London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee Agenda

Wednesday 27 March 2024 at 7.00 pm

145 King Street (Ground Floor), Hammersmith, W6 9XY

Watch live on YouTube: youtube.com/hammersmithandfulham

MEMBERSHIP

Administration	**Opposition**
Councillor Natalia Perez (Chair) Councillor Genevieve Nwaogbe Councillor Emma Apthorp Councillor Ann Rosenberg	Councillor Amanda Lloyd-Harris
Co-optees	
Victoria Brignell, Action On Disability Lucia Boddington Jim Grealy, H&F Save Our NHS Keith Mallinson, Healthwatch	

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Members of the public are welcome to attend but spaces are limited, please email Amrita.White@lbhf.gov.uk if you plan to attend. The building has disabled access.

Date Issued: 19 March 2024

Health and Adult Social Care Policy and Accountability Committee

If you would like to ask a question about any of the items on the agenda, please email Amrita.White@lbhf.gov.uk by 12pm, 26 March 2024

Item **Pages**

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Standards Committee.

3. MINUTES OF THE PREVIOUS MEETING 4 - 11

To approve the minutes of the meeting on 31 January 2024 as an accurate record and note any outstanding actions.

4. SAME DAY ACCESS TO GP PRIMARY CARE 12 - 29

This report presents a briefing paper on the current state of primary care access across North West London following recent changes to GP contracts and plans to improve same day access to primary care for patients. The briefing paper was originally produced for the North West London Joint Health Overview Scrutiny Committee meeting on 14 March 2024 and is presented for information.

Representatives from NHS North West London will provide an updated presentation for discussion at the meeting.

5. WORK PROGRAMME

For the Committee to suggest items for the work programme.

6. DATES OF FUTURE MEETINGS

To note the following dates of future meetings:

- 17 July 2024
- 13 November 2024
- 29 January 2025
- 28 April 2025

London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee

Minutes

Wednesday 31 January 2024

PRESENT

Committee members: Councillors Natalia Perez (Chair) and Genevieve Nwaogbe

Co-opted members: Victoria Brignell (Action On Disability) and Jim Grealy (H&F Save Our NHS)

Other Councillors
Councillor Ben Coleman (Deputy Leader and Cabinet Member for Health and Social Care)
Councillor Rowan Ree (Cabinet Member for Finance and Reform)

Officers
Jo Baty (Director of Independent Living, Strategy, Standards and Regulation)
Dr Nicola Lang (Director of Public Health)
Sukvinder Kalsi (Strategic Director of Finance)
Prakash Daryanani (Head of Finance, Social Care)
David Abbott (Head of Governance)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Ann Rosenberg, Councillor Emma Apthorp, Councillor Amanda Lloyd-Harris, Lucia Boddington and Keith Mallinson.

Victoria Brignell joined the meeting remotely.

The Chair noted that the meeting was inquorate. Members agreed to hold the meeting as an informal meeting.

2. DECLARATION OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

Matters arising

Jim Grealy noted that at a previous meeting members discussed ongoing delays to the rebuilding of Charing Cross, Hammersmith, and St Mary's Hospitals and the healthcare impacts on residents. He told the Committee that, at a recent meeting of North West London NHS Trusts, the Chief Executive of Imperial College Healthcare NHS Trust said no new money had been offered to the Trust for either refurbishment or rebuild. In light of this, Jim Grealy felt the Committee should write to Matthew Swindells, Chair of the Board at Imperial College Healthcare NHS Trust, to express the Council's concerns about the funding situation and the impact on health care provision in the borough. The Chair agreed and asked Linda Jackson to help draft a letter.

ACTION: Linda Jackson

RESOLVED

The minutes of the meeting held on 15 November 2023 were agreed as an accurate record.

4. 2024 MEDIUM TERM FINANCIAL STRATEGY

The Chair noted that the first part of the item would be devoted to the Council's corporate budget and the second part would cover the Adult Social Care and Public Health departmental budget proposals.

Corporate Budget

Councillor Rowan Ree (Cabinet Member for Finance and Reform) introduced the item that detailed the proposals for the 2024/25 revenue budget – including the risks, financial resilience, and impact of those proposals.

Councillor Ree noted that it had been a difficult time for local government, with central government grant reductions and high inflation, but despite the constraints, the Council had delivered a balanced budget that protected core services and continued funding for the areas that were unique to borough such as free home care, universal free school breakfasts, and the Law Enforcement Team. He said this had been achieved through ruthless financial efficiency and reforming how services were delivered. He thanked Sukvinder Kalsi, the finance team, officers across departments, and his Cabinet colleagues for making that possible.

Sukvinder Kalsi (Strategic Director of Finance) gave a short presentation on the corporate budget. He highlighted the following:

- The difficulties of the operating environment including high inflation, pressures on household budgets, new legislative burdens, and uncertainty around local government funding.
- The key objectives of the financial plan were to protect statutory services, deliver services valued by residents, ensure people's safety, promote prosperity, and be a modern and innovative Council with strong financial governance and resilience.

- That council tax would increase by 4.99%, but an estimated 93,000 households in the borough would not pay the full amount due to discounts and exemptions.

The Chair thanked Councillor Ree and officers for delivering a budget that protected the most vulnerable residents.

Jim Grealy asked how sustainable it was to keep finding efficiencies year after year. He also asked how the budget would be communicated to residents. Councillor Ree said local government was not a priority for central government, as they continued to force councils to make savings without taking responsibility. He noted that the financial settlement from central government used to be delivered in November and cover multiple years, to help councils plan ahead. In the past six years the settlement had covered only one year at a time and had been delivered at the end of December, making the budget setting process far more difficult. Regarding sustainability, he said the Council had cut £118m from the budget over the last nine years and that couldn't continue forever. He felt there needed to be a change in the way in way local government was funded.

