Wandsworth GP Federation

2024 / 25

AGM Newsletter

We are pleased to present this summary, highlighting our key activities and accomplishments throughout the 2024–25 period.

Neighbourhood Health Services

The year has seen significant work completed across Wandsworth to establish Integrated Neighbourhood Teams. These teams use proactive care as a foundation to better co-ordinate care and support for those with multiple long-term conditions at greater risk of hospital admission.

The current working model for the four neighbourhoods are:

- Balham, Tooting, and Furzedown
- Battersea
- Earlsfield, Southfields, and Central Wandsworth, and
- Putney and Roehampton

Going forward, all colleagues will start working within these geographies to develop services, with further refinements as we learn more.

Core leadership teams have been confirmed for our neighbourhoods and they will drive service delivery and improvement and support deeper community engagement, tailored to the needs of each neighbourhood.

Work completed during the year placed general practice at the heart of these developments, providing an incredible platform for the ongoing development of neighbourhood health services in future years.

Wandsworth Provider Alliance

The Wandsworth Provider Alliance was launched in April 2025 and is formed of Health and Care partners from across Wandsworth. This includes Wandsworth GP Federation, Wandsworth's nine Primary Care Networks (PCNs), St George's University Hospitals NHS Foundation Trust, Wandsworth Borough Council, South West London & St George's Mental Health NHS Trust, Central London Community Healthcare NHS Trust and voluntary, community, faith and social enterprise sector providers, represented by Wandsworth Care Alliance.

Collaboration between partners will be key to delivering better care, making patients feel better, and supporting staff.

The Alliance will play a significant role in the development and delivery of Neighbourhood Health Services for Wandsworth. Wandsworth GP Federation's participation ensures that general practice will be at the heart of these developments.

Primary Care Programme Board

The Primary Care Programme Board strategy was signed off, and work was undertaken to see how the Board's work aligns with South West London Integrated Care Board (SWL ICB), the Wandsworth Provider Alliance and with other stakeholders.

Winter 2024 Flu & Covid Booster Vaccination Programme

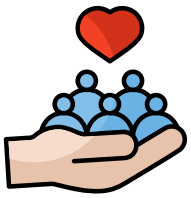
- **2221** patients registered as housebound
- **316** patients vaccinated for Covid booster only
- **147** for Flu only
- **1758** for Covid and Flu.

PCN Enhanced Access Delivery Winter 2024 (09/12/24 – 31/03/25)

- **3,623** appointments offered
- **3,500** appointments booked
- **96%** utilisation.

Diagnostics

- **49%** increase in Spirometry tests (1,045)
- **46%** increase in Ambulatory Blood Pressure Monitoring (2,095)
- **37%** increase in electrocardiograms ECGs (9,153)
- **34%** increase in phlebotomy blood tests (150,402.)



Enhanced Access Hubs

- **27,901** appointments booked
- **43%** face to face consultations
- **57%** remote consultations
- **82%** utilisation.

Enhanced Access Hub Delivery Winter 2024 (09/12/24 – 31/03/25)

- **1,849** additional appointments offered
- **1,787** additional appointments booked
- **97%** utilisation.

Donations to Practices and Local Causes

We're proud to have invested £38,000 of surplus funds to support local initiatives within our practices and to have donated £76,000 to 22 different Wandsworth charities.

The range and breadth of the charities meant that all sections of the population were represented including young people, families, older people and people experiencing homelessness. Supported activities included community kitchens, foodbanks and advice services.

End of Life Care

A Clinical Lead was appointed to support practices.

Coordination Service:

- **457** patient referrals received
- **226** fast track patients
- **189** face to face patient visits by dementia nursing service
- **779** additional remote care contacts with patients or their carers.

Marie Curie Contract:

- **65** patients supported with overnight respite care in their own homes by Marie Curie
- **335** night sitting episodes of care delivered, providing **3015** hours of care.

Net Zero / Carbon Plan

The following objectives were set:

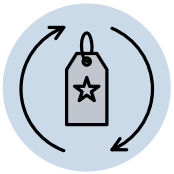
- reducing energy consumption and increasing energy efficiency
- minimising waste and promoting recycling
- encouraging sustainable travel and reducing emissions from transportation
- engaging all WGPF staff in sustainable initiatives, and
- supporting site management in relation to WGPF locations.

