The Great Big MK GP Survey

Resident views on access and support in 2024

healthwatch
Milton Keynes

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healthwatch
Milton Keynes

Introduction

Healthwatch is the statutory body created to help improve local health and social care services and make sure they work for the people who use them.

Healthwatch Milton Keynes is the local independent champion for people using health and social care services in Milton Keynes. Our main statutory functions as local Healthwatch are:

To obtain the views of people about their needs and experience of local health and social care services

To make reports and recommendations about how those services could or should be improved

To promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services

To provide information and advice to the public about accessing these services and the options available.

We represent the voice of local people on various health and social care forums, including the Integrated Care Board and the Health and Care Partnership (formerly called the Health and Wellbeing Board).

We're part of a national network that reports to Healthwatch England, NHS England and The Department of Health and Social Care on national health and social care trends.

Much of our work is driven by the difficulties experienced by people as they try to navigate local health and care services. This meant we were confident in our ability to highlight specific issues to the ICS Inequalities Steering Group as part of a BLMK wide project to explore ways to reduce the inequalities that are growing for some of our residents as the health and care system comes under increased pressure. The evidence we gathered for this report underline the themes we have highlighted in previous work, and we look forward to seeing the results that the renewed interest in coproducing solutions with affected residents will bring

The 2nd Annual GP Survey

Much of the feedback we receive from residents is about their experience of primary care and accessing their GP. While we have a very high number of contacts from people telling us about their difficulties accessing NHS Dentistry, GP Access is still the number one reason people contact us.

Last year we asked the people of Milton Keynes to share their experiences of accessing their GP Practice. Now, twelve months on, the demand for appointments and our difficulty getting the help we need doesn't always feel like it has improved but, in the background, the people that design and deliver Primary Care services have been working hard to improve access.

There is a lot happening: employing more people in GP practices with different specialties, increasing the number of things that pharmacies can help with, improving telephone systems to beat that long hold queue, and increasing the use of digital triage systems to ensure that all of us get the right care, by the right person, at the right time. Some of these changes are welcomed, and some have caused some residents difficulties.

Because many of these changes have been nationally mandated, we wanted to know if they were working, for our residents, the way that NHS England hoped they would.

Methodology

We created a survey that explored the themes and topics around accessing and visiting GPs that people commonly share with us. We also included questions about the areas under review by the professionals tasked with improving and providing GP services.

The survey was widely shared online, and printed copies were also provided to people at the many outreach sites and engagement events we attended across the year. We provided postpaid envelopes for those who felt able to complete the survey independently, and offered support in completing the survey for those who wanted it.

As always, we asked people to offer suggestions for improvements that they feel would enhance the access and care within general practice.

This report lays out the responses and feedback following the format of the survey, starting with registration through to the demographics of people we spoke to. This report ends with a summary of the findings and our recommendations drawn from the evidence.

In total, we had 832 responses to the survey, which is almost double the number of people who responded last year, highlighting the level of interest that people have in primary care services.

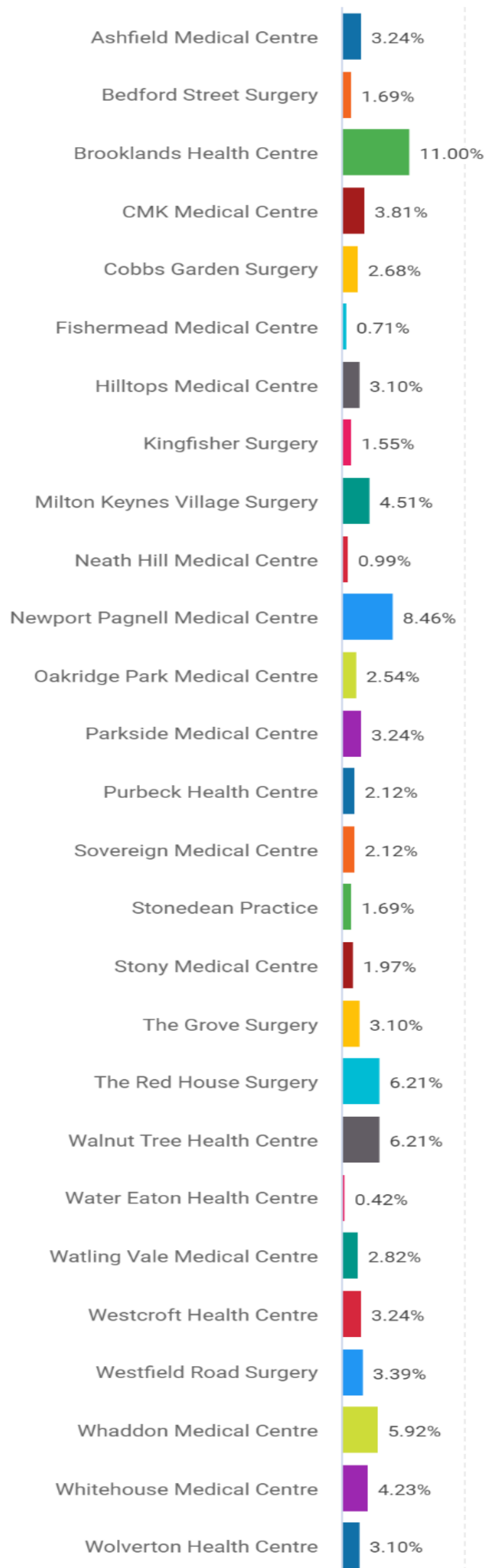
Which GP practices were covered?

We had responses from patients from every GP practice in Milton Keynes.

We also spoke to 42 people said they were registered at a Milton Keynes GP practice but used the Urgent Care Service for most of their GP needs so had selected 'Other' rather than the practice where they were on the patient list.

There were also 16 Milton Keynes residents who are registered at Asplands Medical Centre which does not come wholly under the Milton Keynes GP umbrella but will use Milton Keynes University Hospital and the Milton Keynes Urgent Care service.

We also spoke to 9 people at the Urgent Care Service who lived in Hanslope, Winslow, Leighton Buzzard and Northampton and were attending the Milton Keynes Urgent Care Service because it was the closest after-hours option for them.



Registration

Registration and de-registration with your GP

5% of people told us they had been deregistered from a GP practice in the last 12 months, and only **1%** said that they felt the de-registration process was explained and managed well.

> *Felt it was very minimising. I was midway through treatment and now I was kicked to the curb for being 100m outside their invisible boundary.*

> *After 30 years with one surgery we received a letter giving us 30 days to find a new surgery as we were now out of area. Called surgery to be told that I could appeal but that it would be pointless.*

> *I was very heavily pregnant at the time, and they basically kicked me out right away even though I was worried about not receiving proper care in a cross over between surgeries. It was also my first baby so had no idea how things worked.*

> *I explained that I had a new address. Receptionist said to bring proof of new address which I did. Receptionist then said I was out of catchment area and myself and elderly mother who have been at the practice for over 30 years have to change GPs. The local one to me is not taking on any new patients. This practice knows our history. Now I have 4 weeks to find another practice. I am so upset.*

> *Changed address with reception staff, was told they would enquire regarding my request to stay with them (as had been at the practice 30+ years). Never got contacted back verbally but instead received generic letter advising I would be immediately deregistered, and I had 14 days to find an alternative GP as they would no longer be responsible for me after this (regardless of whether I found a new one or not).*

> *I was advised by my midwife to wait until baby was born before switching Drs as I moved home a week before due date. This had caused confusion with the health visitors going to the incorrect address, along with incorrect address stickers in babies Red Book, even after explaining on numerous occasions of the new address. I should have changed GP before baby was born to avoid the miscommunication between the hospital and GP.*

People are understandably anxious about moving to practices where they, and their conditions, are unknown. There appears to be an opportunity for practices, especially where catchment areas and boundaries are going to be applied as a hard rule, to develop a process to 'hand over' patients to their new practice.

64 people told us they had registered with a new GP practice in the last year and **43** people said they had been asked to provide Photo ID before their registration was accepted.

We are disappointed to find that GP practices are still insisting that photo ID is necessary before they will register a patient. As stated on the NHS.UK website[1]:

> **Do I need ID or proof of address?**
>
> No, you do not need ID, an NHS number or proof of address to register.
>
> Some GP surgeries ask for supporting documentation as it can:
>
> - Help the surgery find your medical records or transfer them from your current GP.
> - Confirm that you live in the surgery's area (or "practice boundary") if they do not accept patients from outside this area.
>
> If you do not have a permanent address you can still register using a temporary address or the address of the GP surgery.

We reported on how people are affected by barriers to GP registration in our 2019 report *My Right to Healthcare: GP Registration and Access*[2], and our 2020 report, *My Right to Healthcare: Review*[3].

We will make a recommendation to the Integrated Care Board Primary Care Compliance team to ensure that GP practice staff are made aware of their contractual obligations to register people. We note that information given on local GP website registration pages (text copied below is taken from a local GP website) is incorrect and gives patients the impression that not having identification is a barrier to receiving healthcare.

> The practice asks patients to provide proof of address and photo ID before registrations will be completed. The registration process can take up to 7 days.

This year, people have reported that GP practices are taking photocopies of their documents and, in some cases, losing these copies. We have contacted the Information Commissioners Office to query this and were told that GP practices must have a clear lawful basis for keeping this personal data.

Through our enquiries, we have yet to determine what the lawful basis for taking photocopies of people's ID would be, particularly as the NHS guidance (Section 4[4]) is clear that people cannot be refused registration if they cannot provide it. It also offers advice to practices about how to proceed in these cases. A copy of this section of the NHS guidance is included as an appendix at the end of this report.

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[1] How to register with a GP surgery - NHS (www.nhs.uk)

[2] My Right to Healthcare: GP Registration and Access | Healthwatch Milton Keynes

[3] My Right to Healthcare: Review | Healthwatch Milton Keynes

[4] NHS England » Primary medical services policy and guidance manual (PGM)

"It was very difficult to get my foster children registered as well. We had to take their passports (which we had to apply for to be able to get them) they photocopied the documents, then lost the photocopies! I am very worried that my documents will end up in the wrong hands! The practice didn't even accept the letter from the Local Authority (because it wasn't Milton Keynes) Social Worker, on letterhead, advising that we held parental responsibility for the children."

"Could only register and upload stuff online, difficult as no Internet at home only on phone, which was difficult to do as fibromyalgia affects my hands regularly, my son done it for me in the end. Awful experience with passwords sent to me didn't work etc difficult to speak to someone."

"I had to take all of my personal information in and they photocopied it."

"Firstly yes, then after no response they changed their process to online. We had no idea until we followed up. Also, no idea how they disposed of all our written papers we took in and they signed. These became irrelevant as had to go through the online process."

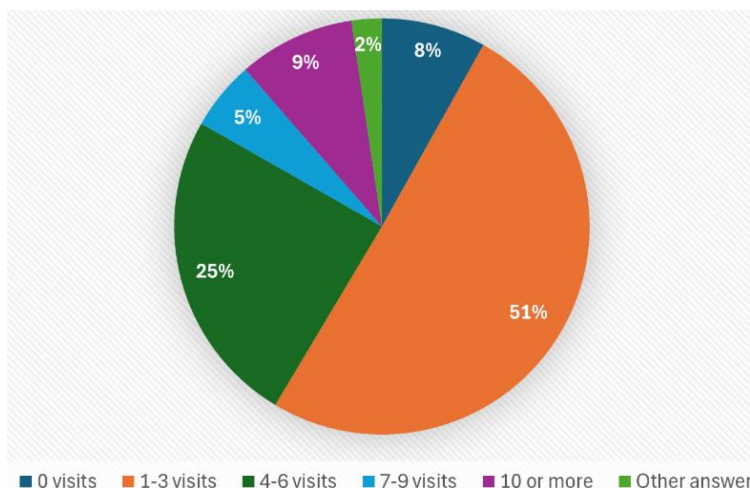
"I had to provide photo ID and proof of address then told it will take up to 28 days to register."

"(My new son-in-law) registered online. Was told that we needed to take photo ID and proof of address, when we took them in, they took photocopies."

