LMC Support Network
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Response to NHS England on the National Patient List Validation (FP69) Exercise

5 November 2026

Dear Amanda,

Thank you for your letter of 10 August, responding to our submission of 21 July and the enclosed survey and financial analysis.

We held back from replying immediately, and we should explain why. Following your letter, we took the deliberate decision to allow time for NHS England and GPCE to reach a swift resolution through the national channel you had urged us towards, rather than press our concerns straight away. Three further months have now passed without agreement or resolution to what even then was a very pressing issue. In the meantime, the position for practices and patients has worsened. Greater numbers of genuine resident patients are being deducted; some practices report that their finances are becoming precarious as a result; and there is still no indication of what the funding "released" by these deductions is to be reinvested in, or when. Against that background, our constituent LMCs have asked us to take this matter forward again, and we do so now because our concerns are serious, ongoing and remain unresolved.

NHS England's reply from 10 August when read closely, and alongside the Statistical Assessment Model set out at Annex 1, confirms in writing two things the profession had suspected, and raises a serious question of discrimination that we must now raise. The letter also suggests that we may have misunderstood how the programme operates. We do not believe that this is the case. We asked a precise question re which datasets constitute the activity check and the letter resolves the matter beyond doubt.

First, and most significantly, NHSE confirms that the activity check does not include general practice. Directly quoting the letter*, the activity data "does not currently include routine GP consultation and appointment activity recorded within practice systems, such as consultations, home visits and other patient contacts", and that this data "is not currently available to NHS England for the purposes of the patient list validation programme".*

This cannot be reconciled with the assurance in your letter of 6 July, which stated that patients are cross-checked against clinical activity and that those "actively using NHS services" are excluded "before any further action is taken". This is not the case, as a patient seen by their GP every week (on repeat medication, under active management, visited at home) can still be flagged as 'gone-away', because not one of those contacts is visible to the check. This is precisely the failure our July letter predicted, and precisely the cohort our survey found being

deducted: the frail, the housebound, the very patients whose only regular NHS contact is with their practice.

NHSEs letter offers, as reassurance, that "patients with other available NHS activity available within the data sources used by the programme should not be flagged". From our constituent practices perspective this fails to provide any reassurance because general practice is not one of the data sources used by the programme. Therefore, that protection does not reach the patients who most need it. The safeguard has been defined to exclude the single largest category of primary-care contact in the country. That is not a misunderstanding on our part; it is a gap/flaw at the centre of the design.

The patients being wrongly caught are neither hypothetical nor, as is sometimes suggested, all genuine departures. They include identifiable groups the process is poorly designed to handle. University practices, for example, report students receiving these confirmation letters over the summer - precisely when students have characteristically moved to new term-time addresses and will not see them until they return in the autumn, by which time any response deadline has passed. The programme appears to make no allowance for this annual and entirely predictable pattern, even though its own criteria single out patients *"registered at an educational facility for four or more years"* and those with *"a university email"*. A student who is actively registered and using their practice can therefore be removed simply for being a student.

Second, NHSE confirm that there is no published transparency record for this programme. The letter states that the Algorithmic Transparency Recording Standard "has not yet been implemented across NHS England". That Standard has, however, been mandatory for central government departments and their arm's-length bodies since 2023, so this is not a standard not yet reached; it is a mandatory requirement more than two and a half years overdue. In its place we are offered an internal assurance review of the statistical assessment model. If that review genuinely provides equivalent transparency, we ask that you provide a copy of it. A statistical model is deciding whether named individuals are removed from their GP list, and its methodology, its performance and its error rate remain unpublished and unreviewed by anyone independent. Information Commissioner guidance is clear that the mechanism of an automated decision with significant effect on an individual must be transparent. Internal review and an internal register do not meet that standard.

There is a further transparency failure, independent of that Standard. NHS England's own published description of this exercise, on the PCSE website, lists five categories of patient checked and makes no mention of any statistical model or algorithm whatsoever. Neither patients nor practices have been told that an algorithm selects individuals for removal. Whatever the position on the Algorithmic Transparency Recording Standard, people are entitled under ordinary fair-processing principles to know the basis on which decisions about them are made, and at present they do not.

Having now seen the Statistical Assessment Model set out at Annex 1 of your letter, we must raise a concern that goes beyond operational accuracy and into the Equality Act 2010 and NHS England's Public Sector Equality Duty under section 149.

The response from 10 August's annex confirms that the model selects patients for the deduction pathway by scoring a set of factors, and that one of those factors is *"Age at NHS*

Number allocation". Age is therefore not an incidental feature of this process; it is an explicit input that raises a patient's likelihood of being flagged for removal. Using age as a factor that makes removal more likely is, on its face, less favourable treatment on grounds of age, which requires objective justification that your letter does not provide.

