Electronic medical certificate (eMed3) Proof of Concept evaluation

Dorothy Chang and Andrew Irving

A report of research carried out by Andrew Irving Associates on behalf of the Department for Work and Pensions
# Contents

Acknowledgements ........................................................................................................... v  
The Authors .................................................................................................................. vi  
Abbreviations ................................................................................................................. vii  
Glossary of terms ........................................................................................................... ix  
Summary ......................................................................................................................... 1  

1 Introduction ..................................................................................................................... 7  
  1.1 Context, aims and objectives ...................................................................................... 7  
  1.2 Research objectives .................................................................................................... 9  
  1.3 Method and sample .................................................................................................... 10  
    1.3.1 Original research design ....................................................................................... 10  
    1.3.2 Final research design .......................................................................................... 12  

2 Background on sickness certification procedure .......................................................... 15  

3 Main findings .................................................................................................................. 19  
  3.1 Attitudes to the eMed3 concept ................................................................................... 19  
    3.1.1 Employers ............................................................................................................ 19  
    3.1.2 Employees ......................................................................................................... 21  
    3.1.3 Non-participating GPs ......................................................................................... 23  
    3.1.4 Practice Managers in participating practices ..................................................... 26  
    3.1.5 Participating GPs ................................................................................................. 26
3.2 Implementation of the trial ..............................................................27
  3.2.1 The Practice Manager viewpoint ........................................27
  3.2.2 The GP viewpoint ..............................................................27
3.3 Learning from the implementation ...................................................33
4  Conclusions and recommendations ............................................................35
  4.1 Conclusions .....................................................................................35
  4.2 Recommendations ...........................................................................36
Appendix A Screening questionnaires ............................................................39
Appendix B Topic guides ...............................................................................47
Appendix C Concepts ....................................................................................57
Appendix D Final self-completion questionnaire for participating GPs.............61
Appendix E eMed3 screen fields ....................................................................67

List of tables
  Table 1.1 Final sample achieved .................................................................13

List of figures
  Figure 2.1 eMed3 form (English) .................................................................17
  Figure 2.2 Med3 form .................................................................................18
  Figure 3.1 eMed3 screen ...........................................................................30
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The Authors

Since joining AIA in 1985, Dorothy Chang has developed considerable experience and expertise in both qualitative and quantitative methodologies in both commercial and social research. She has co-authored research reports on two large scale projects for DWP: Modernising Service Delivery – The Better Government for Older People Prototypes and Developing a Framework for Vocational Rehabilitation: Qualitative Research. Dorothy graduated from University College London with an honours degree in Philosophy and was called to the Bar of England and Wales in 1979. She is a Full Member of the Market Research Society (MRS) and a member of the Association for Qualitative Research (AQR).

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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIA</td>
<td>Andrew Irving Associates</td>
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<td>DWP</td>
<td>Department for Work and Pensions</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>POC</td>
<td>Proof of Concept</td>
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<td>SSP</td>
<td>Statutory Sick Pay</td>
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Glossary of terms

Beta trial

Testing of a computer product such as software. Beta testing can involve sending the product to beta test sites for real world exposure and where the product can be tested in a live operational environment.

Med3

A statement of incapacity for work, commonly referred to as the ‘sick note’ or medical certificate. The Med3 is issued when the patient has been examined by their GP on the day of, or the day before, issue. A Med3 can be issued for a period of up to six months within the first six months of sickness.

Med5

A statement of incapacity for work based on a previous examination of the patient by another doctor or on a report from another doctor less than one month earlier.

RM7

This form is used when a doctor doubts a patient’s ongoing incapacity for work but is continuing to issue medical statements (Med3s). The RM7 requests independent assessment of a patient by DWP. A copy of the RM7 form is included in the Med3 pad. If further action is taken, DWP will write to the GP requesting a report.
### Read codes

Read codes were invented and developed by Dr James Read in 1982 for use in general practice. The NHS bought the Read codes in 1990 and made them NHS Standard. The codes have now been expanded to cover all areas of clinical practice (there are over 98,000 in the latest directory) and include terms relating to observations, diagnosis, procedures and investigations which map to other coding systems.

### SSP

Statutory Sick Pay is payable to employees who are off work sick for a minimum of four consecutive days and who are earning at least £95 a week. It is paid by the employer and can be paid for up to 28 weeks. The employer can require an employee to provide some form of medical evidence of their sickness or incapacity for work after seven days of sickness absence.
Summary

Background and methodology

A key element of the cross-Government Health, Work and Well-being strategy has been the introduction of a revised medical statement. The Carol Black review of the health of Britain’s working age population recommended the introduction of electronic ‘fit notes’ to replace the paper-based sick note (Med3). Recommendation 6 reads: ‘The paper-based sick note should be replaced with an electronic fit note, switching the focus to what people can do and improving communication between employers, employees and GPs.’

There has been a recent trial of a revised format for the Med3 form, and during autumn 2008 and spring 2009 a trial of electronic sickness certification (eMed3) was set up in GP practices in Cardiff and Swansea. The overall aim of the Proof of Concept (POC) was to develop an electronic sick note that GPs could use and to prove the concepts of eMed3 distribution, electronic record keeping, and transfer of data to DWP. The eMed3 data was extracted from GPs’ systems and securely transferred to DWP using the DWP e-business gateway, where it was securely stored and accessed by a small number of authorised individuals. The data transferred contained information from the eMed3 certificate, but did not contain additional information from patient records. The data was anonymised: individual patients and GPs could not be identified.

The POC evaluation sought to get feedback on the eMed3 pilot from GPs participating in the trial, non-participating GPs, Practice Managers, employers and employees in receipt of sick notes. A qualitative methodology was adopted for the evaluation. In the main, this consisted of face-to-face depth interviews, but some group discussions were convened with participating and non-participating GPs and Practice Managers. In order to canvass as many participating GP views as possible, a short self-completion questionnaire was sent to them via the Practice Managers at the end of the evaluation.

It should be appreciated that the aim of the project was a POC and therefore inherently small scale. Given this, the design of any evaluation could not produce robust data. In recognition of this, the overall purpose of the evaluation was to act as a learning exercise should it be decided to extend the eMed3 into national rollout. Whilst every effort was made to secure as wide a range of views as possible, especially amongst GPs participating in the POC, a combination of various factors limited the scope of the evaluation. Findings should, therefore, be read in the light of the small sample sizes achieved.

Main findings

Although the main thrust of the evaluation was with participating GPs, the views of other interested parties were also canvassed.

Employers

Amongst employers, systems for managing sick notes and sickness absence varied, widely reflecting size and structure of the employer. Larger employers were more likely to have more complex and established systems. In contrast smaller employers were likely to have less formal systems that typically involved reporting to the Managing Director or Director responsible for sickness management.

Employers were broadly very welcoming of the eMed3 system. A minority of employers had already received eMed3s. The new form did not seem to cause any consternation largely because it was so similar to the existing Med3. A key benefit of the eMed3 was that because it was printed, time off work, diagnosis and employee’s details were all legible. There were some initial concerns that the new form might be vulnerable to fraud until it was appreciated that the bar code and unique ID system would inhibit misuse.

Some spontaneous interest was expressed in GPs sending eMed3s electronically to employers. From the employers’ perspective this would enable them to store the sick note electronically thereby saving time, paper and the need for filing space. The eMed3 could also be forwarded electronically to other departments such as HR or payroll which could be located in another part of the country. However, in the interests of security, it was noted that the eMed3 from the GP would need to be in pdf format to ensure no one could amend any of the information contained on it, thereby reducing any opportunity for fraud.

Employees

Employee response to the eMed3 concept was also predominantly positive. A minority had actually received an eMed3; they had no concerns about the new system once they had been reassured by the GP that this was the new system and that the form was as valid as the old paper form. Others saw the eMed3 as a natural extension of computerisation in GP practices.
Perceived benefits of the eMed3 were that it was legible; patient details were already printed on it, thereby saving them having to fill it in; it was possibly quicker for the GP to issue; and it was possibly more secure and less open to fraud. There was some expectation that employers would appreciate the legibility of the eMed3. The eMed3 form itself was seen as very similar to the current form and it was noted that it still had to be signed by the GP.

Views about GPs sending the eMed3 directly to employers were mixed. Some welcomed the convenience and speed of doing so; others felt that direct email communication between GP and employer was something of an intrusion on the privacy of the GP-patient relationship. There were hints of greater sensitivity amongst those with possibly less straightforward reasons for getting a sick note. However, reservations were, to a large degree, overcome when employees were reassured that any direct communication between GP and employer would only be with the employee's consent.

Most employees were largely unconcerned about the handling of data generated by the eMed3, noting that personal data would still be held by the GP practice. A minority, however, voiced a more libertarian viewpoint and were concerned that data might fall into the wrong hands. There was also some concern that sending data to a Government department like DWP, even if currently anonymised, could eventually lead to non-anonymised data being transferred. These concerns were heightened in the context of recent stories in the media about various Government departments losing confidential information about individuals.

**Non-participating GPs**

Amongst non-participating GPs there was fairly extensive dissatisfaction with the current sick note system and, for some, resentment at the amount of time it absorbed. Beyond this, some GPs felt that issuing sick notes was not really part of their remit as clinicians. Indeed, there were some suggestions that hospitals and DWP/Jobcentre Plus could take more responsibility for providing sick notes.

The proposal to introduce electronic sick notes attracted a mixed response but was widely seen as tinkering at the edges of a system that was not working very well. The benefits of eMed3 were generally seen as fairly marginal from a GP's perspective. Some felt it might be a bit quicker and could help to ensure that better records of sickness certification would be kept. Others were sceptical as to whether there would be any real benefits.

There were doubts about whether data collected on patient sickness via eMed3s would be of interest to individual practices. There were also concerns, especially amongst the more cynical about the motivations behind collecting this data and how the information might be used in the future. Amongst some younger GPs there was a suspicion that this initiative was a precursor to a more intrusive system and that individual practices and GPs might find themselves under scrutiny at some point in the future. There was also some concern that patient confidentiality might be breached accidentally and, furthermore, that personal medical information might be used against the interest of the patient.
The overall stance of most non-participating GPs was one of reluctant co-operation if the eMed3 system was introduced. They saw eMed3 as an evolution of the Med3 form and it was likely that they would transfer their dissatisfaction with the current paper-based system to the electronic system.

**Practice Managers in participating practices**

Practice Managers saw themselves as the gatekeepers and guardians to their GPs. They had read the initial letter introducing the POC and seen the eMed3 as of potential benefit to their GPs. GPs’ participation in the POC was, it seemed, largely due to recommendation by their Practice Managers.

Practice Managers came across as fairly protective of their GPs. Thus, they initially tried out the eMed3 to make sure it worked smoothly before presenting it to the GPs. Some encountered problems with getting the forms to print but trying to resolve these problems with the software provider was itself problematic. In Cardiff the contact person at the software provider went on holiday shortly after implementation which left some Practice Managers stranded.

At the time of the evaluation, some practices were still experiencing problems with getting eMed3s working properly, especially in branch practices, and one Practice Manager claimed only to have had full implementation in the fortnight prior to the interview. Not surprisingly, given this experience there was a degree of frustration with the POC.

**Participating GPs**

Some delays and difficulties were experienced with the implementation of the eMed3, and GPs were effectively discouraged from trying to use it until it was working properly. Once some of these initial difficulties with operating the new system had been overcome, GPs at the participating practices used eMed3s to issue sick notes and most users felt that it was fairly simple and easy to use. That having been said, some doubted whether it really was any quicker than using the paper-based system, although none thought it would be slower.

