# Scoping the systemic barriers which lead to unsuccessful general practitioner registration attempts amongst Londoners

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# Contact Information

This independent report was commissioned by the Greater London Authority (GLA). The views in the report are those of the authors and all conclusions are the authors' own.

**Carlson Pepper Collaborative** is a consulting collaboration specialising in bridging academic and practical expertise to enhance support for forced migrants and elevate the voices of the world's forcibly displaced.

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# Acknowledgements

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First and foremost, we would like to extend our thanks to the anonymous individuals who offered to share their time and expertise with us in interviews and focus groups. Their contributions to this report are invaluable and we are grateful for their participation. We would also like to thank the members of the advisory group who provided input and guidance throughout this research project. Finally, and perhaps most of all, we would like to thank the commissioning team for their ongoing support for the research and their commitment to carrying its recommendations forward.

# Executive Summary

Promoting equality and actively addressing underlying health inequalities is one of National Health Service (NHS) England's key principles. Yet, for individuals on the margins of society, such as undocumented migrants, homeless individuals, and other health inclusion groups, a number of barriers can deter engagement with health services, including cultural, legal, logistical, and systemic considerations. While much research has been done to explore the barriers registrants themselves face, little has been explored from the perspective of staff within the healthcare system tasked with registering those patients.

Through one-to-one interviews and a focus group with general practitioner (GP) surgery staff across London, key informant interviews, and a review of official guidance materials and literature over the course of a two-month period, this research set out to ask: What systemic barriers do GP surgery staff encounter when registering an individual without ID or proof of address, and how might those barriers be addressed?

**Four key findings** were identified:

1) Systemic pressures on the health system and individual professionals impact GP frontline staff confidence and understanding in enacting registration policy in relation to requiring IDs and proof of address.

2) Communication channels around registration policy and processes are dense and top-down with little support to ensure registration guidance is interpreted correctly and effectively at all staff levels.

3) Accountability and policy buy-in to registration guidance among individual GP practices is limited, potentially undermining the prioritisation of registration policy compliance amongst competing concerns.

4) Digital registration platforms offer potential solutions to some challenges of registering without an ID or proof of address, but should be closely monitored and not used exclusively.

To address some of the barriers and concerns identified in the research, the report makes the following **seven recommendations**.

For some recommendations, the Mayor of London should work with regional partners (recommendations 3 and 4) and for others the Mayor of London should advocate on behalf of London and London General Practice (recommendations 1, 2, 5, 6, and 7).

1) Develop and promote a prescriptive, universal, simplified, and standardised registration process tool for practice managers and receptionists to complement current guidance. This should include information about registering a patient without ID or proof of address, and should clarify risk mitigation measures and responsibilities on the part of practices and individual reception staff to alleviate perceived risk concerns.

2) Redevelop the GMS1 form to clarify what information is mandatory and what is optional, and provide the form in various languages.

3) Provide GP surgeries with clearer and more immediate communication channels for handling registration queries.

4) Develop and strongly recommend a standardised online training for all GP receptionists on registration to ensure a shared interpretation of registration policies at all staffing levels.

5) Clarify or redevelop GP surgery contractual obligations to include accountability measures to ensure that staff register patients who are unable to provide ID or proof of address.

6) In response to systemwide and multi-faceted pressures on primary care services, reassess current staffing levels and resources at GP surgery level.

7) Explore and monitor a standardised online approach to registration that does not require ID or proof of address.

# Introduction

Promoting equality and actively addressing underlying health inequalities is one of the National Health Service (NHS) England's key principles, made more vital during the COVID-19 pandemic. The virulent nature of the pandemic underscores the importance of each individual's access to health services, both preventative and treatment-oriented, in order to protect the health and safety of the community overall. Yet, for individuals on the margins of society, a number of barriers can deter engagement with health services, including cultural, legal, logistical, and systemic considerations.

Everyone in England has the right to access healthcare by registering with and consulting a general practitioner (GP) (Public Health England 2021). Following from this, NHS guidance regarding registration policies clearly states that an inability to provide proof of identity or address are not reasonable grounds to refuse registration with a GP (Primary Medical Care Policy and Guidance Manual (PGM)(v3) 2021). Despite the provision of clear guidance, some Londoners still encounter barriers when attempting to register with a GP surgery, especially undocumented migrants and other health inclusion groups (Farrant et al. 2022; Gunner et al. 2019; Hamada et al. 2021).

Access to health care is in part determined by the ease and confidence with which an individual is able to use health services (Patel et al. 2020). Any barriers encountered when engaging with official health representatives can be detrimental. As the first point of contact with health services in the UK, a GP surgery incorrectly declining to register an individual due to a lack of ID or proof of address, or any other grounds, can undermine efforts to better engage insecure migrants and other health inclusion groups (Hamada et al. 2021). While guidance on these points is regularly cascaded to GP surgeries, the problem has persisted (Hodson, Ford, and Cooper 2019), both prior to COVID-19 and as the NHS and GP surgeries come under increasing pressure due to the continuation of the pandemic and the resulting backlog of care. In this context, inconsistencies in understanding and compliance with official guidance are likely to continue.

This issue of denied registration on the basis of being unable or unwilling to show ID and proof of address is complicated by the fact that there are logical reasons to ask for ID and proof of address at the point of registration. Among these, ensuring that a patient is within a practice's catchment area makes it possible for that patient to receive the full range of health services that they are entitled to, including home visits and referrals, which become complicated for patients living outside of a practice's catchment area. Patient safety is another reason as the merging or use of incorrect medical records in treatment could result in negative health outcomes. Further, concerns related to safeguarding and drug-seeking behaviour can be mitigated against by asking for documentation at the point of registration. Still, requiring ID or proof of address can erect barriers to healthcare access for some individuals, and NHS guidance is clear that ID or proof of address as a mandatory condition of registration is not permitted, and if documentation is requested of any patient, it must be requested from every patient.

While COVID-19 has emphasised the need to break down barriers to healthcare access for every individual in a community, the importance of this issue both pre-dates and will outlast the pandemic. COVID-19 has therefore created the opportunity to further examine barriers to access, but did not create the problem of access itself. This research therefore asks: *What systemic barriers do GP surgery staff encounter when registering an individual without ID or proof of address, and how might those barriers be addressed?* By focusing on systemic issues, we seek to move away from narratives solely examining barriers some patients face in registering without ID or proof of address to look at the challenges GP surgery staff face when attempting to complete those same registrations, thereby uncovering the ways that structural conditions contribute to this problem. We do so by speaking with GP surgery staff and key informants, and through a desk review of guidance available to staff.

We find that several systemic conditions contribute to the problem of incorrect registration refusal for people unable to provide proof of identity or address. We group these as three challenges:

1) Systemic pressures on the health system and individual professionals impact GP frontline staff confidence and understanding in enacting registration policy in relation to requiring IDs and proof of address.

2) Communication channels around registration policy and processes are dense and top-down with little support to ensure registration guidance is interpreted correctly and effectively at all staff levels.

