpose of responding to requests for information and hospital letters etc. They had also worked alongside GPs completing IB113 and other forms such as insurance claims, and thus received on-the-job training in the type of data to extract. They recorded the data on ‘post-its’ which were stuck to the form and then passed the form to GPs to check and amend. One GP in the practice reported the system worked well and they only amended the wording on the form to make it sound more professional. Interestingly, another doctor interviewed in the same practice was more sceptical and felt that if the patient is known to the GP, it could be quicker for the GP to complete the form themselves, rather than go through the layers of the process needed for delegation to work efficiently.

The third example of delegation as a strategy to manage completion of IB113, comes from a GP who had made their own decision to ask practice nurses, who have extensive knowledge of the patients, to complete forms for him. This was not a practice level system, but a personal strategy of expediency in times of high administration burden:

‘I’m not sure if this is actually totally legal, but sometimes I’ve got so many of these forms I share them out. The nurses are actually seeing them, because I don’t see all the patients... the nurses tend to have less paperwork to do than the rest of us.’

(Male, 6 – 10 years as a GP)

These examples of administration staff and GPs completing a task cooperatively were unusual. When some other Practice Managers were asked about their views on this method of working, there was a definite rejection of the model. One Practice Manager said that administration staff in her practice would ‘never’ consider this role (Female, 11 – 20 years as a Practice Manager). It was stressed by others that administrative and clinical work must be kept separate. This suggests that delegation, while an interesting way forward in some practices, could be a controversial way of working for others.
4 Managing the information required in the IB113

This chapter focuses on GP strategies to manage the information, which is gathered, sorted and communicated to the DWP in the content of form IB113.

4.1 Sources of information used for the IB113

GPs will usually access information from medical records – either computerised records or paper – and will draw on their own knowledge of the patient (where possible). Thus GPs use four main sources of information for data extraction:

- Paper records.
- Computerised records.
- Memory.
- Information from the patient.

4.1.1 Paper records

In almost all cases, the original paper records were included by administration staff in the pack passed onto the GP for completion of IB113. This was a standard procedure for completion of all requests for medical evidence. However, in general, paper records were rarely used for completion of IB113, except in practices where their system had not been computerised or, in unusual cases, where a patient’s condition predated their computerised records. In some cases, practices had only recently begun to input records electronically at the time of interview. However, as one GP pointed out, paper records are usually only required for evidence for insurance forms where a long-term history of health is required. One GP estimated that paper records were only needed for one in ten cases. However, where systems are ‘paperlight’, but not ‘paperless’, medical evidence from other professionals such, as consultants, may need to be considered and this was often in the form of paper letters.
4.1.2 Computerised records

Recent computerised data were thought to be the most relevant by GPs for the completion of IB113. Computerised data will only be available for the length of time that the practice has had a system and will depend on how far back they have chosen to input data, and how comprehensive this has been. For most GPs, computerised records usually went back far enough for the purposes of IB113 and the system was appreciated as a vehicle for finding data.

However, searching computerised records was time-consuming and involved ‘trawling’ through what could be large amounts of data. Even seemingly straightforward questions on the date of onset and diagnosis can be problematic, as illustrated by quotes from two GPs in the study:

‘The information required by the form is very difficult to fish out – diagnosis and date of onset for some people, that’s a long list, and dates of onset are very difficult to find accurately.’

(Male, 11 – 20 years as a GP)

Some GPs wondered why they needed to interpret the data themselves and write it by hand into the form. Some went as far as to leave sections of the form blank and instead attached printouts of letters and reports so that the DWP could extract the information themselves, even though they were unsure of how useful this information was to Medical Services:

‘…not sure if it was appreciated [by Medical Services], but it certainly saves time.’

(Male, 6 – 10 years as a GP):

‘I fill in the form with the computer in front of me. To do a good one, you have to look into the patient’s notes, and extract the details, when the patient was last seen – sometimes I think ‘why am I filling this? Why don’t I just send them a printout from the computer and send them that? Let them extract the information they want. It’s probably more accurate than what I could give them.’

(Male, over 30 years as a GP)

The Better Medical Evidence Gathering pilot (Sainsbury et al., 2003) used an approach very similar to this. Patient medical records were sent to Medical Services for them to extract the required information. As described in 1.2.2, this approach was not particularly successful and did not generally result in better quality evidence.

4.1.3 GP memory

Where a patient was well known, GPs frequently called on their own knowledge of the patient and used memory to speed-up form completion. In some cases this was combined with use of computerised data, but in others, doctors relied heavily on their personal recall of patient condition:
'If it’s a patient I know well it’s easy and I almost do them from memory, but if it’s a patient I don’t know well...then I have to look at all the notes...to try to extract that from notes and perhaps even more so from computerised notes is not always easy.’

(Male, over 30 years as a GP)

Other GPs stressed the danger of using memory alone to complete the IB113, although recognised this was common practice. They emphasised the need to check records as well as there may be significant past medical events that they are not aware of – such as suicide attempts. In one case, a GP, who also works one day a week as a Medical Services Doctor, confirmed that it is important to go through the notes: firstly, because there may be hospital letters or treatment by other professionals the GP is not aware of and secondly, that there is a potential litigation risk if something is missed:

‘If you do it without looking through the notes it means you are not doing it correctly…and...we’re trying to save our necks...patients can say ‘oh I have this problem and my GP did not put it down’...they can take you to the GMC.’

(Male, 11 – 16 years as a GP)

4.1.4 Information from the patient

In contrast to requests for a Med 3 or Med 4, the patient does not directly approach the GP for evidence for the IB113, is not present in consultation, and therefore is not necessarily part of the process of selecting evidence that will be used to judge incapacity to work for the purposes of IB113. Indeed, the patient may not have been seen for some time, or even at all, by the GP completing the IB113.

In rare cases would the GP call in a patient for a consultation to substantiate their data, even where there was felt to be poor information in the patient notes and lack of personal knowledge of the patient’s capacity to work. This was for three reasons. Firstly, because GPs did not believe they were required to do this by the DWP – that it was not part of their contractual obligation to organise an assessment. Secondly, GPs felt there was not time to do so – even where some doctors recognised that it would be useful. Thirdly, patient-reported evidence was not used due to a feeling that patient reports are subjective and can be controversial and thus do not constitute factual evidence. One GP reported that if a patient came in for an appointment coincidentally around the time of request for IB113, they might ask them questions relevant to the form. However, when a patient approached the GP directly about IB113 this was usually when there was some concern on the patient’s part that the evidence the GP was likely to give may not support their claim for Incapacity Benefit.
In summary, to complete IB113 GPs would use a combination of computerised medical notes, reports from third parties (such as hospital consultants and other professionals) as supporting evidence, and their knowledge or memory of the patient, where available. However, as discussed in the next section, the processing of evidence from these information sources was problematic to them for various reasons.

4.2 Difficulties with the information for the IB113

There were three main areas of tension described by GPs in relation to selecting, sorting and interpreting information from the four sources listed above for use in completion of IB113:

- Problems of GP recording systems.
- Problems of interface between GP and DWP systems.
- Matching collated data to form requirements.

4.2.1 GP recording systems

Some GPs described how they carried significant amounts of information about patients in their head, partly because there is just too much information gathered about patients to record it all. This makes it especially difficult for GPs in group practices to complete an IB113 about a colleague’s patient. Indeed, since many patients are seen by a number of GPs, variable quality of record keeping makes the task problematic. Doctors pointed out that since personal lists are no longer operated under the new contract, patients in practices with larger practice populations may see a variety of GPs, and thus doctors may not have detailed knowledge of individual patients:

‘I think our note taking is inadequate...for the purposes of filling out accurately Med 4s and IB113s. Much of the information we carry is in our heads is based on daily experience. We couldn’t hope to sit and write everything down...it’s not because of lack of information, it’s due to lack of recording. I believe that’s where the difficulty is.’

(Male, 11 – 20 years as a GP)

4.2.2 The interface between GP and DWP systems

However, the difficulty was also related to a fundamental disparity between DWP and GP systems of communication and recording methods. Whereas the IB113 is a paper document that requires GPs to fill in the boxes by hand, most GPs now use electronic records. It is cumbersome and time consuming for them to rework the data into the hand-written notes required by the manual system operated by the DWP. As one GP commented: ‘the forms are a pain because we’re not used to writing on paper’ (Male, over 30 years as a GP).
In addition, the DWP ask for information that may not be available to GPs in the format required by IB113. The system of READ codes developed for recording diagnoses on computerised medical record systems does not easily lend itself to translation into data that can be used to answer questions in forms such as IB113.

### 4.2.3 Matching collated data to IB113 requirements

GPs have an often complex task in sorting the data they have on patients and matching it to the requirements of the DWP. Their approach was informed by their view on the following two factors:

- Who would read the data?
- What was required by the DWP?

There were a number of different opinions expressed about these factors, which are further explored here. The spectrum of views goes some way to explaining the variability in type and quality of response given by GPs to form IB113.

**Who would read the data?**

Firstly, information was sorted and filtered based on GPs' beliefs about who might have access to the IB113 form at Medical Services. As described in Chapter 6, not all GPs interviewed were aware that a medical professional reads and evaluates the information. This led these particular doctors to simplify their reports and possibly to exclude complex medical information.

**What was required by the DWP – facts or opinions?**

GPs also expressed a variety of beliefs about what was wanted by the DWP in terms of level of detail and kind of information. An important element of this centred on a discourse about ‘fact’ (objective data) and ‘opinion’ (subjective data informed by professional judgment).

Factual information was widely understood by GPs to mean clinical data which draws on a GP’s knowledge of the patient’s medical condition and thus is underpinned by the biomedical model of health. This information is often more readily available to the doctor. Opinions and judgments were understood to invite GPs to draw inferences about a medical condition, its prognosis and how it will affect a patient’s capacity for daily life (including working life). This is sometimes referred to as ‘functional capacity’. This draws on social and rehabilitation models and constructs of health and clinical practice. Information relating to this area may not be as readily available to a GP.

Form IB113 instructs GPs to provide the medical officer with ‘further factual information’. For some GPs the instruction to provide facts alone were clear:
‘We need to give concise, relevant, factual information that’s not based on opinions. We’re not being asked for our opinions.’

(Male, 11 – 20 years as a GP)

However, for others, this instruction was less clear:

‘So it’s not necessarily a medical label it’s actually...the things that the DWP are asking for are not medical labels, they’re actually asking for functional ability in somebody.’

(Male, 11 – 20 years as a GP)

However, it would be simplistic to conclude that some GPs ‘stick to the facts’ while others are prepared to ‘give an opinion’. Even where GPs reported that their policy is to give only factual reports, there were often exceptions where they would venture opinions. Thus the two categories are not mutually exclusive and, in fact, represent two poles of a continuum between the most scientific/objective and the most subjective evidence. GPs would move up and down this continuum given certain circumstances and depending on messages they wished to convey. The two categories are explored here by looking at the circumstances in which GPs may choose to either ‘stick to the facts’ or ‘give an opinion’.

**Sticking to the facts**

GPs are motivated to ‘stick to facts’ by the concepts of neutrality, accuracy, accessibility/expediency, fairness and lack of confidence in the process. These concepts may operate concurrently for a GP, but become more or less important given the circumstances of individual patients:

- the facts were believed to be more accurate in circumstances where information is not sufficient for the GP to have any opinion on fitness to work;
- facts are seen as ‘fair’ for GPs who are concerned not to make an inaccurate assessment of capacity to work that can then have an impact on patients’ income:
  
  ‘...if you get it wrong somebody’s deprived of their livelihood, you know, whether they can eat next week is affected...if you’re going to write any statement about someone you’ve got to make sure its correct. You can’t write a load of hogwash about someone.’

  (Male, 11 – 20 years as a GP)
- factual data is more easily accessible and quicker to record especially for patients who are not known and for whom computer records are the only source of information:
  
  ‘...that’s why I stick very much to the sort of factual information that I know to be true and it’s easily accessible on their record and then that also means there’s no conflict at any time with the patient.’

  (Male, 6 – 10 years as a GP)
• ‘sticking to the facts’ can be a way of remaining neutral by avoiding an issue which is controversial. Return to work and subsequent withdrawal of benefits are highly charged and can in some cases challenge the doctor/patient relationship as is shown in Section 5.6.1. GPs believe that strictly clinical information is not as inherently contestable when the views of doctor and patient vary:

‘If I think someone is a chancer I won’t put that, and I think what you have also got to be careful of is...if people get cut off from their disability allowance they will get mad...And you know I’m happy to put the facts down, but subjective opinions – a patient may be very miffed and understandably.’

(Male, 6 – 10 years as a GP)

Use of strictly factual data was frequently a strategy to ensure that the patient would be called for assessment by the Medical Services Doctor and the decision would therefore ultimately be made by Jobcentre Plus.

Giving an opinion

Circumstances in which GPs are confident in giving an opinion:

• Clear-cut cases – when GPs either knew a patient well and were confident of their information, or there was clear clinical evidence to suggest that a patient is unfit to work, they were happier to give an opinion on the form:

‘And if I really think this person has got really good reasons for not working, I usually make it very clear what my opinion is.’

(Male, 6 – 10 years as a GP)

‘I put factual information. And I try to leave opinions out of it. You know, especially subjective ones, unless there is someone I definitely don’t want them...I really think it would upset them [to go for assessment], then they shouldn’t be going. In which case I use the box 5.’

(Male, 6 – 10 years as a GP)

• Advocacy for ‘deserving’ patients – in instances where GPs wish to take the patient’s side for some other reason such as knowledge of patients circumstances or sympathy for them:
‘I do occasionally, and I do this more with Disability Living Allowance and Attendance Allowance than I do with Incapacity Benefit, fill in the form determined to get the patient the benefit, and I do that partly because I actually do have an idea of what the rules are and am quite certain in my own judgement that they meet it and so on. I’m going to make bloody sure that I provide the evidence that is required, and I’m not for a moment talking about overplaying anything and just making it crystal clear from the information that I’m providing what the relevant information is. And I do occasionally do that for people who are, you know, for example, really substantially disabled and for whom having an additional administrative hassle of having to deal with all of this in a more complex way than should be necessary for them, would just be too much for them to be able to face at the moment, if I happen to know them.’

(Male, 11 – 20 years as a GP)

- Avoidance/collusion with patient – where GP has decided it is easier to go along with a patient’s wishes to avoid conflict, they will give evidence phrased in a way that indicates a patient is not fit for work (to be discussed in Section 4.3.):

  ‘My other policy is that if I think they should be working. I will put in the prognosis box, ‘actively looking for employment’ or ‘should be looking for employment’ or something, just to flag up to them that they ought to have a look at this person and think about taking them off Incapacity Benefit.’

(Male, 6 – 10 years as a GP)

These problems were compounded for GPs by the general difficulty in isolating what is really accurate and ‘factual’ from patient records and also touch on a wider debate about what constitutes an objective ‘fact’ and a subjective ‘opinion’ in any piece of evidence. What for one GP was a ‘fact’, could be perceived by another GP to be an ‘interpretation of’, or ‘prediction from’, clinical data. For example, question 3 of form IB113 asks for details of the patient’s outlook (which is taken by GPs to mean the prognosis). While the form specifically asks for factual information in this question, for some GPs this was more subjective information:

  ‘Well I mean asking about a prognosis for example, I mean that’s not a fact, that’s a prediction isn’t it? So…it’s not just pure facts they’re after. I guess they’re looking for something else, opinion as well. Present medical condition…that’s an opinion isn’t it, how they are at the moment. Two doctors could disagree about that I’m sure. So it’s not a fact, it’s an opinion. But I’m sure they want us to keep it as factual as we can.’

(Male, 11 – 20 years as a GP)

It was opinion on functional capacity that GPs found most difficult and time-consuming to provide. As stated, GPs do not routinely collect and record data on patients’ capacity for daily life and work. Indeed they may not know what impact a patient’s medical condition has on their functional capacity. Therefore they were often reticent about providing evidence based on what they believed to be inadequate information or knowledge:
'I hate making a judgement of someone when I don’t know that the information I’m presenting is correct...I mean I wouldn’t like anyone to do that about me – ‘oh well yeah, I think Bob [name changed] can climb, you know, Mount Everest probably in an afternoon...I’m not certain but I think so.’ You know, you don’t write things about people that you can’t substantiate, especially when their income’s affected.’

(Male, 11 – 20 years as a GP)

There was also convergence in some GPs’ minds about the purpose of different forms requesting medical evidence of capacity for work and benefit assessments.

- The sickness certification process for example, clearly asks GPs to make a judgment about capacity for work. This is not specifically asked for in IB113. However in this study, doctors frequently perceived that this is what was also implicitly wanted by the DWP in the IB113 – almost ‘reading between the lines’.
- The DLA form asks for far more extensive information about functional capacity, or daily living, than is required by IB113. However, GPs also tended to talk about the difficulty of providing information about functionality within the context of discussion about IB113.

The agenda of different agencies and their requirements had become, for GPs, a minefield of demands that have to be dealt with to clear their desk.

4.3 Coding a response

It was in cases where GPs views differed with the patients view on their fitness to work – in that a patient claimed they were not fit to work but a GP disagreed – that some of the most interesting findings about communication with the DWP emerged. Some GPs would want to clearly indicate a truthful opinion that this person was fit.

However, this approach was uncommon. More commonly GPs found it difficult to be honest and a conflict would be avoided in various ways by using subtle mechanisms in their communication to the DWP on form IB113. They described these strategies as ways of ‘getting the message across’, (Male, 11 – 20 years as a GP), or as ‘oiling the wheels of the system’ (Male, 6 to 10 years as a GP). In one case, a GP explicitly mentioned the need for a code to be established. It was clear that GPs were using an unspoken mechanism of coding.

