Primary Care in London: Now and into the Future

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Picture of Health in London

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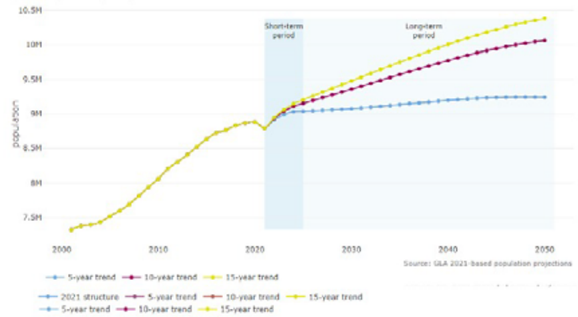
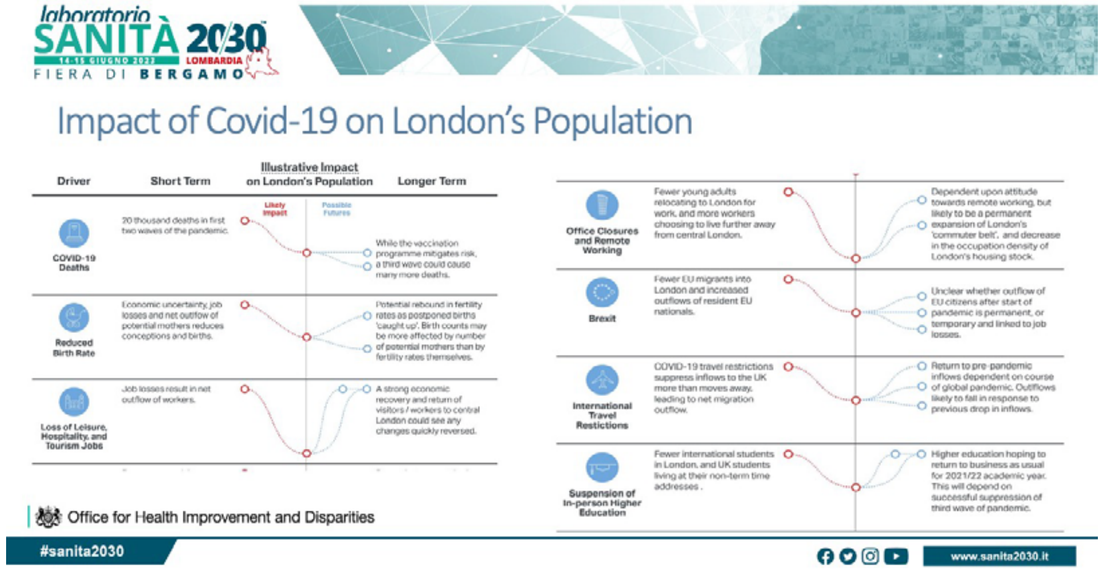
London's population is growing, ageing and transient