3) Accountability and policy buy-in to registration guidance among individual GP practices is limited, potentially undermining the prioritisation of registration policy compliance amongst competing concerns.

In addition to these challenges, we found some innovations in the use of digital registration platforms, which could provide additional solutions, but which carry their own challenges:

4) Digital registration platforms offer potential solutions to some challenges of registering without an ID or proof of address, but should be closely monitored and not used exclusively.

In the context of these challenges, we have developed seven recommendations. For some of these recommendations, the Mayor of London should work with regional partners (recommendations 3 and 4), and for others the Mayor of London should advocate on behalf of London and London General Practice (recommendations 1, 2, 5, 6, and 7).

It is important to acknowledge that there is critical work already being done by many organisations to support compliance with registration guidance, including the Doctors of the World Safe Surgeries qualification, trainings for receptionists on patient care created by Healthy London Partnership, and the development of a Pathways tool to support reception staff in registering homeless individuals. Further, a joint NHSX, NHSD and NHSE programme has been set up to modernise the general practice registration process. The aim is to make registration simpler and easier for all patients so they get the care they need and for practices in reducing their

administrative burden. A pilot of the new registration model including a digital option is currently underway to inform wider roll out. The recommendations contained in this report are intended to complement and contribute to these initiatives to form collaborative solutions.

We next discuss our methodology. Following that, we share our findings and provide recommendations. The last section draws together our conclusions based on the findings.

# Methodology

## Our approach

This qualitative study was designed and implemented using a grounded theory approach (Strauss and Corbin 1998; Charmaz and Thornberg 2020). This approach permitted themes to emerge from the research, regardless of expectations for what the data would show.

We are two research consultants with no formal affiliation beyond this project with the Greater London Authority (GLA), the NHS, or any other related entity. In order to create a collaborative atmosphere, we emphasised our neutrality as research consultants to research participants.

## Desk Review

The desk review included a close reading of the PGM and the GMS1 Form. It was further supplemented by related reports as well as academic research. We further reviewed the websites and online registration processes of five randomly selected GP surgeries in London.

## Recruitment

Our study relied on data collected from fifteen one-to-one interviews, nine key informant interviews, and one focus group with three participants in the two-month period allotted.

By necessity, recruitment involved a varied set of approaches. First, we disseminated an email to practices via Integrated Care Systems (ICS) leads asking for participants (see Appendix A). This did not yield the anticipated response due to a number of factors including slow circulation of the email, overloaded staff who were unable or unwilling to volunteer their time, and emails often not reaching all staff in a practice as a result of existing communication structures.

With initial response rates low, we prepared a random sample of ten percent of all practices in London. This sample was stratified by ICS area (Northwest London, Southeast London, etc.). From this list, we cold-called practices seeking to obtain a contact number or email for practice managers to reach out directly. This approach was not fruitful, but revealed two relevant issues. First, the recruitment email was not reaching reception staff, who were unaware of the project when we called. Second, obtaining direct contact information is difficult, even for a determined researcher.

We reached the final number of participants with assistance in recirculating the email via regional communication channels and with the referral of some participants from those who had already participated in interviews.

## Participants

Participants were represented from twelve boroughs, with a good geographic spread including 11% from North East London, 33% from North Central London, 28% from North West London, 11% from South West London, and 17% from South East London:

**GEOGRAPHIC SPREAD OF GP SURGERY RESEARCH PARTICIPANTS**
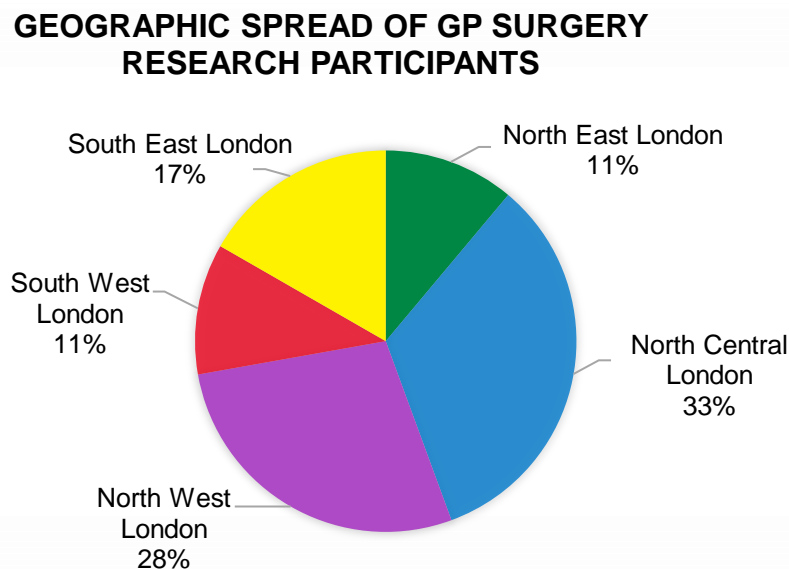


The majority of participants were practice or business managers (13). Other participants worked in reception/registration specifically (4), or as a general practitioner (1).

Fifteen one-to-one interviews lasting 25-35 minutes were conducted via Zoom at a time suggested by participants. These interviews were audio recorded with the permission of the interviewee and later transcribed and coded. The initial interview guide for semi-structured interviews was developed in partnership with relevant parties at the Greater London Authority (see Appendix B).

We were able to secure participants for one focus group interview. This was structured as a journey-mapping exercise, a method for understanding the ways that an individual interacts with a product or system (Richardson 2010). We led participants through hypothetical scenarios involving patients attempting to register without ID or proof of address in order to uncover what such registrations require on the part of practices.

Additionally, nine key informant interviews were conducted. The aim of these was to better understand the context for the systemic issues we were uncovering in our desk review and one-to-one interviews, as well as the constraints within which any recommendations would be enacted.

## Data Analysis

Data were analysed in Dedoose, a qualitative data analysis software program. We employed a grounded theory approach to coding our data to allow themes to emerge from the data itself, rather than seeking to test any hypothesis (Strauss and Corbin 1998).

## Ethics

An ethics statement was submitted to the GLA for review prior to initiating data collection (see Appendix C). Each research participant was sent a detailed informed consent document prior to the interview for their review (see Appendix D). Interviews began with a discussion of the informed consent document and the request for verbal consent both to the interview and to the audio recording. We assured interviewees that their data would be anonymised, and that recordings, notes, and transcripts would only be made available to the two researchers and would be deleted once the research is completed.

## Limitations

The primary limitation to this research is the shortage of interview respondents who are actually responsible for registering patients on a day-to-day basis. This was due to a number of factors, most importantly including the lack of a direct contact mechanism and the shortage of time available to conduct the research, and for staff members to participate. This is ameliorated somewhat by the number of interviews we were able to conduct with people responsible for enacting policy on the practice level, namely practice managers.

# Findings

The established methodology brought to light four key themes regarding current London-based GP surgery registration practices for patients unable to provide ID or proof of address:

1) Systemic pressures on the health system and individual professionals impact GP frontline staff confidence and understanding in enacting registration policy in relation to requiring IDs and proof of address.

