LMC Support Network
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Open Letter from Local Medical Committees in England to the Secretary of State for Health and Social Care and NHS England Regarding the National Patient List Validation (FP69) Exercise

19th June 2026

Dear Secretary of State and Leadership at NHS England,

We write collectively on behalf of Local Medical Committees representing GP practices across England to raise serious concerns regarding the ongoing national patient list validation exercise and the associated FP69 patient deduction process, now embedded in the 2026/27 GP Contract.

Our primary ask is that patients who have had a recorded NHS interaction within the preceding 12 months should be presumed to be genuine active NHS users unless evidence exists to the contrary. We therefore request that patients meeting this criterion are excluded from the deduction pathway until NHS England can demonstrate the accuracy and safety of the current validation methodology.

We fully recognise the importance of maintaining accurate patient registration records and support reasonable measures to ensure NHS resources are directed appropriately. However, we are increasingly concerned that the current process risks generating substantial numbers of false positives, leading to the inappropriate removal of legitimate patients from GP practice lists.

General practice representatives are reporting concerns that patients are being identified through national data-matching exercises despite remaining genuine, active patients of their practices. Whilst these patients may not respond to correspondence issued as part of the validation process, non-response should not automatically be interpreted as evidence that an individual no longer resides within an area or remains registered with their practice.

Many patient groups are inherently less likely to engage with administrative correspondence, including those with limited English proficiency, low literacy levels, learning disabilities, cognitive impairment, mental health difficulties, housing instability, social deprivation, or a general mistrust of unsolicited communications. Others may

reasonably mistake such correspondence for junk mail or fraudulent communications and discard it without response.

As a result, there is a real risk that the process disproportionately impacts vulnerable and disadvantaged populations, potentially exacerbating existing health inequalities and undermining efforts to improve access to healthcare for those who already face barriers to engagement. The patients most likely to be removed incorrectly are precisely those least able to navigate re-registration processes.

We are also concerned about the consequences for direct patient care. Patients who are incorrectly deducted may experience disruption to continuity of care, delays in accessing treatment, interruptions to long-term condition monitoring, difficulties obtaining prescriptions, and significant distress when they subsequently discover that they are no longer registered with their GP practice.

The process treats silence as proof of absence, and a patient who does not reply to a letter is assumed to have left the practice. When a genuine patient is wrongly removed, there may be some serious clinical consequences, and the patient usually finds out only when they next try to access care, often at the worst possible moment. Some examples of these are:

- **Cancer follow-up:** a patient under post-treatment surveillance misses scheduled recurrence monitoring and review, with no practice holding responsibility for chasing them.
- **Diabetes and long-term condition reviews:** a patient loses their annual review, foot and retinal screening, blood monitoring and medication titration raising the risk of avoidable, costly complications.
- **Mental health care:** a patient on antidepressants or under shared-care monitoring loses continuity at exactly the point they may be least able to advocate for themselves, and repeat prescriptions stop.
- **Safeguarding:** a child or vulnerable adult known to safeguarding processes silently drops off the register, breaking a key thread of professional oversight.
- **Frailty monitoring:** an older, housebound patient (precisely the person least likely to open and answer official post) loses proactive monitoring, medication reviews and falls prevention.

It is also ironic that the consequence of this policy works directly against the NHS's own neighbourhood health strategy. This is very hard to reconcile with the national move towards neighbourhood health and proactive, population-based care. The patients most likely to be wrongly deducted are exactly the people neighbourhood models are designed to identify, reach and hold onto. A programme that quietly removes them from the register is pulling in the opposite direction to the policy it sits

alongside: the very people the NHS has pledged to find are the ones this exercise loses.

In addition to the risks posed to patients, there are significant implications for the sustainability of general practice. Erroneous deductions reduce practice list sizes and may have direct consequences for practice funding, service planning and workforce allocation. Some of our practices have reported the removal of up to ten percent of their total practice patient base. Population figures are fundamental to the commissioning and delivery of primary care services. Where legitimate patients are removed, practices and Primary Care Networks may experience financial losses despite continuing to serve the same underlying communities.