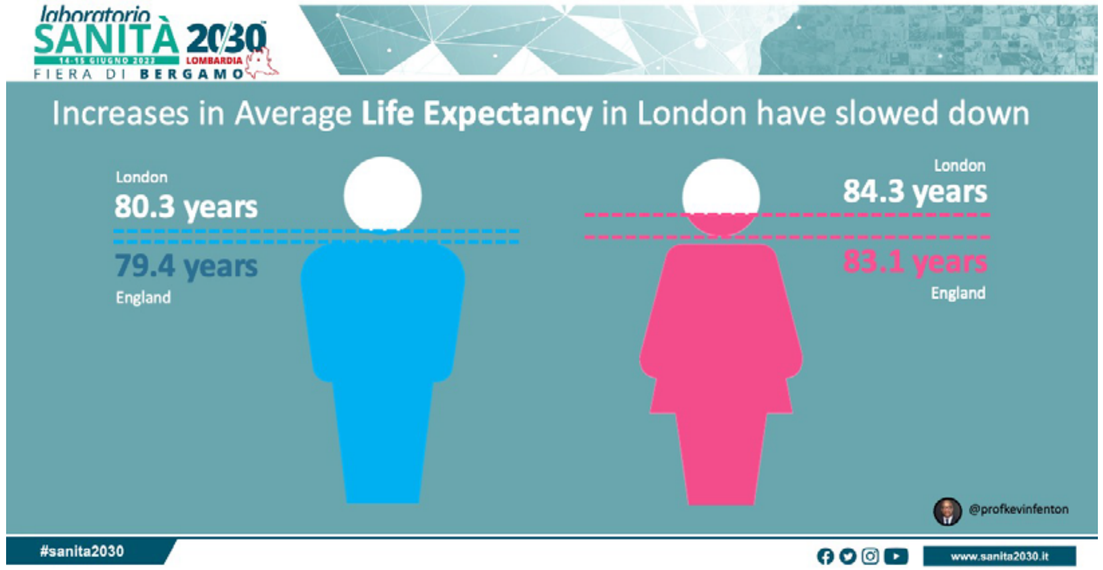
- GLA 2021 based projections suggest London's population will grow from an estimated 8.8 million in 2021 to between 9.2-10.4million by 2050.
- Whilst the population is growing, the rates of future growth has been declining since 2016 due to: impacts of COVID-19 pandemic including effects on census records, declining fertility rates, a reduction in net international migration due to Brexit, and recovery in domestic outflows since the 2008 Financial Crisis.
- London is a relatively young city compared to the rest of the UK, but it is still growing older, with the number of people aged 65 and over predicted to grow from 1million in 2021 to between 1.8-1.9million by 2050.
- While births and deaths are the largest direct contributor to London's population growth, migration plays a large part in London's changing population, and in particular, our working age population (16-64), where the growth we've seen since 2000 is projected to level off or even reverse from 2040.
- COVID-19 saw significant disruption to migration flows both domestically and internationally, and global crises such as the war in Ukraine continue to add to an ever-changing picture of migration in and out of the city.