Jim Grealy said it was important to find a way of showing residents the challenge of setting the budget and how the Council was managing more duties with fewer resources. Councillor Ree agreed and noted that the Council communicated budget setting through public meetings like the Policy and Accountability Committees, Councillors engaging with residents, and the council tax booklet.

Merril Hammer (Hammersmith & Fulham Save Our NHS) felt the Council could do more to highlight the services unique to the borough such as free home care. Councillor Ree said there was always more that could be done in this area, but noted the Council had to be careful with its resources. Councillor Ben Coleman noted that, often the most effective messaging came from residents themselves and encouraged people who were passionate about these services to post about them on social media.

The Chair noted the uncertainty around the Household Support Fund, a £2.8m central government grant used by the Council for its cost-of-living response, and asked if there was any word of a continuation or replacement. Councillor Ree said it was very important funding, but it would be gone in March. The Council had committed £1m in the budget to put towards the response. He noted there may be additional money in the Chancellor's Spring Budget, but the detail wouldn't be released until the 8th of March 2024 and the Council had to set its budget in February.

The Chair asked for more information on the role of the independent auditors mentioned in the report. Councillor Ree explained that the Council had an external audit process currently delivered by Grant Thornton, who provide a detailed audit report to the Council's Audit Committee. He noted they had recently said Hammersmith & Fulham was one of the best run councils in London. Sukvinder Kalsi added that the role of the external auditors was to

provide assurance to members, residents, contractors, and other businesses the Council works with.

Departmental Budget

Councillor Ben Coleman (Deputy Leader and Cabinet Member for Health and Social Care) introduced the budget proposals for the services covered by the Committee. He noted that it had been a very difficult year due to the lack of support, lack of adequate funding, and problems created by Central Government. He thanked Linda Jackson, Jo Baty, Dr Nicola Lang, Prakash Daryanani and their teams, and said he was impressed by the way they had worked to find additional funding for social care and protect home care.

Jo Baty (Director of Independent Living, Strategy, Standards and Regulation) gave a presentation on the department's vision and priorities. She noted the Council's vision of "working compassionately with residents so that they enjoy independent, healthy and fulfilling lives". She then highlighted the following areas of focus:

- Quality and assurance of services
- Digitalisation and artificial intelligence
- Better utilisation of assets to meet increasing demand
- Workforce transformation and integrated workforce development
- Collaboration with Children's Services for transitioning residents reaching adulthood
- Working with Housing Services

Jo Baty then discussed some of Social Care's key achievements:

- A new co-produced service offering day opportunities for independent living for adults with complex autism.
- Achieving Dementia-Friendly Community status from the Alzheimer's Society.
- Establishing an all-age Autism Partnership Board to co-produce improvements to services and support for neurodiverse residents and their families.
- Working with Action on Disability and Strategic Co-production leads to launch the new Independent Living Delivery Group.
- Improving transitioning young people into adulthood.
- Receiving 174 compliments since April 2023 from residents.

Jo Baty gave an overview of the pressures on Social Care, including workforce issues caused by Covid-19, the focus on rapid discharges from hospital, delays in elective surgeries, the lack of a long-term funding model, demographic pressures, and issues of sustainability for care providers.

Prakash Daryanani (Head of Finance, Social Care) gave a presentation on the social care spending plan. He noted that the department has a gross budget of £114.08m, and the Council proposed an increase of £7.6m in 2024/25 (£4.8m investment, £3m inflation, £1.4m additional grants and (£1.6m) of savings).

He noted that over the last two years there had been significant increases in spend in Home Care and Care Homes due to residents being discharged

early from hospital, with greater acuity of need, and uplifts in the minimum living wage. He also noted there had been a steady increase in direct payments year on year.

Dr Nicola Lang addressed the Committee and highlighted recent Public Health achievements, including:

- Procurement of a new integrated drug and alcohol service, co-designed and evaluated by residents.
- The launch of 'Beat the street,' an evidence-based programme of physical activity to promote walking in children and reduce childhood obesity.
- Commissioning of The Listening Place to do expert, bespoke suicide prevention work.
- An innovative education and empowerment programme to promote uptake of flu and Covid vaccines in nursing home staff.
- An in-house infection prevention and control nurse, leading on environmental audits, and designing new safety systems.
- Working with mental health trusts and substance misuse services to build an innovative model of bespoke specialist mental health and dual diagnosis expertise for hostels and mental health supported accommodation.

Victoria Brignell asked if keeping council tax relatively low compared with many other authorities had an impact on the support that could be provided to people. She also asked about the sustainability of the Council's commitment to free home care. Councillor Ree explained that increases in council tax were capped each year at 2.99% and an additional 2% for the social care precept. The Council was increasing council tax by the full amount allowed this year. He noted that the Council had to balance the desired amount of funding with the amount of money residents could afford.

Councillor Coleman said the commitment to free home care required a strong political commitment and careful management of finances. He noted that Hammersmith & Fulham had an advantaged position, with the third highest land values in the country, and the Council used that to benefit residents. He recognised not all councils could do that. He added that H&F Council also provided a subsidised 'daily meals and a chat' service – for which it had not increased the price in nine years.

Merril Hammer noted that there was a national campaign for a national support and independent living service which had publicised that H&F offered free home care.

Jim Grealy asked if the NHS were coming back with budget proposals to the Council, given that the Council was saving them money by providing complementary services. Jo Baty said the Council's partnership with the NHS was developing well. The new neighbourhood model avoided unnecessary meetings and allowed for earlier intervention. She said it was an effective partnership model.

Councillor Coleman noted the point and said if the Council saved the NHS or the police money they would not be compensated. But he noted that since the Covid-19 pandemic, the Council and the NHS had worked better together. There were challenges because the NHS was trying to make operational cost reductions which could have an impact on council services. He felt both parties needed to work to understand each other better.

Jim Grealy asked if the new neighbourhood teams were cost heavy.
Jo Baty said the NHS had funded additional posts – two social workers and a part time post in the Housing team. She explained that housing was a common denominator and said there were further opportunities for joint posts to unblock issues there.