Booking appointments

We asked people how often they had visited their GP practice in the last 12 months. This covers all appointments, not just those seeing a doctor.

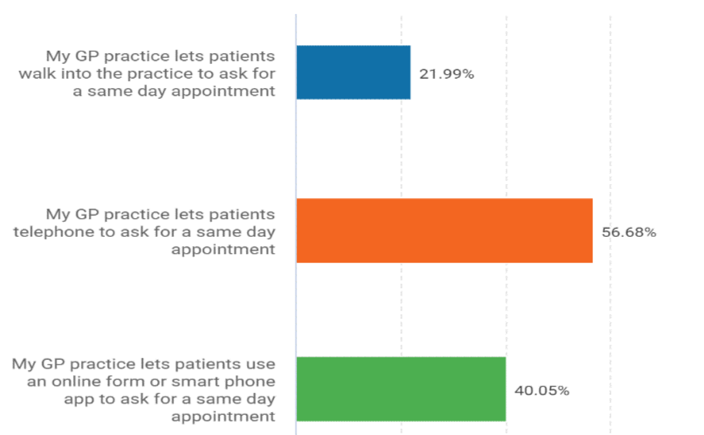
62 people chose to skip this question. We could have assumed that they had not visited their GP practice in the last year. However, we chose not to do this, so these results are taken only from the 763 answers that were given.



The ‘other answers’ given ranged from *“Lost count due to prescription errors”*, and *”Quite a bit, I have a chronic illness”* to the more generic and uncountable *“lots”* or *“many”.*

Booking same-day appointments

We moved on to ask how people were able to make same day appointments. People could select all options available to them. We also asked people to tell us if they had not been able to make an appointment in a way that met their needs. 156 people left further comments about the barriers they experienced when trying to make a same day appointment:



“I don’t think they offer this service.”

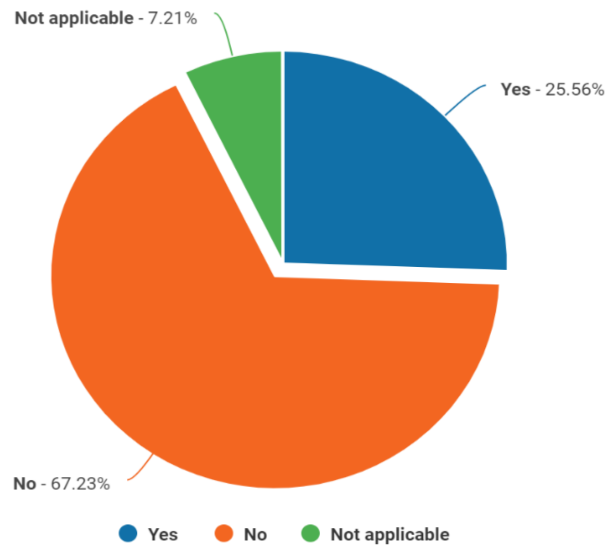
Around 60 of those who commented said that it was impossible to get through to get a same-day appointment because of the well-known ‘8am bottleneck’, there were almost as many saying that the online options have not helped, it has just moved the queue with people saying they now have to be online at 7am instead. We also heard from people who found that appointment booking options were not adhering to the Accessible Information Standards.

Around 30 people used this section to tell us that they ended up going to A&E or the Urgent Treatment Centre either through choice, or because they were advised to do so by the reception team.

Disappointingly, a significant number of people reported that whilst they tried to use the online options, these were often switched off and they were forced to phone or visit the practice.

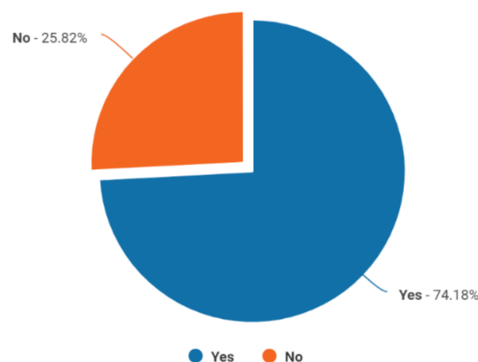
Equally disappointing were the number of comments telling us that when they phoned, they were told that appointments were not being made by phone and that they had to use the online option. These people also said no one asked if they were able to access the internet.

Given the comments made regarding the difficulties people experienced when trying to make a same day appointment, it is not surprising to note that **67%** of people felt that the way they had to make these appointments did not work well.

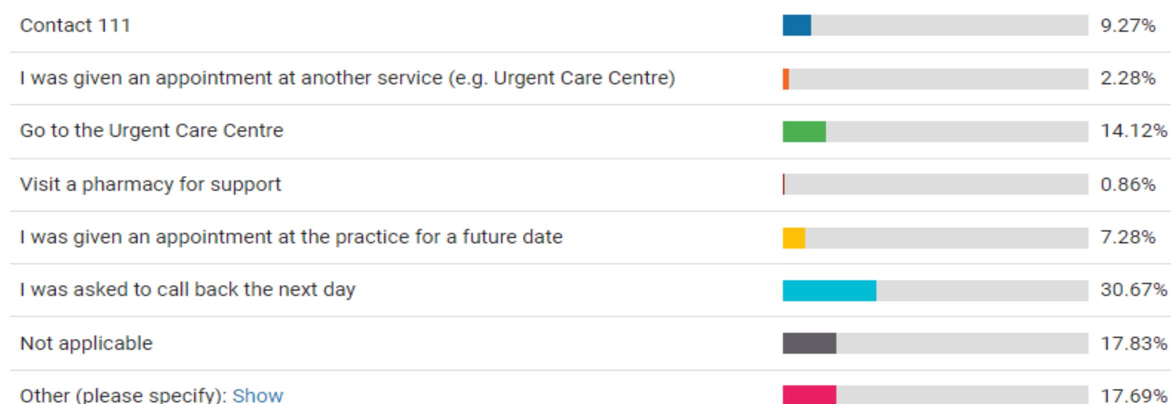


When we asked people to tell us what worked well or did not work well with these appointments, almost 500 people left further comments.

While these comments will be made available to the ICB Primary Care team, the overall feeling expressed was one of frustration. People were frustrated that the online services that they were being encouraged or, in some cases, forced to use were often switched off. The length of time spent in phone queues remains a point of contention, and the questions around the efficiency and effectiveness the current triage system are raised throughout the responses to this survey.



The NHS development of the *Modern general practice* model is designed “to better align capacity with need, improve patient experience and improve the working environment for general practice staff” [5]. With this in mind, we asked people who had struggled to get a same-day appointment what their GP practice had advised them to do:



A significant number of people reported being asked to make contact with their practice again the next day, or advised to attend the Urgent Care service. The 124 people who chose to answer ‘other’ said, on the whole, that they were told their options were to try again tomorrow or to go to Urgent Care. However, there was no indication that this advice was given on the basis of a triaged need.

A concerning number of people told us they had been told to go to A&E, again with no indication that this was due to clinical need, as opposed to a lack of availability of GP appointments. Around the same amount of people said they were told they could either have an appointment in approximately 4 weeks’ time, or they could try contacting their practice again the following day to see if they could get an appointment then.

We had three responses who said the system worked for them as they were given same-day appointments with the nurse practitioner.

People mainly reported that were given very little in the way of an actual triage or appropriate signposting:

> *“I was asked try again the next day and when I said it was urgent, was told to go to Urgent Care.”*

> *“I was given a telephone appointment where I was told to contact 111.”*

> *“Was sent to Urgent Care only to be told to go back to GP. Waste of time.”*

> *“I wasn't able to get through to the practice and the online form was closed.”*

> *“I have been told to go to urgent care every time.”*

> *“I got a phone call with the Dr on the same day, but they said we needed to go to urgent care.”*

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[5] NHS England » Modern general practice model

We then asked **"If you followed this advice from your GP practice, did it take away your concern about needing a same day appointment?"**

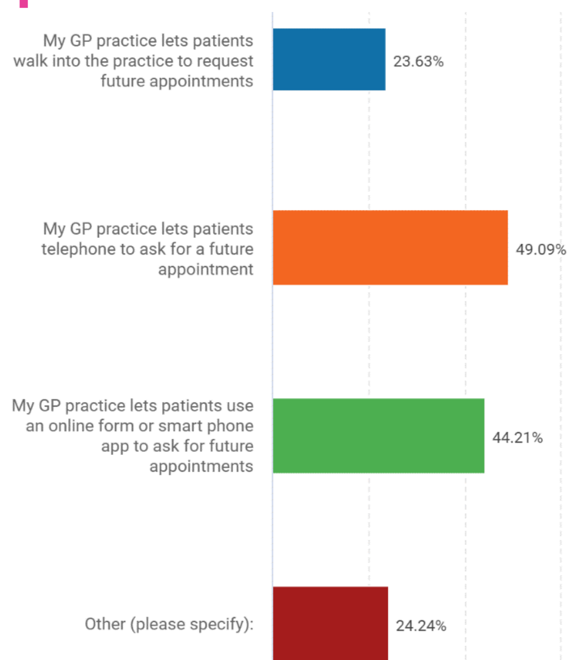
Only **12%** said that it did. Most people said it didn't take away their concerns as, even though many did go the Urgent Care service and waited, the feeling was that this option just pushes the issue to another part of the NHS and removes any chance of continuity of care.

We asked people what they did if they did not follow the advice given by the care navigator* at their GP practice. We received responses questioning whether the care navigator was qualified to be able to provide appropriate clinical triage. The most heartbreaking comments came from those who said they just gave up, those who began to self-medicate, or those who said they just suffered until they needed emergency care:

> *"Nothing, I take it that at my age I have been de-listed from receiving any NHS assistance."*
>
> *"Just went without medication."*
>
> *"I have had to continue living in pain and anxiety."*
>
> *"Give up and self-medicate, and hope the problem resolves."*

Requesting and booking future appointments

We asked the same questions around methods of booking appointments in advance.



The majority of the **25%** who chose to respond 'Other', said that their practice did not offer advance appointments which may indicate the reason that a high rate - **200 people** skipped this question.

"I was told they don't book future appointments and to call back at the time I needed the appointment!?"

"There is no way of knowing. The online system doesn't allow us to book a GP any longer and is frequently offline."

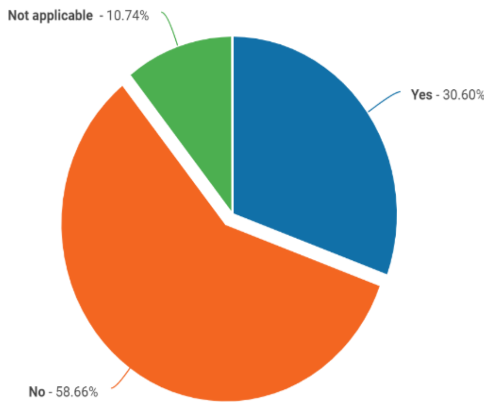
"My Practice only offers same day appointments."

"Planned visit? I only wish they would allow it."

"Can't make one. I tried last week just told to call on day."

*We are using the term 'care navigator' but some GP practices use 'patient navigator'. Both these terms have replaced 'receptionist'.

Whether it is through perception or practice, this way of working increases the pressure on practices to provide more same-day care, whether patients want it or not.



When we asked people if the system for booking advance appointments at their practice worked well, the responses were slightly more positive than they were for booking same day appointments.

Of the **347** people who chose to leave a further comment about this, feedback ranged from frustration at the online systems being switched off - thus removing the ability to make future appointments - and the inability to make the future appointments at a date or time that suited them:

"Yes and no - there always seems to be a long wait e.g. to have a blood test, I can and book, but often the date is weeks later 3-4 weeks. After the test, results always come through quickly, but it takes another 2/3 weeks to get a telephone call slot with the doctor to discuss the results. if further tests are needed, the process is repeated."

