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We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.
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Summary

This report summarises the results of the National Duplicate Registration Initiative (NDRI) 2009/10. We have written it for senior officers at Primary Care Trusts (PCT), National Health Applications and Infrastructure Services (NHAIS) sites and NHS Connecting for Health. It will also be of interest to senior officers at government departments and the NHS Commissioning Board Authority.

General Practitioner (GP) funding is calculated using patient list data.
- Inaccuracies in patient lists can mean that funding is not allocated fairly and accurately.

The Audit Commission runs the NDRI to detect inaccuracies that distort GP lists.
- The NDRI is carried out under the Commission’s audit powers – it matches GP list data within and between organisations.
- In collaboration with the Auditor General for Wales, the NDRI covered England and Wales.
- In October 2009 NDRI matched GP patient list data in England and Wales to identify possible inaccuracies and anomalies in the lists.
- NHAIS sites investigated the NDRI matches on behalf of PCTs and deducted patient registrations where appropriate.

NHAIS sites are responsible for managing GP list data on behalf of PCTs and Local Health Boards in Wales.
Many patient records have been deducted as a result of the NDRI 2009/10.

- Over 95,000 patient registration deductions, 0.16 per cent of the population, have been reported. This represents a 48 per cent decrease on the registrations deducted as a result of the previous NDRI exercise in 2004. This decrease may be due to a number of reasons, including extensive efforts to improve data quality on the NHAIS system and a change in the scope of the NDRI.

- The NDRI duplicate and deceased patient matches led to the greatest patient registration deductions. This is the same as NDRI 2004.

- In the short term, annual savings from deductions exceed £6.1 million. In the long term, the improved data quality will enable a more accurate distribution of available funding.

- The medical records of almost 30,000 patients were able to be transferred from the patients’ former GP to the patients’ current GP. However, more patient records could have been transferred if all NHAIS sites had reviewed the NDRI duplicate matches effectively. For example four sites did not review their duplicate NHS number matches.

- There have been efforts to improve data quality at NHAIS sites, including the use of local data quality initiatives.

- The approach for following up matches at individual NHAIS sites, and the resulting patient deductions, varied significantly. Most sites made effective use of at least some NDRI match types.

- During the 2009/10 NDRI exercise, major changes to the NHS landscape were introduced in the Health and Social Care Bill 2011.\(^1\)

- The proposed creation of the NHS Commissioning Board presents an opportunity to introduce a consistent national approach to data quality initiatives.

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\(^1\) Subject to successful passage of the Health and Social Care Bill 2011 through Parliament.
Recommendations

**Primary Care Trusts should:**
- ensure that their NHAIS site maximises the benefits of the NDRI exercise and, where this is not the case, agree an appropriate way forward;
- confirm what local arrangements their NHAIS site has to validate GP lists and implement best-practice local data quality initiatives, if they are not already in place;
- review their NHAIS sites’ NDRI results against information from the Department of Health’s (DH’s) list inflation exercise, to determine whether further list validation is necessary; and
- ensure that guidance to local counter fraud specialists on GP patient registration fraud is being implemented.

**NHAIS sites should:**
- review their arrangements for tackling inaccuracies in GP lists;
- review the best practice local data quality initiatives highlighted in this report – for example student and multiple occupancy checks – and incorporate them into their standard procedures; and
- contact their PCTs to discuss whether further list validation is required.

**NHS Connecting for Health should:**
- encourage NHAIS sites to share best practice local data quality initiatives and develop a standard set of query reports that could be run to identify potential inaccuracies; and
- review the results of the NDRI and consider how the Personal Demographics Service controls and data quality initiatives could be strengthened in response.

**The future NHS Commissioning Board** should:
- develop a national strategy for ensuring a consistent approach to data quality of GP patient lists;
- ensure that best-practice data quality initiatives are included in standard procedures; and
- consider running the NDRI or an equivalent national exercise periodically to identify anomalies not identified through local data quality initiatives.