Codes were a means of cutting across the ‘fact’/’opinion’ dilemma, especially where a GP wanted to communicate a view that was contrary to the patient’s – for example in cases where there is doubt over the ‘genuine’ nature of an illness. This was a way of giving a subjective opinion in a seemingly neutral way, or giving evidence that is implicit. The usefulness of a code is that it is more difficult for a patient, or arguably another professional, to challenge. However, GPs also reflected that they did not know whether Medical Services Doctors can interpret the codes.
There were several types of code used by GPs in this study:

- Using key phrases to indicate opinion such as ‘how well they’ve improved’, others reported that they would use terms like ‘genuine’ to ‘stress that it’s a genuine problem.’ (Male, 11 – 20 years as a GP).

- Using patient-reported data to indicate that the GPs own view may differ from the patients’:

  ‘Well for example, if we’re asked to comment on incapacity we might say, ‘the patient states that’ because often we have patients coming and saying they can’t do [certain tasks]...Whether people at the other end pick up on the subtlety of that I don’t know.’

  (Male, 11 – 20 years as a GP)

- Omission was an interesting strategy since it implies that what is not said carries meaning – GPs described ‘skimping’ on some questions or leaving key sections blank to indicate to medical services that the patient needs to be assessed:

  ‘I think that when I leave it blank I hope the DWP doctor will get the message – the DWP doctor knows I want to avoid conflict.’

  (Male, 11 – 20 years as a GP)

- Using underlining of key phrases to add emphasis.

One GP directly expressed a view that he would appreciate an agreed code that could indicate to the DWP that a patient was not making a genuine claim:

  ‘Unless there was some sort of coding situation...an agreed code that would say, that would mean this patient’s a malingerer for heaven’s sake and will have to work – that sort of thing. Ok, if there was a column that allowed me to give an opinion – it’s a bit of a hot potato but it could be coded in the way that ‘this is a genuine one and I think you should...and this is not a genuine one’...but we’re too nice people to say that.’

  (Male, over 30 years as a GP)

4.4 Form IB113A

The recent introduction of the form IB113A for re-referrals was explained in Chapter 1. It is normally used for claimants who have been receiving Incapacity Benefit for some time and are having their claim reassessed under the Personal Capability Assessment (PCA) process, to identify whether there has been any improvement or deterioration in their condition. The purpose of the IB113A form is to obtain information from the claimant’s GP about whether there has been any change.

The IB113A is a shorter form than the IB113. (A copy of form IB113A can be found in Appendix D).
The form IB113A was overwhelmingly appreciated by GPs and strongly preferred to the IB113. GPs felt it allowed them to operate at the factual level of information. Providing medical evidence on the IB113A was found to be easier and quicker. The speed of completion was related to the brevity, directness and the tick boxes on the form:

‘It’s not as onerous…it’s an improvement because…it’s more succinct, there’s more boxes to tick, which draw you into the questions better. Yes, that was an improvement in the right direction.’

(Male, 6 – 10 years as a GP)

The IB113A seemed to be appreciated not only for it’s succinctness, but also because it eliminated some of the complexity implicit in the task of completing the IB113:

‘It’s a very easy form to fill in and it certainly suggests more thought about the nature of the involvement of the people who are filling the forms in…it greatly reduces duplication and that’s a real step forward, I think it’s a very welcome thing.’

(Male, 0 – 5 years as a GP)

There were GPs who felt that aspects of the complexity of the task of providing medical evidence applied as much to the IB113A, as it did to the IB113. Or that because the IB113 was for long-term, chronic patients who the GP may rarely see, it would therefore necessarily be harder to fill in – not because of the form itself, but because of the patients. However, for many GPs, it was a great relief to find that the often complex ‘filtering’ and ‘sorting’ tasks, needed to complete the IB113, were rarely required for the IB113A:

‘[The IB113A is] easier to do, certainly, because you’re not having to trawl back through years and years to see when the date is…it’s an easier form.’

(Male, 0 – 5 years as a GP)

‘Pat on the back where it’s due. I think the IB113A is good. Well done DWP.’

(Male, 6 – 10 years as a GP)
5 Influences on completing the IB113

IB113 and IB113A forms are communications from the GP to Jobcentre Plus about a patient. Hence, unsurprisingly, the influences on completion of the form arise from GPs’ perceptions about the three sets of individuals involved in the process: the patient, the GP and Jobcentre Plus. This in turn impacts upon the quality and content of the information they include. The interface between these sets of individuals, caused GPs particular difficulties, and can be construed as sources of tension. These tensions help to explain the strategies used by GPs and practice personnel to manage information and data, which were discussed in previous chapters.

In contrast to GPs, Practice Managers considered the content of IB113 forms as outside their responsibility and so interview data on these issues were sparse. Where present, Practice Managers’ views were largely contradictory to GPs, suggesting administrative staff did not recognise the difficulties and sources of tension GPs felt were raised by the form. Hence, unless otherwise stated, the perceptions explored here are those of GPs.

5.1 Strength of conviction

A clear factor in the time and effort invested by GPs was how certain they were of their diagnosis of the patient’s condition and of their view over whether they were fit for work. GPs considered cases for incapacity along a continuum. Cases falling at either end (e.g. clearly fit to work or clearly not fit to work) were easier to process and for these extreme cases GPs felt convinced, and therefore confident, both in terms of providing fuller details of medical evidence, in particular assessment of patient functioning, but also offering judgements and opinions about fitness to work. Forms for cases when GPs were more strongly convinced, were not only completed more fully, but were also more likely to be prioritised above other cases and other administrative tasks:
‘The problems are not so much when someone is at one extreme or the other of the spectrum…you know when someone is clearly so severely disabled that they meet the requirements eligible for the benefit, or when someone is observed to be scaffolding but at the same time is trying to [claim Incapacity Benefit]. It’s the difficult ones.’

(Male, 0 – 5 years as a GP)

However, where GPs were less convinced in their view of the patient’s condition, fitness for work, or outcome of the PCA assessment, they admitted to providing more limited evidence.

The strength of the GPs conviction was in turn determined by a range of factors that related to their perceptions about the patient, the DWP and themselves, both as GPs and as individuals. These are discussed here in turn.

5.2 GP perceptions about the patient

Six types of perceptions about the patient and their illness emerged as being influential on GPs effective completion of IB113 and IB113A.

5.2.1 Nature of the condition

The first of these was their own belief about the nature of the condition and the clinical features of a patient presentation. Five main clinical features were considered by GPs:

- Complexity.
- Chronicity.
- Stability.
- Severity.
- Frequency of conditions presented by the patient.

Presence of any factor rendered the task of completing the form more onerous.

Complexity

This characteristic incorporates elements of the other four features, and was defined by one participant as an ‘ongoing medical problem that affects other problems. Or mental health related to physical conditions’ (Male, 21 – 30 years as a GP). Complex conditions were more problematic to complete on the IB113 because there was more information to sift through and process:
‘This is the opposite of what it should be, because the more complicated the patient’s problem; the more you have information you have to put down there, and that takes an awful lot of time…and the more other agencies, surgeon and psychiatrists etc etc, and therefore you cannot handle all that information.’

(Male, over 30 years as a GP)

The association between complexity and length of time completing the form held regardless of the practice system used.

**Chronicity**

Not only would chronic problems take longer to complete on the IB113, but the added problem was that patients might not have consulted with the GP recently and the notes might not be available or up-to-date. This was just as problematic for the IB113A form, which is, by definition, for patients with more chronic conditions:

‘In some ways that one’s [IB113A] is fractionally harder, because some of these people…have such chronic problems that they don’t necessarily come and see the doctor for 12 months and so to ask ‘has there been any change since?’…The difficulty is knowing whether that’s a good or a bad thing if they have not been to see the doctor. You would then wonder whether they are as bad as they should be or whether its just the fact that they’ve been so bad for so long and they just live with whatever they’ve got.’

(Male, 11 – 20 years as a GP)

**Stability**

Conditions that were more stable were not necessarily more problematic and the IB113A was generally quicker to complete. However, some GPs did say that they found it irritating to repeat information they had previously provided. Whilst, on balance, stable conditions were easier to offer evidence for, principally because there was no new clinical information to process. One GP did remark that they were reluctant to label a patient with a stable condition because it implied change was not possible and they felt this was stigmatising:

‘Now in truth a lot of these people are personality disordered. Personality disorder is not something I like to put on a sick note, it’s too much stigmatising it, branding somebody, you know, it’s like saying they can’t work because they’re black or whatever, because it’s unchangeable…even in the health fraternity personality disorder is looked on as a bit like, its just the way you are, you can’t do anything about it. So I don’t like putting personality disorder, even though that might be an accurate diagnosis, because you know it’s too damning really from the patient’s point of view, so I tend to put nervous debility or anxiety or whatever the problem symptom is.’

(Male, 6 – 10 years as a GP)
Severity

How severe a condition was related to the amount of information a GP would provide and interestingly also if they offered an opinion. This is because they were more certain over their views on patients with more severe conditions:

“If it’s clear-cut I will [give an opinion]. Say there’s somebody with a long-term psychiatric history. I think the less clear-cut, say mild to moderate depression, with mild to moderate anxiety…I probably don’t give an opinion.”

(Female, 11 – 20 years as a GP)

Frequency of conditions

The simplest and hence quickest forms for GPs to complete were those where a patient had a ‘very isolated, discrete problem’ (Male, 6 to 10 years as a GP). The number of conditions a patient presented with lengthened the time the GP spent on the form for two reasons. Firstly there would be more information to process. Secondly GPs were not always certain about which condition the patient was seeking Incapacity Benefit, or which was the initial presenting condition. They felt wary of contradicting evidence the patient had independently provided to Jobcentre Plus in case they unwittingly sabotaged the claim.

5.2.2 Mental health problems

Whilst the five elements of the nature of the condition were just as applicable to mental health problems as physical health problems, the presence of mental health problems was viewed as a particular factor in itself. Not only would a mental health problem mean a patient’s presentation was more complex and hence take longer to complete the form, but it was also viewed as more problematic. The main reason given for this was that psychiatric symptoms were viewed as more subjective and difficult to assess. Consequently patient records about mental health problems were less reliable or available:

“A lot of what you put on the computer is the bare bones about what tablets they’re on, about whether they’re…mainly happy or sad…So much of the information that a patient comes out with is kept in your own mind; you can’t document ten minutes worth of feelings...You have to summarise very briefly so when it comes to filling in a form for somebody who’s got mental illness, it’s very difficult to expand on your bare bones of information.”

(Male, 6 – 10 years as a GP)

Moreover, GPs were less sympathetic towards patients with mental health problems than those with a physical health problem. This was particularly the case for mild presentations of anxiety or depression, which were often dismissed as ‘stress’.
5.2.3 Unexplained physical symptoms

An issue that was sometimes confounded with mental health problems was where a disease explanation for physical symptoms remained elusive. These unexplained symptoms fell into two groups: pain and fatigue. Such presentations were perceived as difficult to define and were referred to as ‘grey-area-type conditions’ and were described as ‘nebulous or woolly’. Reasons for the challenge posed by these presentations were that the symptoms were subjective and difficult to quantify and were contrasted with symptoms and conditions that could be objectively measured or had clearly defined pathology. It was felt that assessment for unexplained symptoms requires assessment of patient functioning, something GPs felt unskilled in. Hence GPs felt heavily reliant on patient report, rather than data from clinical investigations. This was considered unreliable and potentially open to abuse.

A frequently cited unexplained condition was chronic fatigue and associated diagnoses such as Chronic Fatigue Syndrome (CFS) or Myalgic Encephalomyelitis (ME). Having a diagnostic label for fatigue symptoms made it easier for GPs to describe. For some GPs it was felt that further expertise was required to make such a diagnosis, for which they relied on secondary care services:

‘I would be reluctant to put someone on long-term sick without them having been fully worked on and diagnosed and rubber stamped because I think that [CFS] is a very nebulous sort of diagnosis.’

(Male, 11 – 20 years as a GP)

In the main, GPs felt less empathic towards those with unexplained symptoms compared to those with identifiable pathology. GPs explicitly used a number of strategies to manage these particular challenges including practice guidelines and, on occasion, frank honesty. The latter example was related to GPs confidence from being more experienced:

‘You write what is your provisional working diagnosis…If the diagnosis [CFS] is uncertain you write so…that’s an easy one because you just tell the truth; this is a provisional diagnosis, these are the symptoms.’

(Male, over 30 years as a GP)

5.2.4 ‘Genuineness’ of illness

Many GPs made value judgements and distinguished between patients they considered genuine from those with illegitimate claims. In general it was felt that genuine patients were more deserving and hence GPs were more likely to spend more time and provide more thorough and better quality evidence to ensure the outcome they wished for. They were also more likely to offer opinions on fitness to work:

‘If I felt there was a genuine case that may not be treated fairly then that might be the one that I would put a lot more information to it to back their claim.’

(Male, 11 – 20 years as a GP)
The distinction between legitimate and illegitimate benefit claims was not always clear, which was a further source of tension for the GP. These cases often included conditions that were difficult to define and assess (such as unexplained physical symptoms), or presentations where the GP felt they were being manipulated by the patient. A key influence over whether a GP felt convinced about the legitimacy of a patient’s claim was whether or not they perceived that the patient was culpable for the onset and course of their condition. Conditions blamed on the patient were more likely to be viewed as false whilst those the patient had no intent or control over were considered genuine:

‘My own view is that people get into addiction, most often they don’t intend to wreck their lives by using drugs, they do it for a variety of reasons, some as a response to stress…But they don’t intend to get quite so badly damaged by it and so if they’re presenting in a damaged state due to drug use…they are suffering with an illness of sorts and therefore because they are incapable of working, due to mental or physical symptoms, fair enough, they are unfit to work.’

(Male, 6 – 10 years as a GP)

Whilst GPs were overwhelmingly unsympathetic to patients who presented with symptoms they perceived to be ‘fake’, one GP did express understanding over why a patient behaved in this way:

‘One of the political concerns here I think is people who are…applying for benefits when in fact they could perfectly well work. And one of the things that I find difficult about this is that often actually the alternatives that are available to them aren’t very realistic, you know, there isn’t employment there anyway, and there can be sort of token encouragement from the Jobcentre to be looking for jobs, and the whole process just becomes completely meaningless and I can understand why people would start to take the piss in that situation.’

(Male, 0 – 5 years as a GP)

‘If the patient is trying to fiddle the system, right, you give factual information. The doctor at the Jobcentre Plus will also read what’s in print and from there they will judge, decide himself.’

(Male, 11 – 20 years as a GP)

5.2.5 Patient’s motivation

Many GPs recognised patient attitudes towards returning to work were difficult to overcome and that evidence of this was an influencing factor, both in terms of investing time in completing the form but also the content. The more motivated patients were to return to work, the more GPs would invest effort in helping them get Incapacity Benefit. This seems paradoxical since most patients who were motivated to return to work would not be seeking Incapacity Benefit. Nevertheless, patients’ interpretation of their illness, and their expectations and beliefs about
returning to work were data GPs felt they needed to process. The association between motivation and GP input worked in two ways. Firstly, whilst Incapacity Benefit is not a short-term solution, GPs believed the prognosis would still be more positive for a motivated than for a less motivated individual. Hence an investment in their work rehabilitation (which might include a period on Incapacity Benefit) was more likely to be successful. Secondly, GPs were more likely to believe that patients who were motivated to work were more needy and more likely to be genuinely ill:

‘I can think of two patients with chronic fatigue but I’m sure one of them has it and the other doesn’t... I believe that both of them are ill in their own way but one of them only has genuine chronic fatigue and I would feel a lot happier about filling that form in for her because her prognosis is probably fairly good: She’s a young person desperate to get back to work. While the other one is somebody who does not want to go back to work, whose condition is not getting any better after two years and it’s hard for me to then fill in an IB113 when a lot of her symptoms and her disabling symptoms, there’s no particular reason for it... there is no organic pathology, this is somebody purely saying ‘I’ve got this, I’ve got this, I’ve got this’ and you can’t prove it or disprove it.’

(Male, 11 – 20 years as a GP)

5.2.6 Patient’s circumstances

Not only were clinical aspects of a patient’s problem important, but the contexts of their illness, in particular their personal circumstances, also influenced GPs’ thinking about their IB113. Although GPs recognised these factors could be influential, they were able to reflect on whether this was always appropriate. Three factors within patients’ personal circumstances that were not directly associated to the clinical presentation were described: social situations, financial need and patient age.

Many GPs were aware that they were influenced by their knowledge of an individual’s social situation. The more sympathetic they were with this, the more effort they invested in the patient’s claim:

‘There is obviously an element of sympathy, if someone is a borderline case, but her husband is poorly or dying or whatever, the doctor knows that, so that colours the judgement, and that may or may not be a good thing. I don’t know. It’s all different arguments.’

(Male, 11 – 20 years as a Practice Manager)

Awareness of a patient’s financial need made some GPs feel uncomfortable about being involved in a process that might deny them the extra money Incapacity Benefit brings. This was particularly difficult when contrasting a patient’s financial situation with the GPs own more affluent position:
I’m in a privileged position in society, I earn a nice income…my kids…have everything that they need…Lots of the people that come and see me, they’ve got squalor, you know, they live on low incomes, they’ve got…poor health outcomes, they’ve had poor education…and really have quite difficult lives and very little goes their way for whatever reason…Who am I to deny them an extra £10 on their benefits if we can wangle it?…They come to me when life is difficult and they want me to help…and I’m quite happy to be that help.’

