Introduction

This paper offers a how to guide to tackling list inflation or list cleansing, as it is sometimes known.

Tackling list inflation describes the work needed to ensure that GP patient lists are accurate, including identifying and removing inappropriate patient records.

This document follows the release of the operating framework and information collected by SHA primary care leads and their constituent PCTs to gather together work undertaken to date.

It is not prescriptive but aims to:

- Present the current position and expectations laid out in the 2012-13 operating framework
- Indicate what PCTs and providers of primary care could be doing to tackle list inflation – what are the characteristics of good practice
- Provide suggested principles to consider and agree between local stakeholders.

PCTs should have some measures in place to maintain accurate registered lists, list variances monitored by practice and ghost patients identified and removed. However, how far each local area needs to engage in activities to address list inflation will vary depending on demographics and the measured extent of variation between registered lists and ONS data. It is vital that PCTs and SHAs understand their respective areas’ demographics and the impact of those demographics on list inflation to ensure the most effective measures are put in place to reduce variation.

Background

The 2010 Office for National Statistics (ONS) estimates the latest total number of GP registrations exceeds the PCT population by approximately 1 million people. Some disparity between these figures is expected, however the scale of difference would suggest the need to look at the figures more closely. The operating framework quotes the England average as 5%, but the range of variances can vary up to 30% in some PCT areas. The Department of Health (DH) has recently provided a more detailed comparison between ONS 2010 mid-year figures and Exeter 2010 extracted populations, which previously showed that by reducing average percentage further to 3% would realise indicative savings of £85m.¹

In June 2010 DH also produced a paper titled Funding allocations and practice lists, available on the PCC website [http://www.pcc.nhs.uk/funding-allocations](http://www.pcc.nhs.uk/funding-allocations). It states that when calculating PCT allocations, GP registrations are constrained to ONS resident populations and that as a result, PCTs don’t receive proportionately greater funding if they have inflated GP registered lists. The document summarises that tackling list inflation:

- Saves PCTs money through paying less global sum (or equivalent) in future

¹ Based on GMS per patient cost of £64.59
Improves allocative efficiency because the funding will go to where it is intended – funding real patients and not ghost patients who do not exist

Increases fairness – GPs with overstated lists will receive proportionately more than their fair share of funding.

Since the figures were released, tackling list inflation has been included as a new indicator within the 2012-13 Operating Framework. The indicator – PHF06: tackling list inflation: percentage of general practice lists reviewed and cleaned – is detailed further in the accompanying technical guidance.

To enable monitoring of this, SHAs will be issued with regular updated data on ONS resident and Exeter-registered population data. This will provide details on patient numbers per practice, broken down by Carr-Hill age and sex bandings. These extracts will be compared against previous Exeter data to identify all changes since the last comparison was made to estimate likely list inflation at PCT level.

This will indicate which PCTs are taking active measures to address potential ghost patients and provide indications of the scale of change, achieved to-date.

PCTs are now expected to engage in regular proactive list management with general practices. This is to ensure progress on reducing list variance with the aim of achieving below 3% variance, recording progress to their SHA. PCTs with practice list differences substantially over 5% are to be benchmarked against their achievement in reducing list differences to agreed levels as part of the process of handing over responsibility to the new NHS Commissioning Board from April 2013.

It is therefore necessary that SHAs receive assurance that PCTs are taking the appropriate actions to maintain lists and address excessive variation.

Processes to tackle list inflation

Many PCTs have already made considerable efforts to address inaccurate list inflation. Some of this work is undertaken by the local FHS agency or body responsible for maintaining patient lists. For some PCTs, these regular activities may be enough to manage the issue and reduce variation as required. For others with a greater than expected variation, a more targeted approach may be necessary to try to reduce large discrepancies in one go.

While there is no standard list of routine activities undertaken across all PCTs, many PCTs do undertake broadly similar exercises regularly. These include:

- **Student checks**
  Students are a predominantly temporary population and many fail to inform the practice that they no longer need to be registered. Various methods are employed to identify and remove these patients. NHS Nottingham City has an annualised process in place agreed with its university practices that involves initially identifying all patients registered at the practices aged 18 to 20 at first registration and still registered four years later. Lists are first verified with the practices and letters sent. Depending on the verification process, some PCTs send a follow-up letter. An FP69 action is then initiated.

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• **Pupils in residential schools**
A list is sent to all general practices that provide a service to residential schools – in some areas the list is also sent to the school for further verification. Patients are then removed as appropriate.

• **Multi-occupancy dwellings**
Multi-occupancy checks are carried out where 10 or more residents are registered at the same address. The NHAIS system has, for many years, had specific software to enable FHS providers to extract these addresses. Some areas may choose to investigate addresses that have a lower number of patients at an address and target certain geographic areas.

• **Deceased patients**
Agencies are notified of patient deaths through office of population censuses usually within two weeks of the patient’s death. Notifications are also received from general practices.