At most practices the training to use the system was very limited. Some just managed as best they could and learnt as they went along. There was little recall of seeing the User Guide. When shown it there was a strong feeling that a simpler, shorter guide would have been more useful.

The impression was that almost all the GPs were using the system at a very basic level, i.e. simply to fill in the time off and diagnosis boxes. For routine consultations there did not seem to be any difficulties in using eMed3 and identifying the appropriate Read codes (see Glossary). There were, however, some instances where GPs found it difficult to locate the appropriate Read code for the Diagnosis field and were constrained to enter an approximate code instead. Few used the ‘Remarks’ field.

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3 The various fields are included in Appendix E.
Few GPs were using the optional fields and most were unaware of the rationale for completing these fields. Indeed, because the Clinical Diagnosis field defaulted to the code entered in the Diagnosis field many could not understand why it was there.

Significantly, GPs were not especially concerned about issues relating to anonymisation of data because they were unaware that the information was being sent to DWP. When it was explained that anonymised data was going to DWP, most GPs remained unfazed by this, although some concerns were voiced that the information might be used to check on individual practices/GPs. They were, however, not especially interested in receiving information from DWP about sickness absence, either for their own locality or for the wider area Health Authority.

Conclusions and recommendations

This evaluation was relatively small scale and some samples were, in the event, fairly small. Consequently, care must be taken in the interpretation of the research data. However, in general terms the findings indicate that overall there is broad acceptance of the eMed3 concept:

- employers, especially those with a large workforce and/or multi-site organisations, see many benefits in eMed3. For them, the eMed3 has potential to simplify record keeping and sickness absence management, and the possibility of receiving the eMed3 electronically direct from the GP has many advantages;

- employees have few reservations about the eMed3 (largely because it looks so similar to the current Med3) and many see it as an extension of the growing computerisation in GP practices. However, a minority voice concerns about data going astray and suspicions about how the data might be used in the future;

- non-participating GPs are fairly sceptical as to eMed3s bringing about any benefits for them. They doubt whether information collected would be of interest to individual practices and some are concerned about the motivations behind collecting this information and how it might be used in the future;

- Practice Managers see that eMed3s might save their GPs time, but problems in implementation have left some feeling frustrated; and

- participating GPs were happy to be using the system but were doing so at a very basic level. They were, for the most part, only filling in the ‘For’ and ‘Diagnosis’ fields, with one or two also using the ‘Remarks’ field. Few were using the optional fields and most were unaware of the rationale for completing them.

In taking forward eMed3s into national rollout, the following key issues emerged from this pilot in South Wales:

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4 The transfer of anonymised data was outlined in an email to Practice Managers, and also in the letter to a GP in the practice inviting them to take part in the POC as well as on page 1 of the User Guide.
problems with IT and software compatibility identified in this POC need to be sorted out before the system goes national;

- in this context, there is a need to develop a way of sharing/communicating IT problems identified by one surgery with others and, similarly, the solutions to those problems;

- Practice Managers should be involved in the set-up process. In the event of any problems with the eMed3, Practice Managers are likely to be the primary interface between GP and software provider. Thus, it is important that they should have quick access to help and advice which they can pass on to their GPs;

- in this context, consider setting up a dedicated telephone helpline so that if Practice Managers or GPs experience any problems they can have access to quick and knowledgeable support;

- provide access to training for Practice Managers (and GPs if they are interested) in how to use eMed3; and

- provide GPs with a one-page desk guide on how to use eMed3 for quick reference.

It should be noted that the software provider for the POC is only one of a number of suppliers. There might, therefore, be different issues, not necessarily just of compatibility, with each of the providers. This suggests that each provider needs to identify potential problem areas and offer GPs access to help and support, for example via a helpline.

There is a case for a targeted communications campaign aimed at HR (or equivalent) departments amongst employers informing them about the introduction of eMed3. This could be incorporated into information about Statutory Sick Pay (SSP).

GPs will need to be informed about the purpose of eMed3, in particular the rationale behind the optional fields. Likewise, there is a need to be clear about any data transferred: what data will and will not be transferred and how it will be used. However, it will be important to adopt an appropriate tone bearing in mind levels of cynicism amongst GPs about the possible use of data collected.
1 Introduction

1.1 Context, aims and objectives

The Department for Work and Pensions (DWP) is responsible for the issue and use of medical statements, also known as certificates, and for government policy on the management of sickness absence. The current Med3 certificate is used by GPs to provide information about a patient's sickness and record advice regarding time to refrain from work. However, data on sickness absence, including causes and duration, is negligible. It is believed that a data resource on medical certification across the country would have a range of possible uses and could potentially inform and improve the management of sickness absence.

The current medical statement form (Med3) is essentially unchanged since the major re-organisation of the health and social security systems in 1948, and reflects the paper-based processes of the time. Although there is no accurate data which confirms volumes of issued Med3s, each year around 15.1 million certificates are printed and distributed to the NHS and are assumed to be used. It is believed that Med3s are second to prescription forms in volume. However, there has been very little monitoring of the issuing of Med3s, much less any analysis of the clinical reasons and national epidemiological patterns.

The eMed3 POC project aimed at implementing a working solution which demonstrated the key technical concepts of Med3 data capture, the printing of certificates on GP computers, and the secure transfer to DWP of anonymised eMed3 data, i.e. data which could not be attributed to individual GPs or patients. After initial positive scoping, an allocation of funding was obtained in 2004 to pilot computer-generated medical statements as part of a package of ‘extra support for GPs’\(^5\). DWP set out the proposed work more clearly as ‘GPs do really important work in providing advice about fitness for work, both for their patients and for employers when people first fall ill. Currently, though, the system does not record the issuing of sick notes, something that contrasts starkly with the situation in respect of prescriptions, which are thoroughly audited. Working closely with the health departments and GPs themselves, we now need to explore and develop ways

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to improve the information held. This will pave the way for us to develop a system to feed back to individual GPs information about their certification practice, which can be used for professional development and revalidation purposes. As part of delivering this commitment, the eMED3 POC project was conducted in Wales, in partnership with the National Assembly, the Welsh Assembly Government, and the Welsh General Practitioners Committee.

Working with medical colleagues and a key GP system supplier, the eMed3 solution was designed and implemented in 14 practices in South Wales. In addition to the fundamental aim of proving basic technical concepts, an evaluation was also conducted to explore the views of GPs and other stakeholders about the eMed3. The specific objectives of the POC project were as follows:

- to create an appropriate computer application which enables capture of all Med3 data now on the Med3 form and its incorporation into the patient’s medical record (as is done for prescriptions). Where appropriate, use patient data held on the practice system to minimise work, e.g. names, addresses, date of birth, etc.;

- to print the form (with the captured relevant data) as it is currently defined on standard A4 paper, to be signed by the GP and issued to the patient. Security of the printed form to be provided by assigning/printing a unique ID which is also stored in the medical record to enable future audit, and all data which is printed on the form to be encoded in a 2D barcode layout for machine readability;

- at the discretion of the GP, to enable the capture of two diagnoses: one which is deemed fit for printing on the form and its subsequent distribution (the Diagnosis), and one which may more specifically define the precise clinical condition at hand (the Clinical Diagnosis);

- also at the discretion of the GP, to enable capture of the ‘Circumstances’ under which the certificate is being issued. Working with medical colleagues, a number of circumstances were identified which may be useful to understand the kinds of influences on the GP which give rise to their rendering a valid certificate. Examples which the GP could assign were ‘Patient is on waiting list waiting for investigation/procedure/op’, ‘Long term illness’, ‘Should have been hospital generated’, and ‘Social reasons’; and

- periodically (weekly or bi-weekly), to scan the GP system for all recent eMed3 activity, format activity records without patient or GP identifiers (names, identifying numbers, addresses, etc.), encrypt and transfer those records via secure communication mechanisms to DWP. Protected by DWP’s procedures on data protection and sharing, the data would be accessed by a small number of authorised individuals in DWP to explore concepts of Med3 data analysis.

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7It is envisaged that anti-fraud measures would be reviewed prior to wider rollout.
1.2 Research objectives

The main objectives of the evaluation were:

• To explore and assess amongst participating GPs attitudes towards the process before, during and after taking part in the pilot.

• To investigate their attitudes towards the idea of eMed3 forms overall and in terms of:
  – the practicalities of using them;
  – the likely and possible benefits;
  – the anticipated and actual problems/barriers encountered; and
  – suggested improvements.

• To find out whether the process of using eMed3 forms operated as intended and any difficulties encountered.

• To find out the extent and nature of any cultural barriers or resistances to rolling out use of eMed3s that might exist among GPs or GP practices, and how these might be overcome.

• To establish how best to get GPs to engage with eMed3s and fill in forms correctly.

• Amongst non-participating GPs, to explore and examine attitudes to the eMed3 concept overall and on dimensions such as:
  – perceptions of the current process;
  – the idea of using eMed3 forms;
  – the likely and possible benefits of eMed3s;
  – the likely and possible barriers, concerns and resistances; and
  – suggested improvements.

• To explore and examine patients’ views about the introduction and use of the eMed3 forms in terms of propensity to accept the new system, and establish any resistances or concerns.

• To explore and examine employers’ views about the introduction and use of the eMed3 forms in terms of propensity to accept the new system, and establish any resistances or concerns.

• Overall, to identify the key lessons that can be learned from the POC process with particular regard to the issues relating to implementation on a wider basis.
1.3 Method and sample

A predominantly qualitative methodology was adopted for this evaluation study involving a combination of depth interviews and mini-group discussions. Additionally, short self-completion questionnaires were sent to GPs participating in the trial in order to canvass the views of as many participating GPs as possible.

The sample was designed to include representation of the following key segments:

- GPs who were participating in the pilot;
- Practice Managers in participating practices;
- GPs who were not participating in the pilot;
- employees who had received eMed3s/med3s; and
- employers who might receive sick notes.

1.3.1 Original research design

**GPs who were participating in the pilot**

The original sample design was drawn up while GP surgeries were being recruited to take part in the POC. It was envisaged that around 20 GP surgeries (up to 60 GPs) drawn from the main conurbations in South Wales, Cardiff and Swansea, would participate. The plan was that participating surgeries would agree to take part in the research when they agreed to take part in the trial.

The proposed methodology was to conduct the evaluation amongst participating GPs in three phases. A short depth interview was to have been conducted with at least one of the GPs in each participating surgery before the trial started or in the very early stages of the trial to establish general attitudes to dealing with sickness, issuing of sick notes, etc. ahead of the trial. In the closing stages of the trial, face-to-face depth interviews would be conducted with at least one GP in each of the participating surgeries to explore perceptions of how the trial had gone and to uncover GPs’ detailed attitudes to using the eMed3 and possible barriers and sources of resistance or concern.

It was planned that a short self-completion questionnaire would be distributed to all GPs in the participating practices in the first and last of these phases (before/in the very early stages of the trial and in the closing stages). The questionnaire would be designed to pick up on their attitudes to the trial, the eMed3 process, etc.

This three-phase approach would have provided GPs’ views at different stages in the trial and established how the eMed3 process worked in practice and how it might be improved.

In the event, circumstances were such that this proposed approach proved unworkable and a somewhat different approach had to be adopted (see Section 1.3.2).
Non-participating GPs

It is arguable that GPs who were participating in the trial may have a particular interest in the area of sickness certification. It was decided to canvass the views of GPs who were not participating in the POC to get ordinary GPs’ views on the strengths and weaknesses of the current system, and to explore the basic acceptability of the concept, potential sources of resistance, and issues to bear in mind during rollout.