Recruitment

We successfully recruited to a number of roles, including Communications Manager, Governance Manager, Programme Director (Integrated Care), and Primary Care Digital Transformation Lead.

More recently we have recruited to our MICAS Clinical Team with two new musculoskeletal (MSK) doctors, three new advanced physiotherapy practitioners and two clinical leads.

Organisational Rebrand



We underwent a rebrand to create a new organisational identity. Work included updating our mission, vision and values. A three-year communications strategy and annual delivery plan was signed off by Board, setting the direction for how we will communicate with our audiences and demonstrate the impact of our work.

Pharmacy First

We worked with SWL ICB to transform how GP practices, pharmacies, and patients engage with this initiative to make community pharmacies the first point of contact for patients with minor illnesses. Between September 2024 to March 2025, the number of GP referrals into the programme increased by **40%**.

Better at Home / AGE UK

- **1,191** referrals received
- **123** people matched to a volunteer befriender
- **5,500** be-friending home visits made
- **334** frail, older residents supported with a safe, hospital discharge and after care
- **10,570** volunteering hours completed.

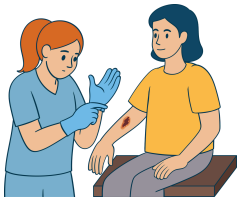
CLEAR Living Well 3 Project

We provided project support for the Clinically-Led workforcE and Activity Redesign (CLEAR) workstream for Wandsworth PCNs enrolled on this cardiovascular disease prevention programme. Wandsworth PCN held two workshops to redesign their hypertension patient pathway.

Patient Engagement

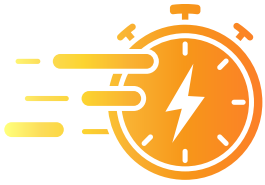
We held our first face-to-face Patient Participation Engagement Event in March to showcase the the work of the Federation and our partners.

There were over 70 attendees including members of the public, patients, healthcare professionals and other partners.



Wound Care

- **3,536** appointments offered
- **3,048** appointments booked
- **86%** utilisation.

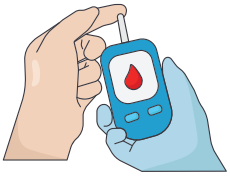


GP Rapid Response

- **4%** increase in home visits completed within 2 hours (1,590.)

Together Clinics

- **5** PCNs onboarded
- **<450** appointments booked and seen / discussed since July 2024.