Jim Grealy noted that Imperial College Healthcare NHS Trust had complemented the Council's approach to discharge and saw it as a model for other councils to adopt.

The Chair asked how complaints were analysed and used to improve services. Jo Baty said Adult Social Care carried out deep dives of service areas then brought officers together to look at data, including quality, risks, trends, and benchmarking with other councils. Complaints were themed and an annual report went to a senior manager meeting. Learning then informed operational practice.

Jim Grealy noted the work some NHS Trusts were doing to identify different communities and asked if the Council could do something similar to see who was being supported and where the gaps were. Prakash Daryanani said officers could look into that. Currently, ethnicity data was requested from users through the case system, but it was not mandatory to provide it.

ACTION: Prakash Daryanani

The Chair brought the discussion to a close and thanked members and officers for their contributions. She then summarised the achievements of the budget, notably that H&F was the only council in the country that provided free home care.

RESOLVED

1. That the Committee considers the budget proposals and makes recommendations to Cabinet as appropriate.

2. That the Committee considers the proposed changes to fees and charges and makes recommendations as appropriate.

5. PUBLIC HEALTH UPDATE

Dr Nicola Lang (Director of Public Health) addressed the Committee and gave a presentation on work to improve vaccination rates. She noted that her team had more staff to work on measles. She discussed hesitancy around the

MMR vaccine. An NHS exercise in Autumn 2023 to contact parents who had not elected to have their children vaccinated resulted in just 10 children being vaccinated. Since then, the team had been working closely with different community groups to improve take-up rates.

Dr Lang also noted that the Public Health team had questioned local data and raised concerns with the NHS that vaccinations for school-age children, and hospital vaccination work was not being recorded consistently on GP records. If confirmed, that would account for some of the low vaccination levels.

Jim Grealy asked if any progress had been made with pharmacies, and if not what the blocker was. Dr Lang said the pharmacies were keen to start delivering vaccinations, but systems and governance were issues. But she was confident that would change, and noted the issue was rising on the national political agenda.

Councillor Coleman said he had raised this issue at a recent ICB meeting and was told progress was being made. Dr Lang said although the issue hadn't moved forward – the willingness was there but the systems were not in place. Councillor Coleman felt the partners should identify the difficulties and overcome them.

The Chair highlighted the actions from the last meeting and noted the efforts to improve the borough's vaccination rates.

6. WORK PROGRAMME

Merril Hammer (Hammersmith & Fulham Save Our NHS) suggested an item on how the Health and Care Partnership was working, with particular focus on their efforts around co-production and engagement with residents. Councillor Coleman agreed and felt it should be a joint paper produced by the Council and the NHS. He also said it would be helpful to have some questions members would like addressed to help prepare the report.

ACTION: David Abbott

Victoria Brignell suggested an item on disabled people's access to healthcare. It was suggested that Action on Disability could be commissioned to gather data to support the item.

RESOLVED

1. The draft work programme, with the additions noted above, was noted.

7. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 27 March 2024

Meeting started: 7.02 pm
Meeting ended: 9.30 pm

Chair .....

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LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Adult Social Care Policy and Accountability Committee

Date: 27/03/2024

Subject: Same Day Access to GP Primary Care

Report author: David Abbott, Head of Governance

SUMMARY

This report presents a briefing paper on the current state of primary care access across North West London following recent changes to GP contracts and plans to improve same day access to primary care for patients. The briefing paper was originally produced for the North West London Joint Health Overview Scrutiny Committee meeting on 14 March 2024 and is presented for information.

Representatives from NHS North West London will provide an updated presentation for discussion at the meeting.

RECOMMENDATIONS

1. To review and comment on the plans to improve primary care access.

Wards Affected: All

Background Papers Used in Preparing This Report

None.

LIST OF APPENDICES

Briefing note – North West London Primary Care and Same Day Access to GP Primary Care
Appendix 1 – Changes to the GP Contract Letter
Appendix 2 – Same day access stakeholder briefing

Request for Report to the North West London Joint Health Overview Scrutiny Committee

14 March 2024

Report Title:	North West London primary care and same day access (SDA) to GP primary care
Report Author:	Javina Seghal – Director of Primary Care
Committee Date:	**14 March 2024**
Report Deadline:	**04 March 2024**

Purpose

To receive a report on the current state of Primary Care Access across North West London following recent changes to GP Contracts.

Highlighting details of same day access to GP primary care

- The scope and rationale for identifying the SDA initiative as an effective method for access to GP Primary Care
- A comprehensive timeline providing information from the initial decision taken to go ahead with this initiative to the recent announcement to roll out across NW London in April
- Details on the consultation and engagement that has taken place with GPs, medical professionals, patients and residents across NW London, local government, NHS clinical senate, Mayor of London, and other partners
- Details of all the pilots taken place, including locations, durations, and evaluations
- Information on the consultants or agencies used by the NHS and ICS to advise them on this initiative and what actual recommendations were made
- Financial, estate, staff, equality, and other implications on delivering the initiative
- The risks that have been identified through consultation and advice sought and what mitigations are in place to address these.

Background:
Current state of Primary Care Access across North West London following recent changes to GP Contracts.

Each year the ICB receive a summary of the changes to the GP contract, the attached letter sets out these for 23/24. The summary changes for 24/25 have not yet been issued.

The Investment and Impact Fund (IIF) and quality outcomes framework (QOF)- incentives are being consulted on and there are currently no changes to what was proposed since last year. More details on IIF and QOF can be found here:
Report template - NHSI website (england.nhs.uk) IIF 23-24
NHS England » Quality and outcomes framework guidance for 2023/24

Our current main focus in primary care is improving access and this paper focuses on our same day access work.

Detail - What is same day access?

NHS North West London is introducing an ambitious but achievable plan to improve same day access to primary care for patients.