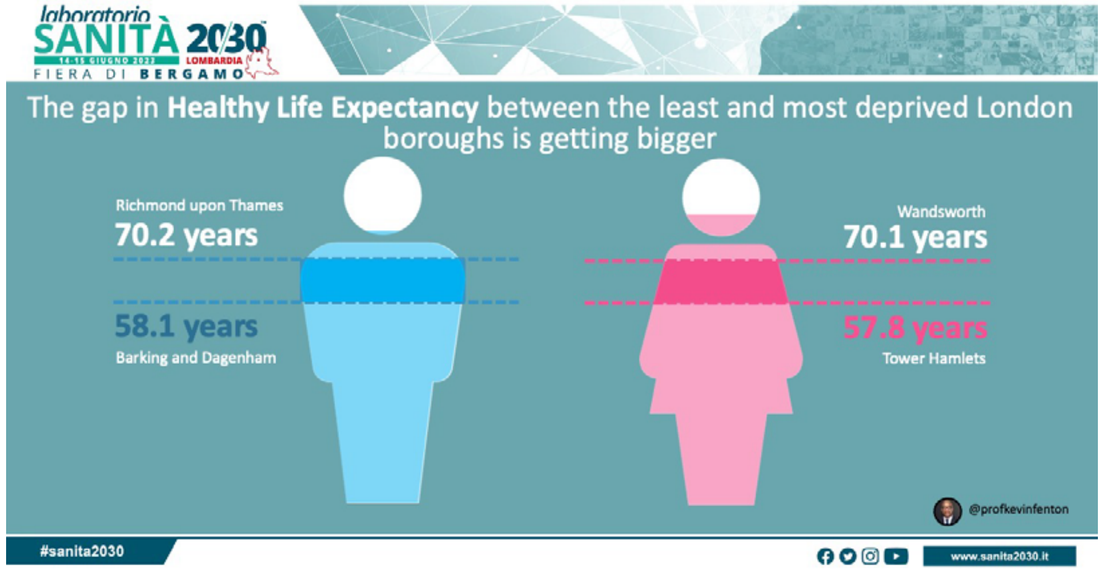
Figure 1: Projected Population, London



Office for Health Improvement and Disparities



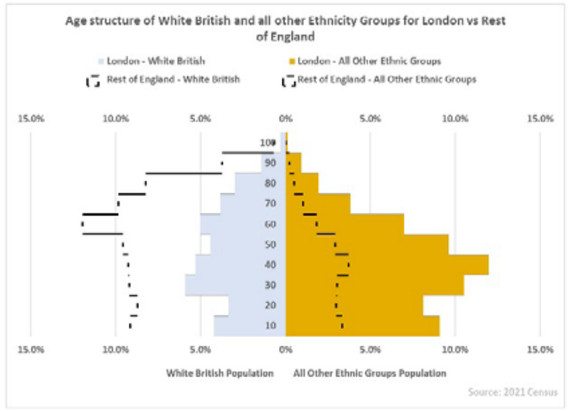


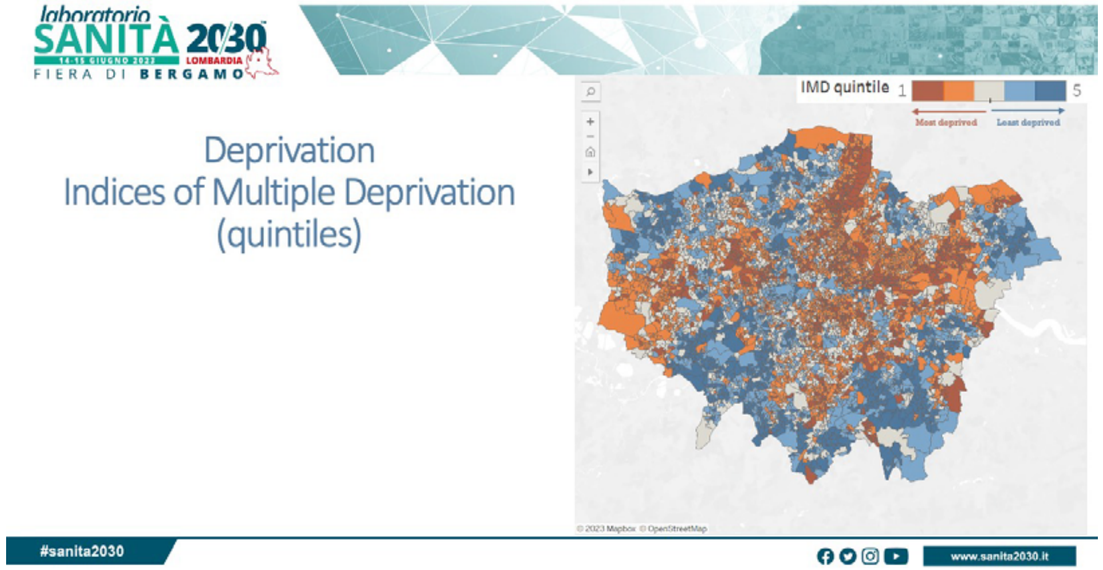


Population pyramid

Rest of England		
Age Band	Rest of England - White British	Rest of England - All Other Ethnic Groups
10	9.1%	3.3%
20	8.7%	3.0%
30	9.2%	3.0%
40	9.3%	3.7%
50	9.6%	2.9%
60	12.0%	1.8%
70	9.8%	1.0%
80	8.2%	0.5%
90	3.7%	0.2%
100	0.7%	0.0%

London		
Age Band	London - White British	London - All Other Ethnic Groups
10	4.2%	9.1%
20	3.3%	8.1%
30	5.9%	10.5%
40	5.3%	12.0%
50	4.4%	9.6%
60	5.0%	7.0%
70	3.8%	3.8%
80	3.0%	2.0%
90	1.4%	0.9%
100	0.3%	0.1%