2) Communication channels around registration policy and processes are dense and top-down with little support to ensure registration guidance is interpreted correctly and effectively at all staff levels.

3) Accountability and policy buy-in to registration guidance among individual GP practices is limited, potentially undermining the prioritisation of registration policy compliance amongst competing concerns.

4) Digital registration platforms offer potential solutions to some challenges of registering without an ID or proof of address, but should be closely monitored and not used exclusively.

The first three highlight a number of systemic challenges impacting registration without ID or proof of address, while the fourth includes recent innovations in registration practices (particularly with the continuation of COVID-19), although ongoing challenges built into digital platforms require continued monitoring.

The following sections detail these challenges and innovations, as well as present recommendations.

## Challenge 1

**Systemic pressures on the health system and individual professionals impact GP frontline staff confidence and understanding in enacting registration policy in relation to requiring IDs and proof of address.**

The NHS has suffered from GP staff shortages over the past several years, despite growing patient lists and health needs (British Medical Association 2022). The recent COVID-19 pandemic has put further strain on GP surgeries in meeting primary care health demands. As a result, there have been effects on patient care, including registration practices. While in no way entirely a result of recent GP staffing challenges, this research has shown that challenges in registering without an ID or proof of address are in some ways tied directly and tangentially to an overburdened healthcare system.

### Time Demands
Given the many millions of patients registered with the NHS, many of whom have very similar names, there is a need to correctly establish a person's identity when

registering them to ensure disparate records are not mistakenly merged and quality of care consequently affected. Providing ID or proof of address is an expedient and reliable way to do this.

Many research participants highlighted that individuals needing to register without ID or proof of address are perceived to represent a greater deal of registration complexity, and subsequent demands on staff time. This is due to a perceived greater likelihood of bounceback from the Primary Care Support England (PCSE) system to establish whether the patient is new to the spine, or is in fact someone with an existing NHS number and record. Such queries from PCSE require staff to dedicate more time to patient follow-up to obtain clarifying information, work to resolve problems with PCSE, and frequently field complaints and queries from the prospective patient as they wait for their registration to be completed. Issues with existing communication between practices and PCSE in resolving registration issues (discussed in subsequent sections) can further delay the process. Many practices therefore ask for ID or proof of address at the point of registration to ensure as much accuracy in the original registration attempt as possible. This sometimes involves encouraging patients to come back with whatever documentation they can provide to help with this process.

> "We always encourage documentation, just so that we don't end up having a rejection that then takes staff hours and hours to try and sort through and get the patient registered."

In addition, some individuals unable to provide ID or proof of address, such as undocumented migrants, may require additional support like language interpretation to complete registration forms, which in turn needs to be arranged by surgery staff. Interpretation difficulties lead not only to extra time in patient interactions, but also potential misunderstandings that a request for documentation is in fact a refusal to register without such documentation (see also Kang, Tomkow and Farrington 2019). A number of practices have found ways of mitigating the time demands around language barriers by having a dedicated patient liaison to offer support, or providing handouts in different languages with different requests for assistance for patients to choose from.

The PGM acknowledges that while there is no regulatory requirement to produce ID or proof of address to register, there can be practical reasons (such as the above examples) to request these, and therefore makes allowances for such requests as long as they are made of all new patients. However, it does state that reasonable exceptions need to be made for patients unable to do so.

Despite the above concerns, some practices reported that they no longer ask for ID or proof of address at all, and have found no notable increase in time demands as a result. In fact, some have found it lessens staff burden. Further, many bouncebacks from the PCSE system are in cases where all information provided was accurate at the outset. This indicates that one of the main reasons GP staff ask for ID or proof of address could be minimised by more robust communication channels for troubleshooting within the registration system overall, rather than requesting ID or proof of address.

## High Volume of Guidance

Guidance clearly states that lack of ID or proof of address are not grounds for refusal to register, and most interviewees said they were clear on this element of the guidance. However, the volume and density of the PGM, its associated resources, and NHS guidance in general places pressure on GP practice managers to interpret guidance and apply it correctly. The PGM alone is a 426-page document with links to numerous complementary resources with additional information. Section 4.4 clearly states who can register for free primary care services (pp.45-46), and Section 4.9 clearly states that ID and proof of address are not required to register and that those who cannot produce it should be registered upon application (p. 52). Still, it is easy to see how this message can become diluted in the context of so much information.

> "I think [we got] like an 82-page document with every single paragraph linking to another document that references the point…It just will all be emailed through, and you've got to sit there and interpret line by line."

For example, Part B, Section 3, "Managing Patient Lists" puts emphasis on the need for accuracy of data and the role documentation can play in ensuring accuracy, seemingly encouraging staff to ask for ID and proof of address. Further, while Section 4.4 also clearly states that eligibility for secondary care should be assessed by the receiving organisation, and not serve as a barrier to registration for GP services, Section 4.11 detailing care for a specific migrant status as "temporary resident" states the "'gatekeeper' role of the NHS GP for accessing secondary care services depends on patient registration" (p. 151), implying GP surgeries should be aware of immigration status when registering a patient, again requiring documentation and placing additional responsibility on GP frontline staff.

## GMS1 Form

Beyond the PGM, the other piece of guidance and paperwork that all GP surgeries have to interpret and manage as part of the registration process is the GMS1 Form. This form requests information required for a registration to be initiated by a surgery (for example: name, date of birth), but also includes additional information that can be helpful, but is not required for registration. The additional information includes questions concerning date of entry into the UK, ethnicity, and a series of questions meant to ascertain eligibility for free secondary care. Only certain parts of this information are marked as optional, and not very clearly. For example, one section containing questions on previous addresses and date of entry to the UK is only noted to be optional in a footnote. Most practice staff we spoke with perceived the entire form as mandatory for registration, with date of entry to the UK raised frequently in interviews as a perceived registration requirement.

Of particular concern are the questions designed to determine eligibility for secondary care. While logical to make patients aware of potential financial liability if obtaining secondary care, interviewees reported that it creates a sense of responsibility to gatekeep at the GP surgery level. Further, this information is difficult to parse, leaving room for confusion and misinterpretation by staff as well as patients seeking to register. One interviewee noted that rather than trying to parse and enforce response to this particular section of the form, they simply inform patients that they may have to pay for secondary care, as they felt they did not understand all the information.

## Confusion and Concerns of Liability

It is clear that dense guidance places a good deal of pressure on individual GP practices and staff to review and accurately interpret guidance. This leaves room for confusion and lack of confidence on the part of GP frontline staff at the point of registration.

Confusion and fear over having missed or misinterpreted something in the guidance fosters a "better safe than sorry" approach for many practices, with staff often wanting to take the most well-established and conservative steps to registering new patients to avoid risk. Fears of potential risk can include personal fault or liability for registering the wrong person. For those who have been in the field for decades, experiences under previous "hostile" policies regarding the registration of some migrants can still influence individual risk calculations. There is also confusion around individual responsibility within the system, including the responsibility to guard against access to free secondary care for those ineligible. Without clear, concise guidance directly addressing some of these concerns, staff are more likely to seek forms of ID or proof of address to avoid such risks.