This approach was co-developed by 10 primary care networks (PCNs-6 individual PCNs and 1 whole borough) between August and December 2023. The approach is aligned to the recommendations set out in the national 'Fuller Stocktake' review of primary care.

The new approach sees the introduction of 'same day access hubs' across North West London. Patients contacting their GP surgery either online or by telephone may be directed to the same day access hub for triage to the right service for their needs. This is an approach that will evolve over time but ultimately, patients may have telephone, online, video or face to face contact with staff at the hub, who will direct them to the right place.

This could be a community pharmacy, a routine appointment with their GP or an urgent appointment with their GP. Where appointments are not available with their own GP or the patient will get easier access, they may be directed to a neighbouring practice.

Hubs can be either physical or virtual and will usually be managed through the local PCNs, with each hub including a senior GP. All clinical decisions will have a senior clinical decision making and GP lead, with support from a multi-disciplinary team.

How the hubs work

Same day access hubs bring GP practices together in networks, making it easier to arrange appointments the same day and to support patients in finding the care that is best suited to their needs. Patients who need a GP appointment that day are more likely to get one and GPs will be able to focus on providing proactive care to patients who need it. Where appropriate, patients may be referred to other services best suited to their needs, such as community pharmacists, physiotherapists or nurses. GPs will continue to see patients who need to see them and will be able to offer proactive continuity of care to people with long term conditions and others who need it.

This approach ensures patients needing primary care services that day are more likely to be looked after in the quickest way. The plan is for this to apply to same day cases only.

Primary care access is the issue most consistently raised by North West London residents we speak to about health services. We have launched a public information campaign called *We Are General Practice* in order to explain how primary care is changing, the challenges it faces and some of the new roles and proposed solutions to improve access and care for patients.

Same day access hubs form part of our 'single offer' to general practice, which aims to introduce a consistent approach to enhanced care across North West London. If practices are not part of same day access hubs, their patients may not be able to access other parts of the single offer, such as specialist diabetes and mental health care. Same day access hubs are not mandated, but we are recommending them to practices and they are part of our single offer as this will help them deliver better access for all the PCNs patients.

Clinical decision making

All clinical referrals and clinical decisions will be made by clinicians and patients will still be able to see their GP.

Staff in supporting roles like care navigators and co-ordinators will signpost patients to the right care for them. They will work in an identical way to how they work in practices now, but with greater clinical oversight as the same day access hubs will all include senior GPs and multi-disciplinary teams and with a better understanding of the types of services that might support their population's needs.

Clinical safety remains our top priority. Clinical consultations will still occur with qualified health professionals and these will be appropriately supervised by senior clinicians.

Decisions made by the same day access hubs will happen with the oversight of the senior clinical decision maker.

By streamlining the way patients achieve access we aim to enable more patients to seek advice and treatment, improving the care patients receive.

Experience of early adopters

The primary care networks who were early ('wave 1') adopters reported that they have been able to provide their most complex patients with increased access and time with their GPs as the simpler requests have been managed by signposting to other parts of the system. Patient experience reports have been positive.

KPMG provided programme management support and shared good practice from elsewhere, supporting PCNs and NHS North West London as they developed their approach, which is closely aligned to the recommendations of the national 'Fuller Stocktake' of primary care, led by Dr Claire Fuller.

The primary care networks are:

- Northolt PCN – Ealing - went live 13 November 2023
- Harness North and South PCNs – Brent – went live 11 December 2023
- Harrow East PCN – Harrow – went live 18 December 2023
- Healthsense PCN – Harrow – went live 30 October 2023
- North Connect PCN – Hillingdon – went live January 2024
- Westminster borough (Central London boroughs 4 PCNs)

Engagement

As part of the on-going programme both with wave 1 and wider PCNS we are working with the community and stakeholders and taking learning forward. We are only just starting work with the remaining PCNs so it is very early days and our engagement will be on-going.

Our primary care work is informed by insights from our ongoing community engagement programme. The 'We are General Practice' Communications campaign in 2023 was designed to support residents to understand how they can access general practice services.

A briefing on same day access has been shared with residents and stakeholders and is available on the ICB website.

Improving same day access to primary care :: North West London ICS (nwlondonicb.nhs.uk)

Primary care networks are asked to work with patients and carers as they implement same-day access from April 2024, and we will continue to support them with insights from general and targeted engagement with residents. The ICB is setting up a residents' forum in March when this topic will be on the agenda. It is also planning targeted community engagement with visually impaired people, people with learning disabilities and with traveller communities to ensure understanding of particular issues for these groups in relation to same-day access plans.

What will happen on 1 April

There is a misapprehension that everything will change on 1 April, whereas our intention is to introduce new ways of working gradually, managed at local level by PCNs. The aim is that practices and PCNs are given time to co-design and collaborate with colleagues and patients to help this way of working improve primary care access. We know that this will take

time and will be a gradual process as each PCN profile is different. There will be no expected radical change but an adopting of new ways of working over time.

Practice workforce

We are flexible about how the plan is delivered. Care coordinators will be trained to signpost patients to the right care; this could be from their own practice in a virtual hub if that is the preferred local approach, or from a physical hub at an agreed location. The means of delivery is a matter for PCNs to decide locally and in a way that works best for local people.

Practices are already working collaboratively at scale to deliver out of hours care or that patients are already being signposted to other members in the primary care systems

Timeline

- Fuller Stocktake review May 2022

  Throughout 2023:

- NHS delivery plan - recovering access to primary care
  Good practice in primary care – collated national and local examples of good practice

- Current state analysis – extensive stakeholder engagement, identifying key challenges, opportunities and enablers across the system

- We are general practice public campaign launch

- System-wide access workshop

- Wave 1 programme – co-design/trial across 10 PCNs – lessons learned informing future implementation planning.