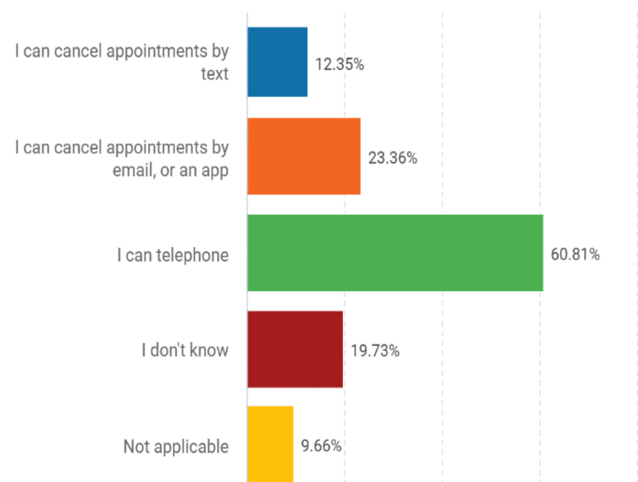
"When I contact the practice online, they don't get back to me."

"The 1st barrier is being able to even send a message as the system is often off. Then you wait for a reply which you may or may not get, then you have to reuse the system to seek an appt, again the system may or may not be available."

"Always told phone back tomorrow or on the day nearer the time."

"Only issue is they cannot book appointments more than 4 weeks, if you require regular appointments for treatment of more than 4 weeks this cannot be made at end of a treatment. Example you need injection every 8 weeks you have the injection; you cannot rebook for 4 weeks."

The next question asked people if they knew how to cancel an appointment if they needed to. A number of people said that they wouldn't dare cancel an appointment as they are too hard to come by in the first place. Most people said that when they have needed to cancel, the process makes it almost impossible. These people suggested having a dedicated text/ email/ phonefor cancellations would help as, quite often, getting through to cancel an appointment takes as long as actually getting it in the first place.



Triage processes and other health professionals

Question 14 asked: GP practices are using new telephone systems and online triage, appointments booking, messaging and repeat prescription services to improve care. Please tell us about your experience of these services: (What is triage? 'Triage' is a word used in healthcare. It means quickly taking some information from the patient, and then deciding what action to take. At a GP practice, this is usually done by a receptionist or 'care navigator'.)

Online triage and appointments on GP practice website

Answer Choices	Responses	
Works well for me	18.66%	137
Doesn't work well for me	28.34%	208
No opinion/neutral	14.31%	105
I am not able to use this	7.63%	56
I've not used this	31.06%	228

NHS App or other used by my GP practice

Answer Choices	Responses	
Works well for me	21.80%	160
Doesn't work well for me	23.71%	174
No opinion/neutral	16.89%	124
I am not able to use this	8.04%	59
I've not used this	29.56%	217

Telephone systems

Answer Choices	Responses	
Works well for me	24.25%	178
Doesn't work well for me	44.14%	324
No opinion/neutral	14.99%	110
I am not able to use this	3.68%	27
I've not used this	12.94%	95

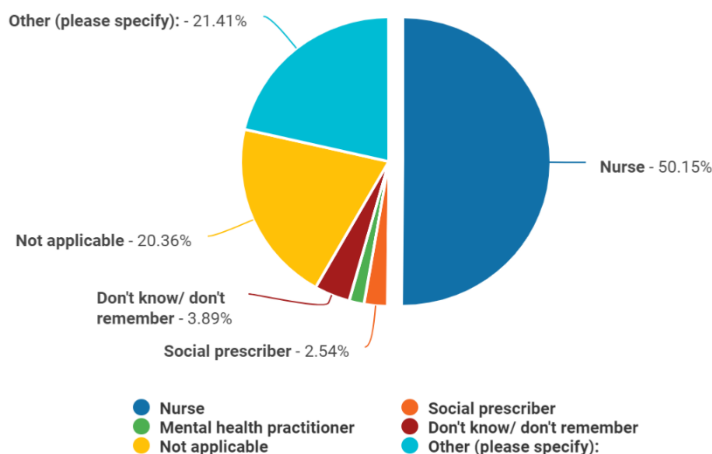
Admin request and repeat prescription apps

Answer Choices	Responses	
Works well for me	50.00%	367
Doesn't work well for me	19.07%	140
No opinion/neutral	10.35%	76
I am not able to use this	2.04%	15
I've not used this	18.53%	136

Other health professionals

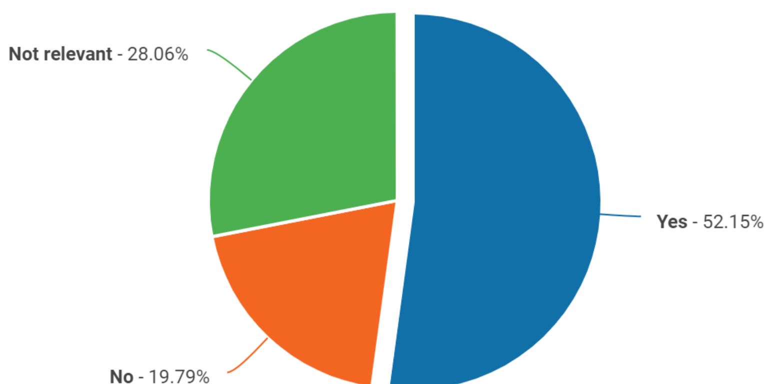
In total, **71%** of patients had seen a healthcare professional other than a GP when they attended their appointment.

The people who said they had seen a health professional other than a GP were asked to specify which health professional they had seen:



In the 'other' category, the majority said they had seen a paramedic, with those saying they had seen a pharmacist following close behind. The few people who had seen a Physician Associate left comments suggesting they were unhappy with this appointment. The reasons they gave were that they had not been informed, or that the Physican Associate had been unable to prescribe and was therefore unable to help.

We did ask whether the person they had seen had been able to provide the advice or treatment that was needed without having to see a GP for the same issue: **208** people chose to leave further comments. Nurse practitioners and paramedics were given the most positive feedback, with physios coming a close third.



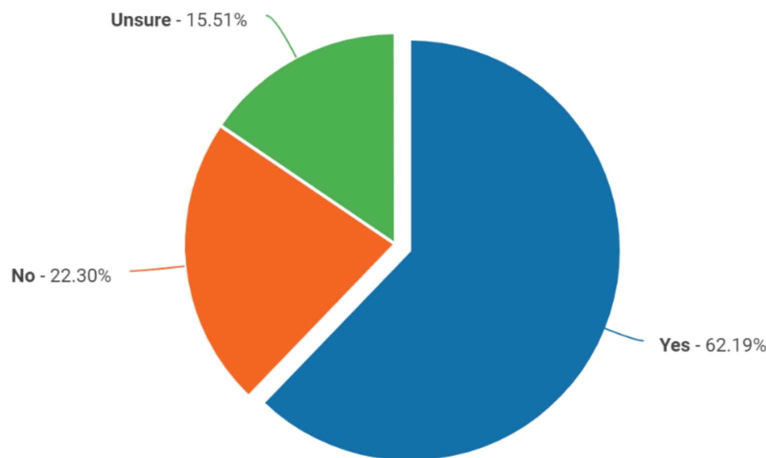
On the whole, people reported that they were dissatisfied seeing a Physician Associate, although this could be partly because of the way other staff refer to them:

"My practice has introduced the physician associates without informing patients of their status. They are NOT qualified. I would prefer to see a nurse. The 'Patient Navigators' refer to them as "nearly Doctors"."

People were generally happy if the person they saw could explain why, or why not, they were prescribing the particular medication or treatment. They were not happy, and lost faith in the triage process, when the professional they were seeing told them they should have been booked in with a GP in the first place, or if they had to try again to get a GP appointment because the person they were seeing was unable to help.

Care, support and keeping yourself well

Did you feel listened to at your appointment?



The most common recommendation that we make is related to communication, so it was reassuring to see so many people felt that they were listened to at their appointments. Over 200 people chose to leave further comments regarding this question, and these tended to say that it depended entirely on the person you saw on the day. The tone of the comments shows that people are preferring to focus on the positives and that while people feel listened to at the appointment, they also feel that they are forgotten as soon as they leave:

> *"I have seen a nurse as well as a GP. When I met with the GP, I initially felt like he listened to some of what I said but that all was forgotten in the follow up visit."*
>
> *"The nurses are amazing. Some of the Drs, however, leave a lot to be desired."*
>
> *"Generally, but not always by GP or receptionist. Nurses are more caring generally."*
>
> *"Can't knock the Drs or nurses I've seen. They have been fantastic. Just a shame they're so overwhelmed."*
>
> *"Most of the time yes, depending on who you are seeing. Sometimes you are rushed out of the appointment and forget to say what you wanted to say as they're running behind. Most of the time it's a positive experience."*

Accessibility needs

We asked people, if they had told their GP practice of any accessibility needs they might have, were these needs being met?

Fewer than **10%** of people responding to this survey said that they had accessibility needs. Around a quarter of the **40** people who chose to leave comments in this section mentioned a need for better understanding of **mobility issues. Another** quarter reported the need for better **neurodiversity** or **mental health** awareness by their health professionals.

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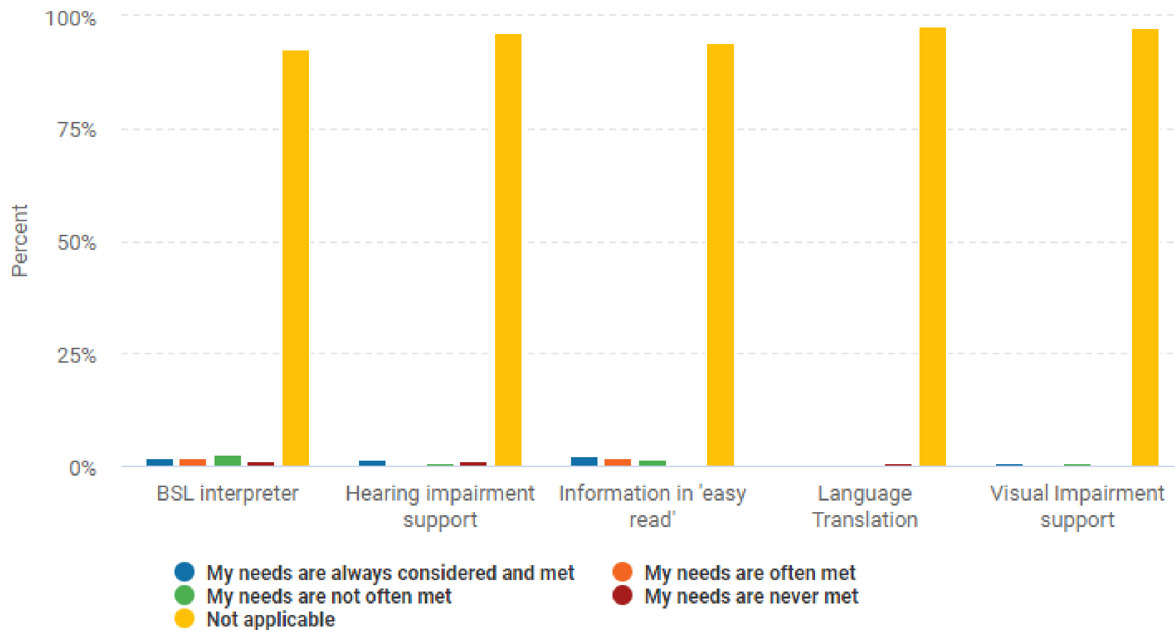


"Often a receptionist will not know they you have accessibility needs. It certainly feels like they are never considered when booking any apt."

"They say my 'English is great' - even when I think it is not. It is my 4th language, so I know how good or not good it is for communicating technical or medical conversations."

"The online needs to be easy read. Instructions for medicine and how to take them need to be easy read."

"They have never asked. I didn't know they could [offer large print]."

"There is a long walk to my Dr's office. I am disabled. It cuts down the amount of time I have to actually talk to the doctor."