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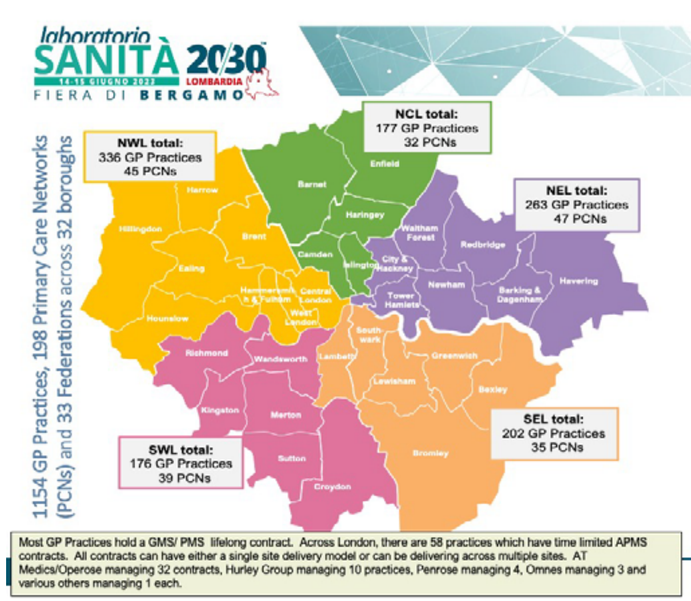
Primary Care in London

NHS England



Most GP Practices hold a GMS/ PMS lifelong contract. Across London, there are 58 practices which have time limited APMS contracts. All contracts can have either a single site delivery model or can be delivering across multiple sites. AT Medics/Operose managing 32 contracts, Hurley Group managing 10 practices, Penrose managing 4, Omnes managing 3 and various others managing 1 each.

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CQC Ratings at 3rd April 2023

Overall rating	Outstanding	Good	Requires Improvement	Inadequate	Total
NCL	1	165	9	2	177
NEL	4	241	11	7	263
NWL	5	306	25	0	336
SEL	1	188	12	1	202
SWL	1	168	7	0	176
London	12	1,068	64	10	1,154

Overall rating	Outstanding	Good	Requires Improvement	Inadequate
London	1.0%	92.3%	5.6%	0.9%
England	4.9%	90.1%	4.1%	0.9%

In April 2023, 1% of London practices were rated outstanding, compared with nearly 5% of practices nationally. Over 92% of London practices were rated good, slightly higher than the national average of 90%. There is unwarranted variation in outcomes, together with inequity across London in funding, estate, investment in technology and enhanced service offers. There is also huge variation in demand which seems to correlate with deprivation.

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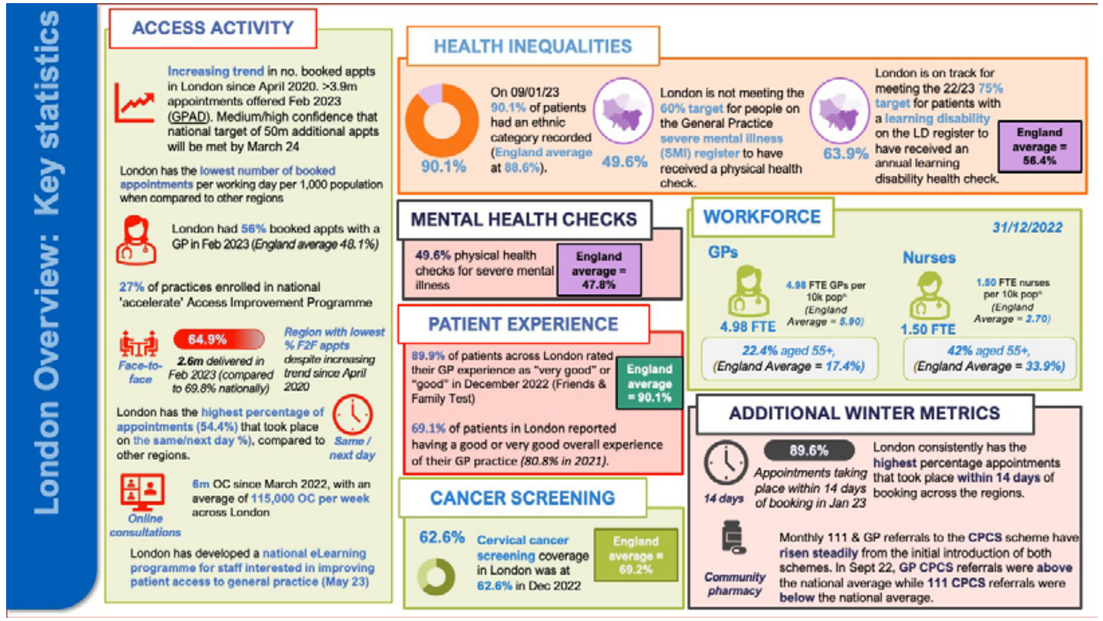