We are particularly concerned that this exercise is taking place against a backdrop of unprecedented demand within general practice. The funding mechanisms underpinning core general practice were developed in a very different operating environment and have not kept pace with the substantial growth in patient contacts, administrative workload, clinical complexity and digital access that has emerged in recent years.

Since the COVID-19 pandemic, practices have experienced a significant increase in patient interactions through a combination of face-to-face consultations, telephone consultations, online consultation platforms, prescription requests, care navigation, administrative requests and care coordination activities. Whilst registered list size remains a key determinant of practice funding, the relationship between list size and actual workload has become increasingly complex.

Against this backdrop, any national programme that results in the removal of legitimate patients from practice lists risks further widening the gap between workload and resources and may inadvertently destabilise practices that are already operating under considerable financial and workforce pressure. This is particularly concerning if deductions arise from false positives within the validation process rather than genuine reductions in the population served.

We therefore seek reassurance that the cumulative financial and operational consequences of this programme have been fully considered and that no unintended destabilisation of practices or Primary Care Networks will result from the inappropriate removal of legitimate patients.

We would urge NHS England and the DHSC to:

Immediate safeguards

1. **Immediately suspend** the automatic deduction of any patient with a recorded NHS interaction (GP consultation, prescription, referral, vaccination, screening, outpatient attendance or other contact) in the preceding 12 months, pending review.

2. Confirm that non-response to correspondence alone is never, by itself, sufficient grounds for removal.

3. Guarantee practices an effective right to challenge proposed deductions, with local clinical and administrative knowledge given decisive weight in the process.

Transparency and data

4. Publish the methodology underpinning the exercise: identification criteria, data sources, accuracy thresholds and false-positive rates.

5. Clarify the triggers that initiate the FP69 process and the data-quality checks applied before a patient enters the deduction pathway.

6. Clarify the use of reason codes associated with FP69 notifications transmitted via GP Links. Practices commonly report receiving notifications citing the reason for review as "Other", which provides little meaningful information to support local validation. We would welcome clarification as to whether this reflects a limitation within GP Links messaging, a data quality issue, or another aspect of the process.

7. Resolve PDS synchronisation discrepancies ("PDS: Patient Differences"), including a means for practices to proactively identify affected patients. Practices report that where demographic information differs between the local GP record and the national Personal Demographics Service record, there appears to be no proactive mechanism by which practices can identify or search for affected patients. We would welcome confirmation as to whether any such functionality exists or is planned.

8. Publish, by practice and PCN, the number of patients who re-register with the same practice following deduction - the clearest available measure of error.

9. Publish the proportion of flagged patients who had any recorded NHS activity in the preceding 12 months.

Equality and impact

10. Undertake and publish a formal Equality Impact Assessment and Health Inequalities Impact Assessment for the exercise.

11. Assess and publish the financial impact on practices and PCNs and ensure none suffers financial detriment as a result of incorrect deductions.

12. Engage directly with LMCs, GP representative bodies and patient groups to agree safeguards that minimise patient harm, administrative burden and financial instability.

The NHS has rightly prioritised reducing health inequalities, improving access and strengthening neighbourhood-based care. Any national programme which risks inadvertently removing vulnerable patients from primary care registration, whilst simultaneously reducing resources available to practices serving those communities, must be subject to robust scrutiny, transparency and appropriate safeguards.

We would welcome the opportunity to discuss these concerns with NHS England and the Department of Health and Social Care at the earliest opportunity and would be grateful for a formal response addressing the issues raised within this letter.

Yours faithfully,

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5. Birmingham LMC
6. Bolton LMC
7. Bradford and Airedale LMC
8. Brent LMC
9. Bromley LMC
10. Buckinghamshire LMC
11. Cambridgeshire LMC
12. Camden LMC
13. Central Lancashire LMC
14. Cheshire LMC
15. City and Hackney LMC
16. Cleveland LMC
17. Cornwall and Isles of Scilly LMC (Kernow LMC)
18. Coventry LMC
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20. Derby and Derbyshire LMC
21. Ealing, Hammersmith and Hounslow LMC
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29. Hull and East Yorkshire LMC
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32. Kent LMC
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