

How well do family practitioner committee and general practice records agree? Experience in a semi-rural practice

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SUMMARY. General practice notes may be inaccurate for various reasons. A study was carried out in one semi-rural practice to investigate the agreement between records held by the family practitioner committee and those kept in the practice. Details on the practice notes and the family practitioner committee list were compared for 800 patients. The details examined included name, sex, date of birth, address and National Health Service number. While 58% of records agreed, discrepancies occurred in 339 records (42%). The most common discrepancies concerned the patient's address (30.6%), date of birth (9.4%) and NHS number (8.0%). Nearly 5% of the practice notes appeared to be for patients who were no longer on the practice list or dependent on its care. These findings have implications under the new general practitioner contract where screening programmes, target related payments, and increased capitation fees require accurate practice records.

Introduction

COMPUTERIZED general practice records are of great value, particularly under the new contract for general practitioners,^{1,2} and they represent an important tool in research, audit, screening, patient recall, and calculations relating to achieving various targets.³ Incorrect patient details may have medicolegal consequences. Accurate records are therefore essential but general practitioner lists may be inaccurate for various reasons.⁴⁻⁶ This study was conducted to investigate the agreement between records held by the family practitioner committee, now called the family health services authority, and records kept in a semi-rural practice. The research was incorporated into the process of computerizing practice records and was undertaken in December 1989.

Method

In the process of computerizing the general practice notes in a semi-rural practice, data was transferred from the family practitioner committee computerized list to the practice computer hard disc, being transferred from computer tape to floppy disc by Value Added Medical Products (VAMP). To ensure accuracy, the practice list of 4800 patients was checked against the family practitioner committee list. For the purposes of this research, one of us (S V) reviewed a sample of 800 records. To reduce possible bias in surname selection every sixth alphabetical block of 18 sets of notes on the practice shelves, for both sexes, was included in the study. Specific patient details examined included name, sex, date of birth, address and National Health Service number. The results were recorded manually after checking each block and tabulated after completion of the study. Any

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discrepancies found were investigated, contacting the patient if necessary, and the notes were then corrected and the family practitioner committee notified of any errors.

Results

The 800 records covered 760 (95.0%) patients with general practitioner notes who were also registered on the family practitioner committee list, 37 patients (4.6%) with general practitioner notes but not listed on the family practitioner committee list, and three patients (0.4%) on the family practitioner committee list but with no general practitioner notes. Of the last group, one patient was seen regularly by another local practice who held his original notes, one was a long stay patient at a psychiatric hospital whose general practice notes were not found and the third patient was untraceable. Of the 37 patients (4.6%) with general practitioner records but no family practitioner committee record, one was seen regularly as a patient but had apparently never registered with the practice while the other 36 had no entry in their records for more than 20 years. Further investigations regarding these 36 patients showed that nine would have been over 90 years of age and were probably deceased and 11 had left the area including four who had emigrated. The remaining 16 could not be traced. Their notes had either never been sent back to the family practitioner committee because of practice error or had never been requested by the family practitioner committee. The family practitioner committee could find no record of any of these patients.

A total of 441 discrepancies were found on 339 (42.4%) records (Table 1). The address did not agree in 245 (30.6%) sets of patient details, 227 (28.4%) being due to errors on the family practitioner committee list, 11 (1.4%) on the general practice notes and seven (0.9%) on later checking were found to be incorrect on both the family practitioner committee list and general practice notes. Of the 245 discrepancies 98 were considered to be a major discrepancy, where an incorrect street name or village was recorded. Errors in house numbers or address spelling were considered to be minor discrepancies, as it was thought probable that a letter would be correctly delivered.

The patient's date of birth was incorrect on 75 (9.4%) records; 69 (8.6%) of these were recorded incorrectly on the family prac-

Table 1. Number of errors including major errors, identified on the family practitioner committee (FPC) list and general practice (GP) notes.

Record detail	Number (%) of errors (n = 800)		
	Total	FPC list	GP records
Address	245 (30.6)	234 (29.3) ^a	18 (2.3) ^a
Major error	98 (12.3)	76 (9.5)	22 (2.8)
Date of birth	75 (9.4)	69 (8.6)	6 (0.8)
Major error	37 (4.6)	18 (2.3)	19 (2.4)
NHS number	64 (8.0)	— ^b	— ^b
Name	53 (6.6)	50 (6.3)	3 (0.4)
Major error	5 (0.6)	5 (0.6)	0 (0.0)
Sex	4 (0.5)	4 (0.4)	0 (0.0)

NB: Some records had more than one error. n = total number of records.

