General practitioners' views about the statutory annual practice report

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Abstract

Objective—To ascertain the views of primary care professionals about the current purpose, uses, potential, and workload implications of the statutory general practice annual report.

Design—Postal questionnaire survey.

Setting—General practices in the Northern region.

Subjects—All practices in the region that were singlehanded, fundholding, non-fundholding and with more than five partners, and a one in three random sample of all non-fundholding practices (n=318).

Results—263 practices responded (83%). The report took a median of 12 hours to produce (95% confidence interval 11 to 15 hours; interquartile range 7-35). The main perceived purpose of the report was to monitor practice activity (165 respondents; 63% (95% confidence interval 57% to 69%)), but 44 respondents (17%; 13% to 22%) produced it only because it was contractually required. Practices included statutory and non-statutory data in these reports and would have liked comparative practice activity information (155 respondents; 59%) and "good ideas" (165 respondents; 63%) fed back to them. Respondents would have liked the annual report used to improve practice development planning (122 respondents; 46% (40% to 52%)), to facilitate audit (115 respondents; 44% (38% to 50%)), and to influence resource allocation (104 respondents; 40% (34% to 46%)). One hundred and eighteen practices (45%; 39% to 51%) would produce an annual report even if not contractually required. Data collected were perceived to be already available elsewhere.

Conclusions—Primary care professionals have concerns about the current annual report. They would prefer to collect relevant, standardised data which could lead to better audit, planning, and resource allocation.

Introduction

General practice reports have been produced by primary health care teams for years, the earliest recorded being in 1970, though 70% of a surveyed group of practices producing them had done so only from 1984. Data most commonly included were practice histories, consultation and visiting rates, immunisation rates, practice population profiles, personnel and staff changes, as well as written contributions from primary health care team members. These pioneers thought that such retrospective practice reports could aid planning in the practice by collating relevant data, helped foster greater spirit and communication, and increased accountability to users of the service.²

The new contract for general practitioners in 1990

included a requirement for each practice to produce an annual report.³ The report was designed to increase the amount of information available to family health services authorities about primary care. The required data included details about premises; staff with reimbursable salaries; prescribing formularies and arrangements for repeat prescriptions; how patients' comments about the practice were obtained; general practitioners' commitments outside the practice; and secondary care referrals, including outpatient and inpatient referrals. The health departments saw general practice annual reports as part of the government's drive to increase accountability within general practice and also as an input into the medical audit arrangements outlined in *Working for Patients*.⁴ However, annual reports have been criticised as being of little practical value either to health authorities or to the practices producing them.^{5,6}

This paper surveys primary care professionals' views about the workload implications of producing this mandatory document and its perceived usefulness.

Method

In summer 1993 all singlehanded, fundholding, and "large" practices (defined as a non-fundholding practice with six or more partners) plus a one in three random sample of all other non-fundholding practices in the Northern region were sent a postal questionnaire. This asked about the current purpose, uses, potential, and estimated workload implications of producing the statutory practice annual report. The questionnaire, containing closed multiple choice and open textual questions, was sent to the senior partner but requested the views of other primary health care team members. Respondents were also asked for details about their list size, number of partners, location, type of computer system, and whether they had a practice manager. Results were analysed by the SPSS PC⁷ and confidence interval analysis software packages. Descriptive statistics with confidence intervals and categorical comparisons by means of the χ^2 test are reported. Continuous variables were compared by the Mann-Whitney and Kruskal-Wallis tests, as appropriate. Ninety five per cent confidence intervals for percentages are calculated to within $\pm 6\%$ unless stated otherwise.

Results

Two hundred and sixty three out of a possible 318 responses were received (83%). Response rates varied with the status of the practices but the differences were not statistically significant. Tables I-III give the profiles of the responding practices in terms of location, numbers with a practice manager, average list size, and types of computer system used.