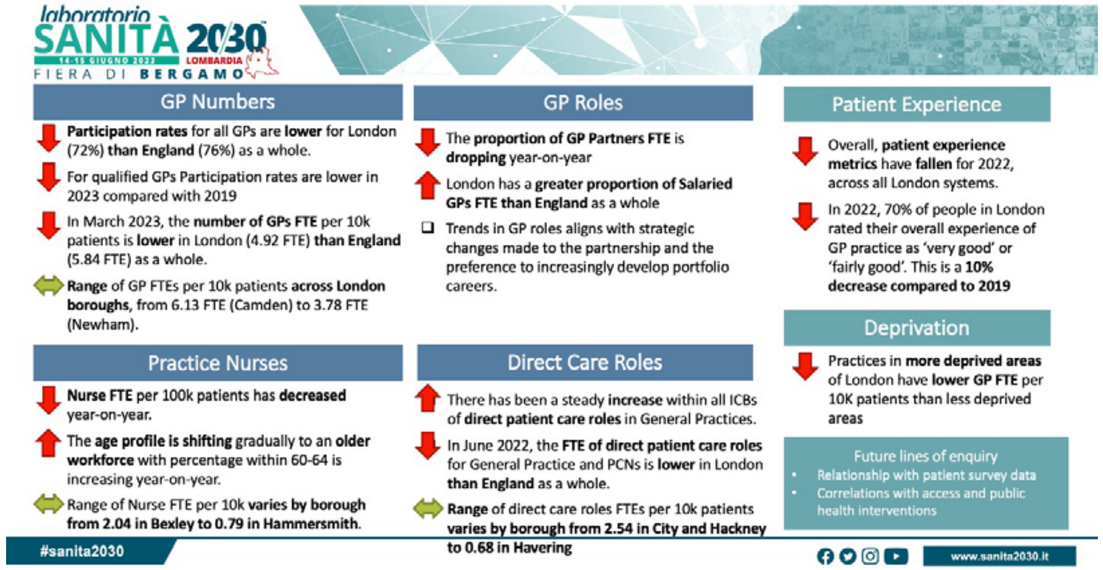

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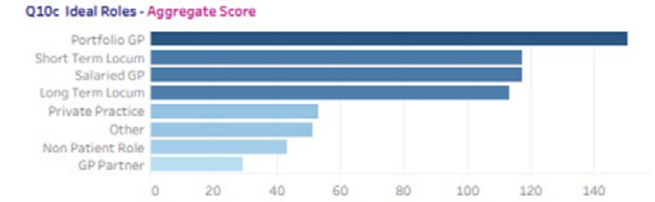
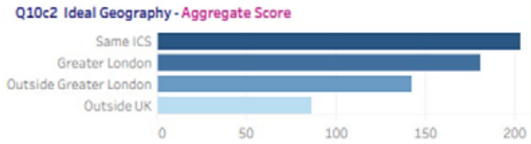
NHS Health Education England

Future employment for GPs in training: Ideal Role and Geography





The top 4 ideal employment modalities on qualifying were cited as:

1. Short Term Locum
2. Salaried GP
3. Long Term Locum
4. Private Practice

For those who stated 'other', some respondents commented that due to burnout and stress they were looking to leave medicine, while others were looking for a combination of different roles e.g. research and academia, clinical lecturer.

In terms of Geography, the same ICS and Greater London scored highest on the aggregate score.