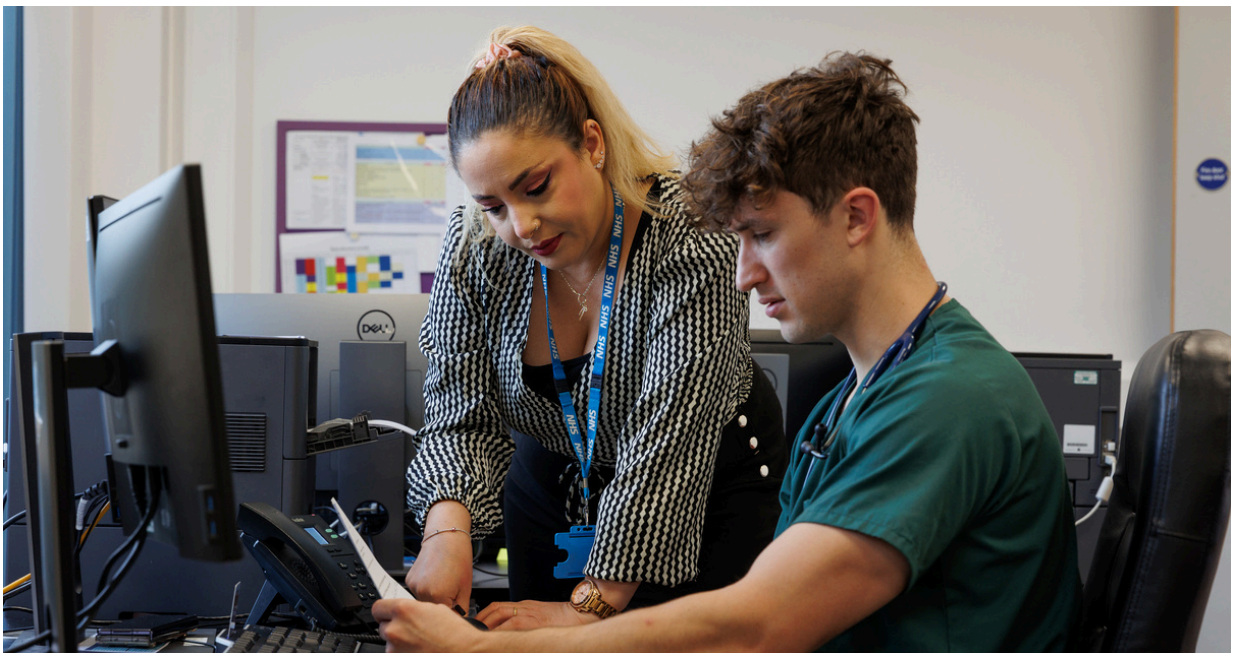


Early Onset Type 2 Diabetes (EOT2D)

- **465** patients with EOT2D between age of 18-39 yrs
- **321** patients achieved the eight care processes
- **134** patients received a Type 2 review
- **143** patients had a diabetes care plan
- **89** patients received all three requirements of the programme.

Planning All Care together (PACT) Proactive Care

- **9%** increase in patients on proactive care register (6,651)
- **6,303** received holistic assessment
- **6,253** received care and support plan
- **91%** increase in patients discussed at a Multidisciplinary Team meeting (MDT) (3,237)
- **11%** increase in carers assessments completed (2,915)
- **20%** increase in Diabetes GP Practice support visits (88.)



Musculoskeletal Interface Clinical Assessment Service (MICAS)

- **292** average number of referrals per month
- **10%** more referrals received
- **7 wks** average wait time.

Clinics are held at Bolingbroke Medical Centre and Mayfield Surgery.

Digital Transformation

- **100%** of practices now offer online contact during opening hours
- **More than two-thirds** have adopted a Total Triage model
- Hosted a popular Total Triage Lunch & Learn series
- Provided bespoke triage training and support packages to practices
- **66%** - uptake among patients aged 13+ of the NHS app, surpassing the national average of 59% and a regional average of 64% (June 2025)
- Provided essential Egton Medical Information Systems (EMIS) training to practice colleagues.

CLCH Contract

- 18-week Referral-to-Treatment (RTT) performance consistently met. No service user waited more than 18 weeks for a clinical assessment
- Rapid Response two-hour response performance met
- Quality scorecard indicators all green
- Significant increase in recruitment and retention of clinical staff
- Specialist nursing services including heart failure, diabetes and respiratory maintained a high quality of performance achieving all their key performance indicators.

Improving Quality in General Practice

- **7** mock Care Quality Commission (CQC) inspections delivered to practices
- **1** mock inspection delivered to a practice and to MICAS.

A range of other support was also offered, including CQC advice, Health and Safety audit completion, advice with practice manager's work, support with EMIS issues and support with completion of the Primary Care At Scale (PCAS) framework application.

Several quality-related events were also delivered. including:

- CQC preparedness
- General Medical Council (GMC) – Good Medical Practice update
- Medical Examiner provision / Anticipatory Care Planning
- Service Pathway updates – Autism / Same Day Emergency Care (SDEC) Services / Rapid Response services.

Care Homes for Older Persons

- GP Clinical Lead co-chairs Care Homes Support Team meeting, ensuring integrated working across care homes, sharing of knowledge, delivering local and national guidance and development of system pathways and identifying potential gaps and solutions
- The Nourish, Move, Connect, Thrive project continues to be funded providing support for care homes with a focus on bed bound residents. The service is delivered by St Georges' Hospital.

Business Intelligence (BI)

- We improved MICAS data quality by remodelling BI Reports and switching to MICAS EMIS and E-Referral Service (eRS)
- We built a new Public Health reporting system, delivering emails to GPs and team dashboards.
- We designed a new portal site for practices to see practice data, send messages to the operations team and manage practice distribution lists.

Public Health Partnership

- We developed a PowerBI model to validate the reporting of public health contracts
- The time it takes to generate a report has gone from ten days to 1 day, with the use of public health's EMIS system.

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