• **Immigrant checks**
A letter is sent to all immigrants, usually one year after they first register with a practice. This activity is undertaken monthly. A follow-up letter is then sent if no response is received. It is good practice in some areas to include a strapline in about 20 languages within the letter or included as an attached information sheet. It tells the patient to contact their practice if they don’t understand the letter. Translations of the letter are prepared in the most common languages used locally and the practice can download it for the patients.

If there is no response after both letters have been sent, an FP69 action is initiated. This is a flag raised to the practice informing them that the patient will be removed from the practice list at the end of six months if the practice does not inform the relevant agency of a new address.

• **Patients who go abroad for more than three months**
Practices should notify their FHS provider if patients are leaving the country for three months or longer. Patients are removed immediately. An FP69 should then be initiated.

• **Elderly patient checks for those over 100**
Lists should be sent for verification to practices of all patients over 100 years old. Deductions can then be made as appropriate. Some PCTs/agencies reduce the age to 90 or 95 years old. Others combine this with the over 65s flu vaccination programme and concentrate only on those patients who have opted out of the flu programme.

• **Routine communications**
FP69s are raised because of undelivered letters from screening and vaccination programmes and other routine mail-outs, such as:
  - Cytology screening
  - Bowel cancer screening
  - Chlamydia screening
  - Breast cancer screening
  - Audits to check eligibility for free NHS care (prescriptions and eye care)
  - Undelivered medical cards
  - Over 65s flu checks

Consideration should be given to using all local and national projects that require mail-outs to groups of patients that may result in returned undelivered mail.
*Monitoring the patient registration process*

Agencies will regularly check the accuracy of patient registration received over the electronic link from the general practice to ensure demographic information is correct and to prevent duplicate registrations. The FHS provider/agency is recommended to continually encourage practices to provide adequate and accurate information when registering patients. FHS providers are also individually monitored on the number of duplicate NHS numbers they create.

*List matching with general practices*

In some PCTs the reconciliation of general practice lists against the Exeter system is included as a standard rolling programme. Some PCTs do this annually, others less frequently. Each PCT needs to consider its own local circumstances when agreeing the frequency of this as an action to address list inflation. It should be noted that discrepancies between general practice systems/Exeter should be minimal if GP/HA Links are well maintained.

*List matching with other NHAIS databases*

The Audit Commission’s National Duplicate Registration Initiative took downloads of NHAIS databases and matched against them. This led to some duplicate records being found and allowed FHS providers to investigate these. The audit commission work will cease soon, so to carry out this type of work the strategic planning group of the NHAIS system has asked the developers of the NHAIS system at Connecting for Health to design similar software to be used by the agencies.

**Potential additional activity**

PCTs may wish to consider whether additional work to reduce list inflation is required and whether this would be productive and cost effective. The most obvious is to:

- Increase the frequency of routine checks as is appropriate locally,
- Increase the number of reconciliations to ensure that all practice databases are reconciled more regularly
- Expand geographical coverage for some checks such as multi-occupancy dwellings to cover the whole PCT area.

The following are also possible areas for consideration:

- **Post Office address file**
  FHS providers/agencies receive data from the Post Office with new, updated or discontinued postcodes. This allows addresses to be matched continually. It also identifies demolished addresses. Where patients are listed at these, letters are sent and if undelivered, an FP69 action is initiated.

- **FP69 orphan report**
  Available software can be used to identify FP69 orphans – where persons have been removed through undelivered mail while family members are still registered at that address. This is to identify scenarios where children remain registered after the parents have been removed.

**Targeted campaigns**

If a PCT has a particularly large variance they may wish to undertake a targeted campaign to reduce this in one large exercise. All PCTs are strongly urged to engage their local general
practices and local medical committee and preferably to work in partnership with them through such a process.

NHS South Gloucestershire wrote to all patients who met the criteria of being registered for more than two years but who had not had a consultation or been prescribed for five years. Of these, 13,250 patients were initially identified, with potential in the end for 2,274 removals at a saving of £146,878 (based on GMS at £64.59). This approach required GP support as GP clinical systems had to be accessed to retrieve the data.

NHS South West Essex also decided to target low users of primary medical services. Its coding in the GP clinical system suggested that the patient was 16 years old or over, had not presented at the practice for three years or more, had not been given a prescription for the same number of years and had no record of a telephone consultation or other contact with the surgery. The exercise is being run in phases and phase 1 has resulted in 5,356 FP69 flags being raised.

NHS Berkshire West commissioned a list validation exercise focused on multiple occupancy housing and patients with an immigration status registered with a GP for less than a year. This identified 10,064 ghost patients with an estimated saving of approximately £650,000 (estimated at £64.59 per patient). By March 2012 they estimate a further 6,482 patients will be removed. It should be noted however that many FHS providers carry out these two exercises as routine.