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| Subject to successful passage of the Health and Social Care Bill 2011 through Parliament, the NHS Commissioning Board will become fully operational on 1 April 2013. The NHS Commissioning Board Authority is a special health authority and the shadow form of the NHS Commissioning Board. |
The government should consider:

- strengthening patient registration procedures to prevent patient fraud and error, by requiring GPs to request identification and proof of address when a new patient registers;
- extending the Audit Commission's data matching powers, when it legislates to transfer these to a successor body, to include data matching to detect maladministration and error – this would allow NDRI to continue to benefit from established data matching systems and expertise; and
- how government departments can effectively share information about patients who have left the country, to help NHAIS sites improve their data quality.
Introduction

What is the NDRI? How does it tackle inaccuracies in GP patient lists?

1 This report outlines the results of the NDRI 2009/10. It analyses patient registration deductions made as a result of the exercise, comments on issues of data quality and, finally, considers the future of the exercise.

2 The NDRI is the Audit Commission’s periodic exercise that uses data matching techniques to review GPs’ patient lists. It is undertaken using auditors' powers under s6 of the Audit Commission Act 1998 (the Act). It identifies inaccuracies in the data that distort both the wider resource allocation within the NHS and, specifically, the payments made to GPs.

3 GP lists can be overstated by registrations that relate to deceased patients, duplicate records or patients who have moved out of the area. These patients are often known as ‘ghost’ patients.

4 By tackling these inaccuracies, the initiative also enables patients’ medical records to be passed to their new GP where former and current GP registrations have not been linked.

5 The General Medical Service (GMS) contract was introduced in 2004 and current contractual arrangements cover over half of GP practices (Ref 1). Typically at least half of the money these practices receive is for core service delivery through the 'global sum'. The exact amount a practice receives is calculated based on the patient list size adjusted for several factors such as age and additional needs of the population. The current average cost is £64.59 per registered patient (Ref 2).

6 In addition to global sum payments, which in 2009/10 totalled almost £2 billion for England (Ref 2), other payments made to GPs are affected by practice population. These include Quality and Outcomes Framework payments and payments made for enhanced services.
7 The NDRI was undertaken in 1999 and in 2004. In December 2008, the Commission was asked by NHS Connecting for Health to consider undertaking NDRI again. As part of the National Programme for IT there have been significant changes to the system since NDRI 2004. Following consultation with relevant stakeholders, the Audit Commission has undertaken a third NDRI exercise at all PCTs in England and, in collaboration with the Auditor General for Wales, at Local Health Boards (LHBs) in Wales, as part of the statutory audit of PCT and LHB accounts in 2009/10.

8 GMS contract regulations specify that a PCT or LHB is obliged to keep an up-to-date list of patients (Ref 3 and 4). The patient list data for all PCTs and LHBs is maintained on 87 NHAIS systems. This data, comprising 58 million patient records, was extracted from the NHAIS system in October 2009 for NDRI.

9 The use of data for the NDRI was subject to a privacy impact assessment to ensure compliance with data protection and human rights legislation. The Commission is required to prepare a Code of Practice to govern its exercises carried out under its data matching powers under Part 2A of the Act. Although the NDRI is carried out under auditors’ powers in the Act, we followed the Code of Data Matching Practice (Ref 5) for this exercise.

10 The data was cross-matched between systems to identify possible inaccuracies in the lists, which might distort resource allocations. It was also cross-matched to other data sources to identify additional data anomalies. These included the Department for Work and Pensions’ (DWP) records to identify patient registrations that relate to deceased persons; and Home Office records to identify persons who remained registered after they had been removed from the UK.

11 A match does not mean that a patient registration needs to be automatically deducted. Matches require examination, either to eliminate them from further investigation, or to justify a patient’s removal from the list.