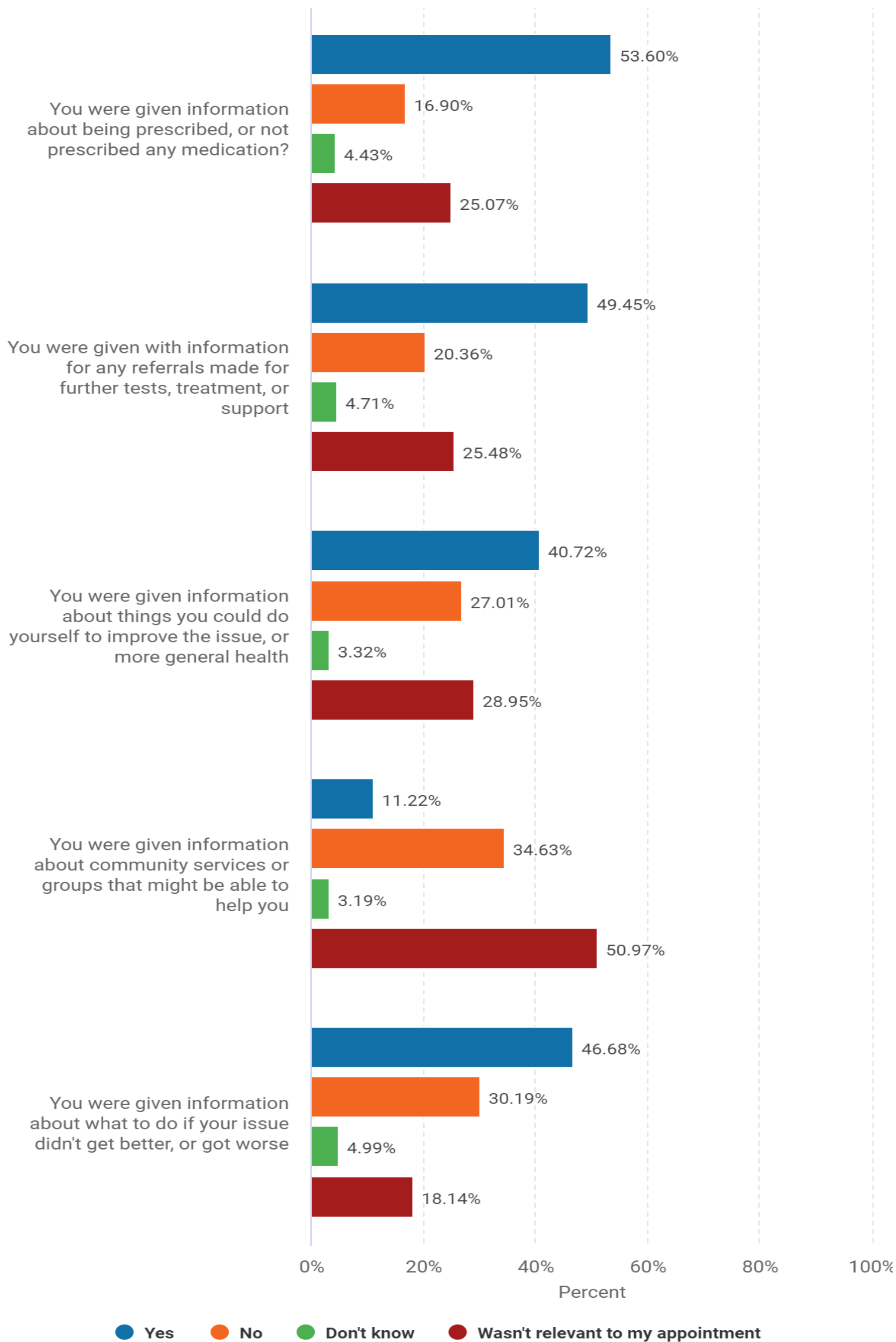
"My daughter or son come with me. On the letters it always says I can have an interpreter - but they have never provided one."

"Some people told us that when their practice changed the digital provider/ system that they were no longer able to use it."

"If they could remember to look at me not at the computer."

"I have asked for large print letters (visually impaired) but never received these."

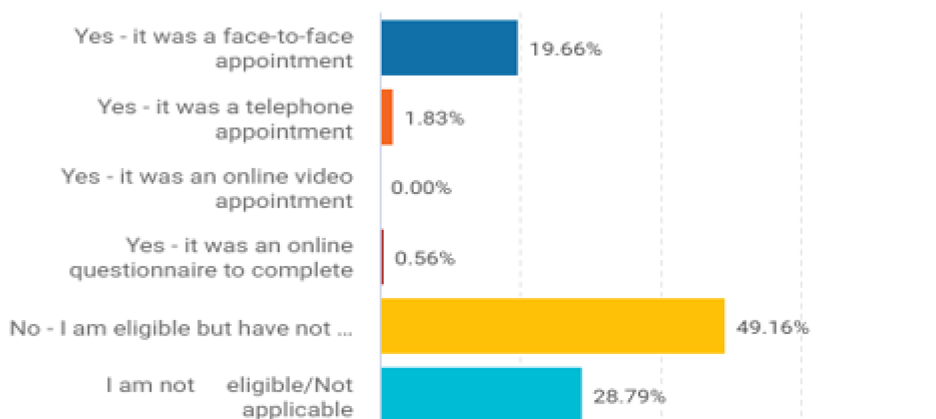
How did you feel after your appointment?



Compared to our 2023 survey results, there has been a slight increase in the number of people being given information about why, or why not, medication, referrals or further tests were being given, and about their general health or how to improve their issue. But there had been a decrease in people being told of community supports, or being offered information about what to do if they didn't get better, or if their condition worsened.

Annual and routine physical health checks

If you are over 40, are a carer, have diabetes, dementia, a learning disability or serious mental health condition, you should be offered an annual physical health check at your GP practice. Have you had an annual health check in the last 12 months and if so, how did this appointment take place?



The NHS Health Check is a check-up for adults in England aged 40 to 74. It can help spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. Those eligible should be invited for this type of physical health check every 5 years. These checks are designed so that the medical professional can screen for developing conditions and diseases. It also supports early intervention to prevent you developing the condition or disease.

In addition, the NHS also include recommends annual physical health checks (including specific blood tests) for people with certain conditions and illnesses. People with conditions such as diabetes, serious mental ill health and people with learning disabilities should also be invited for these checks on an annual basis (every year).

The NICE (National Institute for Health & Care Excellence) Quality Standard rationale states that: annual health checks for children, young people and adults with a learning disability (or a learning disability and autism) can be used to identify and monitor mental health problems. In addition, young people and adults with a learning disability and mental health needs may have difficulty explaining their health problems, so checking for issues and regularly monitoring needs is important to ensure that these are not missed.

The annual physical health check for people with schizophrenia, bipolar disorder or psychosis is not the same as the NHS Health Check for all adults aged 40 to 74. NHS. NICE analysis suggests that where patients have received elements of the health check (such as a blood pressure check) in unrelated appointments, this is incorrectly being reported as being part of the mandatory health check.

Waiting lists

30% of people responding to this survey said that they were currently on a waiting list. When we asked them to tell us what treatment or support they were waiting for, there was a wide variety of responses.

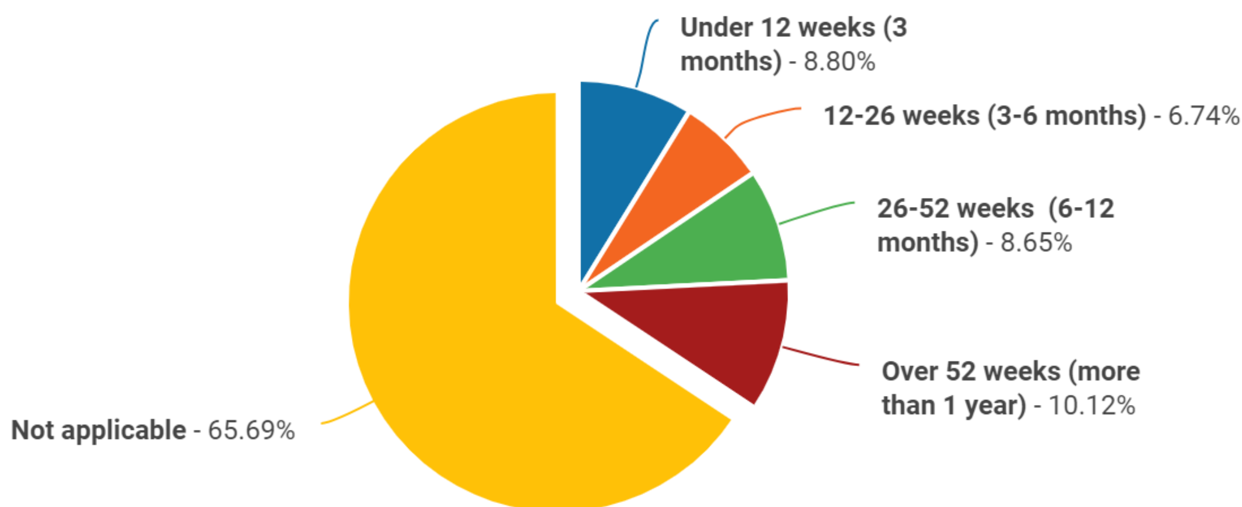
There were many people reporting that they were waiting for assessments for Autism or ADHD, but just as many were waiting for mental health support such as counselling or specialist therapies. Some people said that they had completed the assessment and were now waiting to be triaged for medication or shared care agreements.

Pain management was mentioned fairly frequently, as was cardiology and gynaecology.

A high number were waiting for hospital appointments for diagnostic testing or were on waiting lists for surgery.

There were a number of people who said they had been called for clinics or routine procedures at their GP practice but had not been able to get through to make these appointments, for smears or asthma checks. A comment was made by a resident that they had given up trying to get through to make the appointment for their checks, and felt that these couldn't be that important, as no one was chasing them to attend.

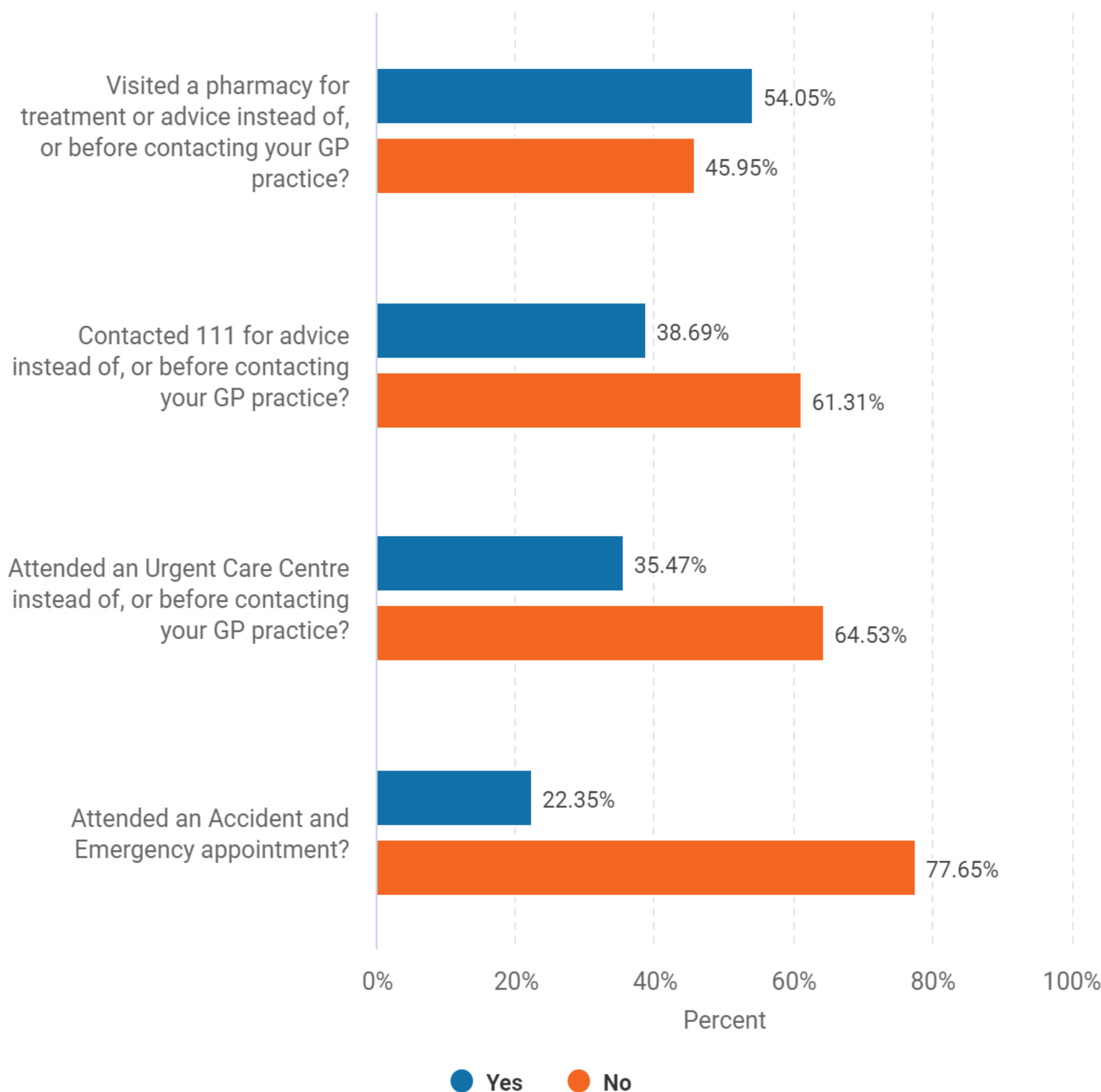
We asked people how long they had been on the waiting lists:



We also helped a **93-year-old** resident fill out the survey at a community event we attended in April. They told us their GP had made a referral to the Specialist Memory Service in September/ October. When we asked the Admiral Nurse, who was stationed next to us, to have a chat with this resident, they noticed that the letter said the referral had not been received by the service until January 2024.