As it was not possible to canvass the views of participating GPs prior to implementation of eMed3, it was accepted that the views of non-participating GPs could be read as indicative of the views of the wider GP audience.

Three group discussions were conducted with non-participating GPs in South Wales but whose practices were outside the POC area. Most non-participating GPs were using the same software provider as those who were participating.

Patients/employees

The original research design envisaged conducting interviews with patients who had been issued with an eMed3. To reach this sample would require either the GPs to provide contact details for qualifying patients or to get patients to ‘opt in’ by asking GPs to give eligible patients a self-completion questionnaire for them to fill in and return to AIA; a reply paid envelope was provided. In discussions with DWP it was agreed that the former course was not practicable, so recourse was made to the latter. GPs and Practice Managers were asked how many patient questionnaires they thought they would require; amounts ranged from five to 20. However, we received only one response. This could be due either to patients being unwilling to put their names forward for interview and/or to GPs being rather less than enthusiastic about giving their patients the questionnaire.

A more practicable alternative for exploring patient opinion was to recruit and conduct interviews or mini-group discussions with a sample of employees who had been issued with sick notes in the last three to six months. As these respondents were recruited in areas where the POC was taking place, some had actually been issued with an eMed3. Two groups were held in Cardiff and two in Swansea.

Employers

Ideally, the employer sample should have been those who had actually received an eMed3 on one or more occasions. However, given the practicalities of being able to locate employers who fell into this category, it was decided to recruit employers who had been in receipt of employees’ sick notes in the last three to six months. As employers were drawn from Cardiff and Swansea there was a likelihood that some would have actually received an eMed3 from one or more of their employees.

The employer sample was drawn from a cross-section of small to medium enterprises (SMEs) and large employers in Cardiff and Swansea. It was structured by number of employees. It quickly emerged that the HR manager and/or the
person responsible for sickness management did not necessarily receive employees’ sick notes. Very often these went initially to an employee’s line manager. Thus, interviews were sometimes conducted with more than one person, especially in larger organisations.

### 1.3.2 Final research design

In the event, the final research design had to be considerably modified, especially for the participating GP sample. At the outset it had been accepted that the cooperation of GPs would be key to conducting the study effectively and it was felt that GPs, when they signed up for the trial, also agreed to take part in the evaluation. Practices which had agreed to take part should have been sent a letter which included a reference to participating in interviews to assess GP opinion. However, it appeared that GPs had not taken this reference on board and thus, seemed to regard participation in the research as a low priority.

Delays in getting fieldwork started largely related to the difficulty in getting GPs to allocate time to take part in an interview about using the eMed3. Other contributory factors included:

- **delay in implementation of the eMed3**: there was limited value in trying to interview GPs about a system that most had not been able to use at the time we were trying to set up the interviews; and

- **time of year**: because of the delays in implementation of eMed3 in various surgeries, the start date of the interviews was progressively pushed back into the period running up to Christmas/the end of the year with the bulk of the fieldwork being conducted in January.

Given the difficulty in arranging face-to-face interviews at participating GPs’ surgeries, it was decided to convene group discussions with GPs in Cardiff and Swansea. Groups were held at convenient hotel venues. Respondents were invited to attend by an experienced market research recruiter and were offered a cash incentive for attending. Four GPs in Cardiff and four in Swansea agreed to attend. In the event, only two GPs attended at Cardiff, although there was full turnout in Swansea.

Secondly, it was decided by DWP to conduct interviews with Practice Managers in participating surgeries. The rationale behind this was that in trying to set up interviews with GPs it quickly emerged that Practice Managers had an important and influential role in managing operational issues within their practice. They saw it as their responsibility to make sure the eMed3 was working properly before getting the GPs to use it and GPs who were experiencing any problems with the eMed3 looked to their Practice Managers to resolve it.

We encountered similar problems in trying to set up face-to-face interviews with Practice Managers and so it was decided to convene evening groups: one in Cardiff and one in Swansea. Four Practice Managers attended the Cardiff group and two attended in Swansea.

Table 1.1 sets out the final sample achieved.
### Table 1.1 Final sample achieved

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A final stage in the evaluation was to ask participating GPs to fill in a brief self-completion questionnaire (Appendix D) which sought to establish their overall views about eMed3. This exercise was an attempt to reach those GPs we had been unable to interview face-to-face.

The questionnaire was sent out via an email to Practice Managers on 16 February, with email follow-ups on 23 February and 23 March. In the event, a total of eight questionnaires were returned. The low level of response would seem to confirm suspicions about GP’s limited engagement with the evaluation.
2 Background on sickness certification procedure

Under their contractual arrangements, NHS general practitioners are required to record fitness for work advice to their patients on a Med3 form. This is a statutory form and is commonly referred to as a sick note. The Med3 is usually issued by GPs but can also be issued by hospital doctors to in-patients and out-patients who are incapable of work because of treatment or medical intervention.

The Med3 can be used by patients to access financial benefits. An employer paying Statutory Sick Pay (SSP) may ask their employee for evidence of their incapacity for work. A Med3 cannot be required by an employer during the first seven days of incapacity for work and can only be issued within 24 hours of examination by the GP who signs the form. When a certificate is required to cover an earlier period based on an examination by another doctor, a Med5 certificate will be issued rather than a Med3.

Other medical certificates produced by DWP are:

- Med4 which is issued prior to the first application of the Work Capability Assessment which is the test which determines entitlement to Employment and Support Allowance after the assessment phase; and
- Med6 which is sent straight to Jobcentre Plus when a diagnosis has not been entered on Med3, 4 or 5 because the patient and/or employer should not know the diagnosis.

The current sickness certification scheme is paper-based which has resulted in a lack of robust and accurate information on how many sick notes are issued. DWP has conducted an impact assessment for the revised Med3 which sought to establish a means of working out how many sick notes are issued\(^8\). An analysis of printing orders gave an estimated figure of around 15.1 million Med3s per year.

Other studies have indicated different numbers of sick notes issued. For example:

- a study by Shiels and Gabbay based on reporting by nine GP practices found that GPs issue an average of six Med3 and Med5 statements per week, an estimated total of 11.5 million per annum\(^9\);

- a survey by Norwich Union Healthcare estimates GPs issue an average of 11 medical statements per week giving a total of approximately 21.2 million\(^10\);

- another study reported that on average GPs will issue 20 medical statements per week, an estimated total of 38.4 million\(^11\).

Employees can self-certify for the first seven days of absence using an SC2 self-certification form or similar, provided by their employer. GPs are not obliged to issue medical certificates for periods of absence under seven days. However, if a patient requires short-term proof of incapacity, the GP may charge a fee for issuing one.

The Med3 is currently provided as a printed pad or loose sheets. Details have to be entered by GPs by hand. The eMed3 would replace the current Med3 form. GPs would enter details of time off work and diagnosis on their computer and these would be printed on the eMed3 form on standard A4 paper. The printed form would also contain the patient’s name, address and date of birth. The aim is to reduce the potential for fraud by including features such as a computer-generated unique ID and a 2D bar code for each form. The unique ID is stored on the issuing system, thereby enabling the audit of valid certificates. It is anticipated that the potential for fraud could also be reduced because the salient details (time off work and patient’s details) are printed and any attempt to alter by hand would be easily noticed. It is anticipated that these anti-fraud measures would be reviewed prior to national rollout.

Figure 2.1 shows an example of the eMed3 form in English. There is a bi-lingual English/Welsh version available but it appears not to have been used by any of the participating practices.

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Background on sickness certification procedure

Figure 2.1 eMed3 form (English)

**For Social Security and Statutory Sick Pay Purposes Only**

*Notes About This Form:* This is a new MED3 form for an pilot project to evaluate new methods for issuing medical statements. There is no change from the existing MED3 form and it should be used in the same way, and for the same purpose.

**The Patient:**

1. For statutory sick pay purposes, Section A (Patient details) is Part 1 of the form.
2. For Social Security purposes, Section B is completed by the patient or the person with whom the patient lives. Section C is completed by the doctor.

**The Doctor:**

Section C of the form can be completed when the patient returns the form to the doctor. The doctor should fill in the date of the examination and the diagnosis(s).

**Doctor’s Signature:**

The doctor’s signature should be legible and should include the date of signing.

**Declaration:**

I declare that the information given on this form is correct and complete.

I understand that the Department of Work and Pensions, or any approved healthcare professional working on their behalf, may request the copy of this form.

I declare that any information given in this form is correct and complete.

**Signature:**

If you have signed this form, please sign here: [Signature]

**For State Benefit Claimants Only**

The names and address of the person to whom the form is being sent should be entered here.

**2D BAR CODE**

*Form MED3 - unique_id*
Figure 2.2 Med3 form

FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY

NOTES TO PATIENT ABOUT USING THIS FORM

You can use this form either:

1. For Statutory Sick Pay (SSP) purposes - fill in Part A only.
   Also fill in Part B if the doctor has given you a date to resume work.
   Give or send the completed form to your employer.

2. For Social Security purposes -
   To continue a claim for benefit fill in Parts A and C of the form
   overlaid. Also fill in Part B if the doctor has given you a date to
   resume work. Sign and date the form and give or send it to your Local
   Social Security Office quickly to avoid losing benefit.

NOTE: To start your claim for State benefit you must be out of work. See SC1 if self-employed, unemployed or non-employed OR if you are
an employee. For further details get booklet IS202 from Social Security Local
Office.

Doctor’s Statement

In confidence to
Mr/Mrs/Miss/Ms .................................................................

I examined you today/yesterday and assessed you to be
(a) You need not
    return from
    work
    for

(b) You should
    return from work
    after

Diagnosis of your condition causing absence from work

Doctor’s remarks

Doctor’s signature Date of signing

Form Med3

NOTE TO DOCTOR*: See inside front cover for notes on completion
3 Main findings

3.1 Attitudes to the eMed3 concept

3.1.1 Employers

Background observations

It should be noted that the sample of 12 employers was a small sample to cover what is a broad and diverse target group.

Within organisations we sometimes interviewed more than one person in order to cover the different viewpoints of sickness absence management. Those from employer organisations included policy influencers, members of the HR/occupational health team, payroll/finance personnel and line managers. The total number of respondents interviewed in the employer sample was 16.

Companies and organisations in the employer sample ranged in size from five full-time employees to over 10,000 employees, and covered a range of different industry sectors including Government, manufacturing, retail, service, charity and financial. Some were single-site operations while others were local branches of national groups.

In larger organisations, those involved in processing sick notes could include line managers, HR and payroll, as well as those responsible for overall policy towards sickness absence management. In smaller companies, one person tended to have overall responsibility for sickness absence management.

Procedures regarding sick notes tended to be more formalised in larger or more established organisations. Typically, the sick note would go initially to the employee's line manager. It would then be sent on to the HR/payroll department where copies would be made: one would be filed in the employee's record file; another would be sent on, e.g. to head office or finance; and, if the employee was claiming benefit, a copy would be sent on to Jobcentre Plus. In large national companies it was noted that a Med3 would sometimes be scanned and sent electronically to the wages department which could be in another part of the country.
‘Once they’ve exhausted their entitlement to SSP and they’re likely then to claim you benefit, yeah, then it [eMed3] would go to DWP.’

(Employer, Swansea)

‘Jobcentre Plus insist on the originals which, when they claim Incapacity Benefit, is a bit of a pain for us because they won’t accept photocopies at all, or so they say.’

(Employer, Cardiff)

Amongst small employers who were employing people on a more casual basis, for example, pubs, the sick note procedure was more informal. The sick note was often put in the employee’s file and no further action taken, especially if SSP was not being paid.