12 Since the last exercise in 2004, significant improvements have been made to the method for reporting matches to participating bodies. A new web-based application has been introduced, which allows data matches to be hosted on a secure website. This uses the same computer architecture as the Audit Commission’s National Fraud Initiative (NFI) web application. This system has undergone full accreditation against the government’s information assurance standards and is formally accredited to handle, store and process information up to restricted classification levels.
Matches were released to sites via the NDRI web application. NHAIS sites then examined the matches and either eliminated them from further investigation; deducted a patient from their list; or set an FP69.\(^i\)

\(^i\) An FP69 is set where the NHAIS data manager has some doubts about the patient registration. It gives a practice six months to validate the registration. At the end of this period the patient is automatically deducted from the practice list unless the patient’s registration has been validated.
Overview

14 NDRI 2009/10 produced over 750,000 data matches. About 30 per cent of these matches were marked as high priority because of the length of time they had been on the system. Matches at individual NHAIS sites varied from 2,600 to 25,000. This variance may have been for several reasons including the size and movement of the population at a site.

15 Over 95,000 patient registration deductions have been reported as a result of the NDRI 2009/10. This is about half of the registrations deducted as a result of the NDRI 2004 (185,000). This may be due to a number of reasons, including extensive efforts to improve data quality on the NHAIS system and a change in the scope of the NDRI.

16 These deductions represent only 0.16 per cent of the population, which suggests that NDRI has not detected significant data quality issues. This reflects both the effects of efforts to improve data quality on the NHAIS system and a change in match types.

17 The standard global sum payment per patient in 2010/11 was £64.59 (Ref 2). Using this figure, the annual savings released to PCTs from the NDRI 2009/10 deductions exceed £6.1 million. This is a short-term saving. In the long term, the improved data quality will enable a more accurate distribution of available funding.

18 Figure 1 shows the NDRI deductions analysed by match type. Deceased and duplicate matches have resulted in the largest number of patient deductions.

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i Population is the total number of records extracted from the NHAIS system in October 2009.

ii Temporary NHS number and ‘gone away’ matching was not undertaken in NDRI 2009. Multiple occupancy matching was introduced in 2009.
Although the number of patient deductions has decreased between 2004 and 2009/10, deceased and duplicate matches continue to be the areas where most patient deductions have been made. Analysis of individual match types can be found in paragraphs 28 to 56 of the results section of this report.

Reported deductions at individual NHAIS sites ranged from over 13,000 to none (see Figure 2). Although variances are to be expected because of the different population demographics at each site and differences in the number of matches released, the range of outcomes indicates that some sites have not followed up the NDRI matches effectively.
Figure 2: **The NDRI deductions analysis by NHAIS site**

![Graph showing NDRI deductions analysis by NHAIS site](source)

*Source: Audit Commission*

21 Figure 3 shows the deduction rate by percentage of the population. These rates ranged from 1.5 to 0.001 per cent, again suggesting that the variability in follow-up has significantly impacted outcomes.

Figure 3: **Deduction rate by percentage of population**

![Graph showing deduction rate by percentage of population](source)

*Source: Audit Commission*
A significant minority of NHAIS sites did not follow up their reports on a timely basis, which meant that, when they came to look at the matches, the data was old and harder to investigate. Details of NHAIS sites’ progress in following up NDRI matches have been given to PCTs, the DH and NHS Connecting for Health.

Follow-up method

The results of the data matching were fed back to NHAIS sites on a secure web-based application, which included a case management facility, online training modules and access to guidance to support the investigation of the data match. Sites were able to report patient deductions to the Audit Commission, via this application, throughout the exercise.

Most NHAIS sites followed up their matches using experienced staff to investigate the matches and using IT software effectively to further interrogate their matches. Table 1 shows examples of good practice.

