

## Frequently asked questions - Patient registration

### March 2009

#### Registering patients

##### **Q. Who is eligible to receive primary care from the NHS?**

**A.** People are entitled to NHS care in the United Kingdom if they are considered to be 'ordinarily resident'. Anybody who is living in the UK voluntarily and for a settled purpose of more than 6 months will normally be considered 'ordinarily resident'. British citizenship does not guarantee patients the right to NHS care. The GMS (General Medical Services) and PMS (Personal Medical Services) regulations provide that a contractor "may" accept an application for inclusion on its list of patients from anyone - and may only refuse such application if it has reasonable grounds for doing so. GPs have a duty to provide immediately necessary treatment to all people regardless of their eligibility to receive primary care. "This is essential treatment, which in the clinical judgement of a health care professional cannot be delayed or avoided." *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, A Consultation, Annex A, para 16, p16*.

In some areas patients are directed to Patient Advice and Liaison service the first time that they want to register with a practice in that area, and PALs takes responsibility for making the initial decision about NHS eligibility. NHS eligibility is a particular problem for overseas visitors and further information can be found in our [guidance on overseas visitors](#).

A number of PCTs have issued documents stating that practices should seek identification documentation from every new patient. It is **NOT** a requirement of the GMS contract for practices to seek identification of any kind from an individual in order for them to complete registration. Practices are free to operate such a policy if they wish, but it is not an obligation.

If a practice has doubts about the eligibility of an individual to NHS treatment, the matter should be referred to the PCT for investigation. Practices are under no contractual obligation to investigate matter of eligibility or to operate checks.

##### **Q. What is the current DH position on eligibility of asylum seekers to NHS primary care?**

**A.** Asylum seekers who have been granted amnesty in the UK or who are waiting for their case to be considered are 'ordinarily resident' in the UK and are eligible for primary and secondary care. Following a judicial review in April 2008 failed asylum seekers can now also be considered 'ordinarily resident' and entitled to free treatment NHS hospital treatment. Registration of refused asylum seekers for primary care is at the discretion of the practice in the same way as for any other patient, but they must not discriminate on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition

For further guidance please see [Access to care for asylum seekers and refused asylum seekers](#) from the BMA ethics department.

##### **Q. What information do patients have to provide in order to register at my practice?**

**A.** In order to register with a practice, patients can be asked to provide their medical card that will have details of their name, address, and NHS number. If the patient does not have a medical card, patients can complete a GMS1 form at the practice in order to be registered with the practice. The GMS Regulations state 'An application for inclusion in the Contractor's list of patients shall be made by delivering to the practice premises a medical card or an application signed (in either case) by the applicant or a person authorised by the applicant to sign on his behalf.' Practices are not required to request any further proof of identification from patients wishing to register and practices and PCOs who choose to request additional formal identification should be mindful of the GMS regulations on discrimination (see below).

**Q. Should practices keep records of those patients whom they do not accept onto their lists?**

**A.** Yes, Practices should keep records and detail the reasons behind their decisions so as to assist in any audit that may take place. Practices should also consider having a set of criteria with which to judge registrations to ensure transparency.

If a practice refuses admission of a patient onto a list, it must give the reason to the applicant in writing. When refusing a patient admission to a list, practices should bear in mind clause 181 in the GMS contract that states "*The contractor shall only refuse an application [to join the practice list] if it has reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition*".

**Q. How do practices guard against fraudulent registration?**

**A.** There have been cases of some patients registering with more than one practice in an attempt to receive multiple prescriptions for the same drugs. Guidance on what to look out for and where to report expected fraudulent patients can be found in the GPC [Focus on fraudulent registration](#).

## List closure

**Q. Can you perform enhanced services if you have a closed list?**

**A.** Practices that seek formally to close their lists usually do so in order to manage excessive workload. For this reason, whilst formal list closure will not prevent a practice from applying to provide opted-out additional services to the patients of other practices or to provide enhanced services, it is likely to prejudice its application. Whilst we understand and support their desire to offer a comprehensive service to their patients, it was considered that if practices were under such pressure that they felt obliged to close their lists to forced allocations, they should not normally take on extra enhanced services although PCOs are still obliged to offer them. This should not affect practices' continuing provision of enhanced services that they were already providing.

**Q. What help is available to practices which are having temporary problems managing their list size? Would practices still have to accept patient allocations from the PCO?**

**A.** In the situation that a practice is unable routinely to accept new patients (beyond immediate family members of existing patients), a discussion between the practice and the PCO should take place to allow the situation to be explored. The PCO is expected to work constructively with the practice to try to jointly achieve resolution. This could take the form of, for example, additional support given by the PCO to the practice. In some situations, practices may wish to use the closed list procedure.

Informal list closure is not recognised under the GMS contract arrangements and under the regulations practices could still have patients assigned to it.

It is recognised that GMS and PMS contractors retain their freedom within the contract not to register new patients, provided they have reasonable, non-discriminatory grounds for doing so in each case.

