# Medical certificates and reports

## Guidance for GPs

Joint guidance from the General Practitioners Committee and Professional Fees Committee

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The references within this guidance relate to the English legislation – however the same obligations exist in the relevant legislation in each of the devolved nations.

## Introduction

The BMA's General Practitioners Committee and Professional Fees Committee receives many queries from GPs and LMCs with regard to their obligations or otherwise in relation to issuing medical reports and certificates.

This guidance looks at:

- GPs' obligations – in GMS, PMS, AMPS and PCTMS contracts particularly in relation to certificates issued by the Department of Work and Pensions;
- Collaborative arrangements – how these work and the GP's position. There have recently been changes to the collaborate arrangement fees, and this guidance reflects this;
- Non-NHS work – where a GP can charge for the provision of a certificate/statement/report.

## GPs' obligations

The new GMS contract continues the statutory requirement for GPs to provide certain medical certificates. The National Health Service (General Medical Services Contracts) Regulations 2004 state:

> **21.** - (1) A contract must contain a term which has the effect of requiring the contractor to issue free of charge to a patient or his personal representatives any medical certificate of a description prescribed in column 1 of Schedule 4, which is reasonably required under or for the purposes of the enactments specified in relation to the certificate in column 2 of that Schedule, except where, for the condition to which the certificate relates, the patient –
>
> (a) is being attended by a medical practitioner who is not –
>
> (i) employed or engaged by the contractor,
>
> (ii) in the case of a contract with two or more individuals practising in partnership, one of those individuals; or
>
> (iii) in the case of a contract with a company limited by shares, one of the persons legally or beneficially owning shares in that company; or
>
> (b) is not being treated by or under the supervision of a health care professional.
>
> (2) The exception in paragraph (1)(a) shall not apply where the certificate is issued pursuant to regulation 2(1)(b) of the Social Security (Medical Evidence) Regulations 1976[52] (which provides for the issue of a certificate in the form of a special statement by a doctor on the basis of a written report made by another doctor).

Schedule 4 is reproduced at APPENDIX 1 – and we have inserted references to the certificates commonly requested in relation to these regulations.

GPs with PMS contracts are equally obliged to fulfil these requirements with regard to certificates. This is laid down in Regulation 12, Schedule 2 of The National Health Service (Personal Medical Services Agreements) Regulations 2004.

The arrangements in APMS and PCTMS are determined in Directions from the Secretary of State and cross refer to the PMS Agreement regulations. A summary of the certificates and statements that general practitioners have a statutory obligation to provide free of charge to their patients or representatives is described in the Department of Work and Pensions (DWP) booklet IB204. This, and guidance on filling in the certificates can be found on the DWP Corporate Medical Group website.

Such certificates include Med 4, Med 5, Med 6 and the statement contained within the DLA or AA claim pack. We recently clarified with the DWP that it is not obligatory for GPs to fill in the factual reports for the DLA, AA and form DS1500 (Special Rules). They attract a separate fee paid by the DWP.

**GPs are obliged, by statute, to provide medical certificates of the cause of death and stillbirth certificates. (This is separate from the GMS/PMS contract regulations.)**

## Statutory Certificates

GPs should be familiar with the guidance issued by the DWP about not providing 'back-dated' statements.

**Med 3 and Med 4 statements** – you must examine the patient on the day, or the day before, you issue these statements. They cannot be 'back-dated.'

**Med 5 statements** – can be used to supply evidence of incapacity for an earlier period but you must either:

- base your advice on examination of your patient on a previous occasion providing you are sure that you would have advised your patient to refrain from work from the date of that earlier examination for the entire period of the certificate or,

- base your advice on a report from another doctor issued less than one month previously and issue form Med 5 for a forward period up to one month.

In any other circumstances it will be necessary for you to examine the patient and if you wish to supply evidence of incapacity for an earlier period you can:

Issue form Med 3 for an appropriate forward period in keeping with your clinical findings from the date of your current examination with a note in the remarks section stating, for example,

'Has been unfit since…(date)….' or
'The above diagnosis has been present since birth'….or
'The above condition has been present since….(date)….'

Retrospective information should only be provided where contemporaneous notes exist. GPs are reminded that they might be asked to provide further information to substantiate certification in such circumstances.

GPs are not allowed to issue duplicate certificates relating to social security claims. An exception is where replacements are required for forms which have been lost. These should be marked 'duplicate'.

GPs are not obliged to issue Med 3 forms for periods of sickness lasting 7 days or less.

## Information that should be provided

**Medical statements** should record the advice given to the patient along with other factual information including an accurate diagnosis except on the occasions when a doctor feels that it could be prejudicial to their patient's wellbeing if the true diagnosis were given.