When we asked people who were on a waiting list if they had needed to visit their GP practice, or find other support, more often as a result of their condition, almost **20%** said yes.

Did people try other options before contacting their GP practice?

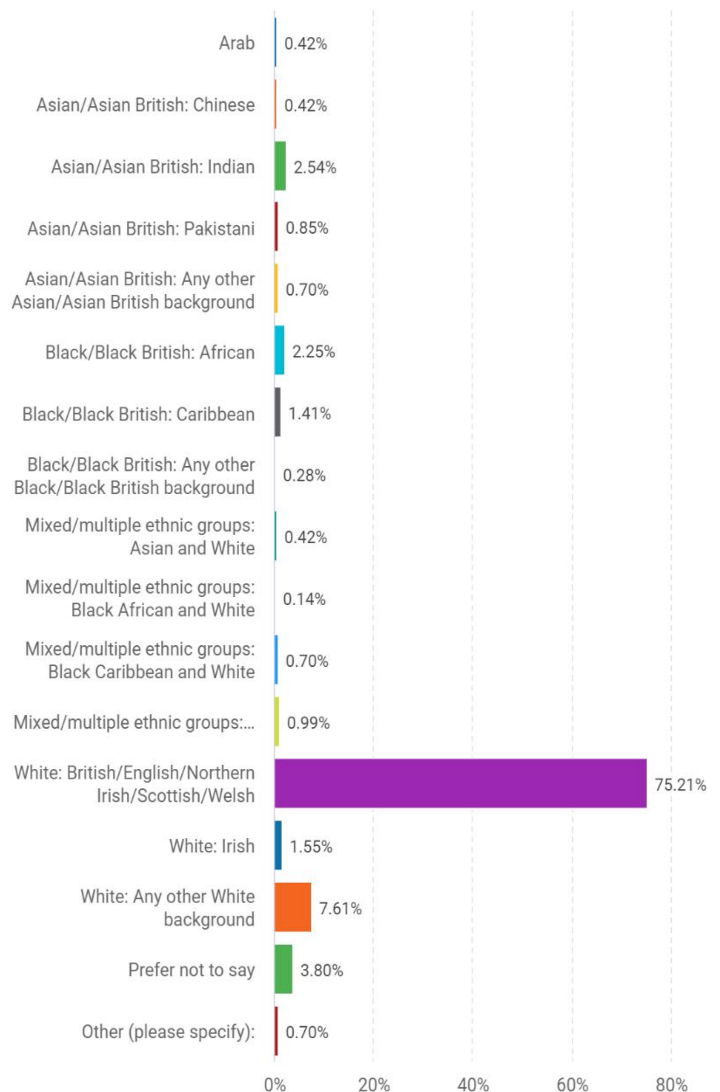


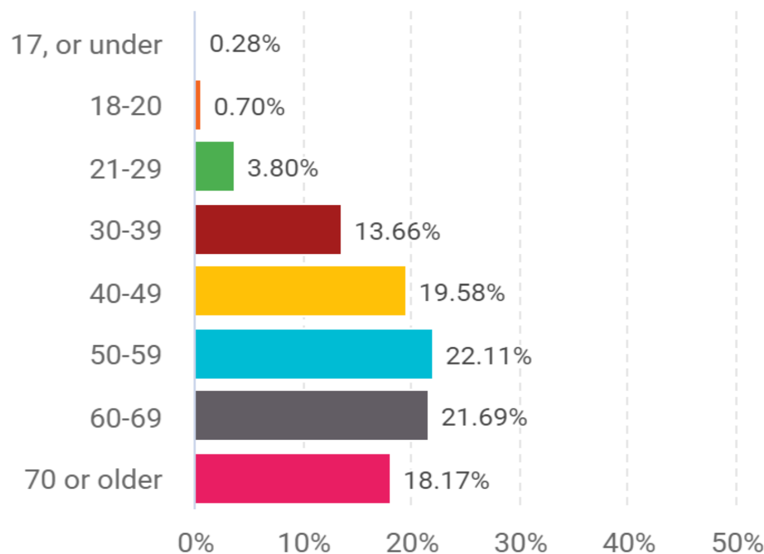
Demographics

We worked hard to ensure that we reached a variety of people, so as to reflect experiences from across our diverse Milton Keynes Community. As always, any report is a snapshot in time, however many of the issues people have shared with us in this piece of work are longstanding. It will take a concerted, co-produced, effort to find lasting solutions to many of the issues highlighted be residents in this report. Local solutions may be helped or hindered by national pressure and short-term initiatives designed to meet political outcomes rather than focussing on what will make the biggest difference to our local workforce and our residents.

The ethnic backgrounds of those people whose experiences and opinions contributed to this report closely aligns to the 2021 census reported population make up of Milton Keynes.[6]: **115** people chose to skip this question.

The age group was largely made up of working age adults, although **115** people chose to skip this question.



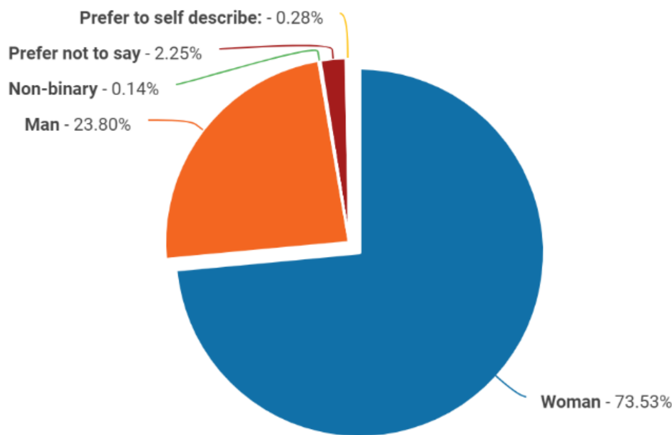


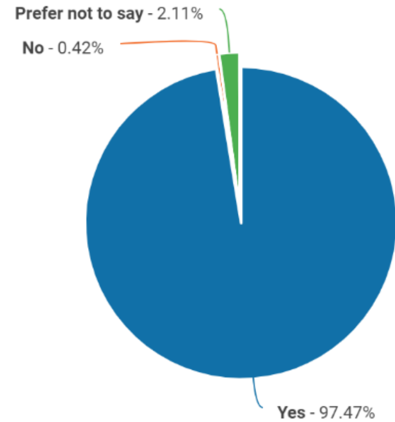
[6] https://www.ons.gov.uk/visualisations/censusareachanges/E06000042/, accessed July 2024

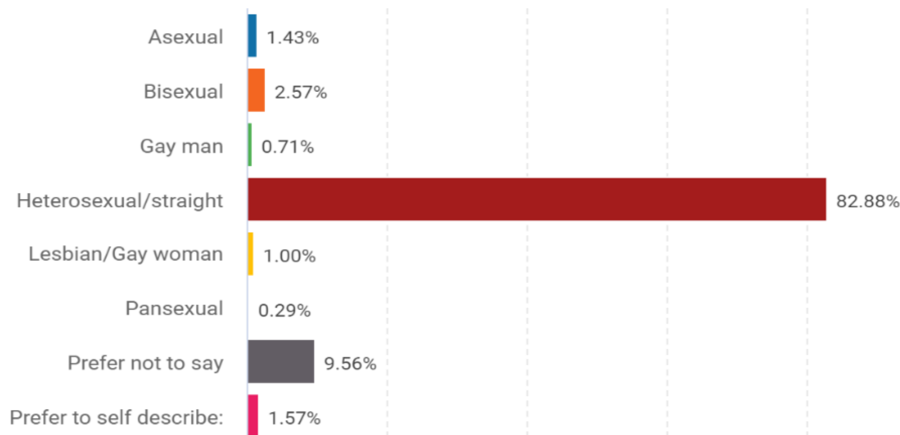
We found that we had a higher representation of women, of people with disabilities and long-term conditions, and more carers contribute to this report than the general population. We believe this is because these groups tend to have more contact, and poorer experiences, with their primary care provider, and so may be more activated to share where the system is not meeting their needs.

When we asked people to tell us their sexual orientation, there were **124** people who chose not to answer, and a small number of people who commented that the question was not relevant to their health care.

However, the NHS England website clearly highlights a correlation: "the evidence that LGBT+ people have disproportionately worse health outcomes and experiences of healthcare is both compelling and consistent. With almost every measure we look at, LGBT+ communities fare worse than others. This is unacceptable, and we need to increase our efforts to address these health inequalities."[7]