**Awareness of, and attitudes to, eMed3**

Only a minority of employers recalled having received an eMed3. There was no evidence of it having caused any great consternation and it seemed to have been accepted fairly readily. One employer had initially assumed it was a photocopy of the current Med3 until she noticed the doctor’s signature. Amongst the majority who did not recall having received an eMed3, the new form was sufficiently similar in content to the current Med3 not to raise eyebrows.

Responses to the eMed3 were overwhelmingly positive. A key benefit was that time off work, diagnosis and the employee’s details (name, address and date of birth) were printed, and therefore legible. Employers welcomed the fact that they would now be able to see clearly what was wrong with the employee whereas in the past they had sometimes struggled to decipher the GP’s writing. Having the employee’s details clearly printed meant that there was likely to be less confusion and time wasted matching employee to sick note. This was particularly important to larger employers where the HR or payroll department might not necessarily know which employee was off sick and were likely to have several with the same name on their payroll.

Interestingly, these potential benefits to employers have already been noted in the context of the proposed ‘fit note’. In a blog on the People Management website an employer wrote that although the current paper-based system was time and labour intensive and therefore expensive, absence management was not a high priority for many employers. The proposed ‘fit note’ would give better information about long-term absence and would allow employers to make faster and more effective interventions; with sufficient data, employers could start to analyse trends in sickness absence within their organisation and improve absence management.

12 [www.peoplemanagement.co.uk](http://www.peoplemanagement.co.uk)
Less positively, amongst our employer sample there were some concerns that the eMed3 form might be open to fraud. At first glance it looked as though it would be easy to scan and/or copy. This concern might, to some extent, have been heightened by the benefit fraud campaign running in South Wales at the same time as the POC evaluation interviews. However, once pointed out, the bar code and unique ID on the form helped to provide reassurance that the system was less open to fraud.

There was some interest in receiving an eMed3 by email, especially amongst large employers and those with multi-site operations. Benefits of doing so included:

- speed in getting the sick note to the employer;
- less chance of the sick note getting lost or mislaid;
- ease of forwarding the sick note on to other departments within the organisation;
- easier to file in electronic personnel records;
- quicker to process because it would remove the need to scan in the paper copy;
- does away with the need for paper copies and reduces the need for filing space; and
- easier for the employee because they do not need to make a special effort to post or deliver the sick note in person.

That said, there was agreement amongst large employers that to be sure about security an eMed3 sent electronically would need to be in pdf format. That way, there would be no possibility of anyone tinkering with the form, especially if it was going to be forwarded on to another department, e.g. HR or payroll, located in another site/office.

### 3.1.2 Employees

The employee viewpoint was gathered primarily from group discussions conducted in Cardiff and Swansea amongst a sample of employees who had had a sick note at least once in the past six months. We also gained some information about employees’ response to the proposed scheme from both employers and GPs taking part in the trial.

The overall impression was that the new electronic sick note had prompted little or no negative response from most employees. Some participating GPs recalled that patients noted that the new form was different to the old paper Med3 and wanted reassurance that their employers would accept it. However, once reassured by the GP (in whom they placed a high degree of trust) they appeared to be quite happy with the new form.

Only a few of the employees in our sample had been given an eMed3. They rather
reinforced the view of GPs that the eMed3 was not a cause of concern to their patients.

‘Well it just came off the computer. It was very similar to the old style ones, just that it is printed on the computer. I can’t really describe it because I didn’t take much notice. I just signed where I had to and handed it into my works.’

(Employee)

Employees observed that the form:

• was easier to read so that they could see for themselves what the GP had written;
• was possibly quicker and easier for the GP to complete;
• required less from the employee because the name and address section was filled in automatically;
• meant it was possibly easier to get a duplicate sick note if necessary;
• possibly increased security.

‘I think for the doctor it is much better because it is less time consuming. So if it is easier for the doctors to do it this way it is fine by me.’

(Employee)

From most employees’ point of view, the eMed3 was a natural extension of computerisation of GPs’ surgeries. They were already familiar with prescriptions being printed off and so it seemed quite natural that eMed3 forms should be produced in a similar fashion. The introduction of the eMed3 was often seen as a further sign of progress in the way GPs managed their caseload. A minority doubted the benefits of the electronic sick note arguing that it saved little or no time.

The eMed3 form was seen as broadly similar to the existing form and some felt it was a bit clearer in the way it was set out. Most expected it would be accepted by employers. It was also noted that it still needed to be signed by the doctor.

Views about the idea of eMed3s being sent electronically to employers were mixed. Some welcomed the idea, appreciating that the eMed3 would be delivered quickly to the employer and saved them having to take it in or post it. Some respondents had been given a sick note for work-related stress and did not find it helpful having to go into work to hand in their sick note, especially if their line manager to whom they were handing the note was the cause of their stress. Others who were recovering from operations or trauma injuries found it difficult having to go into the workplace but were not always confident about asking somebody else to take the sick note in for them.
‘I think it would be good if they did send it to employers as well. It would have saved me a lot of problems ... I had to physically do it myself and that was awful. I didn’t trust anyone to do it for me.’

(Employee)

Others were ill at ease about putting their GP in direct contact with their employer and preferred to retain responsibility for sending or delivering their Med3 to their employer. They argued that if they delivered it to the relevant person at their place of work they would know that it had been received. Most employee respondents had been given time off work for fairly straightforward illnesses and conditions, e.g. trauma, post-operative recuperation, stress, and were open about why they had sought a sick note from their GP. However, one respondent simply referred to a long-standing recurring illness. Arguably, employees with more sensitive conditions could feel somewhat more reluctant for their employer and GP to be in direct contact with each other.

When shown the reassurances about use of data concept13 outlining the proposal for handling data generated by eMed3, the majority of employees were broadly unconcerned. They noted that personal data would be retained by the practice and were reassured by this. However, at all four group discussions a minority voiced a libertarian viewpoint and expressed concern that personal data might be mislaid in some way and fall into the wrong hands. This view was supported by the high profile media stories about Government departments losing confidential personal information. Some also viewed sending of data to DWP with some suspicion: they believed that to start with it would be anonymised but, in time, personal files with individuals’ name, address, date of birth and National Insurance number would be sent to DWP as a matter of course.

Whilst the majority were willing to accept reassurances provided about data handling and the anonymisation of any data that was transferred, there is a likelihood that there will be a minority segment whose concerns about security of data can easily be aroused. It has to be observed that those voicing reservations about data being forwarded to third parties tended to be older and less familiar and at ease with computers and electronic data storage. There were also some signs of a degree of posturing.

3.1.3 Non-participating GPs

Non-participating GPs’ familiarity with and attitude towards issuing sick notes varied. Across the sample, respondents’ patient profile reflected the demographics of the different areas. Some GPs’ surgeries were in fairly affluent areas or where the patients were relatively old, while others were practising in areas where there were fairly high levels of unemployment (e.g. the Welsh Valleys). Consequently, some of the non-participating GPs were issuing more sick notes than others. Indeed, several mentioned that they were running dedicated sick note clinics once

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13 Appendix C, Concept 5.
a week. The sole function of these clinics was to hand out sick notes and involved a fairly cursory five-minute consultation.

Non-participating GPs’ opinions about the eMed3 were coloured by a widespread feeling that GPs should not be responsible for providing sick notes.¹⁴ There was considerable resentment about the amount of time taken up with the routine of issuing sick notes, especially if a patient’s inability to work was self-evident, e.g. in cases of post-operative recuperation or accident trauma. There was a feeling that hospitals could take more responsibility for providing Med3s for post-operative cases rather than leaving it to the patient’s GP to issue a Med5. Likewise, there was some irritation at continually having to issue sick notes for the long-term ill and patients who were unlikely to rejoin the workplace, where the sick note was simply to meet DWP/Jobcentre Plus requirements.

‘We shouldn’t be providing them, basically. We didn’t go to university to tell people whether they should work or not. ...We don’t have time in our consultations to go into what their job actually entails to determine whether the disability they have warrants them to have a sick note. It’s not really our role.’

(Non-participating GP)

There was some sense that the need for GPs to provide sick notes could put them in a difficult position with regard to their patients’ relationship with their employers. This was especially so if their patients put them under pressure to issue a sick note or if they themselves were aware of special circumstances in the patient’s life that might be affecting their ability to work. The GPs in these group discussions recounted cases where they were asked to provide a sick note because the patient had to care for a sick child or partner and their employer was unlikely to grant them compassionate leave, or cases of marital break up or bereavement where the patient simply needed time off. Thus the introduction of eMed3 was seen as tinkering at the edges of a system that many felt was not working particularly well, and many could not see what benefit might derive from it. Consequently, response to the basic idea of eMed3 tended to be fairly mixed.

Any benefits of eMed3 were seen by most as likely to be fairly marginal. If it worked well, some felt it might be a bit quicker and more efficient because information would be entered into patients’ records at the same time. Also, it was likely that more complete records would be kept. Others claimed that the new system would make little or no difference to record keeping. They also doubted that there would be much saving in time.

There were also doubts about the quality of data gathered. Given that many were simply filling in fairly anodyne reasons for absence on the current Med3 (e.g. stress, nervous debility) it was felt that any data collected electronically would

¹⁴ This view is not uncommon amongst GPs and has been referred to in other research for DWP: Hiscock, J. and Ritchie, J. (2001). The role of GPs in sickness certification. DWP Research Report No. 148.
simply record this, and would no more be able to record the real reasons than the current system. Non-participating GPs also did not think that the information collected via eMed3 would be of much interest to their practice. They did not see that their practice would learn much about how they were managing sickness certification, neither could they see their practice being interested in what their local area or the rest of South Wales was doing.

There were also some concerns about the motivations for collecting this information and how it might be used in the future. There were some suggestions, especially from a younger, more radical segment that the proposed collection of data could lead to individual surgeries and/or GPs coming under scrutiny. One GP went as far as to claim it could lead to an ‘infringement of human rights’.

There were also fears of breaching patient confidentiality and/or the patient doctor relationship. While there was a rather cynical lack of faith in the competence of DWP/Jobcentre Plus in handling and retaining this data securely, there were also some concerns about the more deliberate use of personal medical information to make checks on individual patients.15

‘My only concern about this is the anonymity because we all know how safe information is with the Government ... and with a postcode the patients can be identified. ... It makes you feel like asking the question – who is it policing really? Is it policing the patients? Is it policing us? Or is it just to make it easier for the DWP?’

(Non-participating GP)

‘This smacks typically of DWP working a*!e backwards ... this is the first part of the pilot; the second part of the pilot will be that it [information] will automatically go to DWP. If the patient gets rejected they’ll come back to us and say “whatever you put in that form I haven’t got my benefits”.’

(Non-participating GP)

Most of the GPs in this non-participating GP sample resented their role in the sickness certification process. Thus, if eMed3 was introduced their stance would be one of more or less reluctant compliance. However, there was little enthusiasm, especially amongst the younger GPs who tended to come across as fairly cynical and ground down. Older GPs, possibly because they were closer to retirement, seemed rather more accepting of the proposed scheme.

‘I would like us to never have to fill a sick note in again because it’s nothing to do with a person’s health. We are doctors, we did a five-year medical degree to diagnose illness and to treat it and that is not the same as filling in a certificate saying why this patient doesn’t want to go to work.’

(Non-participating GP)

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15 These groups were conducted whilst an anti-fraud campaign was being run in South Wales and this may have heightened sensitivities about both fraudulent claiming and measures against it.
3.1.4 Practice Managers in participating practices

It should be appreciated that the total number of Practice Managers interviewed in the evaluation was small. In all we conducted five face-to-face depth interviews and two mini-groups attended by a total of six Practice Managers.