(Male, 6 – 10 years as a GP)

Some GPs also suggested that it was worth investing in younger patients to return them to work. Under these circumstances the form could sometimes serve as a useful vehicle for this dialogue. For older patients, GPs sometimes felt that it was easier to concede to the patient’s wishes even when the GP felt the patient was fit for some work. GPs justified this view by explaining that it was unfair or unrealistic for patients of older age to retrain for a new, less skilled, or lower-paid occupation.

5.3  GP perceptions about Jobcentre Plus

5.3.1  Effectiveness of benefits system

GPs had contrasting perceptions of the benefits system. Some felt that as taxpayers they had an investment in ensuring it worked, and that it deserved further support, both by their own involvement and government spending. Moreover, they considered the decisions fair and the system effective in achieving its aims. Far more commonly, the opposite view was expressed.

5.3.2  Medical Services Doctors

Not only was the system largely viewed as inadequate by some GPs, but so too were some of the clinicians working within it. Two different views of Medical Services Doctors were held. Firstly, that as individuals they were less experienced and expert compared with general practitioners, and secondly, that the role of the Medical Services Doctor was complex and required different expertise to that of the GP.

Inexpert clinicians

Based on reported experiences of patients, several GPs questioned the expertise of the Medical Services Doctors, both in terms of their ability to make a clinical judgement over fitness to work, but also their skills in examining and interacting with patients. They were described as bureaucratic, unhelpful, rude, with a poor attitude and inadequate communication skills and that they often didn’t examine the patients:

‘People come back and tell me some awful stories; the doctor was 75 years old…and really didn’t look up, was quite rude, didn’t really examine any parts of the body as should have been. I can’t bend forward; he never listened to that.’

(Male, over 30 years as a GP)
A few GPs stated that a patient reported a positive experience with a Medical Services Doctor. One GP recognised that reports of inadequate personnel was not specific to Jobcentre Plus and hence inevitable:

‘It seems to be one doctor can do assessments and all the patients seem to hate him ‘and he never asked me any questions’ and whatever, and then another doctor is absolutely wonderful…But you know that’s the same everywhere isn’t it, we can’t standardise people. You’ll never standardise doctors, not until they’ve got rid of us and replaced us by machines – the Government can but hope!’

(Male, 6 – 10 years as a GP)

**Skilled role**

Some GPs viewed the role of the Medical Services Doctors as complex and requiring a high level of skill and expertise. This view helped some GPs to explain their largely negative experiences with these professionals:

‘I suspect that with a shortage of…GPs and others, it’s hard…to attract thoughtful, socially aware, balanced and highly qualified doctors into that line of work, and I think it’s important if you’re making judgements that are going to determine the future of people’s lives.’

(Male, 0 – 5 years as a GP)

Despite the largely negative views of the quality of the Medical Services Doctors, some GPs recognised that Medical Services Doctors needed skills in one particular area: assessment of functioning. Expertise in assessing a patient’s level of functioning could be achieved by four attributes: time within the consultation to assess disability; knowledge of how to measure disability; knowledge of fitness for work decision-making; independence from any personal relationship with patient. GPs differed in whether they perceived these to be attributes they themselves lacked or chose not to adopt:

‘I imagine most of us could do it [assessment of functioning], it’s just that we don’t do it in our consultations, but given the time…assessing people and all the little tricks you use don’t you. Like observing their engine movements casually and it’s often a lot better than when you’re formally examining them…But they’re not the kind of tricks we would do in the surgery when we’re trying to get people better. So yes, I think they [Medical Services Doctors] are better equipped in that they’ve got the time and their consultation is geared that way.’

(Male, 11 – 20 years as a GP)

Specialist skills that were valued were not only expertise in assessing functioning. One GP believed the job of a Medical Services doctor required specialist expertise in specific conditions and that these should be matched to the condition presented by the patient:
'The quality of examiners used...is not my choice of people. My choice of people would be somebody like myself who has a lot of experience in dealing with musculoskeletal problems. So somebody like myself should be dealing with musculoskeletal problems, somebody with mental health expertise should be dealing with psychiatric problems.'

(Male, over 30 years as a GP)

**Alternative agenda**

A further perception raised by a few GPs was that Medical Services Doctors have an alternative agenda, which could cause them to view a case from a different slant to the GP and hence might influence the clinical judgement over a patient’s fitness to work. This arose from Medical Services Doctors’ responsibility towards the Government, which meant they were not providing a purely independent judgement:

‘One of the issues for me I think is concerned about conflict of interest, where on the one hand, the DWP is notionally a sort of independent adjudicator, on the other hand, actually the politically imperative very clearly, I think even they would agree this, is that they’re not an independent adjudicator. They’re trying to contain the budget...which means that a lot of the investment has been around containing things rather than independence in providing advice. It’s not to say they don’t sometimes provide very good advice and support people who are struggling to claim, but I’m much more comfortable with these questions on [IB113 form] if it was...going to a more independent source than to the DWP.’

(Male, 0 – 5 years as a GP)

### 5.3.3 Trust in Jobcentre Plus

One GP reflected on the need for trust between the GP and Jobcentre Plus. They viewed this relationship as important because they felt GPs were between the patient and Jobcentre Plus, where the Medical Services doctor has the power to grant or withhold money from the patient. Therefore, this GP perceived that Jobcentre Plus needed to trust GPs and the accuracy of the information they provided.

Another reason why trust in Jobcentre Plus was important for some GPs was that many reported paternalistic relationships with their patients and felt concerned about entrusting them to an unknown clinician’s care. This was particularly apparent for patients who were perceived as very vulnerable and for whom the GP worried the experience of a Personal Capability Assessment (PCA) or disclosure of certain details (such as illiteracy), would be distressing. In these situations, some GPs said they would clearly communicate this within the IB113.

Questioning the quality of the efficiency and fairness of the benefit system, and the skill of the doctors working within it, inevitably led some GPs to express a lack of trust in Jobcentre Plus. GPs’ perceived lack of trust in Jobcentre Plus centred on a lack of trust in the system’s confidentiality. Some GPs worried that the Medical Services
doctor might disclose opinions they had expressed on the form. This was an important reason why they chose to communicate in ‘facts’ or left information missing: they felt more confident that they could justify this information if challenged by a patient. The awareness that patients had the right to see the form made them withhold opinions. Another confidentiality concern arose from the fact that GPs were not always aware of who read the forms and whether forms passed through the hands of administrative personnel en route to the medical professional. Some expressed uncertainty over whether patients had consented to the transfer of data between the GP and Jobcentre Plus; this led more than one GP to say they avoided disclosing personal information such as psychiatric problems.

5.4 GP perceptions about their role

Two sets of beliefs about being a GP were influential when completing IB113 forms. Firstly, GPs’ beliefs about their role as GPs and secondly, their view over who was responsible for the decision of whether a patient was fit for work or not. Both GPs and practice personnel identified three contrasting roles for the GP: clinician; advocate; and adjudicator.

5.4.1 GP roles

The clinician managed illness. In this capacity they believed their role in completing IB113s was not one of advocacy but of objectivity. GPs considering this their sole role, felt strongly that providing medical evidence for benefits was inappropriate, as it did not assist clinical management of patients in any way. Moreover, one GP felt that the principal reason for choosing a career in general practice was to help people. Hence if the duty of providing medical evidence to ‘the Government’ was to successfully continue to be a core part of the job, then a fundamental attitudinal change amongst GPs would be required earlier in training. Although this view was not voiced by many GPs, one GP perceived this to be a majority position within the wider GP community:

‘It’s not just me, any doctor in this country. That’s what we’re asking the BMA…we put the question every year: please remove the sick note from us, let us do purely clinical work.’

(Male, 11 – 20 years as a GP)

By far the most commonly endorsed role for the GP was that of patient advocate:

‘Our job is to be sympathetic and our job is to be on the patient’s side and we do have to give any benefit of the doubt to the patient.’

(Male, 6 – 10 years as a GP)

Belief in this role influenced GPs to prioritise patients who were more vulnerable and perceived to be more genuine. In these situations, GPs admitted they would bias forms to secure a successful claim. However this advocacy commitment never extended to patients they believed to have illegitimate claims. Under these situations
they usually provided only ‘factual’ or missing data.

Some participants talked of a public health role, protecting society and the welfare state’s financial investment. These GPs considered their role to be judging which cases were legitimate and offering information to Jobcentre Plus accordingly. This role was never offered as a primary function of being a GP, but adjunctive, and stemmed from being a member of society, an employee of the state and a taxpayer. These GPs felt they had a responsibility to limit the cost of long-term disability by ensuring it was spent only on truly genuine cases:

‘The last thing you want is thousands of people on the sick when they shouldn’t be on sick. Sometimes...I get them in and think well why are they on the sick.’

(Female, 21 – 30 years as a GP)

5.4.2 Balancing different GP roles

Whilst some GPs expressed a preference for one role over another, many recognised that these roles were not mutually exclusive and their task was to balance multiple roles simultaneously. This was in itself a core source of tension. In particular, many GPs perceived that the adjudicator role clashed with advocacy. An emphasis on patient advocacy was difficult to reconcile with accurately assessing incapacity and advising Jobcentre Plus on fitness to work. These GPs were strongly opposed to being contractually obliged to play this part:

‘It bothers me that it disrupts my relationship with my patients to have that adjudicative role as well as the advocative role that I’m more comfortable with.’

(Male, 0 – 5 years as a GP)

‘Sometimes we have a conflict of interest. Trying to help the patient might not be the same thing as trying to make an accurate assessment for their incapacity to work. Quite often it’s actually completely opposite. It puts a major strain on the doctor-patient relationship.’

(Male, 0 – 5 years as a GP)

Taking on the role of adjudicator as an adjunct to the role of clinician was particularly problematic as it threatened the fundamental element of clinical work: the doctor-patient relationship:

‘It’s a dubious role...it’s asking us to make decisions about people and work and we really are about people’s health, albeit influenced by work...I just don’t feel we should be part of that process. It can affect the doctor-patient relationship...I really feel that the process should be outside the GP...it’s not for us to appear in the role of arbiter or even to have a role other than giving the factual information.’

(Male, 21 – 30 years as a GP)
Many GPs reflected on who they believed should have the responsibility for the decision of whether a patient was fit to return to work. From these data, three main perspectives emerge about where the responsibility for this decision should lie: entirely within the GP role, entirely outside the GP role, or shared between the GP and Jobcentre Plus. The minority perspective was that the decision over fitness-to-work clearly lay within the remit of the healthcare service and hence was viewed as GPs’ responsibility:

‘Obviously outside the surgery they have lives to live and bills to pay and if they can’t manage to do their work or whatever then obviously we have got to try…that’s the nature of the health service; part and parcel.’

(Male, 11 – 20 years as a GP)

More commonly, the responsibility of making the decision was an unwelcome duty, but one that many GPs believed they were best placed to take on. This was because they considered their long-term relationship provided greater insight and knowledge about the patient’s condition. One GP remarked that although they considered themselves ideally placed to take responsibility for the decision, they would like to have the option to ‘opt out’ (Male, 11 – 20 years as a GP) if they didn’t know a particular patient so well. Several GPs stated that although they didn’t feel the role was appropriate for themselves, they didn’t feel there are sufficiently appropriately trained occupational health professionals to take the task entirely away from general practice.

Another commonly held view was that whilst the GP was best placed to provide evidence, they did not want the actual responsibility of making the decision about whether the patient was fit to return to work, hence the responsibility for decisions should be shared with an external agency. (According to official guidance from the DWP, this is, in fact, precisely the role that GPs should be playing. However, GPs often, as in this example, did not understand this):

‘The model I have in my mind is similar to the DVLA model…after six months your fitness to drive is assessed by the DVLA. We can provide information, but we do not make the decision. I like that model…that doesn’t then compromise my position with the patient quite so much.’

(Male, 6 – 10 years as a GP)

Reasons given for not wanting the responsibility were that it affected the doctor-patient relationship and could conflict with the GP’s role as advocate or clinician. Moreover their relationship, and the detailed and intimate patient understanding they held, threatened their impartiality. A few GPs felt they were simply not trained to make the necessary assessment for fitness to work decisions. Even if suitably trained, some GPs considered the responsibility undesirable.

Some GPs saw the PCA as a useful mechanism, and valued the opportunity of a second opinion, or simply relief from having to make a decision that might cause conflict. Any blame directed from the patient would then focus on Jobcentre Plus and away from the GP:
‘I think a lot of doctors, they don’t want actually as much autonomy in
decision-making as everybody necessarily thinks. I think sometimes you want
other agencies to actually give you a little bit of support around difficult issues.’
(Male, 6 – 10 years as a GP).

5.5 GPs personal perspectives

5.5.1 Underlying personal beliefs

Underlying personal beliefs that influenced the evidence provided included their
views on work ethics, the relationship between work and health, and their political
views. These ‘worldviews’ arise largely from their cultural and personal experiences.

Some GPs expressed clearly held views of the ethics of work. They recognised these
beliefs had the potential to influence their view of the patient and their illness and
also the completion of the IB113A:

‘It’s difficult, particularly when you hold the philosophy of work hard-play hard
yourself. You can transfer that to your patients, you can’t make that assumption.’
(Male, 6 – 10 years as a GP)

These views contrasted with their perceptions of the patient’s work ethics:

‘You’re battling also with this whole benefit culture and a lot of these patients
come from a culture where parents are on benefit, and you’ll say to them,
‘Why can’t you go back to work?’ and she’ll say, ‘Well I’ve got the children to
look after,’ and I’ll say, ‘Well child care is not sickness.’ But because it’s the
whole family ethos it’s always happened, that the woman in the family has
been on benefit for her nerves, but really what they’re doing is looking after
the kids and just getting on with their lives on sickness benefit, so we have a bit
of a battle.’
(Male, 6 – 10 years as a GP)

Some GPs recognised that their attitudes towards work ethics were developed, not
from clinical knowledge or a scientific evidence-base, but from their personal illness
experiences and family upbringing:

‘Most doctors have a very strong work ethic…most don’t take time off
ourselves, so people shirking are not something that is familiar to us or part of
our direct experience…some people have a large number of days off. That is
not how I was brought up. It is not how my family operate.’
(Female, 0 – 5 years as a GP)

There were some contradictions in GP beliefs about the relationship between work
and health. In the main, GPs considered that work had health benefits for
individuals, both in terms of reducing physical and mental illness.
'I think as a practice we do try to avoid medicalising and encourage people to be in work if possible because I think that’s beneficial on the whole…it can work two ways, maybe you can’t face work, but on the other hand…sitting at home all day isn’t good for them either.’

(Male, 6 – 10 years as a GP)

Moreover, one GP believed that systems that supported unemployment generate ill-health:

‘I really feel that the process should be outside the GP…Ideally I’d like to see benefits taken out of the NHS completely…I think a benefits system just encourages us to improve monies for people who are out of work, it creates illness…tendency for it to encourage people to have an illness where they otherwise might not.’

(Male, 21 – 30 years as a GP)

However some GPs did describe circumstances where it was felt that the health-benefits of not working, at least in the short-term, outweighed those gained from employment:

‘People can be physically able to work, but sometimes people need a bit of time just to get their heads round being drug free…we tend to be relatively lenient while people are actually getting off drugs, because also when they’re off drugs it’s a time for them to start fixing their relationships with the family and whatever else, and everybody needs a little bit of proving that they’re doing all right. Sending out to work too soon, it’s an added stress, which can cause relapse.’

(Male, 6 – 10 years as a GP)

Occasionally GPs voiced political beliefs, which they felt might influence their provision of evidence. This was generally a socialist view, whereby individuals should be supported by the state, and that this served to encourage rather than discourage return to work.

5.5.2 Honesty

It was important to many participants that they were true to their own standards and moral code and that they felt able to be honest when providing evidence. Honesty was deemed important even if it meant trumping other factors that were important, such as the role of the GP. Indeed for one GP, being honest was viewed as a further role of the GP.

If faced with a situation when they felt unable to perform the role of advocacy they preferred, without compromising their moral code, GPs described three different ways of managing this tension. Most commonly they avoided either having to be dishonest or having to confront the patient by providing minimal or factual information. Other GPs felt a more effective strategy was to explain to the patient that their primary need was to be honest:
'I try to be honest with the patients and say if I think that I can’t see why they are being incapacitated I will tell them but I will still, it is still my duty to support them through the process and help them…but of course I will make it clear to them that I have to answer the questions honestly.'

(Male, 0 – 5 years as a GP)

Less commonly however, there were situations when GPs perceived it to be acceptable to be dishonest. These situations were rare, and dishonesty was generally described as biasing information provided to help the patient ‘wangle’ extra benefit, rather than outright lying.

5.5.3 Fairness

Several GPs stressed that it was important to them that the process of the decision over fitness to work was just. There were three views of why fairness was important: human rights, equality and fairness to society.

Firstly, several GPs felt there should be a respect for human rights:

‘It’s not his fault he has fallen ill, he can’t work…we want to keep the dignity of human life…most important, you can’t see a human being degraded.’

(Male, 6 – 10 years as a GP)

This meant that GPs felt they should do their best for patients; a belief that sat comfortably with the role of patient advocate. Under these situations GPs would often try to use the IB113 to achieve what they saw as fairness and would feel more comfortable about offering opinions. However, GPs who held this view of fairness found difficulty in completing forms for patients they did not know well. In these situations they managed the tension by keeping to minimal information.

A second view of fairness put forward was that all individuals should be treated equally and that rules should be the same for all. Some GPs contrasted this view with a perception that the incapacity benefit system was unfair, treating some individuals harshly and others more leniently. Completing IB113 forms fairly, to treat patients equally, usually meant withholding opinions:

‘It’s about having a level playing field. Treat people as you would want to be treated yourself, treat them fairly, treat them fairly because that’s what we ourselves would want. We wouldn’t want someone writing information about us that was based on opinion.’