> "I know the secondary care must be paid for in certain circumstances. So there is a concern, if people are trying to abuse the system, then they can use this as a door of entry. Which would make it, I guess, our responsibility to kind of guard that door."

In addition to fears over personal liability, the concerns most cited by research participants in terms of registering without ID or proof of address included fraud, drug-seeking behaviour, safeguarding, and data security. While key informant interviews with ICS representatives acknowledged many risks were minimal, it is evident that some risks are very real and some staff hold concerns for either community or individual patient wellbeing. PGM guidance is clear that concerns should not be investigated by GP surgery staff, and that registration should proceed while concerns are reported to relevant authorities. Still, it would be beneficial to more directly address frontline staff fears regarding their personal liability and responsibility (or lack thereof), as well as to have guidance that better demonstrates that practical risks have been considered and what mitigation steps GP practices can take.

> "It would be lovely if we didn't have to ask for any ID. And we could just take people at face value and create a record for them based on what they've told us. But practically speaking, that just creates risks, right?"

In terms of data security concerns, some GP practices have put in place an option on registration forms to indicate to staff whether identity was verified and therefore whether medical records can be shared with the patient. This could potentially serve as a beneficial option for registration without ID, while still maintaining data security.

While less frequently cited than the above practical concerns, it is also worth noting that personal politics, beliefs, and biases can still play a role in an individual GP practice or staff member's registration decision-making process. This can have an impact in cases where they may be clear on the guidance, but do not agree with it, and therefore continue to put in place gatekeeping measures.

## Quality of Care

Being outside of a GP surgery's catchment area is an oft-cited reasonable ground to refuse registration, both in the guidance and amongst research participants. While surgeries are not allowed to refuse registration due to the lack of documentation proving a patient is within the catchment area (such as proof of address), there are two practical concerns related to quality of care that encourage some practices to push for documentation to complete a registration application.

First, some key informant interviews highlighted that increasing pressures on the health system have resulted in many GP surgeries reporting that their practice was operating at an unsafe patient-to-GP ratio. Yet those practices still did not meet official thresholds to close their lists to new patient registrations. This can encourage "soft" gatekeeping to "protect" patient lists from further increases, like requesting proof of being within a catchment area to complete a registration application.

> "One of the reasons that somebody can't register [is] they're not in a catchment area…So we could technically say, if they haven't got any proof of address…are we within our rights to say that they're not in a catchment area…which is why we try and ask for something if possible."

A second concern with registering patients out of the catchment area is the ability to provide the full suite of medical support, such as home visits and referrals to other services. Due to practical constraints, access to these services would be more complicated if the person did live out-of-area.

> "Catchment area is sometimes the issue, because what happened is, if I have a child, we need to make sure that they are getting the health visitor visits. Sometimes the mental health, they don't provide care to the patient who is not in the same borough. So sometimes we have tension."

Concerns around quality of care are not restricted to catchment alone. An inability to match someone's medical records correctly to the NHS spine can increase the probability that vital information about an individual's medical history cannot be relied upon to inform continued care. Such concerns around patient safety and quality of care can further heighten the sense of importance around checking ID and proof of address. In the absence of practical guidance around mitigating such concerns, many practices may continue to strongly encourage prospective patients to provide such documentation, adding a layer of gatekeeping that may not constitute a refusal, but nonetheless effectively halts registration until this can be provided.

# Recommendations for Solutions to Challenge 1:

**1) Develop and promote a prescriptive, universal, simplified, and standardised registration process tool for practice managers and receptionists to complement current guidance. This should include information about registering a patient without ID or proof of address, and should clarify risk mitigation measures and responsibilities on the part of practices and individual reception staff to alleviate perceived risk concerns.**

Myriad tools are available to practices to aid them in providing greater access to services for patients. Doctors of the World's Safe Surgeries program, Healthy London Partnership's training available to reception staff, and other initiatives offer general support to staff. However, the findings of this research suggest that wading through the wealth of guidance and resources is often perceived to be a burden. Developing a single, official NHS registration tool in the form of a simple one or two-page flowchart indicating common steps of registration could ensure that those charged with registering patients feel empowered by the NHS directly to proceed without ID or proof of address. With such a tool, the NHS can create greater buy-in amongst surgeries to the current policy, and provide greater confidence on mitigating any perceived risks resulting from registering patients without ID or proof of address. The researchers recommend that such a tool focus on a universal registration process flow ("if this, then this") for maximum clarity, rather than developing one specific to a particular population. Population-specific tools would reinforce the problem of wading through a plethora of guidance, and would likely encourage asking probing assessment questions which are, in fact, irrelevant at the stage of registration. Specified health care based on individual need is highly important, and it is not our view that the NHS should be all things to all people. Specific health needs and pathways should continue once care commences. However, at the point of registration, the tool need only focus on the registration process. The tool should include steps to take if someone is unable to provide ID or proof of address or needs language interpretation assistance. This tool may also mitigate against the observed tendency of some GP staff to take on responsibilities beyond their purview, such as assessing someone's eligibility for secondary care.

Due to reported GP staff concerns around managing risks and misunderstandings concerning responsibilities in some cases, the guidance and the recommended tool should clearly state that risks have been considered in the development of the policy. It should further detail how GP surgery staff can reasonably mitigate some common risk concerns, and for what they are and are not held responsible. Helpful areas to clarify would be: 1) responsibility to assess eligibility for secondary care, 2) potential data security measures, and 3) clear pathways to report safeguarding or drug-seeking behaviour concerns while still proceeding to register the patient. In addition, while immigration and housing status are not currently listed under the "protected groups" definition in NHS guidance, it would be beneficial to add that these statuses should not be discriminated against during the registration process. For this recommendation the Mayor of London should advocate on behalf of London and London General Practice.

"I think if people just knew the process, and they could follow it, it's as easy as that. I would say just streamline the process and make it easy to understand for everyone, and then people would follow it, simple as that."

**2) Redevelop the GMS1 form to clarify what information is mandatory and what is optional, and provide the form in various languages.**

Some GP practices and staff remain under the impression that all sections of the GMS1 form are mandatory for registration, and will therefore refrain from completing a registration until the entire form is filled out. As a result, it is recommended the form be reorganised to make it easily apparent what sections are mandatory for registration, and what are optional. This could be accomplished by putting "(optional)" after each question as appropriate, or placing all optional questions under a single header in the latter half of the form, with an introduction in bold clearly stating all subsequent questions are optional. Given the pressures on GP surgeries to source language interpretation, it would also be helpful to provide translations of the form in different languages for GP surgeries to use. For this recommendation, the Mayor of London should advocate on behalf of London and London General Practice.

# Challenge 2

**Communication channels around registration policy and processes are dense and top-down with little support to ensure registration guidance is interpreted correctly and effectively at all staff levels.**

In the previous finding, we discussed how the volume and breadth of the guidance places pressure on GP practices to accurately interpret information sent. In this section, we offer a more in-depth review of how current communication channels may encourage registration practices that breach guidance. Communication channels concern the way that guidance is shared, the format of the guidance, and the lack of feedback loop between GP surgeries and those who prepare the guidance.