Table 1: Examples of good practice in following up NDRI matches

<table>
<thead>
<tr>
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<tr>
<td>Writing to GP practices at the outset to explain the purpose and remit of the initiative.</td>
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<td>Appointing an NDRI key user with appropriate experience and seniority to coordinate the overall initiative.</td>
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<tr>
<td>Undertaking an initial review of the NDRI matches to identify the key areas and establishing a prioritised follow-up plan.</td>
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<tr>
<td>Making effective use of local IT to eliminate matches already resolved through normal business.</td>
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<td>Assigning roles and responsibilities to match individuals’ skills and experience.</td>
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<tr>
<td>Regularly reviewing the results to ensure resources target the most effective areas.</td>
</tr>
<tr>
<td>Assessing the outcomes of the NDRI review to ensure any underlying issues are identified and appropriate action is taken.</td>
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<tr>
<td>Following up NDRI matches alongside existing local data quality initiatives.</td>
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</table>

Source: Audit Commission
25 Our guidance recommended using the batch trace facility, available in the NHAIS system, to automatically identify patients already deducted from the list through normal procedures. This avoids manual checking on matches that have already been addressed. Case study 1 shows how the Manchester NHAIS site applied this approach to review its deceased persons matches.

26 Although many sites made effective use of this approach, we found that some sites still reviewed all the matches manually, which takes longer.

27 NHAIS sites were encouraged specifically to flag FP69s raised as a result of the NDRI. This allowed the outcomes of these FP69s to be collated automatically, enabling the number that resulted in a patient deduction to be determined. Where sites chose not to flag FP69s in this way, we have had to estimate the reported deductions.

Deceased persons

28 Identifying patient registrations relating to deceased persons is done by matching the patient list data against DWP’s records of deceased persons.

29 Table 2 is an analysis of the number of matches, and the resulting deductions, by date of death.
### Table 2: Analysis of deceased persons matches

<table>
<thead>
<tr>
<th>Date of death</th>
<th>Number of matches</th>
<th>Number of deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 1980</td>
<td>472</td>
<td>157</td>
</tr>
<tr>
<td>1980 to 1990</td>
<td>1,172</td>
<td>335</td>
</tr>
<tr>
<td>1990 to 2000</td>
<td>2,186</td>
<td>429</td>
</tr>
<tr>
<td>2000 to 2003</td>
<td>1,029</td>
<td>282</td>
</tr>
<tr>
<td>2004</td>
<td>1,098</td>
<td>382</td>
</tr>
<tr>
<td>2005</td>
<td>1,396</td>
<td>445</td>
</tr>
<tr>
<td>2006</td>
<td>1,584</td>
<td>503</td>
</tr>
<tr>
<td>2007</td>
<td>1,990</td>
<td>637</td>
</tr>
<tr>
<td>2008</td>
<td>2,806</td>
<td>853</td>
</tr>
<tr>
<td>January to October 2009</td>
<td>6,730</td>
<td>1,589</td>
</tr>
<tr>
<td>After October 2009</td>
<td>431,705\textsuperscript{i}</td>
<td>21,109</td>
</tr>
<tr>
<td>Date of death Unknown</td>
<td></td>
<td>5,947\textsuperscript{ii}</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>452,168</strong></td>
<td><strong>32,668</strong></td>
</tr>
</tbody>
</table>

Source: Audit Commission

30 Table 2 shows that NDRI has led to the identification, and deduction of, over 30,000 patient records relating to deceased persons. These records had not been identified through normal business practices.

31 These reported deductions include a patient who died in 1969, but was only deducted from the GP list in April 2011. Although the levels of deductions are small, particularly when compared to deaths per annum, these outcomes demonstrate that a small minority of deaths go undetected for significant lengths of time. This indicates that existing controls could be improved further.

\textsuperscript{i} Due to problems in accessing an external database the deceased matches were significantly delayed (released January 2011). As a result the matches after the data extract in October 2009 include all deaths in the period October 2009 – January 2011.

\textsuperscript{ii} NHAIS sites were able to report the number of deductions at summary level. As a result there are nearly 6,000 matches where we do not know the deducted patient’s date of death.
Currently, NHAIS sites receive notifications of patient deaths from the Personal Demographics Service National Back Office, which links the General Register Office register of recorded deaths to patient lists. In addition, NHAIS sites use standard procedures such as elderly patient checks, which involve confirming with GPs that elderly patients remain alive and identifying deceased patients that need to be deducted from the list.