Member Request:	**Cllr Ketan Sheth, Committee Chair, January 2024**

To:
- All GP practices in England
- Primary Care Network Clinical Directors

cc.
- ICB Primary Care Leads
- ICB Chief Executives
- Regional Directors
- Regional Directors of Commissioning
- Regional Directors of Primary Care and Public Health
- Regional Heads of Primary Care

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 March 2023

Dear colleagues,

Changes to the GP Contract in 2023/24

1. We recognise and appreciate the incredibly hard work of general practice during this period of sustained significant pressure. The past few years have demonstrated the dedication of practice and Primary Care Network (PCN) teams in innovating and responding to the needs of their populations. In January 2023 General Practice delivered 30m appointments, an increase of 11% on January 2020, a testament to the incredible work of GP teams.

2. 2023/24 is the final year of the 5-year framework agreement which was set out in *Investment and Evolution*. Over the course of 2023/24 NHS England will engage with the profession, patients, ICSs, government and key stakeholders, building further on the Fuller Stocktake from May 2022 which set out the next steps towards integrating primary care. In response to feedback from practice teams, GPC England and the Health and Care Select Committee on the Future of Primary Care, in 2023/24 the profession and representative patient groups will be consulted on the Quality and Outcomes Framework (QOF) and its future form.

3. The Chancellor in his Autumn Statement set out a commitment to publish a recovery plan for General Practice access in early 2023. The Delivery Plan for Recovering Access to Primary Care will be published shortly and sets out how practices and PCNs can be supported to improve access during 2023/24 building on the contract changes outlined in this letter and expanded in Annex A.

4. The changes to the GP contract in 2023/24 set out the requirements of General Practice and PCNs with the goal of improving patient experience and satisfaction and we recognise that this will require both time and support to assess, review and implement changes. We intend to provide this support in a number of ways outlined below including freeing up workforce capacity through significant changes to the Impact and Investment Fund (IIF) and through the QOF Quality

Improvement (QI) modules. Further support for practices and PCNs will be outlined in the recovery plan.

Access requirements

5. **Offer of assessment will be equitable for all modes of access:** To ensure consistency in the access that patients can expect, the GP contract will be updated to make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice. Practices will therefore no longer be able to request that patients contact the practice at a later time. The IIF focus on access will support practices and PCNs working towards achieving this during 2023 recognising the changes that will need to be made.

6. **Prospective (future) record access to be offered by 31st October 2023:** To make it easier for patients to access their health information online without having to contact their practice, the GP contract will be updated so new health information is available to all patients (unless they have individually decided to opt-out or any exceptions apply) by 31 October 2023 at the latest. This builds on the 1,400 practices that are already automatically offering this access, with 6.5 million patients already able to see their prospective records. NHS England will continue to provide support to practices as more patients gain online access to their records. Support will continue nationally and through commissioners to enable practices to make this offer to all their patients.

7. **Mandate use of the cloud based telephony (CBT) national framework:** All practices need to be aware, that from the end of 2025, all analogue ISDN and PSTN lines will be removed for use in all home and business settings. From this point, only cloud-based platforms will be supported. Digital telephony (CBT) provides greater functionality for practices and patients. This includes call queueing or call back which provide a better patient experience when the lines are busy as well as management information and data to support practices gain insight and improve their responsiveness further.

8. Background research and pilot studies have demonstrated how challenging it can be to navigate the telephony market for practices and understand the offers. A Better Purchasing Framework (BPF) has been developed by NHS England to provide recommended suppliers and assure value for money. As part of the 2023/24 GP contract changes, practices will be required to procure their telephony solutions only from the framework once their current telephony contracts expire. The Delivery Plan for Recovering Access to Primary Care will describe further support available for practices who indicate they are interested in making this move in 2023/24.

Changes to Impact and Investment Fund and QOF QI modules

9. The number of indicators in the IIF will be reduced from 36 to five (worth **£59m**) and will focus on a small number of key national priorities: two indicators related to flu vaccinations, learning disability health checks, early cancer diagnosis and 2-week access indicator.

10. The remainder of the IIF will now be worth £246m and will be entirely focused on improving patient experience of contacting their practice and receiving a response with an assessment and/or be seen within the appropriate period (for example same day or within 2 weeks where appropriate, depending on urgency). 70% of the total funding, equating to £172.2m, will be provided as a monthly payment to PCNs during 2023/24 via the Capacity and Access Support Payment.

11. The remaining 30% of the total funding, equating to £73.8m, will be assessed against an access improvement plan agreed with the commissioner in quarter 1 of 2023/24. At the end of March 2024 ICBs will assess for demonstrable and evidenced improvements in access for patients and then award funding. ICBs will be provided with guidance to assist in determining the appropriate payment.

12. In 2023/24, all the QOF register indicators points will be awarded to practices, based on 2022/23 outturn once finalised, releasing £97m of funding and reduce the number of indicators in QOF from 74 to 55 (a reduction of 25%). Two new cholesterol indicators (worth 30 points~£36m) will be added to QOF along with a new overarching mental health indicator. One indicator (AF007) will be retired and replaced with a similar indicator from IIF in 2022/23.

13. This year's QOF QI modules will focus on workforce wellbeing and optimising demand and capacity in General Practice with an emphasis on using data to analyse potentially avoidable appointments and build on care navigation and use of wider workforce or local services to reduce pressure on General Practice.

Increased flexibility of ARRS

14. Recruitment through the Additional Roles Reimbursement scheme (ARRS) has been strong, and as of 31 December 2022 stands at 25,262 additional FTE. PCNs are on track to meet the 26k target for March 2024 over a year early. Staff are providing significant numbers of additional appointments, improving patient access to general practice, and providing personalised, proactive, care for the populations that they serve. To support PCNs to recruit the teams that they need, there are a number of changes to the ARRS, including adding Advanced Clinical Practitioner Nurses to the reimbursable roles, increasing the cap on Advanced Practitioners to three per PCN and removing the caps on Mental Health Practitioners.