It would appear that the initial letter to a surgery inviting participation in the POC had been read first by the Practice Manager. They had formed the view that the eMed3 could have some benefit to their GPs and had put it forward at the next practice meeting.

It was recognised that Practice Managers have an important role to play in the smooth running of eMed3 within a practice. They acted as the interface between their GPs and the outside world. Indeed, one described the role of the Practice Manager as a ‘nanny’ to the GPs. They also felt it was necessary to make sure that were no glitches in the eMed3, and if there were any to get them sorted out, before giving it to the GPs.

‘It’s no point my giving it to him [the GP] until I am sure that it’s working properly and that I know how to make it work. Because if he has any problems with it it’s me he’ll come to to sort it out for him. And if it’s too much trouble he won’t bother using it.’

(Practice Manager)

Beyond seeing that the eMed3 might have a potential time saving benefit to their GPs, Practice Managers had not realised that the data would be anonymised and sent to DWP, nor had they taken on board the fact that the data would be used as a way of gaining a better understanding of how GPs manage sickness certification.

3.1.5 Participating GPs

For participating GPs, eMed3 was, in theory, a good idea and could provide an efficient way of recording information about sickness certification into a patient’s notes as well as producing a legible sick note. However, one GP noted that eMed3 could only be used in the surgery and that the old Med3 pad would still be needed for house visits.

However, since most of the participating GPs had not seen or read the introductory letter setting out the purposes of the POC and explaining DWP’s involvement, there was a widespread failure to appreciate what was happening to the data. Consequently, it was only when they were shown the GPs’ concept, ‘Reassurances about the use of data’ (Appendix C, Concept 4), that they became aware, sometimes for the first time, that data was going to DWP. This, in turn, prompted some concerns about whether the data would eventually be used to monitor individual GPs’ Med3 issuing behaviour. Whilst it was accepted that fully anonymised data could not adversely affect either individual GPs or patients, there was some concern that, at some stage in the future, data would be tracked back to individual practices, and thence to individual GPs. One GP remained concerned about possible conflicts with patient confidentiality if this information was being sent to DWP.
3.2 Implementation of the trial

3.2.1 The Practice Manager viewpoint

It needs to be observed that some Practice Managers seemed not to have appreciated that participation in the trial also involved participation in the evaluation. A few were less than co-operative, but most were very helpful, even those who were still struggling with implementation.

From the small number of Practice Managers we spoke to, it appeared that, to a greater or lesser degree, all surgeries experienced teething problems. Whilst this was not unexpected, the speed and efficiency with which these problems were resolved varied. When Practice Managers experienced a problem they contacted the service provider. The level and quality of support they received varied. One Practice Manager said he had a prompt reply and the problem was solved quite quickly. Two other Practice Managers had had trouble getting hold of a person to solve their problem – the contact person they were given was not there and they were told they would get back to them (but did not) or that they were on holiday. This situation dragged on for several weeks during which eMed3 could not be used and levels of frustration were mounting. What was significant was that these three surgeries were experiencing the same problem, and one which had already been identified at the beta trial\(^1\) (some two or three months earlier).

The main problem recounted was the inability to print the eMed3 form. This was apparently due to a conflict with the software and Word macros. It seemed that the solution was fairly straightforward and required a change to the security settings in Word. Some Practice Managers were told what to do by the service provider and managed successfully to do this for themselves; others struggled and seemed not to be receiving much help from the software provider. At the time of the fieldwork in early January 2009, some Practice Managers were still experiencing problems with printing the eMed3, especially in branch surgeries. There seemed to have been a greater degree of support for implementing eMed3 in beta trial practices.

Practice Managers did not recall any concerns from patients or queries from employers about the eMed3 form. Indeed, one or two noted that employers had not rung up asking for help in deciphering the GP’s writing which they regarded as a potential benefit of the system.

3.2.2 The GP viewpoint

It needs to be stressed that the participating GP sample was very small. We interviewed a total of eight participating GPs, three of whom were from the beta trial. Likewise, response to the self-completion questionnaire sent out at the end

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\(^1\) The beta trial for eMed3 in late summer 2008 involved testing the system in two surgeries.
of the evaluation was also small: a total of eight GPs returned the questionnaire\(^{17}\). We do not know what proportion this is of the total of participating GPs as it emerged that not all the GPs in participating practices actually used eMed3. But, in any event, it is probable that the number of GPs who took part in the evaluation must form a minority. How representative this viewpoint is of the rest of the participating GPs can only be hazarded at. It is, therefore, necessary to view the following findings as indicative rather than definitive.

There were indications that not all GPs were fully aware of the eMed3 trial and what it might involve. In several practices participation in the trial had been largely initiated by the Practice Manager who had persuaded the (senior) GP that taking part would be a good idea. Consequently, GPs’ understanding of what the trial would involve was fairly sketchy. For example, some GPs only appreciated in the course of the group discussions that the data gathered was going out of the practice or that it was going to DWP. There were indications that the beta trial surgeries had had more hands-on guidance and introduction to eMed3 and the purpose of the trial. This impression was confirmed by Practice Managers.

Significantly, GPs were largely shielded from problems surrounding implementation. They did not get to use eMed3 until glitches had been sorted out between Practice Manager and software provider. The speed with which this was done varied, reflecting various factors such as availability of help from the provider, the Practice Manager’s IT literacy, commitment to the trial, and their workload. Three of the eight GPs who returned the self-completion questionnaire claimed to encounter no problems when using eMed3. Of the remainder, four had problems backdating sick notes. Problems were also encountered with printing sick notes, finding the correct diagnosis from the Read directory, and retrieving eMed3 details from the patient’s medical history.

Given the teething problems, eMed3 was not up and running at many practices until several weeks after the official implementation date. Indeed, in at least one practice, the system was not fully implemented until early January 2009. There were hints that in some participating practices not all the GPs were using eMed3. In one particular practice, two of the GPs were still using the paper-based Med3.

None of the GPs interviewed had received any training on how to use eMed3. There was some evidence of GPs turning up at the surgery and, with no forewarning or introduction, finding eMed3 had been installed. The general approach had been one of trial and error. In some practices GPs had worked out for themselves how to use it, and younger, more IT literate GPs claimed to have had little difficulty, at least for more routine cases. In others, GPs had been shown the basics by their

\(^{17}\) As the questionnaires were anonymous we do not know how many of the GPs who filled them in also attended a face-to-face interview or group discussion. However, given the overall low levels of engagement with the evaluation it is probably fair to assume that there was some degree of overlap.
Practice Managers or had turned to their Practice Managers for help as and when needed. Two of the GPs who completed the self-completion questionnaire said that they had worked out for themselves how to use eMed3, six said they had been shown how to use it by someone in their practice, and one had been shown by someone outside the practice.

There was no recall of having seen or being shown the eMed3 User Guide. When shown it in the course of the interview there was consensus that it was far too long, wordy and complicated, and unlikely to be read by busy GPs who were already working under time pressures. Instead, there were requests for a one-page, A4, desk guide which clearly and concisely set out what they needed to do. This was corroborated by the findings of the self-completion questionnaire: five GPs said that they were not shown or given a User Guide and five said a one-page desk guide would have been helpful when starting to use eMed3. Other suggestions for getting started with eMed3 included:

• practice-based training, either for the Practice Manager or for one of the GPs;
• on-line training for the GPs; and
• some explanation about the purpose of the optional fields.

The self-completion questionnaire included a short battery of attitude statements which elicited the following response:

• all eight GPs agreed that eMed3 is more secure than the current system and that it would enable practices to audit the issuing of sick notes;
• six GPs agreed that eMed3 is faster than writing out sick notes. Similarly, six agreed that it could be problematic locating the correct Read code for diagnosis; and
• four GPs agreed that they should be able to trigger an RM7 from eMed3.

How GPs were using eMed3

Figure 3.1 shows how eMed3 would appear on the GP's computer screen.

---

The User Guide was developed by the service provider and intended to be used as an explanation of the POC and a guide to how to use eMed3. It was ten pages long and contained screen shots and fairly detailed explanations of the different fields and how to fill them in, as well as instructions on finding previous Med3 entities, how to print and reprint eMed3s, as well as information about cancelling the Med3 data entry and transmission of data.
The overall impression was that GPs were using eMed3 at its most basic level, i.e. simply to get a sick note printed. Our impression was that they were going straight to the ‘Med3 Form Information’ box.

‘I’m doing exactly on this what I would have done on the paper one.’

(Participating GP)

The default ‘Doctor’s Statement’ in the ‘Read Term’ field was accepted and few had thought to look at the pick list options available. There was some interest in the options when they saw them, in particular ‘9D12.Med3 duplicate issued’ and ‘9D14.Med3 issued - back to work’.

There were no reported difficulties in issuing eMed3s for fairly routine consultations. They would usually click on the ‘For’ field and enter the period, then click on the ‘Diagnosis’ field. Three of the GPs who responded to the self-completion questionnaire said they always used the ‘For’ field, and all said they sometimes used the ‘OR Until’ field. For a straightforward situation, e.g. stress, anxiety, nervous debility, trauma, there seemed to be little difficulty in selecting the appropriate Read code. The GP would then click on the ‘Print Form’ button and, provided the printer was working, sign and hand the sick note to the patient.
However, there were a few anomalous incidents where some GPs experienced considerable difficulty in finding the relevant Read code for the diagnosis, e.g. post-operative infection of a tendon in the wrist. Although there was a Read code for post-operative infection, the GP could not find the correct code relating to the patient. In these situations GPs often gave up the struggle and entered a code which approximated to the condition.

All GPs who responded to the self-completion questionnaire said they used the ‘Remarks’ field sometimes, although only a few of those we interviewed claimed to use it, e.g. to note that the eMed3 was being issued because Jobcentre Plus had required it. It should be noted that GPs used the terms ‘Jobcentre Plus’ and ‘DWP’ fairly interchangeably and, indeed, some GPs still referred to DWP as ‘DHSS’.

Almost none of the GPs interviewed were using the optional fields. This was partly because having already printed the eMed3 and handed it to the patient they wanted to close the application, type up the patient’s notes and move on to the next consultation. However, many seemed unaware of the rationale for the optional fields – why they were there and what they were there for – and so saw no need to fill them in.

When shown the pick list for ‘Circumstances’, there was some feeling that 16 options were too many and that it would have been more user-friendly to have condensed the list somewhat. Given the time constraints inherent in each consultation, GPs were more likely to stick with the default ‘None’. Only two of those who responded to the self-completion questionnaire said they sometimes used the ‘Circumstances’ field, whilst four said they never used this field.

Many were unclear what the ‘Clinical Diagnosis’ field was for. This uncertainty was compounded by the fact that whatever was entered in the ‘Diagnosis’ field (for the purposes of the printed sick note) automatically appeared in the ‘Clinical Diagnosis’ box. Thus, GPs saw a simple replication of data. When it was explained to them what ‘Clinical Diagnosis’ was for, there was some increase in interest. However, there was some feeling that they would enter this information in the patient’s consultation history so saw little need to duplicate effort here. This response needs to be seen in the context in which GPs were using eMed3, i.e. as an electronic equivalent of the current Med3 system. From the self-completion questionnaire, only one GP claimed to use the ‘Clinical Diagnosis’ field always and one claimed to use it sometimes.