The 'remarks' sections on medical statements allow for additional comments about the disabling effects of the diagnosed condition, its treatment and prognosis. In cases where you consider that a patient would benefit from the help or advice of a Disability Employment Adviser (DEA) this opinion should also be included in the 'remarks' section.

**Medical reports** should indicate clearly the information required. Generally GPs should not speculate but should provide only factual information and should not certify something they are unable to verify.

GPs should be aware of the following guidance from the GMC's 'Good Medical Practice'.

**Writing reports, giving evidence and signing documents**
'You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.'

**Electronic printouts of patient notes** are not appropriate substitutes for a report (especially if unedited) and it is important that the requirements of a report are fulfilled, as set by the organisation or individual commissioning the service. It is also good practice for doctors to indicate on the report where 'no information is held' as this in itself is important information.

Only relevant information should be provided and it is ethically unacceptable to provide extraneous information. Doctors must not send originals, photocopies or printouts of full medical records in lieu of medical reports or certificates and those commissioning the service should not accept them. The full records are not necessary and are likely to include information that is not relevant. Disclosure or other processing of irrelevant information is likely to breach the Data Protection Act 1998".

## Patient Confidentiality

All information about a patient is confidential including the fact that they have been ill. Just grounds for disclosure are usually that the patient has given consent.

### A patient's signed declaration as valid consent

A patient's signed declaration on form Med 3 or Med 4 constitutes valid consent. The wording of the declaration reflects good practice and current law in the sense that disclosure should

always be the minimum which is necessary to achieve the objective. A doctor should make as clear as possible the scope of the disclosure to which the patient is agreeing.

Doctors should also be aware that they are only authorised by the current wording on the forms to disclose information that is needed for assessment by the DWP in that particular case and not extraneous details.

Such consent remains valid while the patient's claim is in effect, and not the period of incapacity, and is only superseded by a further claim.

In some cases consent may have been given by a third party, for instance, a person who is making a benefit claim on behalf of a patient. Doctors must make a judgement as to the validity of this consent and therefore whether to release information would be appropriate. The interests of the patient must always be kept paramount. The medical ethics tool kits on Confidentiality and disclosure of health information and Consent give further consideration to circumstances where a patient cannot provide consent.

## Reports to a medical officer

NHS GPs are under a statutory obligation to provide certain information to a Medical Officer when requested by the Department of Work and Pensions under their contracts. The regulations[1] state:

**Reports to a medical officer**

**80.** - (1) The contractor shall, if it is satisfied that the patient consents –

(a) supply in writing to a medical officer within such reasonable period as that officer, or an officer of the Department for Work and Pensions on his behalf and at his direction, may specify, such clinical information as the medical officer considers relevant about a patient to whom the contractor or a person acting on the contractor's behalf has issued or has refused to issue a medical certificate; and

(b) answer any inquiries by a medical officer, or by an officer of the Department for Work and Pensions on his behalf and at his direction, about a prescription form or medical certificate issued by the contractor or on its behalf or about any statement which the contractor or a person acting on the contractor's behalf has made in a report.

The regulations go on to clarify:

(2) For the purpose of satisfying himself that the patient has consented as required by paragraph (1), the contractor may (unless it has reason to believe the patient does not consent) rely on an assurance in writing from the medical officer, or any officer of the Department for Work and Pensions, that he holds the patient's written consent.

[1] The National Health Service (General Medical Services Contracts) Regulations 2004 and for PMS see regulation 76 of The National Health Service (Personal Medical Services Agreements) Regulations 2004

The Access to Medical Reports Act 1988 (c28) allows patients access to medical reports written about them **for insurance or employment purposes** by a medical practitioner who is, or has been, responsible for their clinical care. The General Medical Council publication 'Confidentiality: Protecting and Providing Information' of April 2004 clarifies the position with regard to reports provided to the Department of Work and Pensions (formally the Department of Social Security):

> 'In some cases other bodies give patients access to reports, for example, the Department of Social Security gives all claimants access to reports made in connection with state benefits. In such cases it is not necessary for you to check patients' wish to see the report.'

## Collaborative Arrangements

The 'collaborative arrangements' between health authorities and local authorities were established under legislation in 1974 (current legislation is contained in sections 74 – 82 of the NHS Act 2006). They allowed certain local authority services in the fields of education, social services and public health to be provided by the corresponding health authority without charge. They include a number of services provided in the community health service (particularly sessional work in family planning) which was transferred to the NHS in 1974.