Many research participants stated they were clear on current policy about registering patients without ID or proof of address, and there seems to have been a re-emphasis of the policy in recent years. Yet, even staff who said they were quite clear on the registration guidance overall would later express confusion over that same policy, such as whether overseas visitors should be registered for free primary care or through private care. There also remains confusion over whether some previous policies still apply, such as potential financial repercussions for "wrongly" registering a migrant who should not be registered (see also: Glennerster and Hodson 2019).

"I think if people just knew the process, and they could follow it, it's as easy as that. But it's so shrouded in, you know, almost irrelevant stuff that it becomes so difficult to then put into practice."

Lack of information was not an issue that arose for research participants. As discussed above, the issue seems rather to be inundation with information, but with few communication channels to clarify or troubleshoot issues as they arise. Many

practice managers reported getting multiple emails about any changes in policy, which they agreed was better than not getting enough information. The challenge, however, is working through the abundance of guidance and making sure they understand it correctly.

> "It is information overload and certainly email overload. It's just extensive and non-stop."

> "What you'll get is an email from someone in a folder with a link to another document, or a piece—it's so disjointed and misaligned, that it can be really, really difficult to make sense of it."

> "[Guidance] would come to [the practice manager], and she would filter it through to us…I'm just relying on her."

## Seeking Support

While some participants reported receiving policy clarification support from their relevant ICS, many reported having few channels within the NHS through which they could get definitive answers to their policy questions. There was also feedback that policy did not always seem to align with the realities of day-to-day registration and reception responsibilities, and therefore is in need of reassessment. Some practices reported relying on third-party organisations, such as the British Medical Association, for clear information on policy in terms they could understand. In general, the majority of research participants seemed to feel that the current avenues for seeking clarifications were too often automated, and that having direct lines of communication such as specific phone numbers would make it easier to resolve policy questions.

> "We used to know them, we knew them by name, and we could pick up the phone, and we could call them and you know, now it's a much bigger national portal. And all you can do is send an email…you might get a response weeks later, sometimes just an automated response."

Many more research participants pointed out that the automated communication system with PCSE is even more problematic, as it hinders troubleshooting registration queries. Many reported lengthy delays in receiving even automated responses, and the system does not allow for explaining problems for quicker resolution. Delays tended to result in a good deal of staff time being used to try to push for the issue to be resolved, as well as to field patient queries and complaints about their registration status. This particular issue is not specific to registration without ID or proof of address. However, it does put additional impetus on GP surgery staff to avoid bounceback from PCSE, thereby encouraging staff to request documentation such as ID and proof of address to ensure all information is inputted correctly to avoid further delay down the line.

## Intra-Practice Communication

Intra-practice communication and structure can also impact registration without ID or proof of address. In some cases, practice managers who were clear on registering without documentation reported some pushback by their staff, many of whom were used to previous ways of operating, and either did not agree with current policy or found it difficult to alter their practices. In some cases, practice staff were applying

the guidance correctly, but practice managers inherited structures such as automated phone systems that still stated ID was required to register, and did not become aware of this until later. Some practice managers also stated that in larger practices, it could be difficult to monitor reception interactions to ensure new policies were taken on. In some cases, there is a great deal of individual staff latitude in whether a "pending" registration is completed without ID or proof of address, which may not come to the attention of the practice manager or registration clerk unless the patient pushed it forward. All of this indicates that clear communication of any changes in policy, and getting the buy-in of all staff charged with implementing that policy, can be highly challenging, even in cases where leadership is on board.

GP surgery structures require practice managers to synthesise policy information in order to then relay it accurately to their teams. One ICS key informant stated they did not have a direct line of communication with receptionists at practices, indicating that there are no alternate structures in place to share relevant registration policies with reception staff. This results in an overreliance on practice managers to accurately present policies to their teams.

> "I have gone out several times where some staff are just not understanding because they've been so used to refusing patients if they haven't got the details, whereas I'll go out and say 'That's fine, we'll register you.'"

There is a good deal of reliance on existing staff to train new staff. Many existing staff may have been in their post for decades and have established registration practices under previous policies that no longer apply. Several research participants acknowledged that this kind of knowledge transfer, while beneficial in some ways, does risk misinformation being spread to new staff. Training and communication around registration may therefore require a more standardised approach.

> "If a reception staff is training another reception staff, then God knows what gets told."

It should be noted that some practices have built communication and operation structures that they find helpful for staff understanding of registration and other policies. One practice stated they rotate staff between a variety of roles within the practice so that everyone has a more holistic view of overall patient care from end to end, starting with registration. We note this as a best practice as they reported that it has reduced staff turnover, increased staff capacity to troubleshoot, and created more staff buy-in, including in registration policies.

> "We want to make everything more inclusive…what's more important than the receptionist? And so we rather if everyone sees the full picture and can do everything, and we have a happier team…It makes the team feel more important, more included in all the decisions. Not knowing all the parts I think it's just very demoralising."

# Recommendations for Solutions to Challenge 2

### 3) Provide GP surgeries with clearer and more immediate communication channels for handling registration queries.

All GP surgeries should be provided with a NHS helpline, rather than an automated system, to aid with policy queries, at the regional or national level. It is also highly recommended that a similar helpline be offered for PCSE troubleshooting, rather than exclusive reliance on a web-based form, to ensure timely and efficient resolution of registration queries. For this recommendation, the Mayor of London should work with regional partners.

### 4) Develop and strongly recommend a standardised online training for all GP receptionists on registration to ensure a shared interpretation of registration policies at all staffing levels.

Currently, there is a range of understanding of policy at the practice manager level, lack of direct communication channels with receptionists, and reliance on existing staff to train new staff on registration processes. As such, a standardised online training on registration could be developed and strongly recommended for all GP reception staff. Standardised training would ensure that policy is fully understood by all and that everyone has the same access to accurate information on registration policy. For this recommendation, the Mayor of London should work with regional partners.

# Challenge 3

### Accountability and policy buy-in to registration guidance among individual GP practices is limited, potentially undermining the prioritisation of registration policy compliance amongst competing concerns.

### Invisible Gatekeeping

Incomplete or refused registrations are likely drastically underestimated. This is due to the fact that many "invisible" interactions take place that would not be recorded or reported, either internally within a practice or externally to the NHS or other observers. These interactions often take the form of reception staff requesting that a patient return with documents before agreeing to register them. In place of a clear refusal to register, this is a "soft" barrier that may or may not result in a patient returning to complete registration. With language barriers factored in, it is clear that there is room for patients to misinterpret the request for documents as a requirement or a refusal to register.

The NHS Standard Alternative Provider Medical Services Contract with GP surgeries states in clause 31.20 "The Contractor shall keep a written record of refusals of applications made under Clauses 31.8 to 31.12 and of the reasons for them and shall make this record available to the Commissioner on request" (p. 54). Yet, it is precisely the interactions described above that would not be reported because, from the reception staff member's perspective, there has been no refusal but instead a request for patients to return better prepared to register. As a result, there is no

oversight or accountability for practices that regularly send patients away without registering them in these invisible interactions.