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TABLE I—Status of responding practices, proportions with practice manager, and mean list sizes

Status	No (%) of practices responding	No (%) with practice manager	Mean list size (SD)
Singlehanded	98 (37)	54 (55)	2 111 (658)
Non-fundholding	87 (33)	60 (80)	5 638 (2 202)
Fundholding	58 (22)	57 (98)	10 927 (3 402)
Large	20 (8)	19 (95)	13 501 (2 705)
Total	263 (100)	200 (76)	6 138 (4 488)

TABLE II—Locations of responding practices

Location	No (%) of responding practices
Rural	62 (24)
Inner city	40 (15)
Urban or suburban	127 (48)
Mixed	16 (6)
Did not specify	18 (7)
Total	263 (100)

TABLE III—Computer systems used in responding practices

	No (%) of responding practices
VAMP	49 (19)
AAH Meditel	45 (17)
None	38 (14)
Emis	26 (10)
Genisyst	20 (8)
AMC	15 (6)
Other	70 (27)
Total	263 (100)

PURPOSE OF ANNUAL REPORT

Roughly two thirds and half of respondents, respectively, thought that practice activity monitoring and assisting in audit were important functions of the annual report (table IV). Of the 103 practices (39%) indicating that they completed the annual report because of its contractual nature, 44 (17% of the total; 95% confidence interval 13% to 22%) indicated that the contractual obligation was the only reason they produced it. Over half of these (23; 52%) were singlehanded practices. This difference was significant ($df=3$, $\chi^2=8.5$, $P<0.05$).

PRODUCING ANNUAL REPORT

Two hundred and thirteen practices (81%) indicated that general practitioners were involved in producing the annual report but in only 117 practices (44%) did the practice nurse play a part. Clerical staff also contributed: receptionists in 142 practices (54%), computer operators in 96 (37%), and secretaries in 112 (43%). In practices that had a manager he or she almost invariably played a part (199/200; 95% confidence interval 97% to 100%).

The number of practices reporting that attached district health authority employed staff contributed to the annual report was less than that for practice employed staff, in 34 practices health visitors or district nurses, or both, contributing to the report (13%; 95% confidence interval 9% to 17%). Other participating staff included community psychiatric

TABLE IV—Perceived purpose of producing annual report (respondents could choose more than one response)

Perceived purpose	No (%) of responding practices [95% confidence interval]
For monitoring practice activity	165 (63) [57 to 69]
To assist in audit	130 (49) [43 to 56]
To review practice team activities over year	108 (41) [35 to 47]
To inform family health services authority about practice needs and difficulties	106 (40) [34 to 46]
Statutory requirement	103 (39) [33 to 45]
To provide practice development plan	68 (26) [21 to 31]
To inform practice population	17 (6) [4 to 10]
Other	21 (8) [5 to 12]

TABLE V—Estimated time taken to produce annual report by members of primary health care team

Team member	No (%) of responding practices	Estimated time taken (hours)		
		Median	95% Confidence interval	Interquartile range
Practice manager	175 (73)	6	5 to 8	3-12
General practitioner	180 (75)	3	3 to 4	2-8
Receptionist	111 (46)	4	3 to 6	2-12
Clerical staff	78 (33)	4	2 to 7	2-10
Computer operator	84 (35)	4	2 to 5	2-7
Practice nurse	79 (33)	2	2 to 3	1-4
District nurse	26 (11)	2	1 to 2	1-2
Health visitor	22 (9)	2	1 to 4	1-4
Other	11 (5)	3	1 to 20	2-18
Total	239 (100)*	12	11 to 15	7-35

*Twenty four respondents did not complete this part of the questionnaire.

nurses, physiotherapists, chiropodists, midwives, and counsellors.