The collaborative arrangement certificates and reports are not obligatory in terms of statute but they do allow for the smooth running of aligned local authority services which include: psychiatric sectioning, adoption, fostering and children in care reports and reports for priority housing to name a few. GPs should normally undertake most of this work, especially where it relates to protection of children and vulnerable people.

**Fees**

Prior to the 2005-06 report, the Doctors and Dentists Review Body (DDRB) used to recommend national fees under the collaborative arrangements for doctors providing work in the field of education, social services and public health to local authorities. They include a number of services provided in the community health service (particularly sessional work in family planning, see Fees Guidance Schedule 4) which were transferred to the NHS in 1974.

Following concerns from the profession that the existing fee rates were no longer economic and that many doctors had lost confidence in the collaborative arrangements system with a significant number refusing to work within the current fee scales, the DDRB ceased to recommend fees for this work.

**The BMA therefore advises individual doctors and GP practices to establish and agree their own fees in advance of undertaking the work.** Members of the BMA can access detailed guidance for doctors setting their own fees.

It has been agreed with the BMA that basic health information provided by GPs for community care purposes would not attract a fee (guidance on this was issued by the then GMSC to local medical committees (LMCs) in 1992). Any community care work undertaken by GPs that goes beyond the provision of basic health data does, however, attract a fee as outlined in section A of this schedule.

The key section for GPs (other than PCTMS salaried practitioners) is S80 (7):

(7) The Secretary of State may arrange to make available to local authorities the services of persons—

(a) Providing pharmaceutical services,

(b) Performing services under a general medical services contract, a general dental services contract or a general ophthalmic services contract,

(c) Providing services in accordance with section 92 arrangements or section 107 arrangements,

(d) Performing services under a pilot scheme or an LPS scheme, or

(e) providing Strategic Health Authorities, Primary Care Trusts, Special Health Authorities or Local Health Boards with services of a kind provided as part of the health service, so far as is reasonably necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health.

For salaried PCTMS doctors the arrangement is S80 (6):

(6) The Secretary of State must make available to local authorities—

(a) any services (other than the services of any person) or other facilities provided under this Act,

(b) the services provided as part of the health service by any person employed by the Secretary of State, a Strategic Health Authority, a Primary Care Trust, a Special Health Authority or a Local Health Board, and

(c) the services of any medical practitioner, dental practitioner or nurse employed by the Secretary of State, a Strategic Health Authority, a Primary Care Trust, a Special Health Authority or a Local Health Board otherwise than to provide services which are part of the health service, so far as is reasonably necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health.

(7) The Secretary of State may arrange to make available to local authorities the services of persons—

(a) providing pharmaceutical services,

(b) performing services under a general medical services contract, a general dental services contract or a general ophthalmic services contract,

(c) providing services in accordance with section 92 arrangements or section 107 arrangements,

(d) performing services under a pilot scheme or an LPS scheme, or

(e) providing Strategic Health Authorities, Primary Care Trusts, Special Health Authorities or Local Health Boards with services of a kind provided as part of the health service, so far as is reasonably necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health.

Apart from the services specifically listed in the work for local authorities' fees schedule, it is the view of the NHSE "that the services provided under the 'collaborative arrangements' should be decided at a local level dependent upon the individual needs of an area." Hence, for example, it would be a matter for local decision whether attendance at multi-agency risk panels or reports for local authority housing associations were covered by the 'collaborative arrangements'.

The view of the GPC is that any work commissioned from a GP to enable local authorities to discharge their functions relating to social services, education and public health should constitute work under the collaborative arrangements and that if a PCT does not elect to pay for the work by a GP it is for the PCT and local authority to make arrangements between themselves for the work to be undertaken, or not.

## Non-NHS work

There are a number of reports that may be done on behalf of other government agencies or organisations that are outside of the statutory DWP certificates or collaborative agreements. Such non-NHS work can cover a range of issues from filling in cremation forms, completing OFSTED reports for childminders or providing reports for insurance companies.

GPs do not have a contractual obligation to fill in these reports and all attract a fee. There are various BMA Fees guidance and schedules published on the BMA's website covering the rates GPs can charge for this work. It is the remit of the Professional Fees Committee to negotiate these fees on behalf of doctors where appropriate.

**Model practice procedures in receiving requests for non-NHS reports**

1. Upon receiving a request for a non-NHS report the practice administrative staff should check that all relevant paperwork is provided.

2. If a fee has not already been set, formal notification of the doctors proposed fee and any further terms and conditions relating to the completion of the report should be communicated and agreed by both parties.