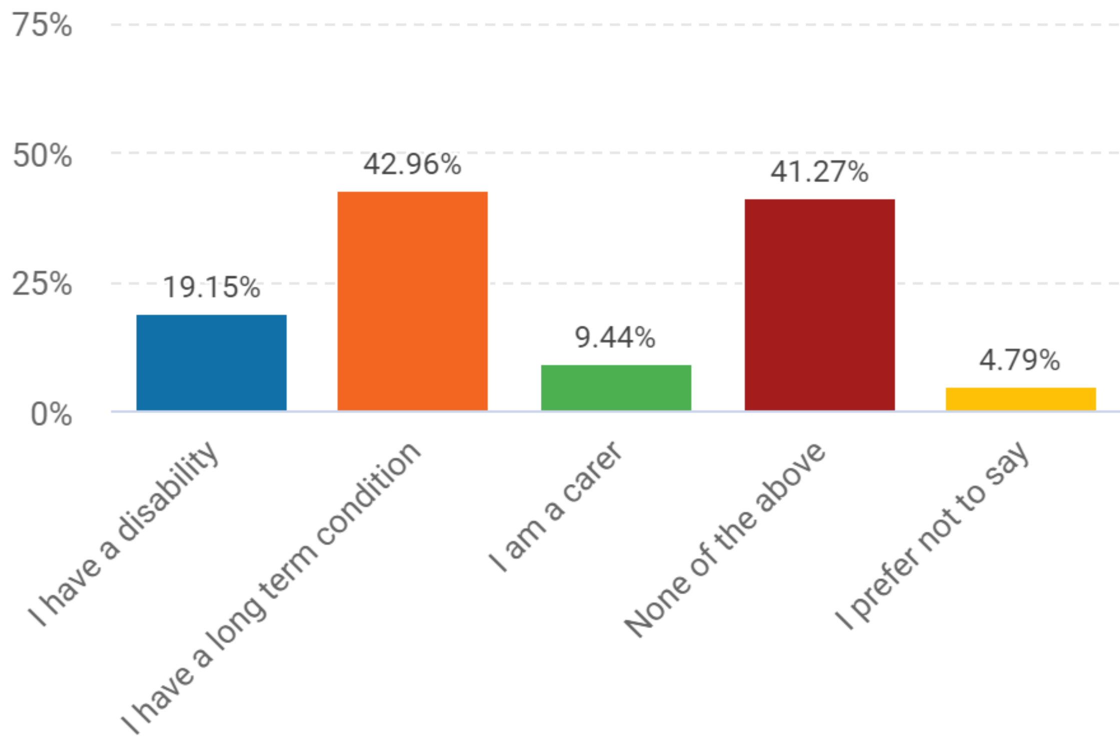


[7] NHS England » LGBT+ health; accessed July 2024

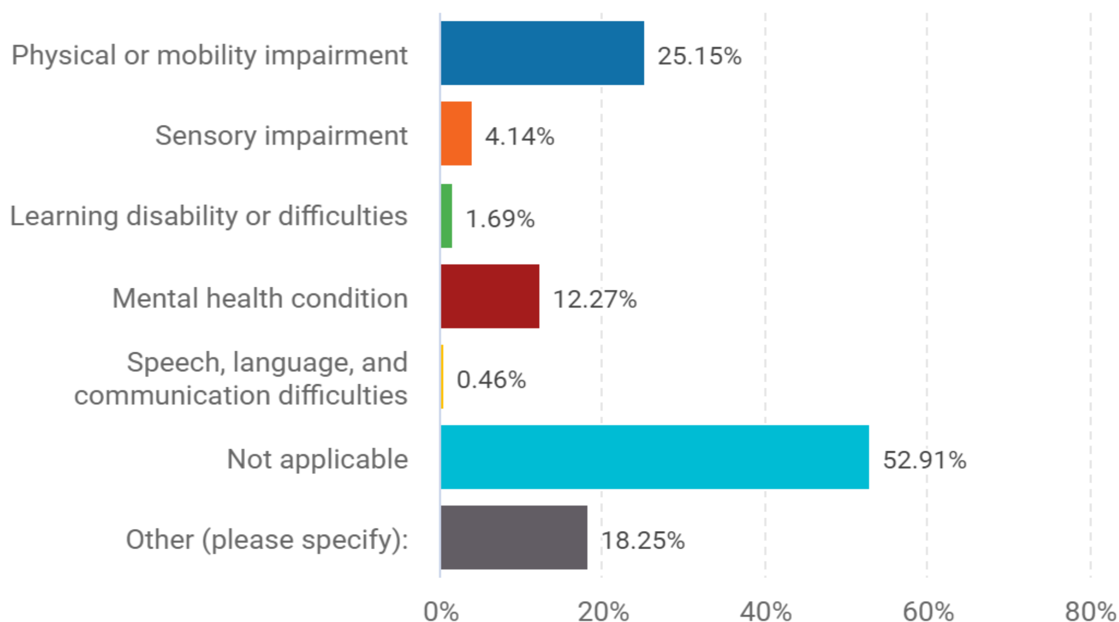
These charts reflect the intersectionality of people's health and their circumstances. This highlights the need to ensure our health system sees each person in the whole rather than working on one section of their lives, or one symptom, at a time.

Around one quarter of the people who contributed to this piece of work reported having a disability that is likely to require 'reasonable adjustments' to be made.

As primary care is so often the gateway to other services and supports, it is vital that services are aware of their obligations, and they have adequate resources to meet these needs.



If you consider yourself to have a disability or long-term condition, how would you describe it?



Recommendations

We would expect the ICB Primary Care team to work collaboratively with our local GP practices to ensure these recommendations are actioned in order to improve access to GP services.

We recommend all practice staff are involved in developing any changes to process and procedure and we encourage all members of staff to familiarise themselves with the Registration Guidance, contained in the appendix, and with the guidance provided by NHS England for improving care, access and capacity in modern general practice:

https://www.england.nhs.uk/long-read/how-to-improve-telephone-journeys-in-general-practice/

https://www.england.nhs.uk/long-read/how-to-improve-care-navigation-in-general-practice/

https://www.england.nhs.uk/long-read/how-to-improve-care-related-processes-in-general-practice/

https://www.england.nhs.uk/publication/how-to-align-capacity-with-demand-in-general-practice/

We will publish the response and any associated action plans as we receive them.

1. Improving access and flexibility

- Tackle the 8am rush: GP practices should think about spreading out the release of appointment slots throughout the day to avoid the usual 8am scramble.
- Make online booking easier: online booking systems need to be reliable and always available when patients need them.
- Ensure accessibility for everyone: GP practices should make sure all booking options meet accessibility standards, so everyone, regardless of their needs, can easily book an appointment.
- Clear communication is key: GP practices should clearly explain the roles and training given to care navigators. This will help patients to better understand how a care navigator's questions help them make the appointment that is most appropriate for the patient's need. It's also important to be clear that people should be referred to Urgent Care because their need is urgent - not because there are no appointments available at the practice.

2. Making future appointments easier

- Offer more flexible scheduling: GP practices should make sure there are a good mix of appointments available for both advance booking and same-day needs, especially for follow-ups or routine checks.
- Keep online booking systems open: It's crucial that online booking systems work smoothly for a variety of advance appointments. If there are any issues, patients should be informed right away.
- Simplify cancellations: GP practices should introduce easy ways to cancel appointments, like a dedicated phone line or a quick online form, so that slots can be freed up for others.

3. Improving triage and use of other health professionals

- Better triage training: receptionists and care navigators should receive thorough training in triage so they can guide patients to the right care more effectively.
- Explain non-GP roles clearly: patients should be informed about the qualifications and roles of non-GP professionals, like Physician Associates and Nurse Practitioners, so they feel confident in the care they receive.

4. Enhancing care, support, and patient wellbeing

- Patient check in after appointments: GP practices should set up a 'follow up' system for patients who need ongoing care after their visits, especially those with ongoing health issues. For example, patients with new medications, a new diagnosis, or those who have just come home from hospital.
- Boost communication skills: all healthcare providers should receive communications or 'customer service' training to ensure they are listening to and understanding their patients' concerns during appointments.

5. Addressing accessibility needs

- Regular accessibility checks: GP practices should regularly review how well they're meeting patients' accessibility needs, including physical access and interpreters, communication aids, and easy-read materials.
- Raise staff awareness: ongoing training is essential for all staff to better understand and address various accessibility needs, whether related to mobility, neurodiversity, or language.

6. Ensuring annual and routine health checks happen

- Keep up with health check invitations: GP practices should regularly check their systems to make sure all eligible patients, especially those with certain health conditions, are invited for their annual physical health checks.
- Educate patients: it's important to inform patients about the significance of these health checks and what they involve so they understand and participate.

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7. Managing and communicating waiting lists

- Speed up referrals: GP practices should work closely with hospitals and other secondary care providers to shorten the time it takes to get patients onto appropriate waiting lists.
- Provide support whilst waiting: for those on long waiting lists, offering interim care or regular check-ins to help manage their health and reduce the need for emergency care would improve the patient experience.
- Be transparent about wait times: patients should be kept in the loop about where they stand on waiting lists and given realistic expectations for when they might get an appointment or procedure.

Registration and the Primary Medical Care Policy and Guidance

Healthwatch Milton Keynes recommends that GP practices in Milton Keynes review their practice procedures to ensure that they fall in line with, and do not contradict Primary Medical Care Policy and Guidance.

The Primary Medical Care Policy and Guidance policy highlights that patient registration is a complex issue. We recommend that Practice Managers ensure that national policy is not applied selectively in practice procedures.

The Primary Medical Care Policy and Guidance must be understood and applied as a whole, and we recommend that the Bedfordshire, Luton and Milton Keynes Integrated Care Board ensure practices comply with it and offer practices appropriate support to manage complex issues.

Appendix

4 GP patient registration standard operating principles for primary medical services

4.1 Policy statement

4.1.1 There has not been any change in national policy in respect of patient registration for primary medical services – this guidance clarifies the rights of patients and the responsibilities of providers in registering with a GP practice in particular issues in relation to:

- who can access free healthcare
- the provision of documentary evidence of identity or residence on registration (in particular affecting migrants, refugees and asylum seekers (including 'failed' asylum seeks) who may not have ID or documents such as household bills)
- the rights of patients who are temporarily resident in a specialist hospital away from their home address and access to their 'usual' GP practice

4.2 Aims

4.2.1 In issuing these patient registration operating principles we aim to:

- clarify the contractual rules in respect of patient registration for patients, practices and commissioners
- reduce the risk of worsening health inequalities for specific populations (eg asylum seekers or homeless people)
- simplify and standardise the patient registration process for patients and practices
- embed best practice approaches for patient registration
- ensure fairness, equity and transparency in the way general practice services are delivered across England

4.3 Context

4.3.1 The Health and Social Care Act 2012 places an obligation on NHS England to secure the provision of primary medical services for patients throughout England. In addition, the Health and Social Care Act 2012 introduced statutory duties on the NHS to "have regard to the need to reduce inequalities" in access to and outcomes achieved by services.

4.3.2 There are further duties imposed on NHS England under the Equality Act 2010 and NHS Act 2006 on equality and health inequalities.

4.3.3 NHS England wishes to establish operating principles for GP practices for patient registration that promote equality, human rights and public health and reduce health inequalities.

4.3.4 In addition, Care Quality Commission (CQC) guidance: GP myth buster 29; looking after homeless patients in general practice can be found on the CQC's website as can GP myth buster 36: registration and treatment of asylum seekers, refugees and other migrants.

4.3.5 In 2014 homeless and health research provided by Homeless Link reported that 90% of the homeless people they surveyed were registered with a GP. However, many responded that they were not receiving the help they needed for their health problems, and 7% had been refused access to a GP or dentist in the previous 12 months. In some cases, these refusals were due to having missed a previous appointment or because of behaviour. Others reported that they were refused access if they did not have identification or proof of address.

4.3.6 Also the General Practitioners Committee (GPC) of the British Medical Association (BMA) has related guidance which can be found can be found on the BMA's website.

4.4 Who can register for free primary care services?

4.4.1 A patient does not need to be 'ordinarily resident' in the country to be eligible for NHS primary medical services – this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge.

4.4.2 Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone; eligibility for free care will be assessed by the receiving organisation.

4.4.3 The absence of any reciprocal arrangements between the nation-states, a patient's nationality is therefore not relevant in giving people entitlement to register as NHS patients for primary medical services.

4.4.4 In October 2017, contractual requirements were introduced to help identify patients with a non-UK issued EHIC or S1 form or who may be subject to the NHS (charges to overseas visitors) regulations 2015.

4.4.5 For those patients who self-declare at the point of registration that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the details of the non-UK issued EHIC to NHS England (nhsdigital.costrecovery@nhs.net) and send the S1 form to the Overseas Healthcare team via email (nhsbsa.faregistrationsohs@nhs.net) or post. If a registration form has been submitted online via the Register with a GP Surgery Service, then such forms do not need to be sent manually as they will automatically be sent to NHS England as part of the service.

4.4.6 The Department of Health has agreed to provide practices with hard copy patient leaflets which will explain the rules and entitlements of overseas patients accessing the NHS in England.

4.4.7 It is important to note that there is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical services.

4.4.8 Therefore, all asylum seekers and refugees, students, people on work visas and those who are homeless, overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice even if those visitors are not eligible for secondary care (hospital care) services.

4.4.9 The length of time that a patient is intending to reside in an area dictates whether a patient is registered as a temporary or permanent patient. Patients should be offered the option of registering as a temporary resident if they are resident in the practice area for more than 24 hours but less than 3 months. In some cases, a prospective patient may not know how long they will reside in an area, for example, destitute asylum seekers housed in temporary Home Office commissioned 'initial' accommodation. Generally, in such cases where there is uncertainty over the length of time that a patient may be residing in an area, but this is likely to be months rather than weeks, NHS England advises that the patient should be registered as a permanent patient.

4.4.10 An immigration health charge (or 'surcharge') is now payable by non-UK nationals who apply for a visa to enter or remain in the UK for more than 6 months. People with indefinite leave to remain in the UK and those not subject to immigration control (eg diplomats posted to the UK) are not liable to pay the surcharge, but maybe ordinarily resident here and entitled to free NHS healthcare on that basis.