Table V indicates the estimated median and interquartile ranges of times for members of the primary health care team to complete the annual report (including only those questionnaires where a time was indicated). Table VI gives a breakdown of the median and interquartile ranges for the time taken to complete the annual report in the different types of practices. The differences were significant (Kruskal-Wallis test: $df=3$, $\chi^2=13.2$, $P=0.004$). Those respondents who believed that the only purpose of the annual report was statutory did not spend significantly more or less time completing the task than all other respondents ("statutory only" group: median time 12.5 hours (interquartile range 5-41); all other respondents: median time 12.0 hours (7-34); $P=0.78$).

TABLE VI—Estimated time taken to produce annual report by practice status

Status	No (%) of responding practices	Estimated time taken (hours)		
		Median	95% Confidence interval	Interquartile range
Singlehanded	87 (36)	12	8 to 13	5-17
Non-fundholding	79 (33)	13	10 to 21	8-34
Fundholding	54 (23)	22	10 to 37	6-48
Large	19 (8)	32	12 to 58	12-58
Total	239 (100)*	12	11 to 15	7-35

*Twenty four respondents did not complete this part of the questionnaire.

The median time taken for practices to develop their annual report if they included a business plan was 29 hours (95% confidence interval for the median 26 to 43; interquartile range 11-51 ($n=68$)) and 11 hours (10 to 13; 6-22 ($n=168$)) if they did not include one. This difference was significant (Mann-Whitney U test: $z=-4.1$, two tailed $P<0.0001$).

An open ended question asked what difficulties or problems, if any, respondents had had in completing the report. One hundred and eighty five questionnaires from respondents (70%) included comments. Of these, one fifth stated that they had encountered no problems. The main difficulty cited by those who had was the time taken to produce the report. This was mentioned by 82 (55%) of those commenting—31% of all respondents (95% confidence interval 26% to 37%). Some of the other difficulties encountered were problems with data handling, including duplication of data (particularly referral data), inconsistent recording, imprecise definitions, and problems with computer software; changing requirements for particular data; lack of motivation; and poor organisation and administration of the reports by the family health services authority. Several respondents questioned the accuracy and quality of the data produced, in particular those relating to referrals to secondary care. Finally, several non-computerised practices reported difficulties in collating the data manually.

DATA INCLUDED IN ANNUAL REPORT BY PRACTICES

Two hundred and fifty four practices (97%; 95% confidence interval 94% to 98%) included outpatient referral data, 228 (87%; 83% to 91%) inpatient referral data, 226 (86%; 82% to 90%) data on practice premises, 154 (59%; 53% to 65%) diagnostic data, 170 (65%) data on employed staff working hours, 153 (58%) information on staff duties, and 204 (78%; 73% to 83%) information on past staff training. A few practices also included prescribing data. These data are statutorily required in the annual report.

Practices also included other, non-statutory data in their annual report. Seventy seven practices (29%) included morbidity data, 76 (29%) details of staff

training required, 162 (62%) the number of surgery consultations, 155 (59%) the number of home consultations, 141 (54%) the number of night consultations, and 221 (84%; 95% confidence interval 80% to 89%) details about the attached staff in the practice. Thirty two practices (12%; 8% to 16%) also included various additional data—from audit figures to other referral information (emergency, self, and private). Seventy two practices (27%) included a practice development plan in their annual report.

FUTURE USES OF ANNUAL REPORT AND FEEDBACK

From a practice perspective 122 respondents (46%) thought that improvement of practice development planning was possible, as well as using the document to facilitate audit (115; 44%) and clinical research (54; 21% (95% confidence interval 16% to 25%)). One hundred and four respondents (40%) also saw the annual report as a valuable tool in influencing the resource allocation process, helping in the targeting of practices with problems and developmental needs (110; 42%), and informing family health services authorities about primary care team activities (114; 43%). Respondents indicated that annual reports could be used to inform the processes of purchasing care (79%; 30%) and health needs assessment (114; 43%). Eight practices (3%; 95% confidence interval 1% to 6%) stated that the annual report should be abandoned altogether in the textual responses to this question.