## Accountability

GP surgery staff reported being unsure of what accountability mechanisms were in place, and none had experienced any negative feedback from the NHS concerning the practice of requiring ID or proof of address in order to register patients.

Several key informants at the ICS level noted that there is no clear accountability mechanism in contracts between the NHS and individual surgeries to respond to repeated incidents of incorrect refusal to register on the basis of a patient lacking ID or proof of address. This issue is compounded by the fact that there are invisible interactions that result in a patient not being registered, but which are never reported. In spite of a lack of clarity on this issue, two key informants noted that they believed that repeated refusals to register on this basis would constitute a breach of contract, but they had never heard of it being enforced.

> "The regulations and contract are not as clear and definitive as they could be in relation to new registrations. What we would like is more clarity on this, which would help with conversations with the practices and, if necessary, enable us to address this issue more formally with them."

Clause 31.17 of the NHS contract states, "The Contractor shall only refuse an application made under Clauses 31.8 to 31.16 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" (p. 53). These characteristics are drawn from the Equality Care Act of 2010. There is no mention of registering patients unable to provide ID or proof of address in this section and there is no reference to citizenship, immigration, or housing status as invalid grounds for refusal in either the contract or in the PGM.

> "If the person is coming from abroad, I really am not happy unless there's proof of ID…we don't absolutely have to have the ID and proof of address. So we're sort of on shaky grounds…there was somebody who wouldn't provide anything. And she [came back and] said, I don't have to provide any of this. So I just had to register."

As there is currently no clear activation of an accountability mechanism for repeated incorrect refusal to register on the basis of a patient being unable to produce proof of address or ID, it falls now to the patient or patient advocates to report and escalate on an individual basis. According to the practice managers we interviewed this rarely happens and, when it does, the patient is simply registered without any steps taken to address the problem on a larger scale.

## Recommendations for Solutions to Challenge 3

**5) Clarify or redevelop GP surgery contractual obligations to include accountability measures to ensure that staff register patients who are unable to provide ID or proof of address.**

A minor addition to the NHS contracts with GP surgeries to include reference to the duty to register patients regardless of their ability or willingness to produce ID or proof of address could lend greater weight to the guidance. It could further activate the potential for accountability mechanisms to be engaged in cases of repeated incorrect refusals to register on the grounds that the patient has not produced such documentation. This would clarify that such refusals are a breach of the contract with GP surgeries. Further, while Clause 31.17 mentions protected identities that may not be discriminated against in registration practices (p. 53), adding reference to immigration, citizenship, and housing status as invalid grounds for refusal could further contractually strengthen the obligation of surgeries to register without documentation. Finally, as practices are already expected to record refusals, a reiteration of this requirement and a monitoring mechanism within contracts could discourage refusals on the basis of being unable to provide ID and/or proof of address. On this point, greater clarity regarding what constitutes a refusal could help counteract "invisible" gatekeeping practices. It is important to note, however, that we recommend implementing these in combination with the other recommendations stated in this report to address the very real practical challenges GP surgery staff face. For this recommendation, the Mayor of London should advocate on behalf of London and London General Practice.

**6) In response to systemwide and multi-faceted pressures on primary care services, reassess current staffing levels and resources at GP surgery level.**

Staffing issues at GP practices are putting undue pressure on staff, including those responsible for registration. This fosters an environment in which surgeries prioritise resource-conservation practices, including additional layers of registration gatekeeping. Additional staffing resources would not only alleviate some of this pressure, but could allow for the dedication of more staff resources to support vulnerable patients through the registration process. The NHS may also find it beneficial to promote the rotation of surgery staff through various roles within a given surgery to increase staff's holistic understanding of service provision. This may encourage individual problem-solving, as well as serve to support greater staff retention. For this recommendation, the Mayor of London should advocate on behalf of London and London General Practice.

## Innovation

**Digital registration platforms offer potential solutions to some challenges of registering without an ID or proof of address, but should be closely monitored and not used exclusively.**

Increasingly, especially with the COVID-19 pandemic, many practices have moved to a digital registration option for prospective patients. In addition, a joint NHSX,

NHSD and NHSE programme has been set up to modernise the general practice registration process. The aim is to make registration simpler and easier for all patients so they get the care they need and for practices in reducing their administrative burden. A pilot of the new registration model including a digital option is currently underway to inform wider roll out.

The move to online registration and service provision has brought with it some possible improvements in the registration process for individuals without ID and proof of address, but is not without its drawbacks as an equalising development. Notably, an online registration process does not mean that patients are not asked for ID or proof of address, as they may be asked to upload them or present them physically at the GP surgery before their registration is complete.

> "[With COVID] we can still register patients without them coming to the practice and without them having to come and show ID, like it can literally all be done online now. So for us it's improved. There's obviously sometimes where people can't physically upload their ID, so they've had to come and show us and so forth"

Online registration presents a potential solution to registration barriers for people without ID or proof of address in that it standardises the interaction between the prospective patient and the GP surgery staff responsible for registration. Everyone seeking to register at a given surgery is asked the same questions, eliminating uneven application of soft gatekeeping measures. Further, it records an otherwise "invisible" gatekeeping mechanism, whereby a surgery staff member would agree to finish the registration for a patient when they return with documentation. This could potentially give a clearer picture of how often registration is attempted, and not completed. Finally, online registration may reduce the need for follow-up on the part of surgery staff as well as PCSE bounceback of registrations because patients fill out the information themselves, ensuring that no errors are made in communication with staff entering information into the system to submit to PCSE. This does not, however, eliminate the possibility of patient error.

In spite of these promising features of online registration, challenges do remain. Online registration processes are largely unstandardised. The vast majority of practices with online registration have developed their own digital platforms. These individually developed systems do not address existing issues with whether a practice's overall registration approach aligns with policy, and are inconsistent in terms of the information they request to complete a registration. Information requested online can also be inconsistent with the policy as enacted by a given surgery in practice. In some cases, this is due to a lack of updates to websites, especially in cases of changes in practice manager. In others it reflects a larger issue of noncompliance with NHS policy (see also Hodson, Ford, and Cooper 2019).

A review of five practice websites, selected at random from across London, found varying policies regarding proof of ID and address. Two requested that patients upload a photo or scan of documentation to complete registration. Two requested that the patient come into the surgery in order to show their documentation before their first appointment. In only one case did the website not request proof of identity and/or address. This is clearly not a representative sample, but does demonstrate the variation possible in online registration systems.

> "Not anymore, no, we stopped doing that [requesting ID and proof of address]. Obviously with COVID we were doing everything online then, and we've not really carried that back on now, because it's done online."

> "For registration online, we print it, we keep it with us for two weeks. And after one week, we'll give them a call and tell them we need these documents…and we can proceed with the registration."