(Male, 11 – 20 years as a GP)

The final view of justice was that the system should be fair to society since Jobcentre Plus was distributing taxpayers’ money. Hence the ‘right’ decision should be made. Essentially this meant that Incapacity Benefit should go to patients who were in genuine need. For patients where GPs were concerned about legitimacy they would try to reconcile this with their belief in fairness by keeping to factual information and withholding any opinions.
5.6 GP perceptions about interfaces

GPs viewed themselves as a ‘buffer’ between the patient and Jobcentre Plus. Some felt expected to interpret and filter information for each party which was perceived as particularly problematic, as it resulted from interaction. Such factors were described in terms of discomfort, tension and, at times, conflict. Two interfaces were identified: Firstly between the GP and the patient and secondly between the GP and Jobcentre Plus.

5.6.1 GP-patient relationship

The doctor-patient relationship was viewed as central to the day-to-day work of the GP. The tension around completing the IB113 primarily centred on protecting this fundamental relationship, and other considerations were largely viewed as secondary. The relationship was viewed as important for a number of reasons.

All GPs believed it was important to protect their relationship with patients and that providing medical evidence to an outside agency had the potential to jeopardise this. GPs felt that the relationship was delicate and should be based on trust and openness to provide effective clinical care:

‘There are more important battles, because we can’t be seen always as adversaries because otherwise you don’t develop a therapeutic relationship.’

(Male, 6 – 10 years as a GP)

Many GPs were concerned that providing medical evidence had the potential to cause conflict with patients. These conflicts were particularly likely to occur when patients were refused Incapacity Benefit. Then they might return to their GP for support at an appeal. Whilst some GPs recognised that conflict was an inevitable occurrence within some patient relationships, GPs were keen to avoid it for several reasons. Firstly, because it could damage this relationship, viewed as a sacred cornerstone of clinical management. Secondly, because it was an unpleasant interaction for themselves. GPs didn’t want to be the person who deprived the patient from benefits and viewed this as an unpopular task. GPs admitted that sometimes it was easier to ‘give in’.

Two clear strategies emerged that GPs employed to protect the relationship from damage: avoid challenging the patient, and devolving responsibility for the fitness-to-work decision to the DWP:

‘Keep it extremely factual...he can’t then argue with that, and we don’t then lose the patient’s respect and the relationship.’

(Female, 11 – 20 years as a GP)

GPs also reported the quality of their patient relationship could influence IB113 completion. Several GPs recognised that they felt less sympathetic about patients for whom they felt hostile towards or irritated by, and would be more willing to offer an opinion on the form indicating they were fit to work:
‘Subconsciously…depending on the relationship you have with the patient. If it’s a patient you can’t stand, and you’re seeing them every two weeks and you think they ought to be back at work [I] maybe adversely influence [the evidence] and even say ‘I think this patient should be back at work’.

(Male, over 30 years as a GP)

Conversely, a positive patient relationship could make it difficult to contradict patients and give evidence that would mean they were unable to get Incapacity Benefit. In these situations, GPs welcomed the opportunity to devolve responsibility for the decision to an independent doctor:

‘There are some patients that I would find difficult to sign off, possibly because of a long-term friendship, and I think it’s easier for the…the doctors at the Ministry to say this patient is fit for work, and I’m quite willing to go along with that.’

(Male, over 30 years as a GP)

5.6.2 Interface between the GP and DWP

The IB113 is a form of communication between the GP and Jobcentre Plus. A number of factors within this relationship influenced the way GPs communicate with Jobcentre Plus:

‘I don’t understand where the DWP come from, and they don’t understand where we come from.’

(Male, 21 – 30 years as a GP)

Feeling unvalued by Jobcentre Plus

Overwhelmingly GPs felt unvalued by Jobcentre Plus. GPs came to these conclusions via two routes. Firstly, that the work they did was not given a monetary value and secondly, that the evidence they gave within the forms was not used in the decision over incapacity.

Some GPs felt that the information they provided to Jobcentre Plus was dismissed. Some GPs even wondered if the information was read. This view encouraged the idea that Jobcentre Plus did not value the GP’s expertise. Evidence to support this view was largely arrived at when an outcome of a claim contradicted the GPs opinion. Surprisingly this was true even when the GP acknowledged they had not invested greatly in the form and had not provided a judgement. Some GPs felt this view justified their lack of investment in the form:

‘Asked to give a judgement as to whether their medical condition permits them to travel in a taxi, and that’s fine, they’ll take my word for that, but they won’t take my word for whether they’re fit to work or not.’

(Male, 11 – 20 years as a GP)
Lack of feedback

GP's often commented that they did not receive personal feedback from Jobcentre Plus about case outcome, or on the relevance or accuracy of their provision of evidence. This was evidently demotivating for GPs and is discussed further in 7.4.4:

“You don’t know how much notice people take of what you write. You don’t get any feedback. Nobody ever tells you whether the information was correct, incorrect, not enough, too little. There’s no qualification of what you write.’

(Male, 6 – 10 years as a GP)

Lack of control over outcome

GP’s did not view themselves as being able to control the provision of evidence for benefiting patients. Nor did they perceive themselves to be in control over the outcome of the evidence provided. This contrasts with their view over their role in providing sickness certificates. It can be conjectured that sickness certificates are seen as a direct link between the GP and claims for benefit for their patients, because the GP is both the source of evidence and the decision-maker about certification. In contrast, in the case of the IB113, doctors feel one step removed from the decision-making process and, as such, unable to influence the fit-to-work decision made by Jobcentre Plus. Some GP’s felt helpless because of this lack of control and so were demotivated to invest time in providing evidence.
6 Providing information and guidance to practices

This chapter focuses on the Department for Work and Pensions (DWP) provision of information to GPs.

One of the main aims of the Engaging Physicians Benefiting Patients project, which this study evaluates, was to pilot an approach to improved provision of information from the DWP to GPs. This chapter describes the ways the DWP currently provide information for GPs, and their views on that. It then goes on to discuss the GP (and Practice Manager) responses to the Engaging Physicians Benefiting Patients pilot communication input.

Before moving to the reactions to the pilot inputs, the chapter begins with a description of the information needs which led to development of the Engaging Physicians Benefiting Patients project. It describes the levels of understanding and awareness which GPs and Practice Managers had about the IB113 and the benefits system generally. The chapter then goes on to discuss the reactions of GPs and Practice Managers to the range of methods through which the DWP communicate with general practice. This is followed by the findings on the reported impact of the Engaging Physicians Benefiting Patients pilot communications input.

6.1 Understanding of the IB113

GPs were, in general, familiar with the IB113 form, though not necessarily by name. Practice Managers were less familiar. However, there was some confusion and conflation between the IB113 and other government forms, notably the Disability Living Allowance (DLA) form.

Although, on the whole, GPs were aware that filling in the IB113 was part of their terms of service and that there was no additional remuneration attached, there were unusual cases of GPs and Practice Managers who erroneously believed that there was a fee for filling in the form:
'I wasn’t aware it was a contractual obligation. But I mean we get so many forms, this is the problem.'

(Male, 11 – 20 years as a GP)

'I would have expected us to get a fee for them. I’d be very surprised if we don’t. Are you sure?...Although I am surprised that we don’t… Yeh, I really am surprised because most requests for things from national government departments, we charge for.'

(Female, 21 – 30 years as a Practice Manager)

Levels of understanding of the purpose of the IB113 varied. The IB113 forms were often viewed as a task to be completed and sent off sometimes with little sense of their impact or of the processes and systems that they are a part of.

However, it was common for GPs and Practice Managers to have (to differing degrees) a general understanding that the IB113 was providing continuing medical evidence for patients who were claiming sickness benefit, and were undergoing a medical examination that would determine if they would continue to claim Incapacity Benefit.

Despite the instructions on the front sheet of the IB113 which informs respondents that ‘the medical officer requires further factual information’ and directs them ‘we would be obliged if you would answer the medical officer’s questions overleaf’, and the IB113A which states ‘Your reply to the Medical Officer’, there was high degree of uncertainty about who read the forms at the DWP and who would make the decision about which patients would be called in for a medical examination.

Some GPs and Practice Managers believed that there was some form of filter in operation at the DWP. For example, some thought that administrative staff (at the DWP) would initially assess the forms, linking the information supplied by GPs in conjunction with some form of DWP criteria, which would then be used to make a decision about which patients would then be medically assessed by the Medical Services doctor:

‘I’ve no idea. I would imagine they would log it, some administrator would see if it needs some minimum criteria and then it would just go to a medical officer for a yes or no. That’s just my imagines, I have no idea what they do there. I do know that sometimes they send them for a medical.’

(Female, 11 – 20 years as a Practice Manager)
6.2 DWP guidance about the IB113

In an attempt to respond to these gaps in knowledge, the DWP provides information and guidance for primary care teams in a variety of media. These include a website (http://www.dwp.gov.uk/medical), desk aids, an IB204\(^4\), DVDs, and information letters. However, there was limited awareness amongst GPs and Practice Managers about the existence of guidance and information provided by the DWP and about its contents.

Some GPs had explored the DWP website. This had tended to be for information gathering, such as finding out how long a patient should be certified for different complaints:

‘I have been on the website…brownie points there! It was quite interesting…Very interesting, yes. One of the things I was looking up was how long you should be off after various illnesses, especially surgery. All patients, all these patients getting lots more time than the DWP thinks. That did alter my [practice]…two weeks after a endoscopic surgery, it’s as little as that…I was giving them six weeks, eight weeks if you are a brick layer, two weeks.’

(Male, 6 to 10 years as a GP)

More commonly, GPs were unaware of the website and unlikely to use it and cited lack of time and/or inclination.

There was even less awareness and use of the other types of communications from the DWP including the DVD, the desk aid, the IB204 and the contact centres\(^5\).

**DWP Communication and Guidance**

**Website** – Some awareness and use

**IB204** – Limited interest and use

**Desk aids** – Limited interest and use

**DVD** – No use

**Contact Centres** – No use

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\(^4\) The IB204 is a booklet for certifying medical practitioners, and is the written official guidance for GPs on their contractual obligations to complete the forms, and guidance on how the forms should be used. A hard copy is mailed to GPs. It is also available on the website (www.dwp.gov.uk/medical).

\(^5\) Contact centres are telephone advice centres run by Medical Services Doctors to give advice to GPs on certificates and forms, including the IB113.
Reasons given for the non-awareness or use of communications from the DWP were the sheer volume of information coming into practices, and the low priority placed on this work, which has been described in proceeding chapters. Although not the norm, there were cases of ‘technophobes’ who did not use computer based information sources. Practice Managers generally did not see communications from the DWP, as they would usually be addressed to, or circulated to, GPs.

6.3 Desire for further knowledge

Some GPs felt that more information about the IB113, other forms and the benefit system generally would be useful. However, it was more common for GPs and Practice Managers to report that they did not want to gain any further knowledge, as the completion of the form was a task to be completed, that did not require a thorough understanding of the process of Incapacity Benefit. In addition, the relative importance of learning about the Incapacity Benefit system was offset against other more pressing educational needs. There was a suggestion that an electronic learning programme for completion of the IB113 would be useful for GPs.

GPs tended to be of the view that any information from the DWP about Incapacity Benefit should be succinct, preferably contained on one A4 page. The most useful kind of information would be brief descriptions of the purpose of each certificate, and how they link together within the ‘sickness/incapacity’ process.

Some GPs made suggestions of types of information they would welcome. However, not infrequently this was information which was already available as exemplified in the quote below:

‘Here is me suggesting that we should have something like that [a website] and actually it already exists…there are people out there who really don’t know about these things, and I certainly don’t.’

(Male, 11 – 20 years as a GP)

Practice Managers

There were some Practice Managers who saw their role as purely functional and task oriented and did not see a need to acquire any greater knowledge or understanding of the IB113. However, there were also Practice Managers, who reported that although it would not alter the way they dealt with the IB113s, it would nonetheless be personally interesting to understand what happens to these forms which they process every day:
‘I mean it might be useful for receptionists to have a better understanding of what they’re actually dealing with, when they’re just expected to put it in an envelope. Sometimes I think it helps the girls, when they know the importance of something or why they have to do it and what’s going to happen to it when it gets there, and the importance to the patient. Because patients are our business and we want to provide a good service for the patients, and if this is part of it, then we really want to encourage the girls to find out more. So if that was something that could be brought to us or delivered you know to reception staff or whatever as training.’

(Female, 11 – 20 years as a Practice Manager)

However, although some GPs felt that they would benefit from some DWP training on completing the forms others expressed lack of motivation to learn about filling in the forms.

GPs had had little or no formal training on how to fill in the forms. Most had learnt from colleagues during the course of their working life:

‘To be honest with you, it isn’t the kind of thing you’re actively going to do, you’re not going to go to a meeting to learn how to fill these forms in because you hate them so much you just wish they would go away, so to be honest with you, you get away with the bare minimum.’

(Male, 6 – 10 years as a GP)

In contrast to previous GP learning, current GP education involves trainees going into benefits offices to learn about benefit processes. This was considered advantageous. There was a sense that it could have an impact on the type and quality of information provided.

6.4 The Engaging Physicians Benefiting Patients pilot communications input

The Engaging Physicians Benefiting Patients pilot project aimed to improve the medical gathering process for Incapacity Benefit through a communications strategy and changing the administration of the end to end process from Jobcentre Plus to Medical Services.

The communications input sought to address the misunderstandings and gaps in knowledge described earlier in this chapter. It was directed at engaging and educating GPs about the importance of the medical evidence they provide, specifically in the IB113. It aimed to improve GPs awareness of their role in the provision of information to aid decision making for Incapacity Benefit, with a secondary objective of improving GPs’ working relationships with Jobcentre Plus and Medical Services.
There were two components of the pilot input – a mailing and a series of face-to-face presentations to GPs. These are described in the two sections which follow, together with the findings on the GPs views on the pilot inputs their accounts of the reported impact of the pilot.

### 6.4.1 Pilot mailing

In July 2005, two months before the fieldwork for this study, information and guidance for GPs about the IB113 was distributed to all GPs in the pilot area, in the form of a letter. The mailing was sent on behalf of the DWP by Atos Origin, the company who currently holds the DWP contract for medical services. The letter was one and a half pages long and gave GPs information about the role and qualifications of Medical Services Doctors; that the IB113 is read by a doctor; the function that the IB113 plays in a patient’s claim and the potential impact of the IB113. It offers further advice and directs the reader to a local Medical Advisor and to the DWP website. It also explains that presentations are being given and invites readers to make contact to register. (A copy of the letter which was mailed can be found in Appendix E).

The mailings were distributed by two means. Some were personalised and mailed directly to the GPs by Atos Origin. Others were distributed as part of Primary Care Trust mailing to practices and were not personalised.

A mailing was also sent to some Practice Managers. This was a pack (12 pages) of the information provided at the presentations.

**Receipt and recollection of the pilot mailing**

It was common for GPs to report that they had never seen the pilot mailing. Those who thought they had received it, typically could remember little or nothing of its’ contents.

Speculation on the reasons for this lack of receipt and recollection, include four possibilities:

- That the mailings never reached the GPs’ practices.
- That the mailings reached the practices, but not the GPs.
- That the mailings reached the GPs, but were not read.
- That the mailings were read, but not recalled.

These possible explanations are discussed below.

Dissemination systems for the mailings could have been inadequate, resulting in the mailings failing to reach some of the practices. It is noticeable that GPs in one of the study areas, in particular, reported non-receipt of the mailing. There could also be other explanations, including inaccuracies in the database that generated the mailing, which it is beyond the scope of this study to explore.
The mailings may have reached the GPs’ practice, but may not have been passed to the GP. Speculating on the explanations for this, two possible reasons are proposed. The first is administrative inefficiency. The second, which is possibly the converse of the first – is that the practice may have administrative systems that are designed precisely to prevent mailings reaching the GPs.

In general, practice systems were such that if the mailing were personalised, it would go directly to the GP (in some cases it would be electronically scanned by the administrative team before sending it electronically to the GP). If the mailing was not personalised, a range of different practice systems for dealing with general mailings were in place. These included systems that should, or could, enable the mailing to be seen by the GP, such as the administrative team circulating the mailing to all GPs (in paper format in their trays, or as an electronic circular) or putting the mailing in a communal place where GPs could read them (such as the coffee room). However, some practices had systems designed to limit mailings reaching the GPs. These tended to be based on the administrative team filtering the mail, and making decisions about whether to destroy a mailing or pass it on to the relevant administrative team member, rather than to the GP.

In general, it was felt that the mailing had a better chance of reaching the GP if it was personalised. However, the alternate view was also expressed, which was that it was important that mailings come via the Practice Manager so that they can ensure they arrive safely with the GP and are then given attention by the GP (in other words, so that the administrative team can manage the GP’s action in response to the mailing):

‘People say to me ‘I’ve organised a meeting or something or other I’ve no responses – well who have you sent it to?’ ‘Well to the doctors. It won’t have got to them to start with, and if it has it’ll have gone straight in the bin. If you’d have sent it to me with a bit more info I could put it in the tray with a note on from me saying oh this does sound good and worth going to or you really must read this and be aware of this,’ otherwise things get binned because they get so much junk.’

(Female, 6 – 10 years as a Practice Manager)

The third possible reason why the mailing may not have been remembered by the GPs is the GPs’ actions on receipt of the mailing. Some explained that they do not look at all the mailings they receive, while others said they would have had a quick glance at the mailing and then shredded or binned it. Others put them straight in their ‘things to read’ pile. There were also GPs who had read the mailing.

Whether or not GPs recalled the pilot mailing seemed not to be straightforwardly linked solely to GP interest or commitment. Those who did not remember having received the mailing included GPs who were interested and engaged in the process, as well as those who were disinterested.