Respondents stated that they would like referral information (154; 59%), morbidity information (118; 45%), and comparative practice staffing information (81; 31%) fed back to them. One hundred and fifty five practices (59%) indicated that they would like comparative practice activity information fed back to them and "good ideas" to be disseminated (165; 63%). Textual responses were often favourable towards the collection of data and feedback to practices, but some caution about standards was also expressed. For instance, one respondent commented that the current "standard of data [was] too poor to be meaningful."

Finally, one hundred and eighteen practices (45%) said they would still produce a document similar to the annual report if it was not contractually required. Table VII shows the responses grouped by status of the practices. Differences were significant ($df=3$, $\chi^2=9.74$, $P<0.025$).

TABLE VII—Status of practices saying they would produce similar document to annual report

Status	No (%) of practices responding	No (%) that would produce similar document
Singlehanded	93 (37)	31 (33) [24-44]
Non-fundholding	83 (33)	37 (45) [34-56]
Fundholding	56 (22)	38 (68) [54-80]
Large	20 (8)	12 (60) [36-81]
Total	252 (100)	118 (47) [41-53]

Differences were significant: $df=3$, $\chi^2=9.74$, $P<0.025$.

Discussion

This questionnaire survey has shown that primary health care professionals have some concerns about the statutory annual report. Production of the report is considered to be time consuming by many, and there are doubts about the quality and usefulness of the data. There seems to be no clear consensus about the purpose or purposes of the report, and a substantial minority of practices see its only purpose as a contractual obligation. There was a greater proportion of singlehanded practices in this second group.

Data collected for the annual report were often found to be duplicated. For instance, statutory data

included in annual reports about reimbursed staff (hours worked, training in the past five years, and duties) and practice premises are recorded by the family health services authorities. Together with the cost of general practice computing, these account for more than 25% of general medical services expenditure (NHS Management Executive, personal communication 1994). Inpatient referral data are also required to be provided in annual reports, yet these data are recorded by hospitals for pricing contracts. That statutory data are not recorded by all practices may indicate either that these practices see little value in their collection or that family health services authorities have waived the need for practices to collect them as they are already held on management information systems. Arguably duplication of data has merit, as nominally comparable datasets may be valuable, especially when existing records are incomplete. Nevertheless, it was clear from many of the respondents' comments that they found this annoying and an unnecessary burden when their administrative workload had already been increased by imposition of the new contract.^{9,10}

Within the non-statutory data included in annual reports the variety is diverse and, as with statutory data, sometimes repetitive—for example, staff training details, night visiting figures, and attached staff details are all held by other agencies. One explanation for the inclusion of all these data is that individual practices may be using the document to review the year's activities and the data serve to reinforce any objectives or problems that the report highlights.

Time spent producing the annual report was highlighted by respondents, the interquartile ranges of the data showing that there is a wide variability in the estimated time spent compiling the document, especially in practices that have embraced a more business-like attitude (as implied by having a business plan). Though there are important implications in terms of staff workload, this investment of time was apparently considered worth while by some practices, as exemplified by one response from a fundholding practice: "We regard the report as a marvellous summary of what is going on each year." Probably the figures for the time taken to produce the report are an underestimate, as respondents were not asked to include the time taken to log and enter the data into computerised and manual systems.

The level of participation of attached staff as opposed to practice staff seems to be low and might be explained by the contractual obligation for annual reports not extending to these practice staff groups. Extending this obligation to attached staff, who may already collect data for their own managers, might lead to the collection of data which could produce a workload redistribution, better manpower planning, and a more integrated primary care team. The actual proportions of employed practice clerical and nursing staff concerned in producing the report may be greater than reported in this survey, as the questionnaire did not identify the numbers of such staff in each practice.