There was little interest in filling in anything in ‘Additional Notes’ on the grounds that it would unnecessarily take up time. The picture that emerged from the self-completion questionnaire was somewhat different. Of the eight GPs who responded, seven said they always used this field, six said they sometimes used it, and only one claimed never to use it. A full explanation of the various fields is provided in Appendix E.
**Problems with eMed3**

At the time of the fieldwork some practices were still experiencing problems with printing the eMed3 in their branch practice. The impact of this was to create a degree of frustration amongst GPs who still had to write out Med3s because they could not use the eMed3 system.

There was some uncertainty as to whether or not information entered in eMed3 was also entered automatically in the patient’s medical history. There was some feeling that the consultation record showed that a Med3 had been issued but not the details. Some were aware that they could find the details somewhere in the Med3 folder; others thought that they could find the details elsewhere but were not sure where.

**Perceived benefits of eMed3:**

- GPs acknowledged that the printed form was more legible and easier to read;
- the system was quite user-friendly;
- it was automatically entered in the patient’s record that a Med3 had been issued;
- it was possibly quicker than writing out a Med3. However, GPs were not entirely convinced that this actually was the case;
- it had the patient’s details (name, address and date of birth) printed out;
- it was more secure than a tear-off pad;
- the patient cannot alter dates or duration of time off work; and
- it can allow a practice to audit the Med3s issued.

**Perceived disadvantages:**

- it added to consultation time and pressure if the printer malfunctions;
- it was not particularly faster than the existing system, but was not felt to be slower (unless there were problems with the printer);
- there was some feeling that GPs would still have to enter separately into the patient’s history any details or clarifications on the diagnosis;
- in anomalous cases, locating the exact Read code for diagnosis can be a slow and frustrating process, and not necessarily successful;
- a printed eMed3 cannot be backdated;
- it did not include an option to be used as a Med5;
- individual GPs and GP practices were unlikely to be particularly interested in auditing the data;
- GPs were not convinced that comparative data would be particularly useful to individual practices;
- eMed3 cannot be used when making house visits.
A few GPs questioned some of their patients’ genuine incapacity for work and wanted a means of alerting DWP to such patients. GPs mentioned using an RM7 form at the back of the Med3 pad to trigger an independent assessment for patients they suspected of ‘swinging the lead’. They looked for a similar facility via eMed3.

**Suggested improvements**

Suggestions for improving eMed3 arose from both the group discussions and the self-completion questionnaire and included:

- incorporating an eMed5 facility;
- allowing GPs to backdate sick notes; and

In terms of national rollout, it was suggested the first point of contact should be the Practice Manager.

### 3.3 Learning from the implementation

The evaluation, limited though it was in terms of overall sample sizes, especially in the key Practice Manager and participating GP segments, threw up some key issues to consider for a national rollout for eMed3.

First, it will be important that IT glitches, e.g. issues of software compatibility, especially those which have been identified in this POC, are dealt with before rollout. This would minimise teething problems and help to ensure that eMed3 would be operational from day one of implementation, thereby reducing pressure and frustration for GPs and Practice Managers.

Practice Managers are gate-keepers whose support will be key to successful implementation and take up of eMed3. They need to feel confident that implementation will happen when scheduled and that the system will work properly from the outset. If problems occur then they will need prompt and supportive assistance, where help is provided within hours rather than days. It was suggested that the process of implementation might have been smoother if the software provider had provided a dedicated person or helpline.

Levels of computer literacy vary amongst GPs. Some will work out for themselves how to use an application; others will need more hands-on guidance. However, GPs are busy people and work long hours – training sessions or lengthy manuals on how to use eMed3 are unlikely to hold much appeal to them. But they would appreciate a brief, one-page, A4 desk guide. If a longer training session is deemed necessary this might be more appropriate for Practice Managers who could then spread the learning back in their surgery.

Almost none of the GPs (and Practice Managers) seemed to have taken on board the purpose of the POC (or even that they were taking part in a POC).
and that anonymised data from eMed3 would be sent to DWP. Consequently, they were using eMed3 at its most basic level as an electronic means of issuing a sick note. There seems to be little, if any, use of the optional fields to provide further information. This is partly because they feel under time pressure in surgery hours and also because they are not aware of the optional fields or the rationale for their presence. Arguably, being better informed about the POC might have been more productive. That said, GPs are unlikely to read lengthy missives – any communication would need to be fairly pithy.

If eMed3 were rolled out nationally and a larger scale evaluation envisaged, then GPs will need to understand clearly from the outset that they may be selected to take part in the evaluation.
4 Conclusions and recommendations

4.1 Conclusions

The findings of this small scale evaluation study indicate that by and large amongst employers and employees, there is little resistance to the concept of the eMed3. Employers see it as a legible improvement on the current Med3. They express some interest in being able to receive an eMed3 electronically from an employee’s GP, and see this as a potentially more efficient way of managing sickness absence. Employees’ primary concern is that the eMed3 form is acceptable to employers or Jobcentre Plus. Having been reassured that this is the case, especially by the GP whom they trust, they think no more of the form.

Non-participating GPs tend to be less than enthusiastic about eMed3 but this is largely due to disillusionment with the current sick note system and the amount of their time that it absorbs. The benefits of eMed3 are seen as fairly marginal from a GP’s perspective and they are fairly doubtful about individual practice’s interest in the data collected. There is, however, some concern about the motivations for seeking to collect this data, with a suspicion that it could be used to monitor individual practices and/or GPs in the future.

Practice Managers in participating practices were persuaded to take part in the POC because they saw eMed3 as potentially time-saving for their GPs. However, problems with implementation have left some feeling rather frustrated.

For participating GPs, the main perceived benefits of eMed3 are:
- legible forms;
- a fairly user-friendly system; and
- less vulnerable to fraud/misuse than Med3.

The perceived disadvantages are:
- it adds to consultation time if there are printer problems;
• finding the correct Read code for the diagnosis can be difficult;
• having to enter details/clarifications of diagnosis into the patient’s history;
• no facility to issue a backdated eMed3, or a Med5; and
• eMed3 cannot be used when making home visits.

The jury remains out on whether eMed3 is faster than writing out a Med3 and whether or not practices would be interested in the data collected or how useful they would find it.

Currently, GPs see eMed3 merely as an electronic version of the paper-based Med3 and of limited benefit to them beyond the potential time saved in issuing one and legibility compared to the written version. They have not taken on board the purpose and value of the optional fields in terms of sickness absence management (largely because this had not been explained to them). There is also some uncertainty as to whether or not the eMed3 data is transferred to the patient’s record.

In terms of rollout, key to ensuring GPs’ wholehearted adoption of eMed3 will be maximising direct benefits to them, by ensuring that it is faster to complete, that the data is entered into the patient’s record, and making them aware of these benefits. GPs also need to appreciate the wider role of eMed3 in managing sickness absence and in the context of the introduction of the ‘fit note’.

4.2 Recommendations

In taking forward eMed3s into national rollout, consideration might be given to the following:

• sorting out problems with IT and software compatibility identified in this POC before the system goes national;
• in this context, developing a way of sharing/communicating IT problems identified by one surgery with others and what the solution is, e.g. through a trouble-shooting email to Practice Managers;
• involving Practice Managers in the set-up process. In the event of any problems with the eMed3, Practice Managers are likely to be the primary interface between GP and software provider. Thus it is important that they should have quick access to help and advice which they can pass on to their GPs;
• setting up a dedicated telephone helpline so that if Practice Managers or GPs experience any problems they can have access to quick and knowledgeable support;
• providing access to training for Practice Managers (and GPs if they are interested) in how to use eMed3;
• providing GPs with a one-page desk guide on how to use eMed3 for quick reference; and
• ensuring that potential benefits to GPs are realised and that GPs know about them.

There is also a need to inform GPs about the purpose of eMed3, in particular the rationale behind the optional fields, and to be clear about what will happen to the data. GPs will need to be reassured about patient confidentiality and that eMed3 is not the first stage in DWP collecting non-anonymised data and checking up on individual patients and GPs. However, it will be important to adopt an appropriate tone bearing in mind levels of cynicism amongst GPs about the possible use of data collected.

Assuming there is scope for modifying the software, we would recommend that:

• to encourage GPs to fill in the optional Clinical Diagnosis field, it does not default to the entry for Diagnosis;

• eMed3 data can be accessed directly via a patient’s record; and

• a way is found of incorporating/accessing a Med5 certificate.

We would also suggest involving GPs and/or Practice Managers in further development and design to ensure that the system is tailored to their needs and works for them.

Finally, there is also a case for a targeted communications campaign aimed at HR (or equivalent) departments amongst employers informing them about the introduction of eMed3. This could be incorporated into information about SSP.
Appendix A
Screening questionnaires
Good morning / afternoon. I am from Andrew Irving Associates and we are conducting a research project looking at new initiatives regarding sickness certification. Could you help us, please? Thank you very much, but first of all can I ask a few questions to make sure that we talk to the right cross-section of people.

Q1. Can I just check - are you the person responsible for human resources and/or staff/personnel matters in your company/business?  
Yes  1  Q2
                                         No  2  See *

* IF 2 CODED, ASK FOR CONTACT DETAILS OF SOMEONE IN THE COMPANY/BUSINESS WHO FITS THE DESCRIPTION.

Can I please have your business title? WRITE IN BELOW

Q2. Can I just check which industry sector your company/business is in?
READ OUT/SHOW CARD A

Manufacturing  1
Automotive  2
Retail  3  Q3
Service  4
Other (write in below)  5

Respondent’s Name: ______________________________  Sex: Male  1  
Female  2
Company Name/Address: ___________________________
Post Code: __________________  Int. Date: ……………………
Telephone: ______________________________  Int. Time: ……………………
Q3. How many employees do you have in your company/business?

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10</td>
<td>1</td>
</tr>
<tr>
<td>11-49</td>
<td>2</td>
</tr>
<tr>
<td>50-99</td>
<td>3</td>
</tr>
<tr>
<td>100-499</td>
<td>4</td>
</tr>
<tr>
<td>Over 500</td>
<td>5</td>
</tr>
</tbody>
</table>

READ OUT/SHOW CARD B

Across the sample, aim to get a spread of company/business size

Q4. In terms of sickness absence amongst your employees, would you say it was ...?

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>1</td>
</tr>
<tr>
<td>Quite high</td>
<td>2</td>
</tr>
<tr>
<td>Quite low</td>
<td>3</td>
</tr>
<tr>
<td>Very low</td>
<td>4</td>
</tr>
<tr>
<td>Negligible</td>
<td>5</td>
</tr>
</tbody>
</table>

READ OUT/SHOW CARD C

If respondent fits quota, send him/her an invitation card confirming date, time and location of the interview. Make sure that respondent’s name, address and telephone number, and the date and time of the interview is clearly recorded on the front of the questionnaire so that you can telephone him/her with a reminder to attend.

I hereby declare this questionnaire has been completed according to the instructions and the Market Research Society’s Code of Conduct, and that the respondent was unknown to me at the time of recruitment.

RECRUITER’S NAME: ________________________________

SIGNED: ________________________________ DATE: __________
Good morning / afternoon. I am from Andrew Irving Associates and we are conducting a research project looking at new initiatives regarding sickness certification. Could you help us, please? Thank you very much, but first of all can I ask a few questions to make sure that we talk to the right cross-section of people.

Q1. Can I just check if you ...

READ OUT

Have been invited to take part in a trial regarding sickness certification and have agreed to take part 1
Have been invited to take part in a trial regarding sickness certification but declined to take part 2 Close
Have not been invited to take part in a trial regarding sickness certification 3 Q2

Q2. How large is your GP practice?