3. Check that (where appropriate) the patient has signed consent

4. Log the arrival of the document in the practice system

5. Notes to be searched, pulled and married up with the information request and allocated to the GP

6. GP assimilates contents of request, confirms patient consent to divulge if in order and ascertain whether or not the Access to Medical Reports Act, Data Protection Act or Access to Health Records Act, applies

7. Read the entire general practitioner notes and the entire hospital letters and laboratory results contained within the patient record

8. Formulate appropriate reply, either in writing, typed directly onto electronic report template, or by dictation

9. Once typed up the Doctor should check the draft report accompanied by the notes (if manually held) and make any amendments and return to the administrator to produce the final report.

10. Notes (if manually held) and final report back to GP for checking and signature.

11. Once signed, the report and any manual held notes should be returned to the administrator where copies should be made and kept in practice record system.

12. Reports may need to be held for 21 days in accordance with Access to Medical Records Act or similar

13. Make diary entry of bring forward date to post completed report

14. Complete payment claim form, log out date of postage or report to relevant authority

15. Chase the payment, if appropriate

16. Receive either payment schedule form requesting authority and reconcile with bank statement, or receive payable order/cheque and arrange banking

As can be seen, there are a considerable number of administrative, financial and legal duties consistent with the professional processing of any request for a report coming in to a practice. The above points assume that at no point does the patient either need to be seen clinically, or request, as is their right under the various legislation, access to the report or the notes. Nor do any of the above take any account of archiving costs consequent upon the generation of any report. Consequently, an appropriate administration charge in view of the above is not an unreasonable request before the professional time and expertise is also taken in to account in producing the report.

It should be noted that GPs are required to read the entire patient record because they are required by the GMC to satisfy themselves, as far as possible, that the facts they certify in a report or certificate are correct.

**APPENDIX 1**

SCHEDULE 4
Regulation 21

LIST OF PRESCRIBED MEDICAL CERTIFICATES
**Please note: we have inserted in bold references to the certificates commonly requested in relation to this schedule.**

| *Description of medical certificate* | *Enactment under or for the purpose of which certificate required* |
|---|---|
| **1.** To support a claim or to obtain payment either personally or by proxy; to prove incapacity to work or for self-support for the purposes of an award by the Secretary of State; or to enable proxy to draw pensions etc.<br><br>**Statutory sick pay and state incapacity benefits:**<br>**Med 3, Med 4, Med 5, Med 6**<br><br>**Statutory maternity pay and state maternity benefits:**<br>**MAT B1**<br><br>**Disability living allowance:**<br>**DLA 1, DLA 1A, DLA 1 Welsh, DLA 1 Child, DLA 434, DLA 580, DLA 581, DLA 582**<br><br>**Attendance allowance:**<br>**AA1, AA1A** | Naval and Marine Pay and Pensions Act 1865[59]<br><br>Air Force (Constitution) Act 1917[60]<br><br>Pensions (Navy, Army, Air Force and Mercantile Marine) Act 1939[61]<br><br>Personal Injuries (Emergency Provisions) Act 1939[62]<br><br>Pensions (Mercantile Marine) Act 1942[63]<br><br>Polish Resettlement Act 1947[64]<br><br>Social Security Administration Act 1992[65]<br><br>Social Security Contributions and Benefits Act 1992[66]<br><br>Social Security Act 1998[67] |
| **2.** To establish pregnancy for the purpose of obtaining welfare foods | Section 13 of the Social Security Act 1988 (schemes for distribution etc of welfare foods)[68] |
| **3.** To secure registration of still-birth<br><br>**Medical certificate of stillbirth – 34** | Section 11 of the Births and Deaths Registration Act 1953 (special provision as to registration of still-birth) [69] |
| **4.** To enable payment to be made to an institution or other person in case of mental disorder of persons entitled to payment from public funds<br><br>**No prescribed certificate; this is usually** | Section 142 of the Mental Health Act 1983 (pay, pensions etc of mentally disordered persons)[70] |

| | |
|---|---|
| **produced as a letter with no fixed format** | |
| **5.** To establish unfitness for jury service | Juries Act 1974[71] |
| **6.** To support late application for reinstatement in civil employment or notification of non-availability to take up employment owing to sickness | Reserve Forces (Safeguarding of Employment) Act 1985[72] |
| **7.** To enable a person to be registered as an absent voter on grounds of physical incapacity | Representation of the People Act 1983[73] |
| **8.** To support applications for certificates conferring exemption from charges in respect of drugs, medicines and appliances<br><br>**FW8 and FP92A** | National Health Service Act 1977[74] |
| **9.** To support a claim by or on behalf of a severely mentally impaired person for exemption from liability to pay the Council Tax or eligibility for a discount in respect of the amount of Council Tax payable | Local Government Finance Act 1992[75] |