LMC Support Network
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Response from Local Medical Committees in England to NHS England Regarding the National Patient List Validation (FP69) Exercise

21 July 2026

Dear Amanda,

Thank you for your letter of 6 July responding to the concerns raised collectively by eighty-six Local Medical Committees regarding the national patient list validation programme and the FP69 process.

We welcome your confirmation that patients with recorded NHS activity in the preceding eighteen months are excluded from the deduction pathway before any further action is taken, and that non-response to correspondence alone is not sufficient to determine removal. These are the safeguards we sought, and we are glad they are intended to be in place. However, practices are not experiencing the programme in the way your letter describes.

In a survey of practices conducted since our last letter, more than two-thirds of those responding report having already had to reinstate patients following deduction. We do not suggest that your letter misdescribes the intended design. Our concern is that the safeguard *as designed* and the safeguard *as experienced* by practices have come apart, and our primary request is that NHS England establishes why, and suspends deductions for patients with recorded general practice activity until it has done so.

That survey, to which approximately three hundred practices across England responded, is attached. We should be clear about the two distinct purposes to which we put this evidence, since they carry different weight.

For the question of whether the safeguard is working, the survey functions as a body of documented counterexamples, and the size of the sample does not arise: a process which is said to exclude active patients from the deduction pathway is not vindicated by the observation that most practices did not respond to a survey. A single patient wrongly deducted despite recent contact with their GP is sufficient to establish that the exclusion is not operating as described, and we have a great many more than one.

For the financial estimate, the position is different, and we say so openly. Those figures are necessarily extrapolated from the responding practices to the national picture, and the basis of that extrapolation is set out in the enclosed analysis. They are therefore an estimate, sensitive to the assumption that responding practices are broadly representative, and we offer them as indicative rather than definitive. We would of course much prefer to work from NHS England's own data. That we cannot is among the reasons we ask for it.

The findings do not support the account given in your letter.

- More than two-thirds of responding practices (69%) have already identified patients who required reinstatement following deduction.
- Forty-six per cent hold specific concerns that patients have been wrongly deducted. Only one in five has no such concern.
- Fifty-six per cent report deducted patients returning to the practice seeking care or seeking help to re-register.
- Eighty-five per cent report that they did not receive sufficient information on the methodology used to identify patients.
- Fifty-eight per cent report that they did not receive sufficient notice before deductions were processed.
- Only twenty-three per cent have submitted a challenge. Among those who have used the challenge route, more rated it difficult than easy.
- Confidence in the accuracy of the national list validation exercise is low. Fifty-two per cent are not very, or not at all, confident. Three per cent are very confident.

Approximately one in three responding practices reported more than 250 patients deducted since 1 January, and around one in six reported more than 500. Eleven per cent have lost more than five per cent of their registered list, and two per cent have lost more than ten per cent.

We would draw your particular attention to the first of these findings. Reinstatement following deduction is not our measure; it is yours. Your letter defines accuracy by reference to patients referred for GP review who are subsequently confirmed as resident. On that definition, more than two-thirds of the practices who responded to us have direct, documented experience of the process getting it wrong. These are not impressions. They are records held on practice clinical systems: consultations conducted, prescriptions issued, long-term condition reviews completed. On the design set out in your letter, these patients should not have entered the pathway at all.

The financial consequences are set out in the accompanying analysis. On the basis described above and annualised at the 2026/27 rate of £130.07 per weighted patient, the net loss to general practice is of the order of £18 million a year, rising to approximately £63 million on a fuller measure of the resources attached to a registered patient. For an average practice losing five per cent of its registered list, the recurring cost is in the region of £65,000 a year.

We would willingly refine these estimates against the national data, were it published. At present it is not, and an extrapolation from the practices willing to tell us what is happening to them is the best evidence available to anyone outside NHS England.

We suspect the explanation lies in the data rather than in the design. The programme is described as data-led, drawing on multiple national datasets. If the eighteen-month activity check operates on nationally held data, it is not clear to us that routine general practice activity is fully visible to it. A housebound, frail patient seen at home each month by their GP, on repeat

medication, with no recent secondary care contact, no screening episode and no NHS App account is among the most actively managed patients on any list. Such a patient may nonetheless be invisible to a national activity feed and is precisely the patient least likely to open and respond to official correspondence. If this is the mechanism, it would explain both the discrepancy described above and why the errors reported to us cluster so closely within the cohorts identified in our original letter.

We would also wish to raise four further points arising from your response.

First, and most fundamentally, your letter asks us to accept a series of conclusions without sight of the evidence on which they rest. It states that the process is over 95% accurate, that accuracy has been significantly improved, and that multiple safeguards are applied. It does not explain how any of these conclusions were reached. There is no description of the validation methodology, no confidence intervals, no evidence of independent review, and no statement of the limitations of the modelling.