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Note: Respondents were asked to score their top 4 ideal roles, with their most ideal being awarded 4 points, second ideal role 3 points etc. The portfolio GP option indicated is, by definition, a composite role and is therefore supplementary to the key question about the preferred mode of employment.

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Policy context and challenges

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Challenges and Opportunities

To deliver the strategic vision, a systemwide approach is required, as holistic, integrated care cannot be delivered by General practice alone. The overarching opportunities below need alignment with Trusts and other partners to be delivered.

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	OVERARCHING CHALLENGES IN THE SYSTEM	OPPORTUNITIES FOR THE FUTURE
DEMAND, CAPACITY AND COMPLEXITY OF POPULATION	❑ There is a 30% increase > 70 since 2010 with one or more Long Term conditions (LTCs) and a mismatch in demand vs capacity. ❑ The 2021 census records London's population increasing 7.7% in 10 years which will impact all services. ❑ The average number of patients each GP is responsible for has increased by 348 – 18% – since 2015, and now stands at 2,286. With the highest proportion of registered population under 35 years of age (48%, against 42% in the rest of the country) and the lowest share of over 65s (11%, compared to 19% in the rest of the country) ❑ London has 11M registered patients and is 4th in the Index of Multiple Deprivation (where 1 is the most deprived) ❑ There is variation in demographics, service delivery models and patient outcomes within each ICB	❑ Addressing the increase in population and demographic challenges requires a systemwide lens incorporating Extended access , 111, UTC and A&E. together with clinical pathways and discharge ❑ Optimal use of data, shared care and workforce to support addressing capacity issues ❑ Improved communication flows which minimise patients having to be seen multiple times for their condition/s ❑ Maximise use of community assets- local champions, voluntary sector, faith bodies and spaces ❑ Develop referral pathways and processes which are easily assessable for GPs and reduce bureaucracy and save time, where possible, enabling more time for care.
WORKFORCE	❑ One in five practices are single-handed and the ratio of practice staff to GPs is lower than in other parts of England. Some parts of London have the lowest rate of Full Time Equivalent (FTE) GPs per patient and London has the highest number of GP's over 60 nationally (13.5%). ❑ General practice is increasingly moving to a multidisciplinary model of working, however there is high turnover in Additional Roles Reimbursement roles (ARRS)- (14%) in London and GPs/ senior clinicians must take on additional clinical supervision requirements, which increases workload pressures ❑ In December 2022, the FTE of direct patient care roles for general practice and primary care networks (PCNs) is lower in London than England as a whole, despite this there is silo working and duplication across the system.	❑ Develop Integrated Neighbourhood teams which support local populations and can work across organisational boundaries to deliver holistic care in the community. ❑ Develop Joint roles, joint training and development opportunities and support for ARRS roles. ❑ Ensure local recruitment and retention strategy aligns with the upcoming workforce plan ❑ Allow for more flexible portfolio careers to support retention.
ESTATES AND INFRASTRUCTURE	❑ Whilst there has been some investment in new facilities, some practices continue to operate from premises that are no longer fit for purpose. Estate is not always optimally utilised. There is not always space for training and team development and the 'premises directions' do not always support innovative solutions. ❑ Shared care planning, risk stratification and interoperability are not adequate and there is a lack of time and resource to undertake a PHM approach effectively	❑ Deliver improvements on space and utilisation, allowing for 'One Public Estate' approach and sharing where possible. ❑ Develop and incorporate technology effectively. Enable shared records and care, joint care planning (Urgent Care Plan) and interoperability across systems and time for a PHM approach
INTEGRATED DELIVERY MODELS	❑ Contractual limitation, organisational structures, together with workforce and resource pressures currently impact on the ability for General practice to actively engage with integration and 'new models of care'.	❑ 'New models of care' developed based on a shared vision, integration and a reflective of changing demographics ❑ Easy access to advice and guidance and streamlined processes which reduce workload ❑ Working with the regional clinical networks, to 1. develop New Models of Care and test a coordinated preventative approach within each ICB 2. Support a focus on Prevention in Cardiometabolic Long Term Conditions (LTCs) and addressing Health Inequalities.