Some NHAIS sites are concerned that they do not have an adequate facility in place to check for patients who have died abroad, so these individuals remain on the GP lists. The NDRI uses data sources that NHAIS sites do not readily have access to, such as DWP records of deceased people. Running the NDRI periodically will help to identify deceased patients and strengthen the accuracy of the GP lists.

Deceased patient deductions at each NHAIS site ranged from none to over 8,000. There were 12 NHAIS sites that did not open any of their deceased matches, so failed to realise the potential benefits. Many of these 12 argued the matches were out of date. We acknowledge that the delay in the release of this match increased the likelihood that many had already been deducted through normal business processes. However, the recommended follow-up approach, using the batch trace facility in the NHAIS system to cross-match to the live patient list, allowed those that remained on the patient list to be quickly identified. Case study 1 provides an example.

### Case study 1

**Manchester**

Once the NDRI deceased person matches had been received, Manchester NHAIS information analyst team used local data matching to check the NDRI deceased patient matches against the Manchester NHAIS database. This quickly identified patients who had already been deducted because they had been confirmed as deceased or removed for other reasons. As a result, the Manchester NHAIS site identified over 230 patient registrations that required deduction.

*Source: Audit Commission*

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The DWP has access to the General Register Office deaths register and also receive notifications of some deaths abroad.
Registrations relating to individuals who were over 100 years old were identified and reported to each NHAIS site. This was to identify registrations where there is a greater risk the person may be deceased, and should have been removed from the list.

Most sites had a similar number of these matches as a percentage of their population.

Over 3,000 patient registrations were deducted as a result of age analysis reports. Deductions at individual NHAIS sites ranged from 345 to none. This is a fifth less than in 2004 and suggests that local initiatives are improving data quality. For example, many sites undertake an annual exercise to confirm that elderly patients remain alive. This good practice should be adopted at all NHAIS sites. Case study 2 shows a site where, following a successful NDRI exercise, they are now incorporating this type of local data cleansing into their routine practices.

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**Case study 2**

**Age analysis reports – Devon**

Devon NHAIS worked with local GP practices as part the NDRI to clarify the registration status of those patients over 100 years old. The process included giving practices a deadline to ensure prompt responses and overall it was successful as it identified 135 patients to be deducted. Given the success of this exercise it will now form part of the inflation management strategy for Devon.

*Source: Audit Commission*

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**Duplicates**

These matches were identified by matching the NHAIS data provided by each site to itself and to the data provided by all the other NHAIS sites.

The matches identify potential duplicate registrations where there may be payments to multiple practices for the same patient. Some duplicates in the system are to be expected while a patient is transferring from one GP to another.

The failure to connect a patient’s new registration with their previous one also means the patient’s medical records do not transfer to the new GP.
The NDRI identified duplicates where:
- a patient had the same NHS number; or
- a patient had the same name and date of birth; or almost identical, unusual names; or where the name was reversed.

In total, 29,416 patient registrations (31 per cent) were reported as deducted as a result of NDRI matches. Table 3 shows the type of duplicates identified by the NDRI 2009/10, the number of matches for each type and the number of patient registrations deducted.

Table 3: Analysis of duplicate matches

<table>
<thead>
<tr>
<th>Type of duplicate</th>
<th>Number of matches</th>
<th>Number of deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with the same NHS number</td>
<td>35,399</td>
<td>8,489</td>
</tr>
<tr>
<td>Patients with the same name and date of birth or almost identical unusual names or where the name was reversed</td>
<td>90,383</td>
<td>20,927</td>
</tr>
<tr>
<td>Total</td>
<td>125,782</td>
<td>29,416</td>
</tr>
</tbody>
</table>

Source: Audit Commission

Usually, registrations showing duplicate NHS numbers were related to the same person, but some registrations appeared to show two people with the same NHS number. This highlighted a data quality issue. NHAIS sites were able to validate the NHS number they held and, where necessary, take action to correct the NHS number held on the system.