The letter tells us that patients are identified through demographic indicators, administrative indicators, statistical modelling and multiple national datasets. It does not tell us what those datasets are, what variables are included, what thresholds trigger identification, how the weighting of the model is determined and by whom, or how false positives are minimised. In short, we do not know the criteria. Nor does any practice in England, as the survey findings above make plain. Nor so far as we are aware, does any patient subject to them.

We would not accept an assurance of this kind from a colleague proposing a new clinical risk score, and we do not think NHS England would either. A tool which determines whether an individual retains access to their general practice is a matter of clinical safety, and the standard of evidence should be commensurate. At present, practices are being asked to act on the outputs of a model they cannot see, cannot interrogate and cannot audit.

We would draw your attention in this regard to the Algorithmic Transparency Recording Standard, which is mandatory for arm's-length bodies delivering public or frontline services, and which applies to algorithmic tools, expressly including statistical models, that have a significant influence on a decision-making process with public effect. A model which determines whether a named individual is removed from a GP list is, on any reading, an operational decision about an individual with public effect. The Standard requires disclosure of precisely the information set out above: the datasets used, the variables, the model's performance and its limitations, and the nature of human oversight. We can find no published ATRS record for this programme, and we would be grateful for confirmation of NHS England's position on its applicability.

Second, in relation to the accuracy figure itself. Your letter states that the FP69 process was over 95% accurate in the 2025/26 pilot, with fewer than 5% of patients referred for GP review subsequently confirmed as resident. Even taken at face value, we would caution against placing significant weight on this figure. It is, to a degree, circular: accuracy is defined by reference to errors that practices identified and corrected, such that a practice with capacity to review its list generates recorded errors, whilst a practice without that capacity generates apparently correct deductions by default. To that extent the figure reflects practice workload as much as model performance. Five per cent is, moreover, a small proportion but a substantial number of individuals when applied to a programme addressing a claimed six-

million-patient discrepancy over four years. It also remains an internal assessment of an unpublished pilot, offered in support of a methodology which has likewise not been published.

Third, in relation to the point of deduction. We accept that non-response is not, in isolation, the basis on which a patient enters the pathway. We do not think this describes the position at the point of removal. Our understanding is that once an FP69 flag has been set, the patient is deducted automatically at three months unless the patient or the practice acts. If that is correct, non-response becomes the sole operative determinant of removal for every patient reaching that stage, and the assurance given in your letter would not hold at the point where it matters most.

Fourth, in relation to funding. You confirm that NHS England is committed to the overall general practice envelope for 2026/27 and that funding released will be reinvested in general practice. If the envelope is fixed and registered list sizes fall, no funding is saved; it is redistributed, away from practices with high list attrition and towards practices with stable lists. Practices with high attrition are characteristically those serving transient, deprived, insecurely housed and non-English-speaking populations. On the funding mechanism as described, the effect of the programme is therefore to move resource out of the most deprived communities and towards the most settled ones. We are confident this is not the intention. It is, however, an inverse care law effect, and it sits uneasily alongside NHS England's stated commitment to reducing health inequalities. The sums involved are set out above and in the enclosed analysis, and they fall on practices which continue to serve the same underlying communities.

We remain concerned that our patient safety concerns have not been fully addressed. Our letter did not simply express concern about the inconvenience of re-registration, and the speed of the Register with a GP service does not answer it. The harm we described arises in the interval before either the patient or the practice becomes aware that a deduction has occurred: missed cancer surveillance, interrupted long-term condition monitoring, lapsed shared-care arrangements, and a safeguarded child or vulnerable adult silently dropping off a register. A patient may re-register within thirty minutes and nonetheless have lost a year of proactive, list-based care of which they were unaware they had been deprived. Rapid re-registration mitigates administrative disruption. It does not mitigate clinical risk.

We would urge NHS England to provide the information set out in the appendix to this letter, which we have organised by theme: the criteria that trigger identification; the evidence by which accuracy was established; the safeguards applied at the point of deduction; matters of equality, impact and funding; and questions of accountability and clinical governance. We recognise that it represents a substantial body of information, some of which may take time to assemble, and we would not wish that to become a reason for delay. Three of those matters are, we believe, capable of immediate answer, and we would ask that they are addressed without waiting for the remainder: the list of national datasets from which patients are identified (appendix, item 1); NHS England's position on the applicability of the Algorithmic Transparency Recording Standard (item 8); and the proportion of flagged patients who had recorded NHS activity in the preceding eighteen months (item 22). The last of these is the single figure which would most directly resolve the disagreement between us, and if the safeguard operates as your letter describes, it should already be known.