Sole GP 1
2-10 GPs 2
10+ GPs 3 Q3

In each group, aim to get a spread of practice size

Q3. How many years have you been practising as a GP?

Under 10 years 1
Over 10 years 2 Q4

In each group, aim to get a spread of experience
Q4. And which software system do you use?

Write in

________________________________________________________________________

Ideally, aim to get a spread of software systems used

If respondent fits quota, send him/her an invitation card confirming date, time and location of the interview. Make sure that respondent’s name, address and telephone number, and the date and time of the interview is clearly recorded on the front of the questionnaire so that you can telephone him/her with a reminder to attend.

I hereby declare this questionnaire has been completed according to the instructions and the Market Research Society’s Code of Conduct, and that the respondent was unknown to me at the time of recruitment.

RECRUITER’S NAME: ______________________________

SIGNED: _______________________________  DATE: ___________________
Good morning / afternoon. I am from Andrew Irving Associates and we are conducting a research project looking at new initiatives regarding sickness certification. Could you help us, please? Thank you very much, but first of all can I ask a few questions to make sure that we talk to the right cross-section of people.

Q1. Do you or any members of your immediate family work in/for

READ OUT/SHOW CARD A

| Market Research/marketing | 1 |
| Adversting                | 2 |
| PR/Journalism             | 3 | Close |
| Primary health care       | 4 |
| Dept. for Work & Pensions (DWP) | 5 |

None of the above | 6 | Q2

Q2. What is the occupation of the chief wage earner in your household?

WRITE IN BELOW AND CODE OPPOSITE

| A | 1 |
| B | 2 |
| C1 | 3 |
| C2 | 4 | Q3 |
| D | 5 |
| E | 6 |

In each group, aim to get a spread of different occupations
Q3. And which of the following age groups do you come into?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
</tr>
<tr>
<td>30-39</td>
<td>3</td>
</tr>
<tr>
<td>40-50</td>
<td>4</td>
</tr>
<tr>
<td>Over 50</td>
<td>5</td>
</tr>
</tbody>
</table>

In each group, aim to get a spread of ages

Q4a. How often have you been off sick from work in the last 6 months?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>1</td>
</tr>
<tr>
<td>Twice</td>
<td>2</td>
</tr>
<tr>
<td>More than twice</td>
<td>3</td>
</tr>
</tbody>
</table>

Q4b. And in the last 6 months did you get a sick note from your GP for any period off sick from work?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, once</td>
<td>1</td>
</tr>
<tr>
<td>Yes, more than once</td>
<td>2</td>
</tr>
<tr>
<td>Not been off sick in last 6 months</td>
<td>4</td>
</tr>
</tbody>
</table>

Q5. Have you ever taken part in any market research group discussion in the last 6 months?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

If respondent fits quota, send him/her an invitation card confirming date, time and location of the interview. Make sure that respondent’s name, address and telephone number, and the date and time of the interview is clearly recorded on the front of the questionnaire so that you can telephone him/her with a reminder to attend.

I hereby declare this questionnaire has been completed according to the instructions and the Market Research Society’s Code of Conduct, and that the respondent was unknown to me at the time of recruitment.

RECRUITER’S NAME: ________________________________

SIGNED: ________________________________ DATE: ________________
Appendix B
Topic guides

1. **Employers**

To explore and examine employers’ views about the introduction and use of the eMed3 forms in terms of propensity to accept the new system, resistances and concerns.

1. **Warm up/introduction**

- Nature of company/organisation in terms of size, area of activity, number of employees
- Role and responsibilities of respondent
- Perceptions of levels of time off sick/reasons/any issues regarding sickness absence

2. **Sickness policy and practices**

- What are current procedures when someone is off sick
- At what stage are Doctor’s certificates required
- What processes are adopted when someone is off sick for longer periods
- When an employee is sick, do you pay Statutory Sick Pay or do you operate your own Occupational Sick Pay scheme

3. **Perceptions of the doctor’s certificates/sick notes**

- How are they regarded
- What are they used for within the company
- How useful are they currently. Do they provide any useful info
- What do they think of any comments GPs might make about patient’s illness
• What improvements to the eMED3 certificate would they like to see, if any
• What type of information would they like to receive from GPs about their employee [Prompt: timeline, cause, symptoms, functional ability, work adaptations, treatment, etc.]

4. Reactions to eMed3 concept
• Spontaneous reactions to proposed eMed3 sick note scheme
• Perceived benefits for employers
• Anticipated problems/sources of confusion
• Any suggestions for improvements, e.g. electronic transfer of the form to the employer
• Would they use the 2D Bar Code capacity on the form to reduce data entry
• Using the unique ID on each form and held by DWP would it be useful for DWP to confirm the form’s authenticity to support audit
• Any other concerns that they might have
  [Probe re: views about receiving form via email]

5. Response to eMed3 Certificate
• Spontaneous comments and reactions
• Have they come across one of these forms
• Did it raise any problems/confusion or would it do so (if not seen before)
• Any suggestions for improving the form to make it more useful for employers

6. Concerns/resistances
• From employers’ point of view – any concerns or resistance to introducing eMed3 system
• Thinking of employees – what concerns/resistances do they think they might have
• How could these be addressed

7. Thoughts on introducing eMed3 system
• To what extent do employers need/want to be informed about proposed new system
• What would be the best way of doing this

8. Ideas for improving eMed3
• Suggested improvements to eMed3
• Which seen as more or less key
9. **Summary**

- Overall views about eMed3
- What problems do they anticipate?
- How can these be addressed?

2. **Non-participating GPs**

1. **Warm up/background**

- Size of practice
- Length of time practising as a GP
- Profile of patients in the practice area
- Approximate number of medical certificates issued per week
- OH qualifications or interest in OH

2. **Spontaneous awareness and attitudes towards eMed3 concept and trial**

- Overall views about using computers to record information about patients
- Perceived advantages over paper-based record keeping systems?
- Any disadvantages?
- What do they think other GPs think about this – is there general acceptance of recording electronically? or is there some resistance? What are the reasons for this? Has willingness to accept electronic recording of information changed over time or not? What kind of GPs are more and less accepting of electronic recording?
- What do they know about electronic certification, if anything?
- What do they see as the advantages and disadvantages of this kind of system versus standard forms [prompt if necessary – fraud, record kept]
- What if any concerns do they have about the introduction of electronic certificates?
- What are their own reservations?
- What are the reservations that other GPs might have? [prompt if necessary – any issues around data going to DWP?]
- What underlies any doubts and reservations they might express?
- What kind of reservations do they think patients might have?
- What about practice staff?
3. **Reactions to the eMed3 trial concept**

Invite respondents to look at and respond to concept board describing the key elements of the proposed eMed3

- Initial response? As GPs what do they see as the good points about the scheme?
- And what do they see as the bad points about the scheme?
- What aspects of the scheme do they see as potentially beneficial?
- And which do they see as more problematic?
- How easy do they think it will be to operate the scheme?
- As GPs what problems do they envisage? How could these be overcome?
- How do they think their patients will respond to the scheme?
- What concerns do they think that patients might have?
- Which patients do they think might be more likely to object to the scheme?
- What might help to reassure them?

4. **Introducing eMed3 – GP training**

- Recall of other initiatives introduced to GP surgeries in recent years which have gone well/less well? (whether DWP related or not)
- What factors are associated with more and less successful introduction of schemes?
- Spontaneous ideas for introducing eMed3 to GP practices
- Key Dos and Don’ts
- Obtain GPs reactions and suggestions for improving the plan

5. **Introducing eMed3 – reassuring patients**

- Whether think patients will have concerns
- Explore anticipated level and extent of patients’ concerns
- Which concerns do they think will be harder to address?
- Find out what role GPs think they might have in explaining the scheme to patients
- As GPs what concerns/reservations do they have?
- What role do GPs think they could/should have in explaining the eMed3 scheme to their patients?
- What factors prompt their stance with regard to this?
6. Reactions to the eMed3 form
- Show examples of the eMed3 form and invite GP’s comments.
- Identify any areas that prompt confusion/uncertainty
- Check responses to look and layout of the form

7. Improvements
- As a GP what improvements would they like to see to the eMed3 form/system (including content format of the form)
- From the patient standpoint what do they think would help to make the form more acceptable?
- Views about it being rolled out nationally
- What are the key concerns that need to be addressed? What would their advice be to those responsible for organising rollout?
- What other suggestions do they have to ease rollout of eMed3?

3. Employees
To explore and examine patients’ views about the introduction and use of the eMed3 forms in terms of propensity to accept the new system, resistances and concerns.

1. Introduction/warm up
Reassure that interview is conducted under the auspices of the MRS code of Conduct and that all information provided is strictly confidential and that the respondent’s anonymity will be fully protected. Respondents do not have to answer any question they do not wish to.
- Current circumstances – working/not working
- Nature of current/recent illness/reason for obtaining sick note certificate

2. Perceptions of the medical certificate system
- Whether have had sick note before. How often? How do you feel about this?
- How did you come to get a sick note this time – what happened?
- Can you describe the discussion you had with the GP: what was discussed; was there any discussion of work-going back to work; was there any discussion of what it should say on the sick note?
- What do you need sick note certificates for – employers/DWP/other reason?
- Have you had any problems with getting certificates? What kind of problems?
- Does your GP provide a sick note automatically or do you have to ask for it?
• What, if any, conversations have you had with your GP about your Med3 certificate?
• What has your GP said to you about the new Med3 certificate?

3. **Perceptions of the eMed3 certificate system**

Those who have had eMed3 Certificate
• Have you received eMed3 certificate from your GP?
• What if anything did he/she tell you about the new eMed3?
• What did you think about the new certificate?
• Did you have any questions/concerns? What were they?
• Was your employer quite happy with the new form? If not, why not?
• Do you have any concerns about the new system?
• What kind of things worry them?

Those who have not yet had eMed3 Certificate [Show Concept and sample eMed3 Certificate]
• Spontaneous reactions to the new scheme
• What, if any, problems do you imagine?
• What do you like/dislike about the scheme?
• What did you think about the new certificate?
• Do you have any questions/concerns? What are they?
• How do you imagine employer might respond to the new form?
• What kind of things worry them?
• Prompt if necessary: any views about data?

4. **Improvements**
• What improvements to the scheme would you like to see?
• Which are more and less important?

5. **Summary**
• Overall response to the scheme – what do you see as its good and bad points?
• What would you think if it were introduced nationally?
4. **Participating GPs**

1. **Warm up/background**
   - Size of practice and profile of patients
   - Length of time practising as a GP
   - Approx no of medical certificates issued per week by GP/by practice
   - How long has the eMed3 trial been live in their practice?
   - How many eMed3 certificates have they issued?
   - Qualifications or interest in OH
   - Views about the Med3 system and the way it works at the moment

2. **Pre trial concerns/expectations**
   - Views/expectations beforehand – positive and negative – why thought it was or was not a good idea
   - What if any concerns did they have about the trial of eMed3 certificates?
   - What expectations/reservations did they have personally. What about other GPs in the practice? What lay behind these?
   - What expectations/reservations did practice staff have?
   - Prior the trial how did they expect patients to react

3. **The eMed3 trial so far – GP’s viewpoint**
   - How did the set up of the trial go? What went well/less well, and why?
   - What training and guidance on how to use the system was provided?
   - How easy has it been to use the eMed3 system?
   - Did they have any teething problems learning how to use the new system
     - was the diagnosis assessment (for both the printed form, and the Clinical diagnosis straightforward?
     - were the optional fields used (Clinical Diagnosis, Requested by and Circumstances)?
     - did you use the Circumstances drop down list – why/why not?
   - What, if any, other difficulties were encountered?
   - How were these overcome? How easy/hard was this?
   - Was the eMed3 form less easy to use for certain types of patient or health condition?
• What, if anything, would have made it easier to introduce new system?
• What benefits can they see in using the eMED3 system?
• Do they see any benefits in having a more structured approach to Med 3 data capture?
• Do they see any benefits to the practice in having structured Med 3 data incorporated into the Electronic Patient Record?
• What disadvantages can they see in using the eMED3 system?