Most sites used experienced staff to follow up the matches, as they were able to judge more easily whether the match related to the same person. Despite this, the approach to the matches remained variable. Four sites did not look at the duplicate NHS number matches at all and so missed the potential benefits the match offered – duplicate NHS numbers, therefore, remain on the NHAIS system.

Sites where there was a high percentage of duplicates mostly cover major cities. This supports the widely held view there is a higher risk of duplicates where the population is more transient.

Duplicates are routinely identified by NHAIS sites using the Personal Demographics Service, the national electronic database of NHS patient demographic details, which includes patients' name,
address, date of birth and NHS Number. The NDRI outcomes show that these arrangements could be supplemented by periodic running of NDRI, or a similar national data matching exercise.

Multiple occupancy

47 The NDRI 2009/10 included multiple occupancy matching for the first time, in response to feedback after the 2004 exercise. Addresses with 10 or more registrations were identified, as these could indicate continued registrations of patients who no longer live at the property.

48 The details of nearly 80,000 addresses were passed back to NHAIS sites to review and investigate where appropriate. The relative risk that each match represented depended on the number of individuals registered at each address and the property type. Sites were able to use local knowledge to consider whether the number of patients registered at a property seemed high for the property type. For example, it would not be unusual for 50 patients to be registered at a nursing home, but 20 patients at a residential property would merit investigation.

49 NHAIS sites have the IT capability to run their own multiple occupancy reports. Some run this report yearly and check GP registrations at addresses where there are eight or more people registered. Sites also carry out reasonableness checks on residences such as residential homes, nursing homes and student halls of residence. These initiatives are highlighted in paragraph 63.

50 Sites that undertook such checks were able to discount these matches and instead focus on residential properties. Case study 3 is an example of where this has been done.

Case study 3

Multiple occupancy reports – Hillingdon

After removing the 800 patient registrations already validated through standard procedures, Hillingdon NHAIS site sent a series of letters to properties where a high number of patients were registered. Patients were asked to confirm they were still resident at the property and given a month to reply. If no reply was received from the first letter, a second, then a third, letter was sent.
GP surgeries were sent a list of patients registered at addresses where there was no response, or where the response indicated the patient was no longer resident at a property and asked to confirm if a patient needed to be deducted from the list.

As a result, Hillingdon set over 2500 FP69s (using the overall deduction rate for multiple occupancy matches we estimate this would have resulted in 650 patient deductions) and validated over 2,600 patient registrations.

Source: Audit Commission

51 The multiple occupancy matches led to over 20,000 patients being deducted from GP lists. Deductions at NHAIS sites ranged from none to over 5,000. Three sites did not look at any of their matches. Sites where there were significant deductions were in urban areas that traditionally have a transient population.

52 NHAIS sites with concerns about possible patient registration fraud are encouraged to alert NHS counter fraud specialists. Case study 4 shows how an investigation into an NDRI multiple occupancy match led to an investigation by the local counter fraud specialist (LCFS). It illustrates the importance of involving the LCFS from an early stage, when irregular activity is suspected, and highlights how, once an issue is identified, an LCFS can work alongside a GP practice to provide further guidance and training to minimise the risk of patient registration anomalies.

Case study 4v

Multiple occupancy – Birmingham and Solihull

While following up its NDRI multiple occupancy matches Birmingham and Solihull NHAIS site wrote to a household where it appeared that 24 people were residing at the address. They received a reply informing them that all the people registered at this address no longer lived there. The site queried this with the GP surgery, which confirmed that all patients had been regularly seen by them.
The site passed the case on to the NHS LCFS to consider. The LCFS found most of the patients registered to the address did not have appropriate status to be in the UK and were no longer resident at the address. They provided further guidance and training to the GP surgery on the requirements for registering overseas visitors. The surgery has since requested the patients be deducted from the GP list.

Source: Audit Commission

Removed asylum seekers

53 Patient list data has been matched to the Home Office records of persons who have been removed from the UK by the UK Border Agency.

54 Nearly 10,000 patient registrations were deducted as a result of these NDRI reports. At NHAIS sites, these deductions ranged from none to over 1,000. Seven sites did not look at their removed asylum seeker matches.