Further exploration of opportunities specific to the Fuller Stocktake recommendations within Slides 8 and 9.

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The Fuller Stocktake Report, commissioned by NHS England, was published in May 2022. It sets out **a vision for integrating primary care, improving access, experience and outcomes for communities**, centred around:

Improve access - streamlined urgent care pathway bringing together out of hours, NHS 111, clinical assessment services, crisis response etc triage at scale and digitally enabled – Develop a more targeted and responsive offer for patients who are otherwise healthy

Separate reactive and proactive care - providing more proactive, personalised and multi disciplinary care for people with more complex needs in an integrated manner.

Freeing up capacity in primary care to focus on complex/ chronic conditions that require continuity and on working with local government, VCS and community leaders on prevention and tackling the wider determinants of health

Enable through population segmentation
Helping people to stay well for longer, through a joined-up approach to prevention, through population segmentation and systematic use of population health data to identify patients most at risk – underpinned by shared care records and interoperable IT systems

These are all underpinned by the requirement to optimise workforce, digital tools and estate

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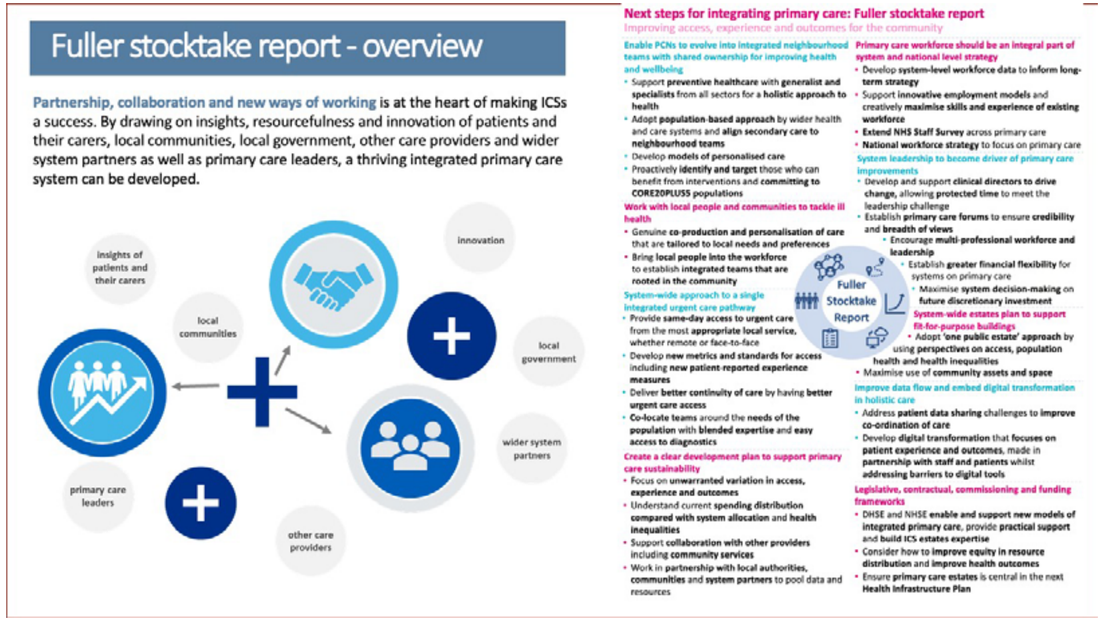


Fuller stocktake report - overview

Partnership, collaboration and new ways of working is at the heart of making ICSs a success. By drawing on insights, resourcefulness and innovation of patients and their carers, local communities, local government, other care providers and wider system partners as well as primary care leaders, a thriving integrated primary care system can be developed.