15. During 2023/24 NHS England will review the ARRS to ensure that it is tailored to deliver future ambitions for general practice. Staff employed through the scheme will be considered part of the core general practice cost base beyond 2023/24 as previously confirmed, and PCNs can offer permanent contracts where appropriate. We encourage PCNs to continue to recruit, making full use of their ARRS entitlement.

Immunisations and Vaccinations

16. Following feedback from PCNs and GPC England, there will be changes to childhood vaccinations. These include the removal of the vaccination and immunisations repayment mechanism for practice performance below 80% coverage for routine childhood programmes along with changes to the childhood vaccination and immunisation indicators within QOF which will see the lower thresholds reduced to 81% - 89% (dependent on indicator) and the upper thresholds raised to 96%.

17. In recognition of the current workload pressures in general practice, no additional requirements will be added to the PCN service specifications in 2023/24. NHS England will instead publish guidance which will suggest best practice to PCNs.

18. Further details on the 2023/24 changes will be published ahead of April including a revised Network Contract DES specification. If any changes are required to commissioner allocations, we will adjust this through the regular allocations update process.

Yours sincerely,

Dr Amanda Doyle OBE, MRCGP
National Director for Primary Care and Community Services
NHS England

Annex A – changes to the GP Contract in 2023/24

Changes to the GP Contract Regulations

Access

1. To ensure consistency in the access that patients can expect, the GP contract will be updated to make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice.

Patient access to their medical records

2. The GP contract regulations will be amended so that patients have online access to their prospective medical records (unless they have individually decided to opt out or any exceptions apply) by 31 October 2023 at the latest.

3. The existing requirements in the GP contract regulations relating to providing online access to historic coded and full records will also be amended so that they are consistent with access to information under the GDPR. Amendment of these existing requirements will also provide clarity on how practices are required to offer, promote and provide online access to patient records.

Supporting Cloud Based Telephony

4. Practices will be required to procure their telephony solutions only from the Better Purchasing Framework once their current telephony contracts expire.

Simplification of GP registration requirements

5. In order to support the simplification of GP registration requirements, the term ’medical cards’ will be removed from the GP contract regulations.

GP retention scheme

6. The four-session cap within the GP retention scheme was lifted during the pandemic and will now be removed permanently. Sessions worked above the cap will be funded by the employing general practice. Any further potential changes to the scheme will be picked up as part of the current review of GP recruitment and retention scheme being led by NHS England.

The Additional Roles Reimbursement Scheme (ARRS)

7. In 2023/24 the following changes will be made to the ARRS:

    a. increasing the cap on Advanced Practitioners from two to three per PCN where the PCN’s list size numbers 99,999 or fewer, and from three to six where the PCN’s list size numbers 100,000 or over.
    b. reimbursing PCNs for the time that First Contact Practitioners spend out of practice undertaking education and training to become Advanced Practitioners.
    c. including Advanced Clinical Practitioner Nurses in the roles eligible for reimbursement as Advanced Practitioners (APs).
    d. introducing apprentice Physician Associates (PAs) as a reimbursable role.

e. removing all existing recruitment caps on Mental Health Practitioners, and clarifying that they can support some first contact activity.
f. amending the Clinical Pharmacist role description to clarify that Clinical Pharmacists can be supervised by Advanced Practice Pharmacists.

8. During 2023/24 the ARRS will be reviewed to ensure that it remains fit for purpose and aligned to future ambitions for general practice.

Changes to the PCN service specifications

9. In recognition of the current workload pressures in general practice, no additional requirements will be added to the PCN service specifications in 2023/24. NHS England will instead publish guidance which will suggest best practice to PCNs.

Enhanced Access

10. Following feedback from GPC England, NHS England has agreed to review the enhanced access requirements in 2023/24 once PCNs have had the opportunity to operate for several months, and to enable links into the wider conversations on urgent and emergency care.

Investment and Impact Fund (IIF)

11. The following changes will be made to the IIF in 2023/24:
    - the number of indicators will be reduced to five to support a small number of key national priorities: flu vaccinations, learning disability health checks, early cancer diagnosis and 2-week access indicator. The value of these indicators will be £59m.
    - the remainder of the IIF will now be worth £246m and will be entirely focused on improving patient experience of contacting their practice and being assessed and/or seen within the appropriate timeframe (for example same day or within 2 weeks where appropriate).
    - 70% of the total funding, equating to £172.2m, will be provided as a monthly payment to PCNs during 2023/24, similar to monthly QOF aspirational payments.
    - the remaining 30% of the total funding, equating to £73.8m, will be assessed against ‘gateway criteria’ at the end of March 2024 by ICBs and paid to PCNs for demonstrable and evidenced improvements in access for patients.

12. The Learning Disability Health Checks Indicator will be amended by adding a requirement to record the ethnicity of people with learning disabilities.

13. A Personal Care Adjustment (PCA) will be added to the indicator on FIT testing (CAN-02) so that PCNs are not being incentivised to refer for FIT testing when there is rectal bleeding. Additional support will be provided where practices are struggling to access tests. This will involve setting up a national ‘supply chain’ escalation system that any GP practice can contact if local supply issues arise.

Additional support is available from the regional cancer alliance to fund FIT kits where needed.

Quality and Outcomes Framework (QOF)

14. QOF will be streamlined in 2023/24 by income protecting all register indicators. This will release £97m of funding and reduce the number of indicators in QOF from 74 to 55 (a reduction of 25%). Funding will be paid to practices based on 2022/23 performance monthly once the 2022/23 QOF outturn is finalised.

15. Two new cholesterol indicators (worth 30 points~£36m) will be added to QOF along with a new overarching mental health indicator. These will be funded by retiring indicator RA002 (the percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months) and reducing the value of DEM004 (annual dementia review). The mode of review of DEM004 will also be amended to be determined through shared decision making with the patient.