55 NHAIS sites have difficulty identifying patients who leave the UK. These include patients who are moving abroad, as well as those who have been removed. This is because there is no direct link between UK Border Agency data and NHS patient registers.

56 Some NHAIS sites, where there are a high number of overseas patients registered, carry out annual overseas patients checks to ensure that patients who are no longer resident in the UK are deducted from GP lists.
Data quality issues and local data quality initiatives

Data quality

57 Data quality issues in the NDRI 2009/10 were similar to those highlighted in the 2004 report. These include:
- inaccurate and incomplete data capture; and
- inconsistencies in the approach to data management.

Data capture

58 Inaccurate and incomplete data capture has reduced the quality of the data held on the NHAIS system. This makes it harder to link new and old registrations and to transfer medical records when a patient changes GPs, especially when a patient moves between NHAIS sites.

59 The current system requires a patient to complete the appropriate form when they register with a new GP Practice. This is usually a GMS1 form, which requires a patient to provide personal details including name, address, date of birth and NHS number, and requests information on the patient’s previous GP (Ref 6). The system does not require the patient to provide any identification, or proof of address, to support the details provided. Failure to verify registration details can leave the system vulnerable to human error.

60 Simple inputting errors are often caused by misspelling or illegible handwriting. Failure to validate registration details also leaves the system open to deliberate abuse by individuals who wish to be registered at multiple GP practices for fraudulent purposes – for example, to obtain prescription drugs for personal use, or to sell on.

61 In an attempt to minimise patient registration fraud, the NHS Counter Fraud Service recently recommended that GPs ask to see a form of identification when registering all patients and a document containing the patient’s address when registering permanent patients (Ref 7). This guidance was prompted by several cases where patients had registered fraudulently with GPs to obtain prescription drugs, including one case where an individual had used over 40 identities to register with multiple GPs to obtain prescription painkillers (Ref 7).

i For example, analysis of the 58 million GP patient records provided for the NDRI identified that the forename Michael had been correctly input 841,354 times, but there were 4,844 instances where it had been input as Micheal.
We endorse this guidance, which would also help address the data capture errors we have highlighted.

Local data quality initiatives

A significant proportion of NHAIS sites carry out regular local data quality initiatives to ensure the data on their system is as accurate and up to date as possible. However, there is no consistent approach across NHAIS sites and, as a result, there are significant differences in the extent and effectiveness of local data quality initiatives.

We have highlighted examples of local data quality initiatives already. They include the following.

- **Student checks** – some NHAIS sites with large student populations have procedures in place to ensure that students are regularly deducted from their patient lists; for example, comparing the number of registrations at a hall of residence against the number of places.
- **Residential and nursing homes** – some NHAIS sites annually compare how many places there are in each home to patient registrations and investigate any variances.
- **Multiple occupancy checks** – several NHAIS sites carry out annual checks to identify households where there are more than eight residents.
- **Annual overseas patient checks** – a few sites check to see if patients who moved to the UK on a temporary basis have left the UK and, if so, cancel the registration.
- **Elderly patient checks** – this is the most common local data quality initiative, which involves checking with GPs to see if elderly patients are alive.

At present there is no effective mechanism for NHAIS sites to share information about the methodology and outcomes of local data quality initiatives. Sites are duplicating local initiatives that have already been delivered at other sites. In addition, the opportunity to share the lessons learned about what works and what does not is also being missed. The introduction of a national mechanism for sharing details of good practice data quality initiatives would both enhance the effectiveness of these local initiatives and enable NHAIS sites to make the most effective use of the resources invested in them.

Other national initiatives

The DH has recently compared GP lists, extracted from the NHAIS system, to the latest available Office of National Statistics (ONS) population data. The work highlighted PCTs where list growth does not appear to match local population growth. PCTs have been informed
of their results and encouraged to review the analysis and consider undertaking further work as appropriate.