4.4.11 Payment of the health surcharge entitles the payer to NHS-funded healthcare on the same basis as someone who is ordinarily resident, from the date their visa is granted and for as long as it remains valid. They are entitled to free NHS services, including NHS hospital care, except for services for which a UK ordinary resident must also pay, such as dentistry and prescriptions in England.

4.4.12 Payment of the health surcharge is mandatory when making an immigration application, subject to exemptions for certain categories of people and the discretion of the Home Secretary to reduce, waive or refund all or part of a surcharge payment. Most of these groups also receive NHS-funded healthcare on the same basis as an ordinarily resident person.

4.4.13 Patients who have paid this surcharge as part of their visa application process should be registered as with any other patients.

4.5 Immediately necessary treatment

4.5.1 General practices are also under a duty to provide emergency or immediately necessary treatment, where clinically necessary, irrespective of nationality or immigration status.

4.5.2 The practice is required to provide 14 days of further cover following provision of immediate and necessary treatment.

4.6 Determining if the patient lives in the practice area or is registered on a Special Allocation Scheme

4.6.1 All practices are required to have agreed an 'inner' boundary with their commissioner. Anyone who resides within the practice's inner boundary is entitled to apply to register for primary medical services and the practice boundary should be clearly advertised to patients on the GPs practice leaflet or website if they have one.

4.6.2 In addition, most practices have also agreed an 'outer' practice boundary.

4.6.3 Patients who move out of a practice's inner boundary area but still reside in the outer boundary area may be able to remain registered with the practice if they wish and the practice agrees.

4.6.4 GP practices are able to register new patients who live outside the practice area without any obligation to provide home visits or services out of hours when the patient is unable to attend their registered practice. It is for a practice to decide, at the point of registration, whether it is clinically appropriate and practical to register the individual patient in that way.

4.6.5 Practices are reminded when considering new patients on the register to check GP links and email from PCSE which notifies the practice the registration should be declined for reasons patient is already registered on the Special Allocation Scheme.

4.7 Access to registration

4.7.1 Practices should ensure there is equitable access for all patients who wish to register with them. Registration should be available to all patients every day rather than on particular days and throughout the practice's advertised opening hours.

4.7.2 Where possible, it is good practice for practices to provide pre-registration documentation in advance, eg to help patients understand the practice and the services they deliver.

4.7.3 It is It is possible for patients to register via paper form or digital/online and practices should make clear to patients the different ways in which they can register with their practice.

4.7.4 Updates to the GP contract in 2022/2023 removed the need for a patient to provide a wet signature for registration.

4.7.5 An online registration service and corresponding paper form, developed by NHS England is now available to all practices in England to use, further information on this service can be found on the Register with a GP surgery service resource hub.

4.7.6 Patients have the right to change practices if they wish. The grounds on which a practice can refuse a registration are limited – see section 4.9 for further detail.

4.8 New patient health checks

4.8.1 It is a contractual requirement that once registered all patients must be invited to participate in a new patient check however neither registration nor clinical appointments should be delayed because of the unavailability of a new patient check appointment.

4.9 Requesting documentary information from patients

4.9.1 Under the terms of their primary medical services contracts, GP practices cannot refuse an application to join its list of NHS patients on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

4.9.2 Practices can refuse an application to join a practice list if:

- the commissioner has agreed that they can close their list to new patients

- the patient lives outside the practice boundary
- if they have other reasonable grounds

4.9.3 In practice, this means that the GP practice's discretion to refuse a patient is limited.

4.9.4 In addition, when patients seek to register there is no regulatory requirement for patients to prove identity, address, immigration status or the provision of an NHS number in order to register. However, there are practical reasons why a practice might need to be assured that people are who they say they are, or to check where they live. Seeing some form of documentation regarding the patient's identity can help to ensure the correct matching of a patient to the NHS central patient registry, thereby ensuring any previous medical notes are passed onto a new practice. It is legitimate therefore for the practice to apply a consistent but non-discriminatory policy to ask for patient ID as part of their registration process.

4.9.5 Any practice that requests documentation regarding a patient's identity or immigration status must apply the same process for all patients requesting registration equally. Acceptable exceptions to this are outlined in 4.9.6, 4.9.7. A practice policy should not routinely expect a patient to present a photograph as this could be discriminatory.

4.9.6 The majority of patients will not find it difficult to produce ID/residence documentation, however there will be some patients who do live in the practice area but are legitimately unable to produce any of the listed documentation. Examples of this may be:

- people fleeing domestic abuse staying with friends, family or in a shelter
- people living on a boat, in unstable accommodation or street homeless
- people staying long term with friends but who aren't receiving bills
- people working in exploitative situations whose employer has taken their documents
- people who have submitted their documents to the Home Office as part of an application
- people trafficked into the country who had their documents taken on arrival
- children born in the UK to parents without documentation

4.9.7 Reasonable exceptions therefore need to be considered and the individual registered with sensitivity to their situation.

4.9.8 As there is no requirement under the regulations to produce identity or residence information, the patient must be registered on application unless the practice has reasonable grounds to decline. These circumstances would not be considered reasonable grounds to refuse to register a patient and neither should registration or access to appointments be withheld in these circumstances. If a patient cannot produce any supportive documentation but states that they reside within the practice boundary then practices should accept the registration

4.9.9 Where necessary, (eg homeless patients), the practice may use the practice address to register them if they wish. Further, they could use an address which the local authority has provided to the patient to use. If possible, practices should try to ensure they have a way of contacting the patient if they need to (for example with test results).

4.9.10 If a practice suspects a patient of fraud (such as using fake ID) then they should register and treat the patient but hand the matter over to the NHS Counter Fraud Authority (NHSCFA)

- NHS Counter Fraud Authority Reporting Line: 0800 028 4060
- report to the NHSCFA using the online NHS fraud reporting tool
- by post to the NHS Counter Fraud Authority, Skipton House, 80 London Road, London, SE1 6LH

4.10 Refusing registration

4.10.1 If a practice refuses any patient registration, then they must record the name, date and reason for the refusal and write to the patient explaining why they have been refused, within a period of 14 days of the refusal.

4.10.2 This information should be made available to commissioners on request. Commissioners may ask practices to submit the numbers of registration refusals, age, ethnicity, and reasons as part of their quality assurance process.

4.11 Patients who are temporarily resident in a specialist hospital away from home

There has been some confusion in respect of part 5, regulation 17 (4) of the GMS regulations.

4.11.1 This regulation is not considered 'reasonable grounds' to refuse registration according to legal advice. 17(4)(b) relates to patients who are already registered with the GP practice and cannot be used as a reason/justification for not registering certain patients. These only become relevant after a patient is registered it does not provide grounds for a refusal to register the patient in the first instance.

4.11.2 There are no legal grounds for refusing to register a patient because they are an inpatient in a hospital. Indeed, the gatekeeper' role of the NHS GP for accessing secondary care services depends on patient registration.

4.11.3 Practices are not however expected to provide anything other than essential and minor surgery in these circumstances. If the resident requires any other services these must be arranged by the hospital or the commissioner. The commissioner who is responsible for securing specialist hospital services should ensure that all services over and above those normally associated with general practice are both agreed as part of the contract specification and actively monitored to ensure delivery against that specification.

4.11.4 A template memorandum of understanding (MOU) is provided to support GPs, commissioners and providers in clarifying the contractual requirements of primary care providers and those of the hospital, and the regulatory and professional obligations of the clinicians to ensure safe care and example MOUs are also provided

that describe ‘shared care’ arrangements/responsibilities so that patients receive holistic care.

4.11.5 There are however instances where patients’ temporary residence is in a specialist hospital away from home. Where spells are for longer periods of time, commissioners should consider establishing integrated primary and specialist care offer for those patients to ensure essential and additional primary medical services are able to be met more effectively. In those instances, the commissioner when securing specialist hospital services will want to ensure those services normally associated with general practice are agreed as part of the contract specification and actively monitored to ensure delivery against that specification. This will require use of the APMS contract ‘bolt-on’ available to the NHS standard contract.

4.12 Registering children

4.12.1 As a minimum requirement the arrangements above in respect of the registration of any patient with a GP surgery should be followed when the person registering is a child. However, there are circumstances that practices should be aware of, in relation to safeguarding guidance.

4.12.2 The legal definition of a child is 0 to 18 years of age; however young people may be able to make independent decisions from as young as 13 years old, depending on their Gillick competency. Section 11 of the Children Act 2004 places a statutory duty on the NHS to safeguard and promote the welfare of all children up to the age of 18yrs. The Victoria Climbie Enquiry Report 2003 (9.104) stresses the importance of GP registration for every child. It sets out the importance of knowing the identity and name of those registering the child and their relationship to that child.

4.12.3 If a child under 16 attempts to register alone or with an adult that does not have parental responsibility, the practice child safeguarding lead should be alerted.

4.12.4 For purposes of safeguarding children, the following should be considered whilst recognising that patients must still be registered in the absence of documentation and policies must be applied in a non- discriminatory manner.

4.12.5 The practice should seek assurance through:

- proof of identity and address for every child, supported by official documentation such as a birth certificate (eg, this helps to identify children who may have been trafficked (Modern slavery: statutory guidance for England and Wales (under section 49 of the Modern Slavery Act 2015) and non-statutory guidance for Scotland and Northern Ireland or children who are privately fostered)
- an adult with parental responsibility should normally be registered at the practice with the child. There may be legitimate exceptions to this, such as where both parents are serving in the armed forces and are registered with an ‘armed forces’ GP or practical explanations, eg parents wishing for their child to be registered with a practice closer to school. The ID of the adult is essential as it can be matched to the birth certificate details. However, the practice should not refuse to register a child if there is no-one with parental responsibility who can register, as it is generally safer to register first and then seek advice from the practice child safeguarding lead, health visitor or

practice manager. (This situation may alert you to a private fostering arrangement which will require notification to the local authority)

- offering each child, a new patient registration health check as soon as possible after registration
- proof of parental responsibility or relevant guardianship agreements
- seeking collaborative information (supported by official documentation) relating to:
    - current carers and relationship to the child
    - previous GP registration history
    - whether the child is registered with a school and previous education history
    - previous contact with other professionals such as health visitors and social workers
- children who have been temporarily registered with the practice should be reviewed regularly and proceed to permanent registration as soon as possible and ideally within 3 months of initial registration. Likely length of stay should be determined at initial registration and patient registered as temp/permanent as appropriate
- children of parents or carers, who have been removed from the list for any reason, must not be left without access to primary care services
- where parents or carers have been removed from the list due to aggressive and or violent behaviour a risk assessment should be completed to identify any risk to their children and the appropriate referrals safeguarding made. Please ensure you consult relevant safeguarding procedures and record any referral decision
- a 'think family' approach should be made when seeing either the adult(s) or child/children within the surgery. If you are aware that an adult has significant risk-taking behaviour, chronic mental health concerns or repeated episodes of stress and anxiety, safeguarding and support consideration should be made to the welfare and safety of the child/children being cared for by that adult

4.12.6 Practices should be alert to potential risks such as those described above when young people aged between 16-18 years of age register alone and dealt with in line with practice safeguarding procedures and escalated outside of the practice through the local procedures if appropriate,16 to 18-year-olds are still children by law of child protection but can also be parents and carers. It's imperative that we consider the risks and vulnerabilities within this age group.

4.12.7 There is nothing to stop a parent deregistering their family and not registering again. It is not compulsory to be registered with a GP whether an adult or a child. To amend this there would need to be legislative change. Such legislation would encroach on areas of personal freedoms and patient and parental rights so would likely attract resistance. In addition, it is difficult to see how to enforce or police as there is no jurisdiction or levers to ensure that all children are registered.

4.12.8 If a practice is concerned about a family who is deregistering their children with no plan to register with another general practice, they need to consider whether this should be raised with the local authority as part of normal safeguarding processes.