NHS London, through the Once for London project, has developed a set of operating principles for list maintenance. Approximately 70 primary care leaders have participated in this work to date with representatives from clusters, contractors, LMC, LDC, FHS organisations, clinicians, practice managers, public health, finance and contracting. Adoption of the principles should prevent list cleansing drives appearing targeted at any particular practice and stop the mass removals some practices have seen with their associated risk of financial destabilisation. The intention is to systematically work through patients alphabetically, but part of the approach is to first share the list of patients with practices to remove any patient that had had contact with the practice in the previous 15 months. This timeframe was chosen to align with QOF recall periods to minimise the possibility of any patient on a chronic disease register being removed in error. It is also more likely that a patient seen in the past 15 months will still be resident. The policy also allows for targeting groups such as over 65s with the flu campaign and multiple occupancies. The Once for London approach is available on the PCC website at (http://www.pcc.nhs.uk/the-once-for-london-project)

The more work that is done to tackle list inflation, the greater the operational cost. PCTs should decide upon the most effective approach for their population and ensure the estimated costs of all additional activities are offset against expected savings. PCTs should consider excluding patients that are included in the groups listed under routine communications, to reduce costs and inconvenience to patients.

**Potential risks**
Removing patients from GP registered lists is not without risk to patient care. Removed patients can subsequently be missed for national screening programmes. They will also cost more money once re-registered as they will register as new patients, thereby increasing their per capita cost.

**Supporting practices**
Some of the risks can be mitigated by ensuring that practices fully understand the FP69 process and PCTs should ensure work is undertaken to reinforce practice understanding and encourage more proactive maintenance of lists and patient addresses.
PCTs could issue good practice guidelines, encouraging practices to deal proactively with returned mail or other indications that patients may have left the area.

They should be trained to use the FP69 process – holding cards in the paper records or flagging electronically on the GP system – then removing the patients if they do not present at the surgery in six months. Some agencies also provide data quality workshops for practices.

Reducing the practice’s registered list has a direct impact on practice funding and therefore, as recommended above, it is advised to engage with practices in any planned activities from the outset. Bear in mind that:

- Practices have a legal responsibility to keep data they hold up to date in line with the Data Protection Act
- Reducing the practice list by removing ghost patients will also reduce the denominator for assessing practice achievement in meeting QOF, hence making it easier for them to achieve the targets.

**Recommended principles**

From the work carried out to date, some recommended principles are deduced.

- **List maintenance should be ongoing**
  List maintenance should be seen as an ongoing, rolling sustained programme of activity and not just a one-off savings drive. For some, the one-off targeted exercise may be necessary to identify accumulated ghost patients and take actions to remove large numbers from practice lists. However, as a general rule, PCTs should work with their practices and supporting agencies to ensure that best practice principles are followed from the day a patient registers and then ongoing checks made to ensure that registration remains valid.

- **Understand your population**
  Local commissioners need to understand their populations and how their particular demography impacts on list inflation. This enables more targeted steps to be taken to tackle list inflation that are more suited to local demography eg students, multi-occupancy houses, etc. This is a more efficient and cost effective approach. Commissioners could consider focusing list cleansing at ward level where inflation at practices within particular wards increases beyond a set parameter.

- **Engage local practices and representative groups**
  Commissioners should fully consult practices and local representative committees to achieve the best results. There is no obligation on the contractor to validate their patient lists but the regulations dictate this is a PCT responsibility. There is no doubt that where tackling list inflation is progressed in partnership with GPs it has proved to be more successful.

- **Equality impact assessment**
  Consider undertaking an equality impact assessment. This will ensure that any process undertaken to address list inflation does not indirectly discriminate vulnerable groups of patients eg immigrants, elderly. It will also reduce the possibility of removing patients in error.

- **Plan the costs**
  Plan the estimated operational costs associated with any initiative to tackle list inflation to assess more accurately the resource impact and anticipated net saving. PCTs need to bear in mind that the process of removal generally takes six months so savings are not immediate. Also, there is a need to minimise the possibility of removing patients in error, which can then increase costs when they re-register as new patients.
Other supporting documents:

To support PCTs the following documentation is available:

- Primary care quality and productivity challenge: good housekeeping guide, which provides advice on how to achieve maximum value from primary care contracts, including a recommended approach to list cleansing exercises. ([http://www.pcc.nhs.uk/primary-care-quality-and-productivity-challenge](http://www.pcc.nhs.uk/primary-care-quality-and-productivity-challenge))

- Funding allocations and practice lists – which outlines the effect GP patient list cleansing has on PCT allocations and also General Medical Services (GMS) general practice allocations ([http://www.pcc.nhs.uk/funding-allocations](http://www.pcc.nhs.uk/funding-allocations))

- Case study: NHS Ealing – reducing list inflation to deliver patient benefits – a useful example setting out how Ealing PCT has improved services for patients as well as saving £500k through its list cleansing exercise, reducing list inflation from 30% in 1998 to 4% today. It also flags up important equality considerations, including the need to carry out an equality impact assessment on the list cleansing programme and to ensure patient letters are sent out in appropriate languages to meet the needs of any diverse populations within the PCT. ([http://www.pcc.nhs.uk/ealing-list-cleansing](http://www.pcc.nhs.uk/ealing-list-cleansing))