Finally, we note your suggestion that Local Medical Committees continue to engage through GPCE. We value the work of GPCE and fully recognise its important national representative

role, and we do not regard engagement with the LMC Support Network and engagement with GPCE as mutually exclusive. Indeed, we believe they are complementary. We would observe that Local Medical Committees are statutory bodies recognised in primary legislation, and that this correspondence carries the signature of over eighty per cent of them. The concerns raised arise directly from the clinical systems of the practices affected, which is a form of evidence Local Medical Committees are unusually well placed to gather and which we would be glad to continue supplying. We would ask only that the matters set out in the appendix receive a direct response, alongside whatever discussions continue with GPCE.

We remain supportive of maintaining accurate patient registration lists and recognise the importance of ensuring NHS resources are allocated appropriately. However, transparency, patient safety and confidence in the process are equally important, and at present the methodology is unpublished, the accuracy claim untested outside NHS England, and the equality assessment unshared, whilst the errors practices are reporting fall hardest on the patients the NHS has committed to reach.

We would welcome the opportunity to discuss the enclosed findings with you and your team at the earliest opportunity and would be grateful for a formal response by Wednesday 12 August 2026, given that patients continue to be deducted whilst this correspondence proceeds.

Yours sincerely,

Dr Adam Janjua

On behalf of

LMC Support Network

Enc. 1. Survey of practices affected by the national patient list validation exercise, June 2026

2. Counting the Cost: the financial impact of the FP69 exercise on general practice

Appendix

Schedule of Information Requested

We would urge NHS England to provide the following.

The criteria: what triggers identification

1. A full list of the national datasets from which patients are identified.
2. The variables included within the model, and the weighting applied to each.
3. The thresholds at which a patient is identified for the deduction pathway, and who determines them.
4. Who is responsible for setting and reviewing the model's weighting, and to whom that person or body is accountable.
5. Confirmation of which specific datasets constitute the eighteen-month clinical activity check.
6. Confirmation of whether GP-held records, including consultations, repeat prescriptions issued, long-term condition reviews and home visits, fall within the scope of that check, and if so through what feed.
7. If GP-held activity does not fall within scope, an explanation of the basis on which patients actively using NHS services can be said to be excluded, given that the largest volume of NHS activity in the country would then be invisible to the check.
8. NHS England's position on the applicability of the Algorithmic Transparency Recording Standard to this programme, and if it is in scope, publication of the corresponding ATRS record.

The evidence: how accuracy was established

9. The validation methodology by which the accuracy of the model was assessed, including the confidence intervals around the reported figures.
10. Confirmation of whether the model has been subject to any independent review, and if so, publication of that review.
11. A statement of the known limitations of the modelling, including the patient groups in which it is expected to perform least well.
12. The false-positive rate, expressed with its confidence interval, and the method by which it was calculated.
13. The absolute figures underlying the pilot result: the number of patients identified, the number referred for GP review, and the number confirmed resident.
14. The number of patients deducted during the pilot without any practice review having taken place, this being the population in which errors are, by construction, invisible.
15. Publication of the pilot evaluation in full.

Safeguards at the point of deduction

16. Confirmation of what, other than a response from the patient or an intervention by the practice, prevents deduction once an FP69 flag has been set.

17. A formal right for practices to challenge proposed deductions, with local clinical and administrative knowledge given decisive weight.

18. Clarification of the “Other” reason code used within GP Links notifications, which at present provides practices with no meaningful basis for local validation.

19. Resolution of Personal Demographics Service synchronisation discrepancies, and confirmation of whether practices will be given any means of proactively identifying affected patients.

Equality, impact and funding

20. Publication of the Equality and Health Inequalities Impact Assessment in full. We would prefer to receive this from NHS England directly rather than to request it under the Freedom of Information Act, which appears an unnecessary step for a document you confirm has already been prepared.

21. Publication, by practice and Primary Care Network, of re-registration rates following deduction, including the number and proportion of patients who re-registered at the same practice within 30, 60 and 90 days of deduction, this being the clearest available measure of error.

22. Publication of the proportion of flagged patients who had recorded NHS activity in the preceding eighteen months. If the eighteen-month exclusion operates as your letter describes, this proportion should approach zero, and its publication would resolve this correspondence.

23. Confirmation of whether funding released through this programme will be reinvested specifically into core General Medical Services, rather than into wider primary care or system initiatives.

24. Confirmation of what practical support or financial protection will be available to practices experiencing disproportionate list reductions, and the timescale for it.

Accountability, clinical safety and equality monitoring

25. Whether the programme has undergone formal clinical safety assessment under DCB0129 and DCB0160, and if so, publication of the associated Clinical Safety Case and Hazard Log.

26. What clinical governance oversight exists for the programme.

27. Which NHS England executive is accountable for the programme, as its Senior Responsible Owner.

28. Which governance committee approved implementation of the programme.

29. Which protected characteristics were found to have statistically different rates of deduction.

30. Whether post-implementation equality monitoring has demonstrated disproportionate effects by ethnicity, deprivation, language or housing status.