4. The eMed3 trial so far – GP’s perceptions of patients’ viewpoint/response
• How have they sought to explain the trial to their patients. Did they try to explain the new form?
• What kind of responses have they had from patients?
• What kind of concerns have patients expressed. Have they sought to deal with these. In what way?
• Have there been any strongly negative reactions? On what grounds?
• Have they given out the questionnaire to all patients or only some?

5. Reactions to the eMed3 form when shown
Show example of the eMed3 form and invite GPs comments.
• Identify any areas that prompt confusion/uncertainty
• Check responses to look and lay out of the form
• Comparison with standard Med3 cert

(If interviewing GP at the practice ask them to go through the eMed3 on screen to identify any issues with filling it in/bits that are useful or less useful/suggestions for improvement)
• Explore how they fill the form in practice, e.g. are there any bits they miss out or are confused about and reasons for this

6. Introducing eMed3 – GP training etc.
• Recall of other initiatives introduced to GP surgeries in recent years which have gone well/less well
• What factors are associated with more/less successful introduction of schemes?
• Spontaneous ideas for introducing eMed3 to GP practices
• Key Dos and Don’ts
7. **Improvements/views about rollout**

- As a GP what, if any, improvements would they like to see to the eMed3 form/system?

- Could the data entry process be improved – in what ways?

- What do they think would help to make the form more acceptable from the patient standpoint?

- Do they see any benefits in analysing the eMed3 data across a community of practices?

- What community would be most useful (PCT/LHBNHS)?

- Views about rolling it out in Wales/across the UK

- Do they see the eMed3 as helping to devolve certification work to authorised colleagues in the Practice (i.e. non-GP)?

- Do they see any benefit in recording the circumstances under which the sick note was issued – why/why not?

- ‘All data shared with DWP has been non attributable to patient and GP’ – any concerns about the data sharing approach – what are they?

- How would you feel if the system was withdrawn from the practice?

- What are the key concerns that need to be addressed?

- What lessons have been learnt from the trial? What would their advice be to those responsible for organising rollout?

- What other suggestions do they have to ease roll out of eMed3?
Appendix C

Concepts

1. Employer concept

**Electronically completed medical certificates**

Department for Work and Pensions (DWP) is running a pilot to test the use of electronically completed medical certificates.

The pilot will run in the autumn of 2008 and will involve approximately 20 GP practices in the Cardiff and Swansea areas.

The pilot’s purpose is to test using electronically completed certificates in place of the traditional handwritten ones.

If you receive one of these medical certificates from employees, you should accept and treat it in exactly the same way as a handwritten certificate.

(These electronically completed medical certificates may be received by some employers outside the immediate pilot area.)

These medical certificates, although electronically completed, will not be sent electronically to employers.
2. Employee concept

**Electronically completed medical certificates**
Department for Work and Pensions (DWP) is running a pilot to test the use of electronically completed medical certificates (sick notes).

The pilot will run in the autumn of 2008 and will involve approximately 20 GP practices in the Cardiff and Swansea areas.

The pilot’s purpose is to test using electronically completed certificates in place of the traditional handwritten ones.

If you receive one of these medical certificates from your GP, you should give it to your employer or Jobcentre Plus in exactly the same way as you would a handwritten certificate.

These certificates will not be sent electronically to employers at this stage.

3. Non-participating GP concept

**Electronically completed medical certificates**
The Department for Work and Pensions (DWP) is running a pilot to test the use of electronically completed medical certificates.

The pilot will run in the autumn of 2008 and will involve approximately 20 GP practices in the Cardiff and Swansea areas.

The pilot’s purpose is to test using electronically completed certificates in place of the traditional handwritten ones.

The new system enables GPs to compile and print off certificates using their computers.

The certificates will contain the same information as that provided by traditional certificates.

Patients receiving certificates would be expected to give them to their employers or the relevant Government agency – they will not be emailed at this stage.
4. Reassurance about use of data – GPs

**Reassurances about use of data**

The personal data used in the electronic Med3 certificate (e.g. name and address) will be retained by the GP practice. It will be available for the Practice to monitor the incidence of Med3s being issued and the reasons for issuing Med3s. Any data passed to the Department for Work and Pensions or other Government body will be anonymised so that individual patients cannot be identified. Information collected could be used to monitor overall levels of sickness absence within post code areas and the reasons for issuing Med3s.

5. Reassurance about use of data – employees

**Reassurances about use of data**

The personal data used in the electronic certificate (e.g. name and address) will be retained by the GP practice. Any data passed to the Department for Work and Pensions or other Government body will be anonymised so that individual patients cannot be identified.
Appendix D
Final self-completion questionnaire for participating GPs
eMed3 Proof of Concept

The Department for Work and Pensions (DWP) is carrying out a modest Proof-of-Concept Project in South Wales to evaluate concepts of issuing electronic sick notes (eMed3s) in GP practices. Andrew Irving Associates has been asked by DWP to conduct an evaluation of this project. We are an independent research consultancy.

As your practice has taken part in the eMed3 trial, we would be grateful if you could complete this short questionnaire and return it to dorothy@aiaresearch.co.uk. All replies will be treated in confidence.

Q1. How frequently do you use eMed3s for issuing sick notes?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every time I issue a sick note</td>
<td>1</td>
</tr>
<tr>
<td>Most of the times I issue a sick note</td>
<td>2</td>
</tr>
<tr>
<td>Some of the times I issue a sick note</td>
<td>3</td>
</tr>
<tr>
<td>I do not use eMed3s</td>
<td>4</td>
</tr>
</tbody>
</table>

Q2. How easy do you find eMed3s to use?

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>1</td>
</tr>
<tr>
<td>Quite easy</td>
<td>2</td>
</tr>
<tr>
<td>Not very easy</td>
<td>3</td>
</tr>
<tr>
<td>Not at all easy</td>
<td>4</td>
</tr>
</tbody>
</table>

Q3. Did you encounter any problems when using the eMed3 application? For example ...

Put 'x' in as many boxes as apply

<table>
<thead>
<tr>
<th>Problem</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems encountered</td>
<td>1</td>
</tr>
<tr>
<td>Backdating sick notes</td>
<td>2</td>
</tr>
<tr>
<td>Finding the correct diagnosis from the Read directory</td>
<td>3</td>
</tr>
<tr>
<td>Retrieving eMed3 details from a patient’s medical history</td>
<td>4</td>
</tr>
<tr>
<td>Printing the sick notes</td>
<td>5</td>
</tr>
<tr>
<td>Other (please write in)</td>
<td>6</td>
</tr>
</tbody>
</table>

Q4. Which of the following **fields** do you use ...

One 'x' for each field

<table>
<thead>
<tr>
<th>Field</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>For</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR Until</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requested By</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circumstances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please go to next page
Q5. Which of the following **pick lists** do you use ...  

<table>
<thead>
<tr>
<th>Field</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read Term (Administrative)</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Requested By</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Circumstances</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Q6. Were you ever shown or given a copy of the eMed3 User Guide?  

<table>
<thead>
<tr>
<th>Shown</th>
<th>Given</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Q7. How did you learn to use the eMed3?  

- I worked it out for myself  
- I was shown by someone in the practice  
- I was shown by a someone outside the practice  
- I used the User Guide  
- Other *(please write in)*

Q8. Would any of the following have been helpful when starting to use the eMed3?  

*Put 'x' in as many boxes as apply*

- A training session for the Practice Manager  
- A training session for one of the GPs in the practice  
- On-line training for the Practice Manager  
- On-line training for GPs  
- A dedicated eMed3 helpline  
- A 1-page "desk guide" on how to use the application  
- Some explanation about the purpose of the optional fields  
- Other *(please write in)*

Please go to next page
Q9. Here are some comments that other GPs have made about eMed3s. Can you tell me if you agree or disagree with each of them.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The eMed3 is faster than writing out sick notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eMed3s are more secure than the current system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices would be able to audit how they issue sick notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes, locating the correct Read code for the diagnosis can be problematic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs should be able to trigger a RM7 from the eMed3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q10. What improvement(s) would you like to see made to the eMed3? Please write in below

Now please go to Q12

Q11. Please answer Q11 only if you do not use the eMed3. Can you tell us why you do not use the eMed3? Please write in below

Now please go to Q12
Q12. When, roughly, was the eMed3 application fully implemented in your practice?

Q13. If eMed3s were to be rolled out nationally, do you have any suggestions on how this rollout could best be achieved? Please write in below.

Thank you very much for your help.
Appendix E

eMed3 screen fields

Standard information

Date of Recording  i.e. date of the examination. The field defaults to the current day. The system allows the GP to back date the Date of Recording but will not allow an eMed3 which is dated more than one day in the past to be printed

Clinician  the clinician (GP) authorising the eMed3

Private/In Practice flags  these can be selected/deselected to record whether the patient or certificate is NHS or private

Read Term  The GP needs to select the appropriate Med3 Read Term from the following picklist:

9D1MED3 doctor’s statement
9D11.MED3 issued to patient
9D12.MED3 duplicate issued
9D13.MED3 Not Issued to patient *
9D14.MED3 issued - back to work
9D1Z.MED3 - NOS Clinically Appropriate - New

n.b. the default is 9D1MED3 doctor’s statement
Med3 information

The information contained in this section will be printed out on the eMed3 form.

Refrain from work
For/ OR until GP has to fill in one or other of these fields
For allows GP to enter the period the patient should refrain from work. The maximum time allowed is 6 months
OR until will display the date the patient should refrain from work. Maximum time allowed is 2 weeks from the ‘date of recording’

Diagnosis GP can enter a preliminary Read code using Read search functionality or free text for the diagnosis. Free text is limited to 60 characters. Diagnosis is a mandatory field if the eMed3 is to be printed

Remarks this is an optional field. The GP can enter up to 350 characters in free text

Additional information

Information included here will not print on the eMed3 form. It can be added after the eMed3 has been printed.

The Requested by field is optional to printing the eMed3, but is mandatory to saving the data entry form. All other fields are optional.
Requested by: this allows the GP to record who requested the Med3. The picklist options are:

- By Patient
- By GP
- Both

Circumstances: records relevant information both when a Med3 has or has not been issued. The picklist choices are:

- Clinically appropriate – new
- Clinically appropriate – existing illness
- On waiting list for investigation/procedure/op
- Should have been hospital generated – post op/OPD
- Should have been hospital generated – trauma
- Social reasons – e.g. bereavement, family illness
- Addiction problems – e.g. alcohol, substance misuse
- Long term illness – e.g. learning difficulty, blindness
- Patient records not available – e.g. temporary resident
- Employer pressure – include threats of some kind
- Patient pressure – e.g. denial of sick pay
- Clinically inappropriate
- Within first 7 days of illness so SSC1 (Self certification)
- Social problems (not medical) so sickness absence n/a
- No clinical evidence for patient request

Clinical diagnoses

The default entry is none

Clinical Diagnosis: this field automatically defaults to the entry in the Diagnosis field. If the Clinical Diagnosis field is entered before the Diagnosis field, it will carry over to the Diagnosis field

Additional Notes: allows the GP to enter further free text