16. Indicator AF007 will be retired and replaced with the indicator below (which was in the IIF as CVD-05 in 2022/23):
    - AF008: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist (12 points, LT 70%, UT 95%).

17. There will also be a number of other small changes to indicator wordings and values in 2023/24.

18. The QOF QI modules in 2023/24 will focus on:
    - workforce and wellbeing
    - optimisation of demand and capacity management in general practice.

19. Work will need to be undertaken during 2023/24 to review QOF in its current form with the aim of making it more streamlined and focussed. The profession, patients and the broader system will be consulted to determine the most appropriate form in 2024/25.

Childhood immunisations

20. The following changes will be made to childhood vaccinations:

    - the removal of the V & I repayment mechanism, removing the payment clawback for practice performance below 80% coverage across the routine childhood programmes.
    - changes to the childhood V & I QOF indicators.
    - clarification of the wording in the SFE that an Item of Service (IoS) fee will be payable for vaccinations administered for medical reasons and incomplete or unknown vaccination status (‘evergreen offer’) for the

programmes outlined in the SFE Part 5 Vaccinations and Immunisation, section 19.

21. The changes to the childhood vaccination and immunisation indicators within QOF will see the lower thresholds reduced to 89% (VI001) 86% (VI002) and 81% (VI003) and the upper thresholds raised to 96%[1]. All the points for each indicator will be put into a sliding scale of reward between the lower and upper threshold. Reducing the lower thresholds will decrease the number of practices receiving no payment across the three indicators.

22. A new Personalised Care Adjustment will also be introduced for patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK national schedule (or, where they differ, the requirements of the relevant QOF indicator).

Vaccination and Immunisations

23. The contract will also be updated to reflect forthcoming changes to the routine vaccination schedule as recommended by the Joint Committee on Vaccinations and Immunisation (JCVI), specifically in relation to Human papillomavirus (HPV), and Shingles.

Human papillomavirus

24. JCVI recommended a move from a two-dose schedule to a one dose schedule for the routine adolescent programme up to the age of 25 years. This change will align HPV vaccine doses across age groups, aligning the school's programme, sexual health and general practice provision, therefore minimising the risk of conflicting or missing doses. This change will not apply to those who are immunocompromised and those known to be HIV positive for whom the three-dose schedule will remain.

25. There will be a change from a two-dose to a one-dose HPV programme for those aged 14 to 25 years from 1 September 2023 to align with the school's programme.

26. General practice delivery remains opportunistic or on request. Eligibility remains up to 25 years of age for girls born after 1 September 1991 and boys born after 1 September 2006. This difference is due to the programme for boys being introduced at a later date (2019).

27. The IoS payment will continue to be paid at £10.06 per dose administered.

[1] VI001: The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months; VI002: The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months; VI003: The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years.

28. Further information on the programme change will be provided in due course.

Shingles

29. The JCVI advised in 2018 that Shingrix had been shown to be effective and cost-effective, recommending its use in the NHS Shingles Programme for individuals for whom the live Zostavax was contraindicated. This change was implemented in the programme in September 2021.

30. In 2019 JCVI recommended the replacement of Zostavax with Shingrix and the expansion of the cohorts in the Shingles Vaccination Programme. JCVI have recognised that there may be more clinical benefit from starting Shingles vaccinations at a lower age, with modelling indicating that a greater number of cases would be prevented with vaccination at 60 years for immunocompetent and 50 years for immunocompromised.

31. From 1 September 2023 changes to the Shingles Programme to implement the JCVI recommendations will be as follows:
    - replacement of Zostavax with the 2-dose Shingrix vaccine as Zostavax goes out of production.
    - 2-dose Shingrix vaccine for the current 70-79-year-old cohort with a period of 26 weeks to 52 weeks between doses following the depletion of Zostavax.
    - expansion of the immunocompromised cohort to offer 2-dose Shingrix to individuals aged 50 years and over with a period between doses of 8 weeks to 26 weeks.
    - expansion of the immunocompetent cohort to offer 2-dose Shingrix routinely to individuals aged 60 years and over with a period between doses of 26 weeks to 52 weeks, remaining an opportunistic offer up to and including 79 years of age.

32. The expansion of the immunocompetent cohort will be implemented over two five-year stages as follows:
    - first five-year stage (1 September 2023 to 31 August 2028): Shingrix will be offered to those turning 70 and those turning 65 years of age in each of the five years as they become eligible.
    - second five-year stage (1 September 2028 to 31 August 2033): Shingrix will be offered to those turning 65 and those turning 60 years of age in each of the five years as they become eligible.

33. Additionally, practice call/recall for the immunocompromised and immunocompetent cohorts as they become eligible for the programme will be implemented from 1 September 2023, as well as catch-up call/recall for the newly eligible immunocompromised 50-69-year-old cohort.

34. Shingles can be delivered at any time during the year thus enabling practices to manage timing for when the individual is invited and can also be opportunistically delivered if clinically appropriate when an individual attends the practice for another reason.

35. The Shingles GPES extraction will be updated to accommodate these changes.

36. Further information on the programme changes and management of the immunocompetent cohort expansion will be provided in due course.

Unchanged programmes

37. The following programmes will continue unchanged for 2023/24:
    - 6-in-1 (DTaP/IPV/Hib/HepB)
    - MenB
    - Rotavirus
    - PCV (infant pneumococcal)
    - Hib/MenC
    - MMR provision to remain unchanged for both the 0-5-year-olds programme and 6 years and over programme
    - 4-in-1 pre-school booster (DtaP/IPV)
    - 3-in-1 booster (td/IPV)
    - Men ACWY (provision for those aged up to 25 years who miss the schools programme)
    - PPV (65-year-olds and 2-64-year olds in defined clinical risk groups)
    - HepB (Babies)
    - Pertussis (pregnant women).

Weight Management Enhanced Service

38. The Weight Management Enhanced Service will continue into 2023/24, retaining the £11.50 referral payment.

NHS
North West London

BRIEFING FOR STAKEHOLDERS

Same day access to primary care

What is same day access?