67 Where NHAIS registered populations are significantly higher than the current equivalent ONS registered population equivalent, the DH identified the potential for savings at both PCT and SHA Level. PCTs have been encouraged to investigate these variances, which may be due to:

- duplicates, deceased patients and patients who had moved abroad not being taken off the lists;
- inaccuracies in the ONS population data; or
- a combination of the two.

68 The Commission has shared a high-level analysis of the NDRI results with the DH. The information is still being evaluated and will inform both the work on the ONS data and the ongoing review of the resource allocation strategy.
Looking to the future

The Audit Commission

69 In August 2010, the Secretary of State for Communities and Local Government announced the intention to abolish the Audit Commission. Although the NDRI is carried out under auditors’ powers, it utilises the Commission’s existing data matching expertise. This link, between the audit and data matching functions, will be affected by the Commission’s abolition.

70 A particular strength of the NDRI is that it successfully incorporates data from other government bodies to provide NHAIS sites with intelligence that they would otherwise not have access to – for example, DWP records of deceased people and Home Office data on persons removed from the UK.

71 For NDRI to continue in its current form, and to continue to take advantage of the existing data matching systems and expertise, the government would need to extend the Commission’s current data matching powers, as part of the transfer to a successor body, to allow data matching for the purpose of error and maladministration. The DH/NHS Commissioning Board could then procure NDRI from the new successor body to which the Commission’s data matching powers are transferred.

72 Alternatively, the DH/NHS Commissioning Board would need to consider making its own, separate arrangements for carrying out a similar exercise.

The NHS Landscape

73 In July 2010, the government published a white paper, Equity and Excellence: Liberating the NHS (Ref 8), which announced the phasing out of PCTs, an increased role for GPs and giving patients the choice to register with any GP regardless of where they live. This has subsequently been followed by the Health and Social Care Bill (Ref 9), published by the DH and introduced to Parliament in January 2011. At the time this report was published, the Bill was passing through Parliament. As a result the exact impact the Bill will have on NHAIS sites and their responsibility to maintain GP lists remains uncertain.
The Bill proposes the establishment of a new body, the NHS Commissioning Board. The NHS Commissioning Board Authority, a special health authority and the shadow form of the NHS Commissioning Board, became operational in October 2011 (Ref 10). The NHS Commissioning Board will become an independent body from October 2012 (subject to the successful passage of the Health and Social Care Bill 2011 through Parliament) (Ref 10). It will become fully operational on 1 April 2013, when it will take on complete legal responsibilities for managing the NHS Commissioning system (Ref 10).

The Commissioning Board will have several functions; including supporting and holding the new Clinical Commissioning Groups (CCGs) to account and commissioning certain services at a national or regional level (Ref 10).

PCTs will be abolished in April 2013 (Ref 8) and their primary care responsibilities will transfer to the Commissioning Board or CCGs. This represents a significant change to the structure and funding of primary care services. The new Commissioning Board will be faced with the challenge of ensuring that the data quality of patient lists is maintained and continues to improve. However, this could also present a unique opportunity to rationalise the current arrangements with the aim of introducing a single national approach to assuring the quality of GP list data, for example by standardising the approach to data quality initiatives at all NHAIS sites.

In preparation for these proposed changes the Operating Framework for the NHS in England 2012/13 requires PCT Clusters to 'work with GP practices to undertake a full review of practice registered patient lists, ensuring patient anomalies are identified and corrected by March 2013.' (Ref 11).

Resource allocations that were previously provided to PCTs will be provided to CCGs (Ref 12). Currently resource allocation to PCTs is based on ONS data. In a recent House of Commons Committee of Public Accounts report (Ref 12) it was noted that allocations to CCGs are likely to be based on GP lists rather than ONS data (Ref 12). The report also stated that, given the discrepancies between GP list data and ONS estimates, the DH is accelerating its work to improve the accuracy of GP lists. We welcome this initiative.
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We welcome your feedback. If you have any comments on this report, are intending to implement any of the recommendations, or are planning to follow up any of the case studies, please email: nationalstudies@audit-commission.gov.uk