Some practice managers also had not seen the GP mailing. The Practice Managers who were circulated the Practice Manager mailing had also not seen that mailing.
Views on the pilot mailing

As it was common for GPs not to have seen or be able to remember the pilot mailing, in the interviews they were shown a copy of the mailing and their immediate views sought on it. Those who did recall the original mailing reported recalling little except that there was a website they could refer to.

In general, GPs felt that the mailing would have little impact on their knowledge, attitudes and behaviour towards filling in the IB113. This is discussed below.

It was unusual to find a GP who reported learning something totally new from the pilot mailing. For those who did, it tended to be the fact that the IB113s are read by a medical doctor, or, as mentioned above, that there is a website that can be referred to. There were GPs however, who reported that the mailing confirmed or clarified their previous assumptions; for example, that some patients can be exempt from the Personal Capability Assessment (PCA) medical examination. There were also GPs who reported that they already knew the information contained in the mailing.

GPs reported no change in behaviour as a result of the mailing. This is largely explained by the fact that they had not received or read the mailing. However, some felt that a change in behaviour towards filling out the IB113 would be impossible because the structural tensions and limitations, such as not having the information that is required, as described in Chapter 4, still remained.

Format of the mailing

Views on possible areas for improvement in the format of the mailing included reducing its length:

‘Whether or not we act on [the mailings] is difficult, because to be fair, a lot of these things are written in such a verbose way. When I want a letter and I get a letter from a consultant I want it sharp, I want it to the point, I want to be able to scan it. If I have a pile of letters I have to be able to get that information just like that. If I get a booklet that is 20 or 30 pages long. I am not going to read it I just couldn’t physically have the time to do it. So if there is maybe a summary chart or an easy flowing chart that’s great, that’s fine, but don’t give me piles of paper because I just haven’t got the time to read it.’

(Male, 11 – 20 years as a GP)

and it’s appearance, which was described by one Practice Manager as lacking in visual appeal:

‘I think probably the way the information is presented it looks like it’s just an update, you know, nothing’s changed and it’s not that important, so it never looks like it should be read, it’s always quite plain and boring.’

(Female, 6 – 10 years as a Practice Manager)

The mailing was described by one GP as a ‘me too letter’ – meaning that it did not stand out from the many other mailings arriving in the practice which seek attention.
‘That was like a me-too letter that we see a lot of, it wouldn’t sort of stand out as being particularly informative, the sort of letters that might come inside a glossy magazine that’s wrapped in polythene that you open up and things drop out that you don’t really read [laughs].’

(Male, 6 – 10 years as a GP)

The respondents who held these more negative views about the format of the mailing also tended to be those who were less engaged in the process generally.

Some felt that the fact that the mailing had arrived in paper, rather than electronic, format was an important disadvantage. For practices that were paperless or ‘paper light’, systems were not always set up to support paper mailings. Where communications were expected electronically, descriptions were given of how oversights could easily occur where they arrived on paper. However, some practices did have systems to scan in paper mail and circulate it electronically. On the other hand, there were also GPs who were not IT literate or preferred paper communications.

Two aspects of the mailing were particularly welcomed by GPs; the clearly visible contact telephone number and a named person who could be contacted.

The pilot mailing-letter was printed on headed paper with the Atos Origin logo. This raised considerable comment from GPs and Practice Managers, and was often the first thing they noticed and sometimes the only thing that struck them as new. While some merely felt interested that the contract appeared to have moved since they were last aware of it, others expressed some annoyance:

‘I think the main thing is [pause] yes, honestly I think the private firm there, this has been privatised hasn’t it? …I disagree with the whole idea they have been private placed and having that private firm on there it makes me feel they can do the work, they can do the assessment that is what they are getting paid for, which may not be the right attitude but I’m afraid…that’s my initial reaction.’

(Male, 6 – 10 years as a GP)

6.4.2 Pilot presentation

The second component of the communications strategy of the Engaging Physicians Benefiting Patients pilot was a number of face-to-face presentations which were offered to GPs. They were attended by an average of about 10 – 12 GPs and were held during the summer of 2004, between one and four months before the interviews were conducted. Three presentations had taken place at the time our data gathering interviews took place, in one part of the pilot area only. All of the presentations had taken place at local GP postgraduate centres. They were commonly run as part of the routine local area ‘time out’ training afternoons. However, one presentation, the participants of which formed part of our sample, was added to the programme of a routine quarterly meeting for a particular group of GPs. At the time of our fieldwork, there were some plans in place to give at least one presentation at an individual practice.
The presentations were designed and delivered (with input from the Engaging Physicians Benefiting Patients pilot project board) by Atos Origin. The content of the presentation included an explanation of the process used for the IB113, a quiz, case scenarios and time at the end for questions from the GPs.

The presentation material, which was also distributed to some Practice Managers in the pilot area, is available on the DWP website (http://www.dwp.gov.uk/medical).

**Rationale for attending**

GPs chose to attend the presentations for a number of different reasons. These could be categorised into three main areas.

The first reason could be described as ‘an awareness of a knowledge deficit’. Some GPs who attended the presentations did so because they were conscious of gaps in their knowledge of this subject and felt they should seize the opportunity to try to address this. This should not be confused with having an *actual* knowledge deficit – they may know more about the subject than many other GPs, and indeed one of them had previously been a Medical Services Doctor, but they were motivated by the fact that they were aware that they had gaps in their knowledge.

The second reason that led GPs to attend the presentations could be described as ‘happenstance’. This tended to be that they had come to the Primary Care Trust training afternoon which offered a choice of two or three presentations to attend, and chose the presentation on the IB113 because, as described by one GP, ‘other options looked less interesting’ (Female, 11 – 20 years as a GP).

The third group was GPs who had not chosen to attend the presentation, but found it incorporated in a quarterly meeting they attended. These GPs talked about their attendance at the presentation with a slight hint of resentment that the presentation had been imposed upon them.

**Format of the presentation**

There was general approval of the format of the presentation sessions.

The examples and role-plays that were used in the presentations, were particularly valued by GPs, in all three of the presentations. They were found to be affirming as well as educative. Some appreciated observing differences in their fellow GPs’ responses to the role-play exercise, and to witness both shared values and alternative approaches.

Views were divided about the ideal duration of the presentations. Some felt they were too short, others too long, and in fact the three presentations were not of exactly the same length. However, the concern about the presentation being too long was raised in relation to the presentation which was tagged on to a quarterly meeting. These were the GPs who did not choose to attend the presentation, so the preference for a shorter session could possibly be related to a lack of strong
motivation to attend the presentation in the first place, as described above. One attendee suggested that the ideal duration might be five minutes, accompanied by an explanatory leaflet.

**New knowledge and understanding gained from the presentation**

GPs who attended the presentations reported four areas where they gained new knowledge and understanding which they attributed to the presentation:

- Information on the IB113 process – Some GPs found it useful to be given the information on the process that the IB113 goes through on its route to a decision. For example, clarification of how decisions were made about whether or not to examine a patient was found to be valuable.

- Information on the DWP requirements from an IB113 – For other GPs, the benefit of the presentation was described in terms of understanding what it is that the DWP want in an IB113.

- Good quality Med 4s and IB113s could, in some circumstances, prevent more IB113s – The presentation helped GPs to appreciate that by filling in good quality Med 4s and IB113s, they could find that they received fewer IB113s to complete.

- That a medical doctor reads the IB113s – This was the single piece of information that was recalled most and valued most by GPs attending the presentations. It tended to be the GPs who had had less initial motivation to attend the presentations (i.e. the ‘happenstance’ and clinical governance groups) for whom this was new information. It had quite an impact on GPs’ thinking about their approach to the IB113, which is discussed below.

**Changes in behaviour attributed to the presentations**

Some, although not all, of the GPs reported some changes in the way they completed the IB113s as a result of attending the presentation. Three main changes are identified:

- More substantial detail – Some GPs described how, since attending the presentation, they tended to fill more detail on the form, and that their responses on the IB113 are no longer as ‘one worded’ (Male, 11 – 20 years as a GP). One GP, who had been a Medical Services Doctor in the past, went as far as to describe how they now put in as much information as possible, on the basis that Jobcentre Plus can discard what they don’t want, which they cannot do if the information is not there.

- Following the suggestions given in the presentation examples – The examples used in the presentation were found useful by some, and had been used as a guide in providing simple responses on the IB113.
• Use of medical terminology – The fact that the IB113 was read by a medical doctor was a revelation for some, and influenced practice in a number of ways. For example, this freed the GPs to use medical language and terminology in the IB113, without having the additional burden of ‘translating’ it, on the mistaken assumption that it would be read by a non-clinician.

Changes in attitude attributed to the presentations
As well as changes in behaviour, some GPs also reported attitudinal changes, which they related to having attended the presentation. These tended to be the GPs who had shown less interest in attending the presentation at the outset (the ‘happenstance’ and clinical governance groups). Conversely, GPs who had initially been more motivated to attend the presentations, while reporting changes in behaviour, described how they did not change attitude, having always had a relatively positive attitude towards the IB113.

Two main types of changed attitude were identified. A strong influence on both attitudes and behaviour was the new information mentioned above; that the IB113s were read by a medical doctor.

The fact that the IB113 is read by a medical doctor had a very significant impact on GPs views on whether it was worthwhile completing the form well. They described a greater disposition to complete the IB113 to a higher standard, to feel more confident about it and to see it as ‘less of a chore’ (Female, 11 – 20 years as a GP). This was linked to a sense of security that judgements made on the form were not going to be taken by a clerk on an arbitrary basis, as some GPs had previously feared:

‘Yes, you can use vocabulary that you both understand then, you’re not feeling as though you’re having to translate, and even as far as abbreviations, there’s lots of things I can think ok, well now I can do that, and it’s perhaps less of a chore.’

(Female, 11 – 20 years as a GP)

Some GPs went further and were relieved to be reassured, not only that a doctor reads their IB113s, but also that anybody at all reads them. The lack of feedback had led some GPs to wonder if the forms ever reached their destination, or were ever consulted as part of the decision-making process. Related to this was the value, as described by some, of making a personal contact with the DWP or the Medical Services Doctors. The effect, for some GPs, of this reassurance was to feel more positive about completing the form:

‘No. Well perhaps to be a bit more positive, maybe a bit more positive about doing it. There is somebody at the end of the post-box who actually does read these things, that’s quite nice to know, because nobody ever before has ever said that. As far as I know they [IB113s] could all have been sitting in a box somewhere for the last 20 years and nobody looks at them, I don’t know.’

(Female, 21 – 30 years as a GP)
Feeding back

Some practices had a system for feeding back information from meetings to practice staff who had not attended. This was usually done through practice meetings. This did seem to have an impact, with some Practice Managers, who had not attended the presentations, recalling information fed back from the presentation; particularly that it was a medical doctor who read the IB113s.

6.4.3 Creating change

The two communications pilot inputs sought to create a change in GPs understanding and views of the medical evidence gathering process. Change in behaviour is notoriously hard to facilitate. Where change does occur it is often extremely difficult to attribute the change to any particular influence or input. This section discusses factors that study respondents believed did create a change in their behaviour.

The mailing resulted in limited, if any, reported change. Those who attended the presentation however, did report some actual, or intended, change in the way they fill in the IB113, as well as new knowledge gained.

Respondents also described two other types of influences that they believed had effected a change in their behaviour. These were direct contact and the passage of time through their career.

Direct contact

As discussed above, the face-to-face contact of the presentation appeared to be more successful in influencing change than the mailing. This is reinforced by the experience of two practices that, long before the pilot presentations, had had the experience of inviting a member of staff from the local Jobcentre Plus offices to come and talk to their practices about the completion of medical evidence for Incapacity Benefit. In both cases this was described as having been a very useful exercise and a turning point for those practices in the way the documentation was completed.

In discussing why their behaviour towards the IB113 may have changed, GPs also referred to the influence of colleagues. This was usually either colleagues who were also Medical Services Doctors, or colleagues who were trainees and had, for example, made a visit to the local Jobcentre Plus offices as part of their training.

The passage of time through their career

It is well documented in the literature that GP age is an influencing factor in sickness certification practice. In this study, GPs, most of whom were entering the middle stages of their careers, described how they now completed the IB113s differently from the way they had done so earlier in their careers. They attributed this to greater experience.
The pattern was not neat. Some GPs described how the shift had been towards completing the IB113s more quickly, and one described how ‘When I first started I used to spend hours and hours and hours filling in the forms, like most new GPs do I suspect.’ (Male, 11–20 years a GP). Or how they were now more ‘wised up’ on the art of filling in the form to have the required effect.

Other GPs, however, reported a change over time towards being more diligent and serious in the way they complete the forms.
This chapter presents a range of suggestions made by a number of GPs and Practice Managers with regard to the IB113 and their role in relation to it. The suggestions are presented as respondents’ ideas about how to improve the IB113 and the process of completing it, and not reviewed here in terms of their policy feasibility.

The suggestions are organised into four main areas: suggestions about the IB113 form itself; suggestions for communicating covert messages to the DWP; suggestions about systems which could support the effective completion of the IB113; and suggestions relating to the provision of information, guidance and feedback.

It is perhaps not surprising that those GPs who were more interested and engaged in the process of the IB113 were the ones who tended to propose possible improvements. There were also GPs who remained disinterested in, or opposed to, their part in the IB113. The suggestions from these GPs tended to focus on removing the responsibility for the IB113 from GPs, or on limiting the impact of the role.

As has been noted earlier in the report, Practice Managers and other administrative staff interviewed differed considerably with regard to the extent of their experience of, and involvement with, the IB113. This seemed to be related to the extent to which they saw the responsibility of the IB113, and the systems to support it, as a part of their role, rather than entirely the responsibility of the GPs. It can be assumed that this in turn may be a result of intra-practice roles, dynamics and relationships.

7.1 Suggestions for the IB113 form

Underpinned by the current way of working in many practices, there were widespread calls from GPs, and also some Practice Managers, to produce the IB113 in an electronic format. The operating practices of many surgeries were often either fully paperless or ‘paper light’. In these practices, systems were designed to operate electronically. For example, some practices scan in completed IB113s in order to have an electronic copy stored on the patient’s electronic medical record. In addition, most of GPs’ written work (such as patient records or referral letters) was carried out electronically.
Two related, but distinct, suggestions in relation to computer technology were made.

7.1.1 Electronic forms

There was a call for the IB113 and IB113A forms to be produced in electronic format. Proposals were made for either a form that could be submitted electronically or merely in an electronic format which could be completed on the computer and e-mailed back to the DWP.

Although this was a widely held view, it was not unanimous. There were GPs who described themselves as ‘technophobes’ and practice administrative staff who did not have access to e-mail. Respondents expressed two particular concerns about the idea of an electronic IB113. Firstly, a Practice Manager pointed out that an electronic IB113 e-mailed directly to the GPs would mean that the administrative team would not be able to have any role in checking or monitoring the completion of the forms. Secondly, one GP was concerned about the practicalities of an electronic IB113, and in particular of needing to jump between the electronic IB113 and the patient electronic record – with only one screen:

‘No it wouldn’t be …I don’t think that would help really because we need to access the computer screen to get the information that we’re trying to write about so if we had to then do an e-mail about it, flip between the two, especially on two screens, I think it would be easier to write it.’

(Male, 11 – 20 years as a GP)

7.1.2 Automated forms

Some GPs also proposed the idea of an automated, or semi-automated, IB113, which would transfer the READ codes in the electronic patient record to the IB113. This idea was based on a piece of software that is used to provide semi-automatically generated insurance forms:

‘Yeah, what they can do is now if we have an insurance form we can have some software whereby you can just print out what comes on a standard insurance form, it would just all come out on the format…to make it much easier…they’ve got these standard questions and if they left a block at the bottom for them to put the last little piece in I think the turnover would be quicker. The computer would put in all relevant…like bits and pieces like that, that they might need and then there’s a block at the bottom to write any comments that they wish to put, additional information which would be needed on this kind of thing.’

(Female, 21 – 30 years as a Practice Manager)

Some GPs currently leave certain sections of the IB113 blank and attach the relevant information (for example a medication list or a letter from a hospital consultant) separately. An automated or semi-automated form would, at best, collect this information from the database automatically, and at least allow the GPs to attach the information electronically.
7.1.3 The layout and wording on the form

There were a number of suggestions about the layout of the IB113 form. The general thrust was towards a shorter form with smaller boxes. Tick boxes in particular were preferred. The IB113A form, which incorporated these suggestions, was popular, and was seen as a great improvement on the IB113.

Some GPs recommended that the IB113 be sent to GPs with some information, such as the patient’s condition, already filled in. This was to help with the exercise of trying to identify the particular condition for which the patient was applying for Incapacity Benefit. Trying to ascertain this information from the patient’s medical records was often a time-consuming or frustrating exercise.

Some GPs felt that completing the IB113 was a complex and, at times, frustrating process (see Chapters 4 and 5). Some responded to this by leaving the boxes blank, or contributing minimal information. Others, who wanted to fill in the form as well as possible, suggested that it would help if the DWP could be more explicit and directive on the form, with regard to exactly what was required, and what information would be useful in each of the boxes:

‘The left hand side of the form is very straightforward. It’s the right hand side, what sort of things are useful and not useful, would be sensible.’

(Male, 6 – 10 years as a GP)

7.2 Suggestions for covert messages to the DWP

Chapter 4 described the way some GPs used ‘coded messages’ to the DWP in the IB113. They did this to convey a message to the DWP about a patient who they felt was fit for work. The GPs would not want to write this on the form, as they were aware that the patient could see it, with consequent damage to the GP-patient relationship. This led some GPs to reflect on the need for an agreed code, or an agreed way of deciphering the codes.