**Q. The decision to close the practice list could mean that practices are close to providing unsafe care. As the contract stands, we have concerns that practices have to wait a further ten weeks before they can close their list.**

**A.** The system is better than the former arrangements but it does not go as far as the General Practitioners Committee (GPC) had wanted. It is intended to make allocation less easy for the PCO and a very exceptional event. Rather, the emphasis should be on the PCO providing support to a struggling practice and finding other ways to provide care for patients who cannot find a doctor. The only patients that a practice with a closed list would be expected to register would be the immediate family members of registered patients. We have an assurance that we can re-visit this issue should it prove to be insufficiently effective.

## **Allocated patients**

### **Q. How will PCOs provide for 'allocated patients'?**

**A.** Primary legislation states that the Secretary of State for Health (or his/her equivalent) has an obligation to allocate patients as a last resort. This is a power that he/she is unwilling to give up. We have developed a three-stage, two appeals procedure to encourage the PCO to deal with the problem up-front and in discussion with practices. The three-stage process will be established to deal with allocated patients. Either a PCO will provide assistance to allow a practice to keep its list open (stage one), or a practice may issue a formal closure notice to its PCO (stage two). If the PCO agrees to the closure of the list this can be either for a period of 12 months, or until the number of patients recorded on the list has reduced by a percentage of the practice list size agreed with the PCO. Should the PCO reject the notice, this will be remitted immediately for determination by an assessment panel under the dispute resolution procedures (stage 3). Remember the act of allocation is now a top-level executive decision which will be very public and have to be reported to the highest levels. Furthermore, legislation allows PCOs to become providers or to invite tenders for additional provision. In that way, they may be able to arrange services for patients and thus prevent allocations.

### **Q. No-one seems to know what to do about allocations. People have to go somewhere. How are the PCOs going to be able to do this without top-slicing General Medical Services (GMS) and Personal Medical Services (PMS) funding?**

**A.** The three-stage process, outlined above, will address the problem of patient allocations. PCOs cannot top-slice the global sum as it is a direct, guaranteed amount, although if a PCO is directly providing care to a population it would receive the global sum associated with that population. If the PCO still intends to allocate patients, the PCO Chief Executive will be required to spend a lot of his or her time in allocation meetings and appeals.

## **Practice assignment and choice of practice**

### **Q. May PCOs allocate from outside the practice area?**

**A.** Yes they may. They can allocate a patient resident within the PCO area to any practice with an open list inside the Primary Care Organisation (PCO) area. However, the GMS Regulations say that the PCO must 'have regard to the distances between the patient's place of residence and the contractor's practice premises' when assigning. Equivalent PMS Regulations have the same provision, but the APMS Directions are less specific. If practices are reducing their practice area this may reduce the risk of allocation but it should be noted that a PCO has a duty to provide primary medical services to all its residents.

### **Q. Does the allocation formula remove the right for a practice to remove a patient from their list?**

**A.** No. The formula and its operation have no bearing on a practice's right to remove patients from its list. The right to remove patients has not changed. There is, however, an obligation on the practice to give the patient a reason why. This can in certain circumstances be simply a statement that the doctor – patient relationship has irrevocably broken down.

### **Q. Who is responsible for ensuring that my practice list is accurate?**

**A.** PCTs are responsible for ensuring that practice lists are accurate.

### **Q. Can PCOs remove patients from my practice list without my knowledge?**

**A.** Patients have a right to change their doctor and are not required to give reasons or any period of notice when they change practices. When patients move from one practice to another, PCOs are entitled to remove the patient from the practice list without prior notification to the practice.

### **Q. How are non-violent but excessively demanding patients who are registered but rotated between practices by assignment dealt with in terms of minimising forced assignments?**

**A.** They will be treated the same as any other potentially allocated patient.

## Removal of patients

**Q. Can practices remove patients from the practice list shortly after they have been assigned, or does the system force practices to keep such patients on their list for a long period?**

**A.** Practices are able to remove patients by giving written notice. However they should note that that they will normally be expected to have warned the patient and give them a reason.

**Q. Can we have reassurance that the allocations formula does not remove the right for a practice to remove a patient from its list?**

**A.** Yes. The formula and its operation have no bearing on a practice's right to remove patients from its list. The right of removal is in part 2, 192-209 of the GMS contract.

## Violent patients

**Q. I am concerned that I have been assigned a violent patient.**

**A.** PCOs should not assign violent patients, that is, those removed for acts of violence or aggression by a previous practice. If a practice has not used the immediate route the PCO may not know the reason for the removal. While we do not assert that removal is always the answer for all violent or abusive patients we would encourage practices who intend to remove a violent or threatening patient to use the immediate removal procedure as this will help forewarn future practices about patients with a history of violence. For further guidance please see the guidance [‘GP-removal of patients from their lists’](#).

## Choice of practitioner

**Q. Must we always provide the professional or class of professional requested by the patient?**

**A.** No. There is a requirement to endeavour to provide that person, but the practice may decline when that person does not provide the service or on other reasonable grounds. We believe that both urgency and unavailability are reasonable grounds when it is inappropriate for the patient to wait, or the patient is unwilling to wait.