NHS North West London is introducing an ambitious but achievable plan to improve same day access to primary care for patients.

This approach was co-developed by 10 primary care networks (PCNs -6 individual PCNs and 1 whole borough) between August and December 2023. The approach is aligned to the recommendations set out in the national 'Fuller Stocktake' review of primary care.

The new approach sees the introduction of 'same day access hubs' across North West London. Patients contacting their GP surgery either online or by telephone may be directed to the same day access hub for triage to the right service for their needs. This is an approach that will evolve over time but ultimately, patients may have telephone, online, video or face to face contact with staff at the hub, who will direct them to the right place. This could be a community pharmacy, a routine appointment with their GP or an urgent appointment with their GP. Where appointments are not available with their own GP or the patient will get easier access, they may be directed to a neighbouring practice.

Hubs can be either physical or virtual and will usually be managed through the local PCNs, with each hub including a senior GP. All clinical decisions will have a senior clinical decision making and GP lead, with support from a multi-disciplinary team.

This approach ensures patients needing primary care services that day are more likely to be looked after in the quickest way. The plan is for this to apply to same day cases only.

Primary care access is the issue most consistently raised by North West London residents we speak to about health services. We have launched a public information campaign called *We Are General Practice* in order to explain how primary care is changing, the challenges it faces and some of the new roles and proposed solutions to improve access and care for patients.

Frequently asked questions

Why is NHS North West London introducing same day access hubs?

We want to increase access to primary care services for patients. The most consistent message we hear through talking to residents and patients is that access to primary care is difficult: they are struggling to get through to their GPs or to get a timely appointment, especially when they need one the same day.

Same day access hubs bring GP practices together in networks, making it easier to arrange appointments the same day and to support patients in finding the care that is best suited to their needs. Patients who need a GP appointment that day are more likely to get one and GPs will be able to focus on providing proactive care to patients who need it. Where appropriate, patients may be referred to other services best suited to their needs, such as community pharmacists, physiotherapists or nurses. GPs will continue to see patients who need to see them and will be able to offer proactive continuity of care to people with long term conditions and others who need it.

Will I still be able to see my GP?

Of course. The aim of this programme is to make access to GP appointments easier for those who need them.

Will non-clinical staff such as Care Navigators and Care Co-ordinators be making decisions about my care?

No. All clinical referrals and clinical decisions will be made by clinicians. Those in supporting roles like Care Navigators and Co-ordinators will signpost patients to the right care for them. They will work in an identical way to how they work in practices now, but with greater clinical oversight as the same day access hubs will all include senior GPs and multi-disciplinary teams and with a better understanding of the types of services that might support their population's needs.

Clinical Safety remains our top priority. Clinical consultations will still occur with qualified health professionals and these will be appropriately supervised by senior clinicians. Decisions made by the same day access hubs will happen with the oversight of the senior clinical decision maker. Our aim is by streamlining the way patients achieve access we will be able to enable more patients to seek advice and treatment and that this will improve the care patients receive.

Will I have to travel further for care?

Where appointments are needed the same day and no slots are available at your local practice, it is possible that you might be referred to a different practice, in much the way patients sometimes see different GPs out of hours. You may also be referred to another service such as a community pharmacist if they could better meet your needs.

This might involve travel in some cases, but not all same day access hubs will be physically co-located: it is for local primary care networks to decide whether their hubs are physical or virtual. Patients can currently move to other local practices to access some services such as physiotherapy, ECG testing or particular services not available at their own practice location. This will work in a similar way.

What influence can patients have on the new system?

We are asking primary care networks to work with their patients to co-design the same day access hubs and how they will work in their area.

Are GPs being mandated to introduce same day access hubs?

Same day access hubs form part of our 'single offer' to general practice, which aims to introduce a consistent approach to enhanced care across North West London. If practices are not part of same day access hubs, their patients may not be able to access other parts of

the single offer, such as specialist diabetes and mental health care. Same day access hubs are not mandated, but we are recommending them to practices and they are part of our single offer as this will help them deliver better access for all the PCNs patients.

Are same day access hubs there to provide appointments when a practice has none left?

No. Same day access hubs are about ensuring more patients get the help they need the same day. They are not a 'surge' service for when practices run out of appointments. This is about pooling all the clinical resources in an area – GPs, community pharmacists, nurses, physiotherapists and other clinicians – to ensure people can quickly access the care they need.

Will the new approach be introduced from 1st April?

There is a misapprehension in some quarters that everything will be expected to change on 1st April, whereas our intention is to introduce new ways of working gradually, managed at local level by PCNs. The aim is that practices and PCNs are given time to co-design and collaborate with colleagues and patients to help this way of working improve primary care access. We know that this will take time and will be a gradual process as each PCN profile is different. There will be no expected radical change but an adopting of new ways of working over time.

What has been the experience of early adopters of the scheme?

The primary care networks who were early ('wave 1') adopters reported that they have been able to provide their most complex patients with increased access and time with their GPs as the simpler requests have been managed by signposting to other parts of the system. Patient experience reports have been positive,

Will practice staff recruited through the Additional Roles Reimbursement Scheme (ARRS) will be expected to work differently, and what will be the impact on their practice?

We are flexible about how the plan is delivered. Care coordinators will be trained signpost patients to the right care; this could be from their own practice in a virtual hub if that is the preferred local approach, or from a physical hub at an agreed location. The means of delivery is a matter for PCNs to decide locally and in a way that works best for the population of residents

Practices are already working collaboratively at scale to deliver out of hours care or that patients are already being signposted to other members in the primary care systems

What was the involvement of KPMG?

KPMG provided programme management support and shared good practice from elsewhere, supporting PCNs and NHS North West London as they developed their approach, which is closely aligned to the recommendations of the national 'Fuller Stocktake' of primary care, led by Dr Claire Fuller.