Other GPs expressed disappointment that the RM7 form was no longer in use, as this had provided them with a means, similar to the use of ‘codes’, to alert the DWP of cases that they felt were not genuine:

‘In days gone by we used to use the RM7 and they used to respond fairly quickly and get them seen to, but they haven’t used the RM7 very much, but on the occasions I have done, the response has been extremely slow.’

(Male, over 30 years as a GP)
7.3 Suggestions for systems to support the completion of the IB113

The extent to which Practice Managers were prepared to engage with the business of perfecting their systems to ensure the efficient completion of the IB113 depended upon a number of factors (as described in Chapter 2). These included the degree to which the practice was run on an ‘efficiency model’ and whether or not the Practice Managers’ own job satisfaction and professional pride were produced through efficient and effective systems in the practice.

Some Practice Managers, however, proposed that they could take their role further and would ‘willingly’ (Female, 21 – 30 years as a Practice Manager) play a more active part in ensuring the successful completion of each IB113 that came into the practice.

It is, of course, possible that GPs would not be keen for Practice Managers to spend their time in this way.

Suggestions from Practice Managers about ways in which the administration team could facilitate the completion of the IB113 tended to focus on monitoring and ‘chasing’ systems to follow up outstanding forms. In the light of this, one Practice Manager thought that it would be very helpful if the DWP could send reminders for overdue IB113s to help the administration team in following-up these particular forms:

‘I would appreciate it if they did give you a monthly list of what they’re waiting for at the end of the month, because I haven’t received something for four weeks. I would like a deadline of…a reasonable deadline of say four weeks and I would like just if they would send to the Practice Manager a list of what’s outstanding so that…I mean we have our book, but you can see you get swamped in other things and you don’t think to go and look it up. Where wouldn’t it be better to be a week before the deadline’s up even, to drop a line to the manager and say right, these are what we’re waiting for, and you could chase them up that way.’

(Female, 21 – 30 years as a Practice Manager)

Follow-up calls from the DWP enquiring about specific outstanding forms were also found to be helpful by Practice Managers, who recognised that although they might not welcome the calls, they did tend to have an impact:

‘We don’t like being chased up for things, you know, it’s a nuisance to have to think well ‘oh crikey I’ll have to go and look for this now’ you know it should have been done in the first place but I think it wasn’t just these forms that made us do the procedure, it was other forms and requests for copies of notes and requests for insurance forms to be completed, we knew that we were losing track of some things and especially, and certainly round where fees were being attracted so we had to tighten that up and we thought well we’re doing it for this and we’re doing it for that, well we’ll just do it for them all and whether it attracts a fee or not it still has to go through the same procedure.’

(Female, 11 – 20 years as a Practice Manager)
7.4 Suggestions for guidance, training and feedback

There were some GPs who felt that the subject of training and guidance for the IB113 was irrelevant. They believed that GPs should have no role in the IB113, and that they therefore required no training on how to do it better:

‘It’s not a matter of training how to fill in the incapacity form. I would say, take it away from us, that’s all I would say, take it away, please, let us do the clinical work...We don’t feel comfortable with the situation. And we face this every day, very uncomfortable situations.’

(Male, 11 – 20 years as a GP)

However, there was a second group of GPs who were engaged and interested in the best way to provide guidance on the IB113 and made a number of suggestions. Their suggestions can be grouped under four main headings: electronic guidance and training materials, face-to-face communication of information, guidance for Practice Managers and feedback. These will be discussed in turn.

7.4.1 Electronic guidance and training materials

There was a strongly held view that all guidance should be disseminated in electronic format and e-mailed to GPs. This was for largely the same reasons that electronic forms were suggested (see 7.1.1). Two specific advantages of guidance being delivered in electronic format were noted:

- It could be stored in an electronic file and would be easy to find when it was needed.
- It could be put on the practice intranet and circulated, or available to practice colleagues:

‘We, like many other practices we are completely paperless so all the information we get is electronic, all the guidelines, referral patterns so we have on this, on our computer system for example we have an intranet on which we would give guidelines on how to do all kind of things. This could be very usefully put on there.’

(Male, 11 – 20 years as a GP)

Section 6.2 describes how, compared to other forms of guidance, the DWP website had been found to be of some use. GPs made suggestions to maximise its benefit:

- Further publicise the website, for example by putting the address on the IB113 form itself.
- GPs themselves could download relevant areas of the website and store it in their electronic file for reference, or put it on the intranet where other forms of guidance are stored.
One GP suggested that training could also be delivered electronically and was enthusiastic about the idea of an interactive web based training package (along the lines of those currently available on Doctors.net), where initial knowledge would be assessed (in the form of multiple choice questions), and a learning package would be presented according to an individual’s knowledge. (This is discussed in Chapter 6). Despite the enthusiasm from some GPs for electronic guidance, there were other GPs who preferred it to be on paper.

Interestingly, there was a suggestion from a GP that one way forward in terms of GPs gaining a greater understanding of the incapacity benefits system (including the filling in of the IB113/A) was for an interactive website, (such as doctors.net) where initial knowledge would be assessed (in the form of multiple choice questions), and a learning package would be presented according to an individual’s knowledge. The benefits of such a system would include: being part of a Personal Development Plan; standardised guidelines; all GPs would use the same guidelines:

‘E-learning is the way forward…being able to take this information away, take a CD or a DVD and work on it…and actually produce yourself a report at the end of the day.’

(Male, 11 – 20 years as a GP)

7.4.2 Face-to-face communication of information

There were widespread, and often enthusiastic, suggestions, from both GPs and Practice Managers, for face-to-face communication and dissemination of information from the DWP.

In particular, there were unsolicited proposals for presentations from the DWP or Medical Services Doctors. Section 6.4.2 describes the reaction to presentations run as part of the Engaging Physicians Benefiting Patients pilot, which were held at Primary Care Trust level. However, there were respondents who suggested presentations also without being aware (often because they were not being offered in their area) that a pilot was being run, offering presentations not dissimilar to those that they were suggesting.

Some respondents went further, and made quite detailed suggestions of how any presentations should be run.

These included that:

- The session could include two-way communication, with an opportunity for questions or comments from GPs to the DWP.
- The presentation should be given by a ‘bright boy from the DWP’ (Male, 21 – 30 years as a GP). This would be to ensure that a more positive outcome is achieved in terms of GPs attitudes towards Medical Services Doctors and the DWP, rather than a more negative one.
• The approach taken by the presenter should be positive and constructive and should never have any hint of being patronising.

• Locum cover could be provided which would encourage more GPs to attend.

There was a strong call for these presentations to be held at practice level. Descriptions were given of how practices have regular meetings or ‘input’ sessions where there are slots for external speakers. Practice Managers who were in favour of presentations felt that their administration teams could be interested in attending such an event, if it was held at the practice.

Some GPs felt that if the presentations were not held at practice level, then there could be a problem with attendance, because many GPs see the IB113 as a low priority issue:

‘I think it’s very difficult to get GPs because of time constraints to get people in to do meeting. It’s bad enough trying to get meetings ourselves and I think, in all honesty, it’s best to keep it succinct, one page piece of advice or whatever and with an example of perhaps a case just to show what is good, bad or indifferent.’

(Male, 11 – 20 years as a GP)

One GP went so far as to suggest that it should be obligatory, or people would not attend.

These calls for presentations are related to a wider call for face-to-face contact with the DWP or Medical Services Doctors. Some GPs wanted to be able to ring the DWP with a specific enquiry. Others felt that such a presentation could help them to challenge or overcome some prejudices and possibly feel that the DWP do work hard and that ‘they’re trying at least.’ For some GPs this was related to having a sense of who the Medical Services Doctors were, and to be able to put a face to an otherwise anonymous body:

‘It would on occasion be useful to be able to communicate more easily with adjudicators and Jobcentres, for example, patients not infrequently come from the Jobcentre asking for a Med 3 or whatever, ‘because the Jobcentre told me I ought to get one because of this,’ and I think there’s an educational role I would be pleased to perform from time to time with some of the frontline counter staff. Like with all things I think, you know, you can get pissed off with them and they probably get pissed off with us, and it would just be a little bit helpful occasionally just to pick up the phone and talk to people.’

(Male, 0 – 5 years as a GP)

### 7.4.3 Guidance for Practice Managers

Practice Managers fell into two main groups with regard to their desire for information and guidance. While there were some Practice Managers who were focused on the task of completing their administrative tasks, there were others who felt that they would be interested to know more about the purpose and path of the IB113.
Those Practice Managers who could see a positive role for further guidance from the DWP suggested information that would:

- Be brief.
- Provide an overview of the Incapacity Benefit system.
- Be in a format that they could include in the practice procedures manual or for staff training:
  
  ‘I mean if people were aware of what they were for and what the next step would be, even a brief overview of what they do at the department when they receive them.’

(Female, 11 – 20 years as a Practice Manager)

### 7.4.4 Feedback

A request for feedback was a recurrent suggestion from GPs. Four different types of feedback were proposed:

**Recognition**

It was not uncommon for GPs to feel slightly unsure about whether their IB113 had reached the DWP, and whether it had been used as intended. Related to this was a sense that a ‘thank-you’ would also be appreciated. This was envisaged as a regular, but not frequent, communication from the DWP. For example, one GP suggested an annual letter from the DWP thanking them for their work:

> ‘If it [giving feedback to GPs] was my responsibility I would probably send a very brief amount of information to GPs once a year or once every other year just to say ‘can I just remind you?’ You know, if I was at DWP, [I’d think,] what’s the biggest thing that’s irritating me about what GPs do? What would we like GPs to do differently? And I would probably send them [GPs] a letter every year, just to say, you know in the right frame you know is it possible that you could do things this way?’ Can I just remind you that there is a website with all the rules and regulations, there’s a guide book as to what will be declared fit for work and what won’t be, there’s a telephone number you can ring, there’s a series of speakers coming around the country on these dates over the next year if you’re interested get in touch.‘ On one A4 sheet and then that just reminds everybody. Then, and then a year or two years later you can just repeat the process again maybe ideally with a slightly different edge on it you know so whatever they’re what’s the biggest thing that’s irritating us about the GP’s at the DWP.’

(Male, 6 – 10 years as a GP)
Feedback on the outcome

There were also calls from some GPs for feedback on the outcome of the Personal Capability Assessment for particular patients. They wanted to know not only whether they should stop issuing certificates, as they are currently informed, but also whether the patient had been given, or refused, Incapacity Benefit. One GP, who felt that filling in the IB113 ‘feels like a professionally meaningless thing to do’ (Male, zero to five years as a GP) felt that this kind of feedback would give some meaning to the exercise.

Feedback on the value and quality of IB113 completion

Chapters 3, 4 and 5 describe the dilemmas and tensions some GPs reported in filling in the IB113. As they were not clear as to exactly what the DWP wanted from the IB113, they were unable to determine whether or not they achieved it. For this reason, there were some GPs who felt that it would be useful to have some positive and constructive feedback on whether or not their IB113s provided the type of information that was valuable to the DWP:

‘I work most efficiently when I’m driven by an incentive to do some piece of work, and really with these [IB113s] I don’t see a direct incentive to complete them...No financial incentive and very little feedback as to the quality.’

(Male, 6 – 10 years as a GP)

Area wide statistics on IB113 completion

The last type of feedback proposed by GPs was area-wide statistics on the IB113 and the process of which it forms a part. Such information could include, for example, the numbers of patients accepted and rejected. It was felt that this could be compiled at Primary Care Trust or national level.
8 Conclusions

GPs described a range of attitudes and behaviours concerning their role in the completion of the IB113. Many of these were similar to the attitudes, problems and tensions described in previous studies of GPs’ role in the broader provision of medical evidence for Incapacity Benefit (Hiscock and Ritchie, 2001; Ritchie et al., 1993). This indicates that the attitudes and behaviour of GPs are deeply rooted and may, in policy terms, represent a long-term challenge, and that some GPs at least, may be resistant to change.

8.1 Complexity

Throughout this report, research evidence indicates how the process used by practices and by GPs to respond to their role in the IB113 is often much more complex than may have been envisaged.

For many GPs, the process of completing the IB113 was not simply a straightforward transfer of information. Instead it involved filtering, translating and interpreting data. It required them to be the interface of a conflict of roles and loyalties (patient, GP, society), which often felt beyond their control. It required constant consideration of the GP-patient relationship. It differed not only according to different GPs, but also according to a range of other influencing factors (described in Chapters 4 and 5).

This complexity may not be perceived, or indeed required by the DWP. It is however, at the core of most of the tensions and difficulties that result in behaviours that GPs describe, which resulted in them completing IB113s which are of limited use for the DWP’s decision-making process.

In response to the tensions that they experienced in completing the IB113, some GPs used ‘codes’ on the form. They hoped that these may be understood by the DWP, but not by their patients. It is this motivation which also led GPs, both in this and previous research (Hiscock, Ritchie, 2001), to call for the wider use of the RM7 form.
GPs who used codes, did so as a response to their position at the interface between conflicting pressures or responsibilities (to the patient and to the DWP). The codes should therefore be seen within the context of a requirement to provide information in which GPs find it complex to manage their dual role.

This use of codes should be viewed as a product of the tensions that GPs experience in completing the IB113, not as a solution to them. A simple method of agreed codes, or a ‘key’ to decipher the codes, may not be feasible or appropriate. Apart from data protection considerations, there could be significant problems with misinterpretation of the information intended in the codes.

In theory of course, such coded messages are not needed. The IB113 does not require GPs to offer advice to the DWP about whether or not a patient is fit for work. However, the fact that some GPs do try to provide this type of information suggests either a misunderstanding of what is required of them, or a lack of trust in the Medical Services Doctors to make what the GP believes to be the right decision for the patient.

8.2 Functionality

The Personal Capability Assessment medical examination, conducted by Medical Services Doctors, assesses a patient’s functionality. However, GPs pointed out that they felt that some questions on the IB113 (particularly question 5, but not solely), required the GP to provide information on functionality as well. Provision of this information is very problematic for some GPs, not least because they often feel that they do not have that information. Previous research (Hiscock and Ritchie, 2001; Sainsbury et al., 2003) also reported that GPs find it difficult to provide information on functionality. This problem persists mainly because even if GPs were aware of the patient’s functionality (which is not routinely discussed in many consultations) the findings are not recorded in patients’ medical records.

GPs described how their objectives for collecting and recording information is different from those required for the IB113. A recent pilot explored an alternative to the IB113, with Medical Services Doctors gathering information directly from patients’ medical records. It was found to be impossible for the Medical Services Doctors to provide information from patients’ medical records on functionality (Sainsbury et al., 2003). Some GPs, on some occasions, may have information on functionality in their heads about a patient for whom they are filling in the IB113. (GPs try to maximise the benefit of this knowledge by redistributing the IB113 forms to the GP who knows the patient best, as described in Section 2.4).

However the knowledge that GPs have ‘in their heads’ about patients may be negligible or non-existent for some patients. It will certainly be less extensive than in previous models of general practice, where personal lists operated to facilitate continuity of care, GPs made more home visits to witness patient coping skills in their
own environment, and there were fewer alternative sources of primary care. This approach provided a broader and greater level of personal knowledge about more of their patients.

A further consideration about the provision of information on functionality on the IB113, is the fact that it seemed that some GPs were, in their minds, conflating all the various forms of medical evidence required for the DWP. Thus some GPs may be responding to the IB113 with the objective of exercising the same kind of judgement and information on functionality as they consider when completing medical certificates issued during the patient’s first six months of sickness absence.

The evidence from this study and the report by Sainsbury et al., (2003) on the Better Medical Evidence Gathering pilot, suggests a strong message that information on functionality is very difficult, or impossible, to obtain from general practice unless prospectively requested and time and resources can be allocated for this purpose.

8.3 Explicit and implicit requirements of the IB113

The difficulty with the IB113 for some GPs was that they believed that the form, as it currently stands, could not be answered using solely facts. They felt that GPs were also being asked for their opinions. This was because from their perspective, it would be impossible to answer some of the questions without giving an opinion. (See Chapter 4 for a further discussion of this.)

However, the explicit message given to GPs about the IB113 is that they are required to fill in the form based on the facts alone. While some were happy with this request, others felt that there was also an implicit requirement in some parts of the form for opinion. Thus, to some GPs there appeared to be a mixed message and dual agenda. GPs perceived this as creating confusion, uncertainty and some frustration. In the absence of clear, explicit and feasible guidance indicating that some sections required facts alone, whereas other sections required the GPs opinion, some GPs resorted to a range of interpretations and behaviours that could sometimes result in IB113s that were less useful to the DWP.

8.4 The impact of systemic factors on the completion of the IB113

8.4.1 Paperless practices

Chapter 2 describes the ways that the practical and cultural operating methods of general practices and the DWP can affect the completion of the IB113. Many of the practices interviewed were paperless or ‘paper light’, yet DWP communications and forms come in paper format. This was perceived by some GPs as creating not only practical inefficiencies and irritations, but also a sense of organisational distance.
8.4.2 NpfIT and SNOMED⁶

Proposals for the rolling out of the national Spine medical record, and the phasing out of READ codes to be replaced by SNOMED may have important implications for the collection of medical information to process claims for health and work related benefits. Both the Personal Demographics Service and Health Record may be potentially accessible to the DWP medical services. This may negate the requirement for routine GP involvement in decisions regarding the need for a medical examination when incapacity benefit claims are made or reviewed.