^a Seven errors appeared on both the FPC list and GP records. ^b Source of error could not be identified.

itioner committee list and six errors (0.8%) were found on the general practitioner records. Thirty seven (4.6%) errors in date of birth were considered to be a major discrepancy, where incorrect year of birth was recorded. Sixty four (8%) general practitioner records had a different NHS number from that recorded on the family practitioner committee list.

There were discrepancies regarding patients' names in 53 (6.6%) cases, with the majority of errors (50) appearing on the family practitioner committee list. Five (0.6%) errors in which a different forename or surname was recorded were considered to be major discrepancies. Four errors (0.5%) regarding patients' sex were found.

Discussion

Any computerized system of record keeping requires a sound database and the importance of establishing such an accurate database is well known.^{7,8} Transferring patient details directly from computerized family practitioner committee lists is becoming widespread mainly because of speed and cost considerations and the lists used are presumed to be accurate. However, this study has revealed discrepancies in 339 of 800 sets of patient data on family practitioner committee lists and general practice notes.

Two partnership changes had taken place in the practice in the past 10 years which resulted in the family practitioner committee writing to every patient to inform them of these changes. This will have resulted in some correction of patient details, and this needs to be acknowledged when considering the results of this study.

The inconsistencies between the two sources of data are of great importance in many areas other than capitation payments and calculation of target populations.^{9,10} Use of computerized mailmerge letters aids recall of patients but if over 12% of patients' addresses show major discrepancies, as in this study, this will result in wasted effort and resources. This will also apply to inaccurate patient notes used for manual recall. Letters regarding abnormal results and follow up may not reach the patient. The study revealed seven addresses which were recorded incorrectly on both the family practitioner committee list and general practice notes. Unless immediately obvious or known to the checker, the same errors which appeared on both sets of data were difficult to identify without contacting the entire patient list,⁶ and the number found in this study may therefore have been an underestimate.

Discrepancies in NHS number may cause problems with transfer of records or tagging of records at the NHS central registry. It was difficult to identify the source of error in the 64 discrepancies found in this study. The family practitioner committee presumed that the NHS number on their computer was correct but this was difficult to verify without contacting the NHS central registry about each patient. Since the four errors in the recording of patients' sex were all found on the family practitioner committee list, it may be that the colour coding of record cards to indicate sex makes this error less likely on the general practice notes.

Inaccurate medical records have legal implications. They may not be accepted in law if patient identification details are incorrect. Claims for capitation fees for patients no longer dependent on the practice for care may be fraudulent if no effort has been made to ensure that correct records are maintained.

The causes of the discrepancies found in this study could be attributed to typographical error and unrecorded patients' movements including emigration.¹¹ Errors also arose from the failure of the practice to notify the family practitioner committee of changed patient details, exemplifying a poor level of communication between general practitioners, the family practitioner committee, hospitals, and the NHS central registry.

After the study all of the notes were checked. This took ap-

proximately one minute per record giving a total of approximately 80 hours of staff time to check all the practice records. Further investigation of the source of discrepancies and their correction would obviously require extra resources. Transferring patient details from the family practitioner committee computer and then checking patient records against the data produces a more accurate data base but the advantages must be weighed against the time and cost involved.

The computer is a powerful tool for use in research and audit but the possibility of an inaccurate database must be recognized. The practice was unaware that approximately 5% of records on its shelves, that is some 220 sets of notes, appeared to be of patients who were no longer on the practice list or dependent on its care. The increase in storage space created by removing these records would be welcome by most practices. This and some of the above points may have a financial benefit which would offset the cost of providing an accurate database.

Following the study the practice is trying to maintain a more accurate database on patient registration details. Details of new patients registering with the practice are entered on to the practice computer with the patient present and the records are checked again when they arrive from the family practitioner committee. The computer registers all those living at one address as a family and this should reduce errors involving individual records and increase the likelihood of errors being noticed. Efforts are now also being made to record every patient's postcode. The family practitioner committee and practice computer capitation figures should be similar and any discrepancies will be investigated.

Patients who do not inform the practice of changes in their names or addresses will continue to be a problem. It may be that repeating the exercise described in this study will be required every time there is a change of practice partner. It is hoped that with a large percentage of the practice population being contacted on a regular basis for health checks, immunization or screening the diligence of all practice staff will result in the continuing improvement of the computerized practice database, which will, in turn improve the service for patients.

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