A second factor compounds this. The model also scores the *"Size of gap between ONS/PDS in local area"*. On the face of the Annex, the combined effect of these two factors appears to be that an older person living in an area of low life expectancy (a person who has, in effect, outlived the local average) is treated as more likely to be a 'gone-away' or a data error, and so is up-weighted for deduction. If that is the effect, the model is most suspicious of the very patients who have survived longest in the most deprived places - concentrating the harm precisely where health inequalities are already greatest, and in direct tension with NHS England's statutory duty to have regard to them. We ask that NHSE confirm or deny that this is how these factors operate, and to publish the weightings applied to each.

Beyond age, the process indirectly discriminates against disabled patients. Those with cognitive impairment, learning disability, serious mental illness, dementia, or sensory impairment are (for reasons connected to their disability) least able to open, understand and respond to an official letter within the window before deduction. A letter-and-deadline mechanism therefore removes disabled patients at a disproportionate rate - the classic shape of indirect discrimination under the Act. NHSE's Annex lists "No reasonable adjustments" as a filter, but that protects only those patients already flagged as needing adjustments on the Personal Demographics Service, which is a small and unreliable subset of the disabled population. It is not an answer to the duty.

The selection model raises a further and related concern. Among the factors the Annex confirms it scores are whether a patient *"has a visitor/migrant registration"* and whether they have *"a university email"*, and the published PCSE criteria separately single out patients who *"migrated to England 12 months ago"*. A model that weights migration markers and foreign or recent-registration proxies towards removal risks discriminating indirectly on grounds of race and nationality, and risks doing so in precisely the communities already least well served. We ask you to confirm whether the outputs of the model have been tested for disproportionate impact by ethnicity and nationality, and to publish the result.

The same mechanism falls hardest on further groups who are not themselves protected characteristics, but who sit squarely within the health inequalities NHS England is bound to have regard to: patients with limited English; low literacy; no digital access; or insecure housing. Taken together, the people most likely to be wrongly deducted are the elderly, the disabled, and the most deprived. These are the exact populations the NHS has committed to protect, and the exact populations least able to put the error right once it is made.

The 6 July response told us that an Equality and Health Inequalities Impact Assessment has been undertaken, but NHSE have not published it. If that assessment has genuinely grappled with the matters above, publishing it would reassure us. If it has not, that is itself a failure of the Public Sector Equality Duty. Either way, we renew our request that it be published in full, and we will pursue it through the Freedom of Information Act if it is not provided.

Taken together, these admissions lead to one conclusion that we now put to you directly.

By NHS England's own account, patients whose recent NHS contact is with their GP are invisible to the activity check and can therefore be flagged and deducted despite being actively under care. We ask that NHS England suspends the deduction of any patient with recorded general practice contact until that gap is closed. We should be clear about what we are asking for, and what we are not. We are not asking you to ingest detailed GP consultation records, which would be disproportionate and intrusive. We are asking for no more than a simple indicator of recent GP contact - a date of last contact/data entry in the GP records - sufficient to keep an actively managed patient out of the deduction pathway. Until such a signal is in place, these patients are being wrongly flagged now, on a basis your own letter shows to be incomplete.

You state that access to GP activity data "would require a separate legal direction". We note that objection with some surprise, because your Annex confirms that the programme already draws on some of the most sensitive clinical data held in the NHS - Hospital Episode Statistics, the Emergency Care Dataset, Primary Care Medicines, the National Pathology Exchange and the Second-Generation Surveillance System. A bare indicator of recent GP contact is far less intrusive than any of these. If a privacy threshold stands in the way of a simple contact signal, it is difficult to understand how these far more sensitive datasets have been brought into an administrative list-cleansing process. We therefore ask NHSE to set out the lawful basis on which the programme accesses each of those datasets, whether that access has approval under Section 251 of the NHS Act 2006, and who, within or outside NHS England, is accessing this individual-level patient data. We are willing to support the proportionate inclusion of a contact indicator, but it cannot be right to continue deducting the affected patients while the fix is pending: the remedy and the harm are running concurrently, and only one of them is within your gift to pause.

NHSE may respond to state that none of this actually matters because a practice can stop any wrongful removal during the FP69 review by selecting a reason or entering free text. That is not an answer to our concern. It is our concern.

A safeguard that consists of asking practices to manually catch every error in a process you have confirmed is blind to general practice activity is not a safeguard at all. It is the transfer, onto practices, of the cost and the liability of an incomplete design. And it works only where a practice has the capacity to review every flag before the deadline. Where it does not, a real patient is deducted automatically - and recorded, on your own accuracy measure, as a correct removal. The protection is therefore strongest for the best-resourced practices and weakest for those under most pressure, which are disproportionately those serving the very populations most likely to be wrongly flagged. Our survey bears this out: more than two-thirds of responding practices had already had to reinstate patients following deduction, and a majority reported insufficient notice before removals were processed. Those are the errors that were caught. We cannot count the ones that were not.

The review process cannot bear the weight your letter places on it for a further reason as well. Practices report that FP69 notifications frequently carry only the reason code "Other". A practice is therefore not shown NHS England's evidence and invited to rebut it; it is handed a bare flag and required to disprove a proposition it cannot see, against a clock. That is not a fair or sufficient opportunity to prevent an erroneous deduction.