8.4.3 The role of administration teams

Practice Managers and administration teams differed considerably in their involvement with, and approach to, managing the IB113. There were some practices however, described in Chapter 2 as ‘efficiency model practices’ which operated systems which greatly facilitated the timely return of the form. Indeed, as described in Section 7.3 some Practice Managers even offered to take on an enhanced role for ensuring the efficient management of the IB113 in their practice. In general, the established practice level systems have been created for forms which generate a fee. The IB113 benefits from being dealt with by the same system. But there is another factor in operation. That is that for many Practice Managers and their teams, it is a source of great professional pride and job satisfaction that all the forms are dealt with in a correct and timely manner. In practices where this applies, it also facilitates a timely return of the IB113. There is the potential to publicise some ‘effective practice’ examples to meet some of the IB113 training requests highlighted by some practices. These may include effective means of monitoring and tracking forms.

8.4.4 Monitoring and tracking the IB113

Systems for monitoring and tracking the path of the IB113 through the practice were another effective mechanism operated by ‘efficiency model’ practices. Although practice staff cannot force GPs to fill in the IB113s a gentle ‘nudge’ often proved to be effective. This could only happen where administration staff were aware of when a GP had overdue forms, or indeed when a form was due.

‘Chasing’ of overdue forms was also an effective mechanism. In general, this worked to the benefit of the IB113 because Practice Managers and their teams, particularly those who operated within the ‘efficiency model’, did not like to be chased up, as it suggested inefficiency. They were therefore likely to develop systems to ensure that this did not happen, or when it did they were able to identify where the missing form was.

⁶ NpfIT is the new common IT record for the NHS and social care.
8.4.5 Delegating the IB113 within practices

Some practices have developed effective mechanisms for collecting background information, partial ‘form’ from completion or even delegation of the whole task to other involved clinical staff, such as practice nurses or members of the administration team. These approaches merit formal evaluation and successful approaches piloted more widely and the results disseminated.

8.5 IB113A

This form was widely welcomed by our GP respondents, and it is to be hoped that this development can be retained. The advantages of this form, of clarity of purpose and the specific type and format of information required, may be usefully applied to any future revision of the standard IB113, whether in paper or electronic format.

8.6 Guidance from the DWP

It is a challenge to find ways to provide GPs (and other practice staff) with the information and guidance which some of them say that they would like, and evidence suggests that they need, but which is largely ignored or rejected as a low priority upon receipt.

There were a few clear messages from GPs about how guidance should be delivered. It should be succinct, high quality and electronic. However, as discussed in Chapters 6 and 7, this will not guarantee that it will be read, used, or acted upon.

Face-to-face communication, such as the pilot presentations, or individual presentations at practice level and visits to Jobcentre Plus offices as part of GP training, was seemingly more appreciated and more effective than other means of communication. As well as conveying information, such communications may also make some contribution to the more intractable problems of organisational mistrust, distance and suspicion, that some GPs may have about the DWP.

8.7 The Engaging Physicians Benefiting Patients pilot

The communication strategy of the Engaging Physicians Benefiting Patients pilot, which this study has evaluated, involved two different types of input in an attempt to inform GPs about the IB113. These were a mailing, sent to all GPs in the pilot area, and presentations that were offered to GPs in one part of the pilot area.

The mailings were not effective means of communication in most instances. In the case of this pilot, this may have been partly related to problems of mailing distribution, but probably also reflects general responses at practice and GP level to paper mailings.
The presentations, however, were found to be more acceptable, and in some cases GPs reported behavioural change in filling in the IB113, which they attributed to attending the presentation. Interestingly, this appeared to apply to GPs who had not particularly wanted to attend the presentations, as well as those who had.

This reinforces the point made above that face-to-face means of communication may be the most palatable way to inform GPs, and may have potential for generating change in knowledge or behaviour.
Appendix A
A profile of the respondents

The Practices

The Engaging Physicians Benefiting Patients pilot was carried out in Northeast England. Interviews were conducted in 24 practices in three parts of the pilot area. In addition, six respondents were included in the sample because they had attended a pilot presentation which was part of the pilot communication input.

<table>
<thead>
<tr>
<th>Practices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>6</td>
</tr>
<tr>
<td>County Durham</td>
<td>7</td>
</tr>
<tr>
<td>Teesside</td>
<td>5</td>
</tr>
<tr>
<td>Presentation attendees</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

Although the prime sampling strategy was designed to obtain diversity in terms of the way GPs filled out the IB113 (as described above). The sample was also selected with secondary sampling criteria in mind. These were established to reflect a range of other characteristics considered to be important to the study, including different Primary Care Trust and Jobcentre Plus districts and a range of practice types, in terms of catchment area and practice size.
Table A.2  Sample practices by practice size: list size

<table>
<thead>
<tr>
<th>Practices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4,999 and under</td>
<td>4</td>
</tr>
<tr>
<td>5,000 – 9,999</td>
<td>8</td>
</tr>
<tr>
<td>10,000 – 14,999</td>
<td>8</td>
</tr>
<tr>
<td>15,000 – 19,999</td>
<td>2</td>
</tr>
<tr>
<td>20,000 and over</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

Table A.3  Sample practices by practice size: number of GPs

<table>
<thead>
<tr>
<th>Practices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single handed</td>
<td>1</td>
</tr>
<tr>
<td>Two to three</td>
<td>3</td>
</tr>
<tr>
<td>Four to six</td>
<td>10</td>
</tr>
<tr>
<td>Seven to nine</td>
<td>7</td>
</tr>
<tr>
<td>Ten to 12</td>
<td>2</td>
</tr>
<tr>
<td>13 and over</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

The GPs and Practice Managers

A total of 25 GPs and 18 Practice Managers were interviewed. The intention had been to recruit 24 GPs, one per practice. Problems with the database resulted in two GPs being inadvertently recruited from the same practice.

While recruitment of GPs was easier than anticipated, recruitment of Practice Managers was more difficult than anticipated. The table below shows that 18 Practice Managers agreed to be interviewed out of the 24 practices. Although these are listed below as Practice Managers and are referred to in the report as Practice Managers, it is important to note that of the 18, four held posts with different job titles (an Office Manager, an Assistant Practice Manager, an Administration Manager and a Senior Receptionist).

It proved to be impossible, with a limited database from which to recruit, to select a sample with an equally balanced number of male and female GPs.

Table A.4  Gender of respondents

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Practice Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>18</td>
</tr>
</tbody>
</table>
Table A.5  Number of years experience of respondents

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Practice Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero to five years</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>21 – 30 years</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Over 30 years</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>18</td>
</tr>
</tbody>
</table>

Table A.6 shows that we interviewed one GP who also worked as a Medical Services Doctor, and two GPs who had done so in the past. Although we did not select our sample on this basis, the information was recorded and was used in the analysis.

Table A.6  GPs with experience as Medical Services Doctors

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Experience</td>
<td>1</td>
</tr>
<tr>
<td>Past Experience</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
</tr>
</tbody>
</table>
Appendix B
Approach letters

Approach letter to GPs
Dr «GP_Initial» «GP_Surname»
«Practice»
«Address1»
«Address2»
«Address3»
«Postcode»
2nd September 2004
Dear Dr «GP_Initial» «GP_Surname»

Research Study: Engaging Physicians Benefiting Patients

We are writing to ask if you would agree to be interviewed as part of a qualitative study of attitudes and behaviour towards GPs role in providing medical evidence for Incapacity Benefit. See attached information sheet.

The interview will take about 45 minutes and will be conducted in September. In appreciation of the time you give to the study, we will pay you an honorarium of £75.

If you are willing to be interviewed, you need do nothing. A member of the research team will contact you to discuss your participation in the study. If you do not wish to be interviewed, please telephone, fax or e-mail one of the researchers below (contact details are on the information sheet) and you will not be troubled further.

We hope that you will be able to participate in this interesting study.

Yours sincerely

Dr Mark Gabbay
Acting Head of Department

Julia Hiscock
Qualitative Researcher
Approach letter to GPs who attended presentation

Dr «GP_Initial» «GP_Surname»
«Practice»
«Address1»
«Address2»
«Address3»
«Postcode»

2nd September 2004

Dear Dr «GP_Initial» «GP_Surname»

Research Study: Engaging Physicians Benefiting Patients

Earlier in the summer you attended a presentation about medical evidence for Incapacity Benefit and the GP. On the presentation feedback form, you specified that you would be happy to receive an invitation to participate in any follow-up research.

In response to this, we are writing to ask if you would agree to be interviewed as part of a qualitative study of attitudes and behaviour towards GPs role in providing medical evidence for Incapacity Benefit. See attached information sheet.

The interview will take about 45 minutes and will be conducted in September. In appreciation of the time you give to the study, we will pay you an honorarium of £75.

If you are willing to be interviewed, you need do nothing. A member of the research team will contact you to discuss your participation in the study. If you do not wish to be interviewed, please telephone, fax or e-mail one of the researchers below (contact details are on the information sheet) and you will not be troubled further.

We hope that you will be able to participate in this interesting study.

Yours sincerely

Dr Mark Gabbay
Acting Head of Department

Julia Hiscock
Qualitative Researcher
Approach letter to Practice Managers

Dear [Practice Manager]

**Research Study: Engaging Physicians Benefiting Patients**

We are writing to ask if you would agree to be interviewed as part of a study of the attitudes and behaviour in general practice towards providing medical evidence for Incapacity Benefit.

In the study we will be interviewing both GPs and Practice Managers (in the same practice). We have spoken today to Dr X who has agreed to be interviewed and we are therefore asking you if you would also agree to a short interview.

The interview will take about 20 - 30 minutes and will be conducted in September. In appreciation of the time your practice gives, an honorarium of £75 will be paid.

We are attaching an information sheet about the study. If you are willing to be interviewed, you need do nothing. A member of the research team will ring you tomorrow to discuss your participation in the study. If you do not wish to be interviewed, please telephone, fax or e-mail one of the researchers below (contact details are on the information sheet) and you will not be troubled further.

We hope that you will be able to participate in this interesting study.

Yours sincerely

Julia Hiscock
Qualitative Researcher
Letter to participants from DWP

Dear Dr

MEDICAL EVIDENCE GATHERING FOR INCAPACITY BENEFIT

I am writing to ask for your help with a study seeking your views on the medical evidence gathering process for Incapacity Benefit. We are interested in your opinion about communications received from DWP, to learn more about your experiences of completing the IB113 forms, and in hearing any suggestions you may have for improving the medical evidence gathering process in order to benefit both GPs and their patients. The research will be used to inform the design of policies, guidance and training for medical practitioners. The study has been approved by a Multi-centre Research Ethics Committee.

We have asked the University of Liverpool, Fit for Work Research Group to carry out the study on our behalf. Their work will involve interviewing GPs and practice managers in the North Eastern region of the UK. One of these areas is the area in which your practice is located. The sample for the research has been carefully selected to represent different types of practices. You have been selected to take part and we would therefore be grateful if you would agree to be interviewed.

If you are willing to take part, a researcher will come and talk to you at your practice. We are also interested in hearing the views of your practice manager who will be contacted separately should you decide to take part. Please refer to the enclosed information sheet for further details.

All the information you give will be treated in the strictest confidence by the University of Liverpool. The evidence collected will be presented in a form from which neither your practice, nor your patients, could be identified.

We hope you are able to take part. Please refer to the letter and information sheet from University of Liverpool for any further information required. Alternatively you may contact me on 0207 962 8838 or e-mail me at philip.sawney@dwp.gsi.gov.uk.

I do hope you will be able to help us with this important piece of research.

Yours sincerely

Dr Philip Sawney
Principal Medical Adviser
Study information sheet to GPs

Study Information Sheet

Engaging Physicians, Benefiting Patients

You have been invited to be interviewed as part of a qualitative study of attitudes and behaviour towards GPs’ role in providing medical evidence for Incapacity Benefit.

The research is funded by the Department for Work and Pensions (DWP) and is being conducted by the Fit for Work Research Group, in the Department of Primary Care, University of Liverpool.

The aim of this information sheet is to provide you with some basic details of the study, to enable you to decide whether you wish to agree to be interviewed.

Purpose of the Study

To explore GPs’ and Practice Managers’ role in and attitudes to the provision of medical evidence for incapacity benefit. More specifically, it wishes to explore behaviour and attitudes to completion of the DWP form IB113. (The form IB113 is the form which GPs are requested to complete about patients whose claim for Incapacity Benefit is being assessed by the DWP and whose condition could potentially exempt them from examination or further assessment by the DWP funded doctors.)

Study methodology

Qualitative – as this study aims to explore attitudes and behaviour, a qualitative approach has been chosen

Data gathering – data will be gathered through face-to-face in-depth interviews with 24 GPs and 24 Practice Managers (one of each per practice) in a range of locations in North East England

Analysis – The data will be analysed using ‘Framework’ a manual, matrix method which facilitates thematic and cross-case interpretation.

Honorarium

In appreciation of the time your practice gives, an honorarium of £75 will be paid.
What participation involves:
A qualitative face-to-face interview lasting approximately 45 minutes
Conducted in September or October 2004
The researcher will come to your practice, at a time suitable for you
Interview will be audio-taped (with your permission)
We would also like to interview the Practice Manager in your practice for about 30
minutes, about his or her role

Confidentiality
All information you give will be treated in the strictest confidence
The tape of the interview will be destroyed after it has been transcribed
The information you give will be collected and presented in a form which neither
you, your practice, nor your patients could be identified.

How the research will be used
Disseminated through conferences and peer reviewed journals
Published as part of the DWP research reports series
Inform the DWP in their development of policy in relation to GPs role in the form
IB113, and more generally in the provision of medical evidence for Incapacity
Benefit.
A one page summary of the findings of the research will be circulated to all
respondents

Next steps
If you are willing to be interviewed, you need do nothing. A member of the research
team will contact you to discuss your participation in the study.
If you do not wish to be interviewed, please telephone, fax or e-mail one of the
researchers below and you will not be troubled further.

Contact details for further information
Julia Hiscock or Dr Mark Gabbay
Qualitative Researcher Acting Head of Department
Mersey Primary Care Research and Development Consortium
Department of Primary Care, University of Liverpool, Whelan Building
Brownlow Hill, Liverpool L69 3GB
Telephone: 0151-794-4552
Fax: 0151-794-5613
E-mail: Julia.Hiscock@liverpool.ac.uk
M.B.Gabbay@liverpool.ac.uk
Study information sheet for Practice Managers

THE UNIVERSITY of LIVERPOOL

Study Information Sheet

Engaging Physicians Benefiting Patients

You have been invited to be interviewed as part of a qualitative study of attitudes and behaviour towards GPs role in providing medical evidence for Incapacity Benefit.

The research is funded by the Department for Work and Pensions (DWP) and is being conducted by the Fit for Work Research Group, in the Department of Primary Care, University of Liverpool.

The aim of this information sheet is to provide you with some basic details of the study, to enable you to decide whether you wish to agree to be interviewed.

Purpose of the Study

To explore GPs’ and Practice Managers’ role in and attitudes to the provision of medical evidence for incapacity benefit. The study aims to understand the processes and approaches used in general practices to provide the forms and information requested by the DWP. These processes often involve Practice Managers and other practice staff, as well as GPs.

More specifically, the study also wishes to explore approaches and attitudes of both Practice Managers and GPs to completion of the DWP form IB113. (The form IB113 is the form which GPs are requested to complete about patients whose claim for Incapacity Benefit is being assessed by the DWP and whose condition could potentially exempt them from examination or further assessment by the DWP funded doctors. A copy is enclosed for your information.)

Honorarium

In appreciation of the time your practice gives, an honorarium of £75 will be paid.

Study methodology

Qualitative – as this study aims to explore attitudes and behaviour, a qualitative approach has been chosen

Data gathering – data will be gathered through face-to-face in-depth interviews with 24 GPs and 24 Practice Managers (one of each per practice) in a range of locations in North East England

Analysis – The data will be analysed using ‘Framework’ a manual, matrix method which facilitates thematic and cross-case interpretation.
What participation involves:
A qualitative face-to-face interview lasting approximately 30 minutes
Conducted in September or October 2004
The researcher will come to your practice, at a time suitable for you
Interview will be audio-taped (with your permission)
We will also be interviewing one of the GPs in your practice, about his or her role

Confidentiality
All information you give will be treated in the strictest confidence
The tape of the interview will be destroyed after it has been transcribed
The information you give will be collected and presented in a form which neither you, your practice, nor your patients could be identified.

How the research will be used
Disseminated through conferences and peer reviewed journals
Inform the DWP in their development of policy in relation to GP and Practice Manager roles in the provision of medical evidence for Incapacity Benefit.
Published as part of the DWP research reports series
A one page summary of the findings of the research will be circulated to all respondents

Next steps
If you are willing to be interviewed, you need do nothing. A member of the research team will contact you to discuss your participation in the study.

If you do not wish to be interviewed, please telephone, fax or e-mail one of the researchers below and you will not be troubled further.

Contact details for further information

Julia Hiscock or Dr Mark Gabbay
Qualitative Researcher Acting Head of Department
Mersey Primary Care Research and Development Consortium
Department of Primary Care,
University of Liverpool, Whelan Building
Brownlow Hill, Liverpool L69 3GB
Telephone: 0151-794-4552
Fax: 0151-794-5613
E-mail: Julia.Hiscock@liverpool.ac.uk mbg@liverpool.ac.uk
Appendix C
Topic Guides

GP Topic Guide

Engaging Physicians Benefiting Patients

TOPIC GUIDE (GP)

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To evaluate the effect of the pilot communications input (mailing to GPs and presentations)</td>
</tr>
<tr>
<td>2. To understand GPs attitudes to their role in the provision of medical evidence for incapacity benefit</td>
</tr>
</tbody>
</table>

Introduction

(Introduction, objective, funder, timing, confidentiality, taping, consent form)

1. Background information

1.1 Catchment area
   - Nature of practice population
   - Unemployment levels
   - Ethnic composition

1.2 GP
   - Number of years as GP
   - Number of years in this practice
   - Hours worked in practice
   - Any special interests/other roles (e.g. PCT)
   - Any special interest in occupational health
   - Check whether GP knows which form and can distinguish between other requests from DWP
   - Estimate of number of IB113 and IB113A per month
2 Initial reaction to IB113

Way respond when receive IB113?  
(explore broadly)

- How long it takes to complete the forms on average.
- Which questions are difficult to answer
- Any specific problems with the IB113 (and IB113A) forms
- Views on the addition of a shorter IB113A for re-referrals and knowledge of when it should be used.