Practices see a value in producing a document similar to the annual report. They would also like to see some data fed back to them to enable comparisons to be drawn with other practices in the area and to learn from the experiences of other practices in developing innovative solutions to problems. This would be dependent on data being collected in a standardised way and being fed to practices in an acceptable and effective format.^{11,12}

As Wilkinson has suggested,⁶ the current structure of the annual report and the value of the data collected via this mechanism should be re-examined in order to reach a compromise which fulfils the needs of both the primary care team and the health authorities and is not

Practice implications

- The new contract for general practitioners in 1990 required each practice to produce an annual report
- These reports have been criticised as being of little practical value either to health authorities or to practices
- This study shows that 31% of those primary care professionals surveyed were concerned about the time taken to produce the report, although the reported median completion time was only 12 hours
- Other concerns included problems with data handling, inconsistent recording, imprecise definitions, software difficulties, changing requirements, and poor central organisation and administration
- However, there was a strong commitment to the concept and use of practice based data collection and a wish to collect relevant, standardised data

too time consuming. Other workers have shown that collection of standardised data in general practice is possible, is beneficial to the practice, and is actively used by them.¹³ We propose that a standardised minimum dataset should be collected via a mechanism similar to the annual report under agreed and appropriate definitions which focuses on relevant items not available elsewhere, such as primary care consultation rates and patterns, intrapractice referrals, and other non-reimbursable practice activity.

This dataset could then be brought together with other relevant data on aspects of primary care provision collected by non-practice organisations (such as family health services authorities, district health authorities,¹⁴ the Office of Population Censuses and Surveys, and provider units), including inpatient referral data, socioeconomic data, and cervical cytology screening data. In this way accurate, comprehensive, and useful

comparative feedback could be provided to practices and managerial bodies to facilitate better planning, audit, and targeting of resources.

In conclusion, we have shown that primary care professionals at present are not wholly convinced that the effort expended in producing an annual report is worth while. However, they perceive a role for data collection and activity reporting if these could be made more relevant to the needs of general practice and the patients it serves.

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A PATIENT WHO CHANGED MY PRACTICE

Mistaken identity

When I was a registrar in respiratory medicine one of the clinics was running late. I had two patients left to see—Mr Jackson and Mr Jackman—neither of whom I had met before. I stuck my head out of the consulting room door and called Mr Jackson. A man in late middle age wearing a hearing aid entered the room. I looked through his notes and told him the results of his recent bronchoscopy. As sympathetically as possible I explained that the shadowing on his chest x ray examination showed that he had lung cancer and because of his poor underlying lung function he would not be suitable for surgery. I explained that his condition was incurable but that I was optimistic that if symptoms were troublesome we would be able to offer effective palliative treatment. Many patients express disbelief when given such bad news but he was completely dumbstruck. He asked no questions and slowly left the consulting room, shaking his head.

I stuck my head out again and called Mr Jackman. I was surprised when the only man left in the waiting area did not respond. I asked the nurse where Mr Jackman was. She said I had just seen him and he had gone home. I suddenly felt ill and sweat started to gather on my brow. I told the nurse that the man I had just seen was called

Jackson. She patiently explained that Mr Jackson was sitting in front of me. I begged her to race after Mr Jackman and bring him back while I saw the real Mr Jackson.

I repeated my previous interview and it came as no surprise to Mr Jackson that he had cancer of the lung and he said that he was going to make the most of what time he had left. The nurse had not found Mr Jackman, so I spent the next six hours ringing his home. I had visions of him having thrown himself under a train. When he eventually answered he was drunk. I apologised profusely and told him the true story of his illness. He had extrinsic allergic alveolitis caught from his budgerigar and the blood test results had proved it. All he needed to do was get rid of the bird. I felt the relief in his voice and he thanked me for having taken the trouble to ring.

I now always make a point of checking with a patient that the notes in front of me are the right ones. When I saw Mr Jackman four weeks later he told me that he had not got rid of his budgerigar. He had wanted to wait in case I rang again and told him that it was not the budgerigar but the cat that needed to go.—KEVIN JONES is a consultant physician in Bury