This has a direct legal consequence, which we now put to NHSE. The practice and NHS England are joint controllers of the patient record, and both are under a data-accuracy obligation. If NHS England's defence is that practices will catch its errors, then NHS England is conceding that it is processing deductions it cannot itself justify from the data available to it and relying on the other controller to prevent unlawful removals. An FP69 flag, unaccompanied by the evidence for the proposed removal and without a genuine opportunity for the practice to block it, does not appear sufficient to discharge that obligation. Information Commissioner guidance further requires that the mechanism of an automated decision with significant effect on an individual be transparent - which, as above, this programme is not.

We would much rather resolve these concerns directly with NHS England, and we write in that spirit. We would observe only that the matters raised (data accuracy, the transparency of an automated decision, and the equality concerns set out above) fall within the remit of the Information Commissioner, and that affected patients retain the right to raise their own complaints through their practices. We hope a satisfactory response will make that unnecessary.

We must also raise a development that troubles us greatly. Practices are now reporting that rejections they have entered during the FP69 review are not being actioned - that patients are being deducted despite a valid practice rejection having been submitted. If that is happening, it removes the last safeguard on which your 10 August letter relies, and it does so silently.

We raise this plainly. A process that flags patients without checking general practice activity, that cannot show practices the evidence behind a flag, and that now appears to override the practice's own rejection, is increasingly difficult to reconcile with a neutral exercise to correct inaccurate records. *We are not yet drawing a conclusion as to why that is.* But the cumulative effect (whatever the intent) is to destabilise practices and to strip them of the very funding they depend on to serve these communities, and we are bound to ask NHS England to account for it. We ask you to confirm how a practice rejection is handled once submitted, and in what circumstances, if any, a patient can be deducted after a practice has rejected the flag.

We must also address the financial effect of this exercise, which is serious and, we believe, has not been properly thought through. Even leaving aside the patients wrongly deducted, the programme does structural harm to practice funding. For many years the registered population of England has exceeded the Office for National Statistics population estimate - a longstanding and well-recognised feature, not a sudden error. NHS England's own analysis puts the excess at around six million patients, roughly a tenth of the registered list. General medical services funding is negotiated and allocated based on registered populations, not ONS figures, and the annual contract funding envelope is built upon them. To reduce registered numbers part way through the year, after the per-patient value has been set, is to reduce practice income without any corresponding uplift. This is therefore in effect a clawback of negotiated funding by administrative means.

That excess has also, in practice, operated as a rough correction to the Carr-Hill allocation formula, which is widely acknowledged to under-fund deprived and coastal practices. The Nuffield Trust has documented, and the Government itself acknowledged in announcing its reform, that practices in deprived and coastal areas already receive roughly ten per cent less funding per needs-adjusted patient while facing higher patient-to-GP ratios and greater multi-morbidity. Those same practices tend to serve more transient and migrant populations and

are therefore hit hardest by this exercise. Removing the registered-list correction, without reform of Carr-Hill and without compensating funding, deepens that existing shortfall in exactly the places least able to absorb it. This is therefore the opposite of the Government's stated commitment to reform Carr-Hill and to improve access in poorer areas.

It cannot be right to conduct list reduction on this scale before that reform (to which the Government is committed) has been carried out. Your letter in July states that work to understand the distributional impact of this exercise has been undertaken and is continuing. We have seen no such analysis, and we are not reassured that this is not a worsening of Carr-Hill for some of the poorest practices in the country. We ask you to publish that distributional-impact analysis in full, to confirm what the funding released by these deductions is to be reinvested in and when, and to confirm whether any modelling of the impact by practice deprivation was completed before deductions began, rather than after.

On the questions your letter does not answer: our submission asked for the absolute figures underlying the pilot, the number of patients deducted without practice review, the validation methodology and confidence intervals, the false-positive rate, the independent review, and publication of the pilot evaluation and the Equality and Health Inequalities Impact Assessment. We now add to that request the assurance review of the statistical assessment model, the distributional-impact analysis referred to in previous correspondence, and the lawful basis - including any Section 251 approval - for the programme's access to the datasets named in your Annex. None of this has been provided. As set out in our submission, these requests were made under the Freedom of Information Act 2000, and we will now pursue the unanswered items through the Act's internal-review procedure rather than by further correspondence.

Finally, the last two responses have directed national matters to GPCE. We continue to value GPCE's role and do not regard the two channels as alternatives. But the concerns in this correspondence arise directly from the clinical systems of the practices affected and are evidenced by a survey carried out on behalf of over eighty per cent of the Local Medical Committees in England - statutory bodies recognised in primary legislation. A referral onward is not a substitute for answering the questions those bodies have put to you.

We would be grateful for a substantive response by 30 November 2026, and in particular for a decision on the suspension requested above, an answer on the operation of the age, area and migration factors in the selection model, an account of the financial and distributional impact of this exercise on deprived practices, and confirmation of exactly what the funding released by these deductions is being reinvested in during the current financial year, and where - given that patients continue to be deducted while this correspondence proceeds.

Yours sincerely,

Dr Adam Janjua

On behalf of
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