- Different reaction in different circumstances? (explore) (use examples where appropriate)

- Where fill the form well (explore reasons)
- Where not filled in well – (explore reasons)
- What could help motivation to complete IB113 well

- Extent feel information on IB113 can influence patients’ claims

Probe re: persuade/advocate/exaggerate/subjective or objective

3 Influences

(explore)

- Influences on way form filled in and if filled in
  Practical factors
  Practice factors
  Prompts:
  - paperwork and
  - whether there are any prompts to get the IB113s done

- Patient factors
  Prompts:
  - GP-Patient relationship
  - Patient’s condition
  - Effect on clinical management

4 Attitudes

(start open, then explore:)

- Attitudes to importance/role of the forms
  - Awareness of contractual obligation to provide this information.
  - Awareness of link between generation of IB113s and the sick notes they have been issuing.

- Value for whom
  - GP
  - practice
  - patient
  - DWP
• Attitudes to broader system
  – attitudes to IB/Benefit assessments
  – attitudes to vocational rehabilitation
  – attitudes to role of work for health

• Attitudes to GP role in provision of medical evidence for incapacity benefit

5 Understanding and awareness

• Understanding of IB medical assessment process
• Understanding of purpose of IB113 and IB113A
• Understanding of what happens to information provided
• Understanding of potential impact on patients/GPs/Jobcentre Plus

• Awareness of ways DWP communicate with GPs [prompt each]
  – website;
  – IB204;
  – Desk Aids;
  – DVD;
  – medical centres contact centres);
  – explore usefulness/reasons not used;
  – How learn about IB113 and IB113A;
  – Whether learning included transfer of attitudes;

• Areas of understanding feel are lacking
• How would like to receive this information

6 Pilot communication inputs:

6.1 Mailings
(Explore whether received mailing. If no knowledge / memory – show letter)

• Receipt of
• How used
  Prompts:
  – Read (explore)
  – Stored/filed
  – Discussed with colleagues
• Views on mailing
  • Content
  • Format

6.2 Attendance at presentations (for respondents who attended)

• How came to attend (probe – influenced by mailing?)
• Rationale for attending
• Aspects found most/least valuable
• Information which was new
• Views on presentation
  – Content
  – Format
6.3 Ways communication input has changed:

- **Knowledge**
  - Understanding of IB113 systems
  - Understanding of how IB113 is acted upon
  - Understanding of potential impact on patients
  - Understanding of rationale for questions on IB113
  - Awareness of sources of guidance

- **Attitudes**
  - Attitudes to role
  - Whether still feel duplicating information

- **Behaviour**
  - Approach to IB113 (probe reasons) (prompts: time taken, level of detail)
  - Relations with/attitude to DWP, Jobcentre Plus, Medical Services
  - Whether or not they used the website/participants pack/IB204/helpline/booked a presentation as a result of the communications strategy
  - Example of changed behaviour?
    
    **Probe:**
    - what changed
    - aspect of communications input which lead to change
    - other influences

If no/little change – *explore reasons*

Suggestions to improve communication inputs (*explore*)

7 Suggestions

- Any further guidance needed about IB113 and IB113A
- Preferred method of communication for guidance
- Other suggestions for improvements to informing practices about IB113s
- Suggestions about IB113 and IB113A system/procedures
- More general suggestions about how GPs can best play a role in the provision of medical evidence for incapacity benefit

*Thank you*

*Remind about confidentiality and about honorarium*

*Ask to whom cheque should be made*
Practice Manager Topic Guide

Engaging Physicians Benefiting Patients

TOPIC GUIDE (Practice Managers)

Objectives
1. To evaluate the effect of the pilot communications input (mailing to GPs and presentations)
2. To understand GPs attitudes to their role in the provision of medical evidence for incapacity benefit

Introduction

(Introduction, objective, funder, timing, confidentiality, taping, signing of consent form)

1 Background information

1.1 Practice
- List size
- Number of partners
- Size of admin team

1.2 Practice Manager
- Number of years as Practice Manager
- Number of years in this practice
- Full or part time
- Description of role
- Other members of team with specific roles in incapacity benefit forms
- Check whether PM knows which form and can distinguish from other requests originating from DWP.

1.3 IB113
- Estimate number of IB113 and IB113A per month
2 Practice process
(Talk me through the process used in the practice for IB113)

- Who involved – roles
- Own role
- How/when IB113 reaches GP
- Arrival – individually or batches
- Any follow up if not completed
- Any parts filled in by other people in practice
- Any role in accessing information sources (e.g. records, other)
- Any role in quality assurance of completion of IB113 (e.g. gaps, illegible)
- Any guidance used
- Circumstances when different practice system is used (explore)
- Circumstances when practice system works well
- Circumstances when practice system breaks down
- Advantages/disadvantages of practice system
- Ways system is different for IB113A

IB113a
- Views on addition of IB113A for re-referrals
- Ways process/approach to completion differs from IB113 (probe reasons)

3 Influences on process/system used for IB113
(start open, then explore:)

- Practical factors
- Practice factors

4 Objectives and attitudes
- What (Practice Managers) want to achieve by getting IB113 filled in (explore broadly)
  Different objectives in different circumstances? (explore)
- General attitudes to practice role in provision of medical evidence (for incapacity benefit)
  How that effects the way they play their part
- Has the message work is good for you got across to PMs
5 Understanding and awareness

- Understanding of purpose of IB113 and IB113A
- Understanding of what happens to information provided
- Understanding of potential impact on patients/GPs/practice/Jobcentre Plus
- Awareness that NHS terms of contract obliges GP to complete IB113 promptly on request
- Awareness that IB113s are Dr to Dr communication if they appear to be completing themselves
- Areas of understanding feel are lacking
- How would like to receive this information
- Others in practice who need to know
- How learn about IB113 and IB113A
- Whether learning included transfer of attitudes
- Attitude towards influence of IB113 on claims

6 Pilot communication inputs:

6.1 Mailings
- Receipt of
- How used

Prompts:
- Read (explore)
- Stored/filed
- Discussed with colleagues

- Views on mailing
  - Content
  - Format

6.2 Presentations (for respondents in presentation area)
Aware of practice receiving invitation to presentation – what did with it?

Views on inputs
Prompts:
- Content
- Format/practicalities
6.3 General views on pilot communication inputs (both)

How influenced

*Explore ways they feel communication input has changed their attitudes, knowledge or behaviour – of selves and/or practice*

**Prompts:**
- Approach to IB113 (probe reasons)
- Attitudes to role
- Understanding of IB113
- Awareness of sources of guidance
- Relations with/attitude to DWP, Jobcentre Plus, Medical Services

*(Probe all)*

- Example of changed behaviour?
  *Probe:*
  - what changed
  - aspect of communications input which lead to change
  - other influences

Suggestions to improve communication inputs *(explore)*

7 Suggestions

- Any further guidance needed about IB113 and IB113A
- Preferred method of communication
- Other suggestions for improvements to informing practices about IB113s
- Suggestions about IB113 and IB113A forms
- Suggestions about IB113 and IB113A system/procedures
- More general suggestions about how practices can best play a role in the provision of medical evidence for incapacity benefit

*Thank and remind about confidentiality*
Appendix D
IB113 and IB113A form

Dear Doctor,

Your patient has claimed benefit due to incapacity and we now have to assess their capacity to perform any work, not just their own job, using the Personal Capability Assessment procedures. People with certain severe medical conditions can be accepted as meeting the threshold of incapacity for benefit purposes without undergoing the Personal Capability Assessment or, if the assessment has to be applied, without undergoing a medical examination.

From the information you have provided on a medical statement (for example form Med 3), or information otherwise available to the medical officer, it appears that this may be such a case. In order to advise the decision maker in accordance with the law, the medical officer requires further factual information. We would be obliged if you would answer the medical officer’s questions overleaf clearly indicating on a separate sheet, any medical evidence that you think would be harmful to the patient’s health. An example of what may be harmful information is a diagnosis that is not known to your patient such as malignancy, progressive neurological conditions or major mental illness.

Your patient has given written consent on their claim form to allow us to approach you for this information.

If you have agreed to treat this patient under the NHS (General Medical Services) Regulations 1992 as amended March 1998 and equivalent regulations in Scotland, and have issued, or refused to issue, a medical certificate to them, you are obliged by your terms of service to supply clinical information to a medical officer. A similar obligation applies to most hospital and community doctors working within the NHS. You are not obliged to do this if you have not agreed to treat the patient under the NHS but any information you are willing to provide will be much appreciated. Unfortunately, we will be unable to pay you for it.

A reply within 7 days will be appreciated and a business reply envelope is enclosed for your use. If you have any queries about this form please contact the medical officer at your local Medical Services Centre, see leaflet IB204 Guide for Registered Medical Practitioners.

Thank you for your help.

Yours sincerely

On behalf of the Manager
For the Medical Officer

Social Security Office
Part of the Jobcentre Plus network,
Department for Work and Pensions

For official use

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<th>First day of incapacity</th>
<th>DO</th>
<th>Ref type</th>
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Incapacity for work

Our phone number is

If you have textphone, you can call on

If you get in touch with us, tell us this reference number

Date

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</table>

About your patient

Surname
Other names
NI number
Date of birth
Address
Postal code

Dear Doctor,

Your patient has claimed benefit due to incapacity and we now have to assess their capacity to perform any work, not just their own job, using the Personal Capability Assessment procedures. People with certain severe medical conditions can be accepted as meeting the threshold of incapacity for benefit purposes without undergoing the Personal Capability Assessment or, if the assessment has to be applied, without undergoing a medical examination.

From the information you have provided on a medical statement (for example form Med 3), or information otherwise available to the medical officer, it appears that this may be such a case. In order to advise the decision maker in accordance with the law, the medical officer requires further factual information. We would be obliged if you would answer the medical officer’s questions overleaf clearly indicating on a separate sheet, any medical evidence that you think would be harmful to the patient’s health. An example of what may be harmful information is a diagnosis that is not known to your patient such as malignancy, progressive neurological conditions or major mental illness.

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Yours sincerely

On behalf of the Manager
For the Medical Officer

Social Security Office
Part of the Jobcentre Plus network,
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<tr>
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</table>
About your patient – continued

Your reply

Please answer the following questions from the information which is currently available to you.

1. Date patient was last seen or examined for the condition(s) causing incapacity.

2. Diagnosis of all relevant conditions and date(s) of onset.

3. Factual details of patient’s condition.
   Where possible, please include brief factual details of:
   • present medical condition
   • medication and other treatments (eg attendance at day-care centre, hospital outpatient)
   • outlook for your patient and any proposals for future management.
About your patient – continued

4 Where available to you, please give brief details of what the patient has been told about the likely clinical course of their condition(s), and any future treatment.

5 Any other information.
   • If you have evidence which indicates that, as a result of their medical condition, your patient would not be able to attend an examination by using public transport or by taxi please include this here.
   • Any additional information about the effects of the medical conditions on daily living (self care, indoor mobility, judgement and compliance with medication) would be very helpful.

Only complete the section below if you have diagnosed a psychiatric condition at question 2.

6 Where available to you, please give brief details of any history of recent or serious attempts at suicide or other self injury, or any history of threatening or violent behaviour towards others.

Declaration

I understand that if this person appeals, or asks for an explanation or reconsideration of the decision, a copy of the information I have given here may be sent to the person, their legal representative and the Appeals Service.

I also understand that the only information that can be withheld is medical evidence that would be harmful to the person’s health. I have stated any medical evidence that I think may be harmful to the person’s health on a separate sheet of paper.

Your signature

Signature

Name Dr

Date / /
Dear Doctor,

Your patient has claimed benefit due to incapacity and we now have to assess their capacity to perform any work, not just their own job, using the Personal Capability Assessment procedures. People with certain severe medical conditions can be accepted as meeting the threshold of incapacity for benefit purposes without undergoing the Personal Capability Assessment or, if the assessment has to be applied, without undergoing a medical examination.

From the information you have provided on a medical statement (for example form Med 3), or information otherwise available to the medical officer, it appears that this may be such a case. In order to advise the decision maker in accordance with the law, the medical officer requires further factual information. We would be obliged if you would answer the medical officer's questions overleaf clearly indicating on a separate sheet, any medical evidence that you think would be harmful to the patient's health. An example of what may be harmful information is a diagnosis that is not known to your patient such as malignancy, progressive neurological conditions or major mental illness.

Your patient has given written consent on their claim form to allow us to approach you for this information.

If you have agreed to treat this patient under the NHS (General Medical Services) Regulations 1992 as amended March 1998 and equivalent regulations in Scotland, and have issued, or refused to issue, a medical certificate to them, you are obliged by your terms of service to supply clinical information to a medical officer. A similar obligation applies to most hospital and community doctors working within the NHS. You are not obliged to do this if you have not agreed to treat the patient under the NHS but any information you are willing to provide will be much appreciated. Unfortunately, we will be unable to pay you for it.

A reply within 7 days will be appreciated and a business reply envelope is enclosed for your use. If you have any queries about this form please contact the medical officer at your local Medical Services Centre, see leaflet IB204 Guide for Registered Medical Practitioners.

Thank you for your help.

Yours sincerely

On behalf of the Manager
For the Medical Officer

Social Security Office
Part of the Jobcentre Plus network, Department for Work and Pensions
### About your patient – continued

#### Your reply to the Medical Officer

Thank you for the information you have already given us about this patient.
The Medical Officer needs more information for the benefit decision maker.
Please answer the following questions from the information that is currently available to you.

1. **Date patient was last seen or examined for the condition(s) causing incapacity.**

2. **List of all relevant conditions and date(s) of onset.**

3. **Has there been any change that significantly effects your patient’s physical or mental abilities since / / ?**
   - **No** ☐ Go to question 4.
   - **Yes** ☐ Please give brief details about your patient’s present condition and any changes in treatment, including aids.

4. **If your patient has a recent history of mental health problems, have they:**
   - a. attempted suicide or self injury? No ☐ Yes ☐
   - b. threatened or been violent towards others? No ☐ Yes ☐

   **Is their care supervised by a psychiatric service?**
   - No ☐ Yes ☐

5. **Is there another health care professional primarily responsible for your patient?**
   - No ☐ Yes ☐

   If you answered Yes to questions 4 or 5, please give all relevant information, contact details, etc.

#### Declaration

I understand that if this person appeals, or asks for an explanation or reconsideration of the decision made by the decision maker, a copy of the information I have given here may be sent to the person, their legal representation and the Appeals Service.

I also understand that the only information that can be withheld is medical evidence that would be harmful to the person’s health, I have stated any medical evidence that I think may be harmful to the person’s health on a separate sheet of paper.

#### Your signature

<table>
<thead>
<tr>
<th>Doctor’s signature</th>
<th>Practice stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name in CAPITALS</td>
<td>Dr</td>
</tr>
<tr>
<td>Date</td>
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</table>
Appendix E
Copy of letter used for pilot mailing

Dear «Title» «Surname»,

Medical Services from Atos Origin is responsible for giving medical advice to the Department for Work and Pensions which administers Incapacity Benefit (IB). Although the provision of medical evidence in relation to IB is part of an NHS GP’s terms of service, I appreciate that this work may not strike you as a high priority.

Evidence from you as the patient’s General Practitioner is of great importance in ensuring that their progress through the IB assessment procedures is as smooth as possible, and that the degree of disability arising from their medical condition is accurately determined.
All of our Medical Advisers have undertaken further training to achieve Secretary of State Approval and many were practising GP’s before joining Medical Services. Our Medical Advisers use the information provided on an IB113 and Med 4 to advise the Department of Work and Pensions about the disabling effects of your patients’ medical conditions. Without this information our Medical Advisers are unable to provide accurate and timely advice. In some cases this will mean that a patient with a severe condition is not identified promptly or they are called for an examination which might have been avoided.

With this in mind, I felt that the following points might be useful:

- The information you provide on IB113 reports and Med 4 statements is used by a Medical Adviser

- The information may allow your patient to be statutorily exempted from the fitness to work procedures, for example, if they have a severely disabling condition

- Alternatively the information may allow a patient’s stated level of disability to be accepted without the need to call them in for an independent examination

- Even where an examination is required any factual information you may be able to provide about the effects of the condition on the patient’s day to day activities would be very helpful

If you need advice about general issues relating to certification or the provision of IB medical evidence, this can be obtained from a Medical Adviser in your region by telephoning number 0191 223 3110. This number is for doctor-to-doctor advice only. Patients should still be directed to contact their local Jobcentre Plus/Benefit office.

- The DWP website (www.dwp.gov.uk/medical) is also an excellent source of information – see hot topics for further information on IB medical evidence.

- Medical Services has produced presentations for GP’s and Practice Managers. These focus on the role of both the GP and the Medical Adviser in advising on fitness for work. They are interactive, and are designed to fit into a Personal Development Plan, which can be used to support appraisal and revalidation. I am planning, if possible, to deliver a presentation to GP’s in each PCT area over the next few months. I may also be able to arrange a number of presentations to individual or groups of GP practices. If you would like to know more about these presentations, please contact me.

Thank you for your continuing support.

Dr Paul Clasper
Medical Manager
References