Several other issues remain that feed into barriers to registration for people unable or unwilling to show ID and proof of address. First, language barriers remain a major issue for many patients, as online forms are widely only available in English. While the ability to use online translators and English-speaking friends or relatives to support the online registration process is made somewhat easier by the asynchronous nature of such registrations, there is a major opportunity missed as a once-and-done written translation is much simpler and cheaper for a surgery than using Language Line with its associated costs and waiting time. Second, digital exclusion is also a major issue. The ability to access the internet reliably and the digital literacy to know how to navigate it is not guaranteed for many. Finally, online registrations make immediate follow-up or clarification with a prospective patient more challenging for surgery staff. If they receive an online registration form that is incomplete or incorrect or need additional information to complete a registration, the staff member cannot ask the necessary question at the point of registration, but must follow-up.

> "We were asked to join a pilot that would push people towards online registering. And, and I just said no, because I know our population, it will be really inconvenient for them because of all the language difficulties, the literacy problems, and also the amount of chasing up we'd have to do when nothing matched up."

## Recommendations for Continued Innovation

### 7) Explore and monitor a standardised online approach to registration that does not require ID or proof of address.

Online registration systems have demonstrated that they have the potential to alleviate registration pressures around staff time as well as reduce PCSE bounceback. They could also possibly reduce some of the "invisible" gatekeeping of incomplete registration interactions. However, online registration systems need to be closely monitored to ensure that they do not continue to require elements contrary to the guidance, such as ID or proof of address, to complete a registration. Ideally, there would be a centralised online NHS system for registration to ensure compliance with policy, with translations of the GMS1 form elements for greater accessibility. For this recommendation, the Mayor of London should advocate on behalf of London and London General Practice.

# Conclusion

Our research provides insight into the systemic issues leading to barriers for GPs in registering patients without ID or proof of address in London. The overarching theme to emerge from this research is that there is not enough clarity and support for frontline staff who actually manage registrations, leading to a misunderstanding of guidance and perceived additional workload pressure. In short, the system as currently designed leaves too much at the feet of GP surgery staff to interpret and enact the guidance as currently written and communicated.

## Avenues for Further Research

Future research could more comprehensively explore some of the issues raised in this report in order to further illuminate causes and consequences of systemic conditions that result in incomplete registrations for people unable to provide ID or proof of address in London. First, better understanding of the scope of the problem would be valuable in determining how and where to most effectively implement the above recommendations. A survey assessment in particular could be useful to target pilot practices or boroughs for different interventions, but it's possible that recruitment/dissemination issues could hinder such an effort. Second, an exploration of the ways that theory concerning behavioural change in large organisations could be applied to this issue could be informative. Finally, continuing evaluation to assess how effective any new model is in practice would be invaluable and could offer insights useful beyond London.

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# Appendices

Appendix A: Recruitment Email

Appendix B: Semi-Structured Interview Guide

Appendix C: Ethics Statement

Appendix D: Informed Consent Form

# Appendix A: Recruitment Email

Dear Colleagues,

The Greater London Authority, on behalf of the Mayor of London, is urgently seeking to recruit general practice staff to participate in research exploring barriers faced by GP surgeries in registering new patients without proof of ID or address. Your participation will be invaluable in ensuring GP surgery staff experiences are fully represented in the work, and to contribute to developing recommendations for improved systems and guidance.

**The primary purpose of this project is to examine gaps and increase needed support to GP surgery staff to ease registering of patients, particularly amidst the many competing demands and priorities currently facing staff in their day-to-day service delivery.**

To help understand these barriers and give voice to GP surgery staff suggestions, the GLA have contracted Carlson Consulting to undertake a series of focus groups and one-to-one interviews to map GP surgery experiences in registering patients without ID or proof of address. The results of these interviews and focus groups, combined with a comprehensive desk review of existing policies and best practices, will be used in a final report to the GLA providing recommendations for any additional staff support that may be identified, and guidance changes as appropriate.

Carlson Consulting is therefore currently looking to recruit participants to take part in these interviews and focus groups. **We would like to hear from GP surgery staff across London who are responsible for either setting surgery policies around registration, or putting those policies into practice each day (such as GPs, practice managers, and receptionists) to learn from your experiences and hear your insights**.

**Participation is voluntary, confidential, and completely anonymous.**
Participants will be known only to the two independent consultants facilitating the interviews. Participant responses will be anonymised to ensure they do not contain any identifying information. Data will not be shared beyond the two consultants conducting the research, and will be destroyed upon completion of the project. Participation would last no more than 20-30 minutes, and will be conducted remotely via phone or Zoom. Timings can be arranged to be convenient for you.

**We are looking to start interviews on 7th February, and would greatly appreciate hearing from people interested in participating as soon as possible.** For more information (including details on confidentiality, anonymity, and data security), and/or to state your interest and arrange a time to participate, please contact Mallory Carlson at mcarlson.consulting@gmail.com.

We understand the continuing and massive demands on GP surgery staff time and resources, and greatly appreciate you taking the time to share your experiences and thoughts. Please do not hesitate to contact Carlson Consulting with any questions or concerns you may have.

# Appendix B: Interview Guide

**Commissioning Authority:** Greater London Authority on behalf of the Mayor of London

**Researchers:** Mallory Carlson of Carlson Consulting and Mollie Pepper, PhD

**Project Title:** GLA Scoping the systemic barriers which lead to unsuccessful GP registration attempts amongst Londoners

### INTERVIEW GUIDE

**Introductions and Verbal Informed Consent Process**

**Basic Info to collect:**

1. Practice geographical location (borough, specifically)

2. Role

3. Years in the role

**Semi-structured interview guide:**

1. Can you talk through your practice's new patient registration process and policy?

    a. What are your specific GP surgery's policies on registering without ID/address, and why?

2. What are the most common reasons for incomplete or declined registration in your experience?

    a. How does a patient's housing status impact their ability to register? Immigration status?

3. Have you ever encountered a new patient trying to register without an ID or proof of address, and how did you handle the situation?

4. Do you have any concerns about registering a new patient without ID or proof of address? If so, what are those concerns?

5. What do you think would help reduce the rate of declined or incomplete registration in these instances?

    a. How easy do you think it is for patients to provide this kind of documentation? Why would they be unable to?

6. How easy do you find it to adhere to NHS policy on registration? Do you feel the guidance is relevant, clear, and easy to follow?

7. How are registration policies communicated to you and by whom? How is national guidance implemented in your surgery?

**Additional Questions – if time allows**

a. The guidance indicates that a GP surgery may refuse registration to an individual on "reasonable grounds." What, in your understanding and experience, are examples of "reasonable grounds" for registration refusal?

b. In your experience, are registration difficulties occurring with first time registrants who do not have NHS numbers or also to people seeking to change surgeries who do have NHS numbers? What are the challenges associated with both situations?

# Appendix C: Ethics Statement

**Commissioning Authority:** Greater London Authority and the Mayor of London

**Project Title:** GLA Scoping the systemic barriers which lead to unsuccessful GP registration attempts amongst Londoners

**Consultants:** Mallory Carlson, Carlson Consulting and Mollie Pepper, PhD

## Methods Statement on Research Participant Wellbeing

## Prepared by Carlson Consulting

The protection of human subjects is of the utmost importance in the conduct of research. This statement details the anticipated potential risks to participants and the measures that will be taken to ensure no harm is caused by the research process.