4.13 Registration of those previously registered with defence medical services and priority NHS care for veterans

4.13.1 Defence medical services (DMS) have their own GP services that look after serving personnel, mobilised reservists, and some families. These specific primary care services are commissioned separately by the DMS of the Ministry of Defence. When servicemen and women leave the armed forces, their primary healthcare reverts to the responsibility of the local NHS. As a minimum requirement, the arrangements set out above in respect of the registration of any patient with a GP surgery should be followed when the person registering is a veteran. Prior service should be recorded on registration and allocated the correct read/SNOMED code. This should enable access to specialist or bespoke care or charity support as necessary for such patients and for the delivery of the armed forces covenant.

4.13.2 A veteran is an ex-service person or reservist who has served in the armed forces for at least 1 day. There are around 2.5 million of these veterans in England at the time of drafting.

4.13.3 All veterans are entitled to suffer no disadvantage from their service and to receive priority access to NHS hospital care for any condition as long as it's related to their service (subject to clinical need), regardless of whether or not they receive a war pension.

4.13.4 All people leaving the armed forces are given a summary of their medical records, which they are advised to give to their new GP when they register. The practice will also normally be advised automatically of prior registration with defence medical services (with a summary of their in-service care).

4.13.5 More information on the duty of care owed to service personnel and specific services is contained in the Armed Forces covenant.

4.14 Persons released from prisons, immigration centres or children's secure facilities.

4.14.1 We have introduced a contractual change in October 2017 to allow patients who do not have a registered GP or are being released to a different area ability to register with a practice before they leave the detained estate. This agreement includes the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the practice from the detained estate healthcare service to enable better care when a new patient first presents at the practice.

4.14.2 Those in contact with the Criminal Justice System may get a letter from the Youth Offending Service, the Committee for the Right of the Child or the National Probation Service

4.15 Registering civil servants and their dependants, and the dependants of members of the Armed Forces, returning from overseas postings

4.15.1 Contractual changes in October 2021 enable civil servants who are posted overseas, and their relevant family members (see 4.15.9 for the definition of 'relevant

family member') who have accompanied them on their posting, and relevant family members who have accompanied a member of the Armed Forces (a 'service person') posted overseas, to register with a GP practice more easily. This includes as a permanent patient or temporary resident, and in advance of (or upon) their return to the UK. This is because these individuals have faced challenges registering and accessing primary medical services in a timely way when returning to the UK from overseas postings.

Registration with a patient's previous practice or its successor

4.15.2 Where an application is made to a contractor by one of the following individuals, the contractor must accept them, even if their patient list is closed. (The only exception to this is where the contractor has reasonable grounds to refuse the application; see 4.15.8):

- civil servants returning to the UK from an overseas posting (or former civil servants who were posted overseas and are returning to the UK for the first time since leaving the civil service) – provided they were registered with that contractor or a predecessor contractor immediately before that posting or the first of consecutive postings. A 'predecessor contractor' is a contractor ('A') whose obligations to provide services have been partly or fully assumed by the contractor to which the application for registration is made. This will cover practice mergers, as well as where, in relation to a general medical services contract, there has been a change of status from individual medical practitioner to partnership (or vice versa).
- relevant family members of a civil servant (or former civil servant) who are returning to the UK and immediately before their return are or were accompanying the civil servant (or former civil servant) on their overseas posting – provided the civil servant (or former civil servant) was registered with the contractor or a predecessor contractor immediately before that overseas posting or the first of consecutive postings
- relevant family members of a current or former service person who are returning to the UK, and who, immediately before their return to the UK, are or were accompanying the current or former service person on an overseas posting – provided the family member was registered with the contractor or a predecessor contractor immediately before accompanying the service person on that overseas posting or the first of consecutive postings

4.15.3 The application in 4.15.2 may be made up to, but not more than, 1 month before that individual's planned date of return to the UK, and if the application is for permanent registration, it must be made no later than 3 months after the patient's arrival in the UK. Applications for permanent registration made after the end of the 3-month period are to be dealt with in the same way as any other patient registration request.

Registration with a new practice

4.15.4 Where an application is made by one of the following individuals, the contractor must register them, if their patient list is open. (The only exception to this is where the contractor has reasonable grounds to refuse the application; see 4.15.8):

- civil servants (or former civil servants) returning to the UK from an overseas posting, who were not previously registered with the contractor or a predecessor contractor
- relevant family members who are returning to the UK and who: (a) are or were accompanying a civil servant (or former civil servant), or a service person (or former service person), on their overseas posting from which they are returning, and (b) are not required to be treated as previously registered with the contractor (see 4.15.2)

If the contractor's list of patients is closed, it may register the individual if they are an immediate family member of a registered patient.

4.15.5 The application in 4.15.4 may be made up to 1 month before that individual's planned date of return to the UK. If the application is for permanent registration, it must be made at least 24 hours before the planned return date. Applications for permanent registration which are made less than 24 hours before the planned return date, or after the individual returns to the UK, are to be dealt with in the same way as any other patient registration request.

4.15.6 Applications in 4.15.2 and 4.15.4 may be made in-person or remotely, for example via posting or emailing a signed printed or scanned GMS1 or GMS3 form (as relevant) to the contractor. The form should be sent to the contractor with the following additional information:

a) Confirmation the patient is seeking registration under the contract provisions for crown servants returning from overseas postings.

b) The patient's planned date of arrival in the UK.

c) Anticipated length of stay in the UK (if not permanent and if known).

d) List all relevant family members (where applicable).

e) Proof of being, or having been, overseas in the circumstances defined in 4.15.2 and 4.15.4. This would normally be some documentary evidence or cover letter from the employer of the current or former civil servant/service person.

Should the practice need to validate that a patient was previously registered with them (or their predecessor contractor) immediately before they went overseas, the practice may confirm this through the PDS or National Health Application and Infrastructure Service(NHAIS)/Primary Care Registration Management (PCRM).

If the practice cannot confirm prior registration with them, it may request proof from the patient (eg letter, email, text message). If neither the practice or the patient are able to evidence prior registration, the practice may still choose to accept the individual's application if it is nevertheless satisfied that they or the patient of which they are a relevant family member (as the case may be) was previously registered with the practice (or its predecessor contractor) – eg a practice may see proof of an individual being previously resident in that practice's area as sufficient to accept their application.

Date of registration and duty to provide care

4.15.7 Where a contractor accepts an application in 4.15.2 or 4.15.4 for:

- temporary registration, it must confirm this with the individual or the appropriate person. The contractor's responsibility for that individual begins on the later of: (a) the date on which the contractor accepts the application, and (b) the date on which the individual returns to the UK. The contractor must notify its commissioner that it accepted the individual as a temporary resident at the end of the contractor's period of responsibility for that individual

- permanent registration, the contractor must give notice in writing to its commissioner of that acceptance as soon as possible. If the application is accepted before the individual's planned return date, the contractor must notify the commissioner of that return date. The commissioner must add the individual to the contractor's list of patients from the later of: (a) the date on which the commissioner receives the relevant notice from the contractor, and (b) the date on which the individual returns to the UK. The contractor is not required to provide primary medical services to that individual before their actual return to the UK

Once a contractor has accepted an application, regardless of whether the individual is still overseas, the contractor may book upon request appointment(s) for that individual which are only to take place once the individual has arrived in the UK. Individuals must not attend appointments (ie remote appointments) with the contractor while they are still overseas.

4.15.8 A contractor may only refuse to register individuals in 4.15.2 under the crown servant registration provisions where it has reasonable grounds for doing so. Such grounds must not relate to the patient's race, gender or gender reassignment, marriage or civil partnership, pregnancy or maternity, social class, age, religion or belief, sexual orientation, appearance, disability or medical condition. Reasonable grounds may include, in the case of an application for permanent registration, that the patient does not live, or does not intend to live in, the contractor's practice area or the outer boundary area. Where a contractor refuses to register a patient, this decision, and the reasons for it, must be communicated to the patient (or the person who made the application on their behalf) in writing within 14 days of that decision being made. The contractor must keep a written record of applications and reasons for refusal.

4.15.9 Under these specific regulations, the following are relevant family members of a current or former civil servant/service person [1]:

- their children (including adopted and stepchildren, as well as natural children), if:

- they are, or were, at the time of leaving the UK to accompany the civil servant or service person on their overseas posting, under 21 (or under 25 in the case of the child of a service person) and wholly or mainly financially dependent on the civil servant or service person whilst accompanying them, or

- they are or were wholly or mainly financially dependent on the civil servant or service person whilst accompanying them on their posting because of a disability [2]

- their spouse, civil partner, or individual whose relationship with the current or former civil servant or service person has the characteristics of a relationship between spouses or civil partners

- their former spouse, civil partner, or individual whose relationship with the current or former civil servant or service person has ended (for any reason) but had the characteristics of a relationship between spouses or civil partners
- their widow/widower or surviving civil partner if the civil servant or service person passed away while on their posting

Individuals who become relevant family members of a current or former civil servant/service person during an overseas posting and are returning to the UK are to be treated in the same way as those who were family members before the start of such a posting. This includes, for example, a child born, or adopted, during an overseas posting who remains with their civil service parent throughout that posting, or a person who marries a civil servant during their overseas posting and accompanies that person on their posting from that time.

[1] See the definition of "relevant family member" in paragraph 32A(7) of schedule 3 to the National Health Service (General Medical Services Contracts) Regulations 2015 and in paragraph 31A of schedule 2 to the National Health Service (Personal Medical Services Agreements) Regulations 2015. These provisions were inserted by the National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) (No. 2) Regulations 2021.

[2] As defined in part 2, chapter 1, section 6 of the Equality Act 2010.

4.16 Armed Forces: dual registration and GP Contract

4.16.1 Under the terms of their primary medical services, general practitioners (GPs) have the ability to register members of the armed forces of the Crown for a period of up to 2 years. To be eligible for registration, the patient must obtain written authorisation from the defence medical services and must reside or work within the practice area during the specified time period mentioned in the authorisation.

4.16.2 The arrangements for including armed forces personnel on a contractor's patient list are outlined in clause 13.5A of the GMS Contract. You can find the latest version of the contract, which includes this clause, on the NHS England website.

The same clause is included in the 2015/16 GMS Contract (page 67).

The corresponding regulations can be found in the GMS regulations 2015, schedule 3, paragraph 19.

4.17 Temporary residents

4.17.1 A contractor may, if the contractor's list of patients is open, accept a person as a temporary resident. This is provided the contractor is satisfied that the person is temporarily resident away from their normal place of residence and is not being provided with essential services (or their equivalent) under any other arrangement in the locality where that person is temporarily residing; or moving from place to place and not for the time being resident in any place.

4.17.2 It is of note that a notification to the commissioner of the acceptance of temporary resident on to the contractor's list only occurs at the end of the period of 3 months beginning with the date on which the contractor accepted that person as a temporary resident; or if the contractor's responsibility for that person as a temporary resident came to an end earlier, at that point. Any clinical records relating

to the TR period of care can/should be submitted via PCSE for repatriation to the registered GP practice or storage in archive.

4.17.3 As this type of registration does not get flagged with PCSE at the commencement of the temporary registration, there is potential for a contractor to accept as a temporary resident a patient who is actively registered with a Special Allocation Scheme (SAS). Should a contractor become aware that a patient is registered with a SAS, the contractor should contact their local commissioner who may seeks to secure temporary primary medical services for the patient with a local SAS.

4.18 Sensitive patient registrations

4.18.1 GP practices are required to work with PCSE and take actions on their clinical systems to ensure that the registration information for patients who undergo a change of identity is accurate and up to date. This is also the case for adoptions, gender transition and patients in witness protection schemes. This ensures data is kept up to date and held in line with information governance requirements on national demographics systems.

4.18.2 Commissioners must also work with PCSE in relation to managing escalations where there are potential blockages or delays in practices responding to PCSE requests.

Healthwatch Milton Keynes
Suite 113, Milton Keynes Business Centre
Foxhunter Drive
Linford Wood
Milton Keynes
MK14 6GD

www.healthwatchmiltonkeynes.co.uk
t: 01908 698800
e: info@healthwatchmiltonkeynes.co.uk
Healthwatch_MK
Facebook.com/HealthwatchMK