Risks to participants in this research are minimal. The project does not involve the recruitment or collection of data from vulnerable persons at any point. All participants will be required to be of at least 18 years of age and we will not specifically recruit members of protected or vulnerable groups, though such individuals may volunteer to participate as a result of broader recruitment. Further, the research topic does not require divulging personal or sensitive information.

Anticipated potential risks include the following:

1. Risk of employer objection to employee participation and retribution.

2. Emotional distress resulting from participation in the research.

These risks have been carefully considered in the preparation of the research methodology for this project and we anticipate that several factors in the nature of the inquiry and the research design will mitigate these risks.

1. The research is positioned as seeking to support GP surgeries in executing their duties with regards to patient registration. As such, we anticipate any form of retribution or objection to be unlikely.

2. Research participation will be confidential. At no point will the researchers or the research participants be required to divulge the identities of any interview or focus group participant, or their GP surgery, to anyone beyond the consulting research team. The exception to this may be in the case of key informant interviews, where the participant may grant permission for their name or organisation to be attached to their input in the final report.

3. Research participation is exclusively voluntary. No individual will be compelled in any way to take part in the study and may withdraw their consent to participate at any time.

4. As the research does not deal in highly sensitive subject areas (such as trauma or negative personal experiences), we anticipate participant distress to be minimal to none. Participants will be asked questions regarding their

professional duties and experiences and will be approached from an attitude of allyship, rather than seeking to assign blame, which should assuage any concerns.

5. The interviews will only collect relevant and necessary data and will not deviate from the general themes covered in the initial interview guide. Any major changes will be submitted for review to the GLA.

6. Participants will be provided with the contact information for the researchers as well as our commissioning office, should they wish to make a complaint regarding the conduct of this research.

Informed consent is fundamental to the protection of the participants in this research study. To that end, we will ensure that several best practices are observed:

1. From the first contact for recruitment via email we will clearly communicate the purposes of the research, its confidential nature, and planned data usage and storage. This will be communicated in writing when scheduling interviews and again verbally at the beginning of each interview when we will ask for verbal consent.

2. A written document detailing informed consent will be distributed to all participants prior to the interview or focus group.

3. Participants will be informed that their participation is exclusively voluntary and that their consent, once given, can be withdrawn at any time and the interview will end without any repercussions.

4. Participants will be informed that the interview will be audio recorded and will give their verbal permission for this form of data collection. They will be informed that this permission may also be withdrawn at any time.

Data security is essential to ensuring that confidentiality is maintained. To that end, we will:

1. Keep all identifying information separate from any audio recording or transcript of interviews in a key that only the consulting researchers will have access to. This key will be stored in a password protected and encrypted file.

2. Store all data in an encrypted and password protected database. Only the consulting researchers will have access to this database.

3. Destroy all data at the completion of the project following the satisfactory delivery of the final report to the GLA.

Finally, having assessed potential risks and made plans to mitigate those risks, we have determined that the potential benefit to participants and society outweighs the potential risks.

# Appendix D: Informed Consent Form

**Commissioning Authority:** Greater London Authority on behalf of the Mayor of London

**Researchers:** Mallory Carlson of Carlson Consulting and Mollie Pepper, PhD

**Project Title:** GLA Scoping the systemic barriers which lead to unsuccessful GP registration attempts amongst Londoners

## INFORMED CONSENT

## INTRODUCTION

Hello, our names are Mallory Carlson and Mollie Pepper and we are consulting researchers commissioned by the Greater London Authority on behalf of the Mayor of London to conduct this research project. We are trying to learn more about the systemic barriers that lead to unsuccessful GP surgery registration attempts amongst Londoners, particularly due to lack of proof of ID or address. This interview will be used along with other interviews and research to write a report that will be submitted to the GLA to inform their policies and practices going forward. This report may be made publicly available but no identifying information such as your name or GP surgery details will be included in the report.

We invite you to take part in this research project by consenting to an interview. Choosing to talk with us is your choice alone and you should not be compelled by any other person or organisation to participate. You can decide at any time to stop talking with us today or to stop taking part in the research. If at any time we ask you a question that you do not want to answer, just tell us that you do not want to respond and we can skip that question. If at any time while we are talking you have questions for us you are invited to ask.

You will not receive any direct benefits from talking to us; likewise, as participation is voluntary there will be no consequences if you decide not to speak with us.

If you decide to take part in this research study, you will be asked to give your verbal consent.

## PROCEDURES

You must be at least 18 years of age to participate in this interview.

If you agree to speak with us, there will be one interview lasting 30-60 minutes. It will be conducted via phone or Zoom and scheduled at a time convenient to you. You may be interviewed by both consultants or only one, though in both cases collected data will be seen by both consultants, but no other parties

We will ask if you agree to the interview being audio recorded. We will audio record this interview only for use by the two research consultants. No one else will have access to your interview recording or any notes made during our conversation. You may choose not to have the interview recorded.

At the end of the interview we will ask if you agree to possibly be contacted again if we have further questions. If you consent, we will collect your preferred contact information, which we will keep separate from our notes about our meeting today. If you do not consent, we will not contact you again.

## RISKS & CONFIDENTIALITY

There are no foreseeable risks or discomforts to you for taking part in this study. We will maintain confidentiality for anything you tell us and I will not attribute what is said to you as an individual unless you give us express permission. We will keep your name and other identifying information separate from our notes about this interview and any other communications.

We will carefully protect the information we write and record with you by storing it in a password protected and encrypted database. Only the consultants conducting this research will have access to that database. At the conclusion of this project, all audio files, transcripts and notes will be destroyed.

At the end of this form we have included our contact information and contact information for our commissioning authority.

## BENEFITS

This study will be used to help us create more knowledge about the issues around GP registration refusal in London. There is no compensation for your time and you and your organisation will not receive any direct benefit from participating in this study. However, we intend that the information you share with us will be used to better support GP surgeries in the registration process in the future.

## PARTICIPANT CONSENT

1. Do you have any questions based on what I have explained to you?

2. Are you at least 18 years of age? [If no, thank you for your time]

3. Do you feel you have been fully informed concerning the purpose of the study with its risks and benefits, and do you agree to participate in this interview? [If no, thank you for your time.]

4. Noting that the audio files will be stored encrypted on a secure computer until the project is finished, when they will be deleted, do you agree to be audio recorded during this interview?

5. [At end of interview] Do you give me permission to contact you again about this study?

## CONTACT INFORMATION

If you have any questions about this study, please contact the consulting researchers:

● Mallory Carlson, Carlson Consulting: mcarlson.consulting@gmail.com

● Mollie Pepper, PhD, Mollie Pepper Consulting: mpepperconsulting@gmail.com

If you have any questions about your rights in this research or concerns about its conduct, please contact a representative at the Greater London Authority:

● Ella Johnson, Citizenship and Integration Project Health Advisor: Ella.Johnson@london.gov.uk

**\*\*\*We thank you sincerely for your time and input\*\*\***