Next steps for integrating primary care: Fuller stocktake report

Improving access, experience and outcomes for the community

Enable PCNs to evolve into integrated neighbourhood teams with shared ownership for improving health and wellbeing

- Support **preventive healthcare** with **generalist and specialists** from all sectors for a **holistic approach to health**
- Adopt **population-based approach** by wider health and care systems and **align secondary care to neighbourhood teams**
- Develop **models of personalised care**
- Proactively **identify and target** those who can benefit from interventions and **committing to CORE20PLUS5 populations**

Work with local people and communities to tackle ill health

- Genuine **co-production and personalisation of care** that are **tailored to local needs and preferences**
- Bring **local people into the workforce** to establish **integrated teams that are rooted in the community**

System-wide approach to a single integrated urgent care pathway

- Provide **same-day access to urgent care** from the most **appropriate local service**, *whether remote or face-to-face*
- Develop **new metrics and standards for access** including **new patient-reported experience measures**
- Deliver **better continuity of care** by having **better urgent care access**
- **Co-locate teams** around the **needs of the population** with **blended expertise** and **easy access to diagnostics**

Create a clear development plan to support primary care sustainability

- Focus on **unwarranted variation in access, experience and outcomes**
- Understand current **spending distribution compared with system allocation** and **health inequalities**
- Support **collaboration with other providers** including **community services**
- Work in **partnership with local authorities, communities** and **system partners** to pool data and resources

Primary care workforce should be an integral part of system and national level strategy

- Develop **system-level workforce data** to **inform long-term strategy**
- Support **innovative employment models** and creatively **maximise skills and experience of existing workforce**
- **Extend NHS Staff Survey** across primary care
- **National workforce strategy** to focus on primary care

System leadership to become *driver* of primary care improvements

- Develop and support **clinical directors to drive change,** allowing **protected time** to meet the leadership challenge
- Establish **primary care forums** to ensure **credibility** and **breadth of views**
- Encourage **multi-professional workforce and leadership**
- Establish **greater financial flexibility** for systems on primary care
- Maximise **system decision-making** on **future discretionary investment**

Fuller Stocktake Report

System-wide estates plan to support fit-for-purpose buildings

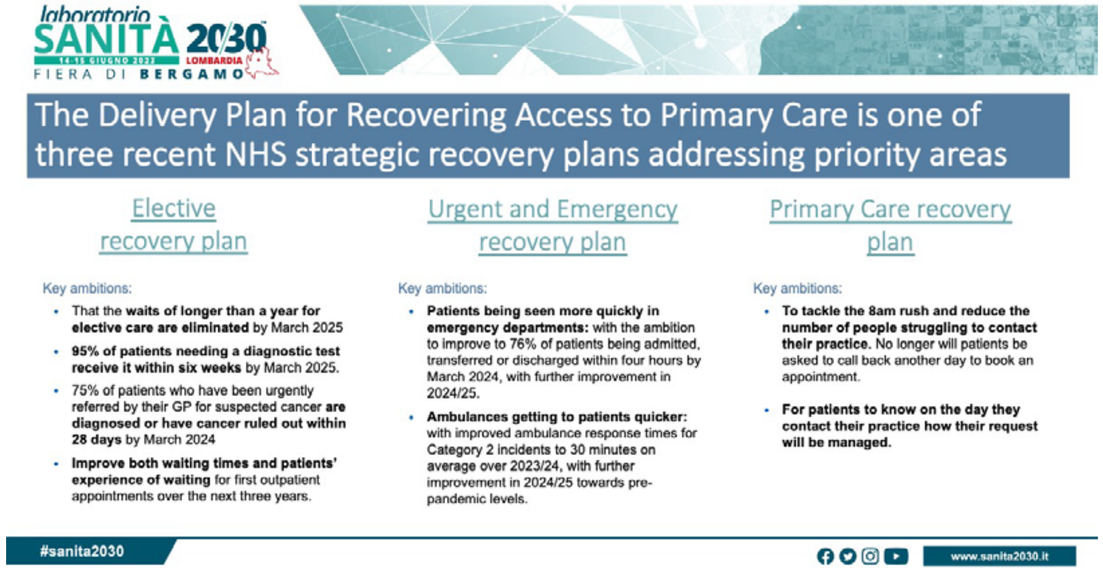
- Adopt **'one public estate' approach** by using **perspectives on access, population health and health inequalities**
- Maximise use of **community assets and space**

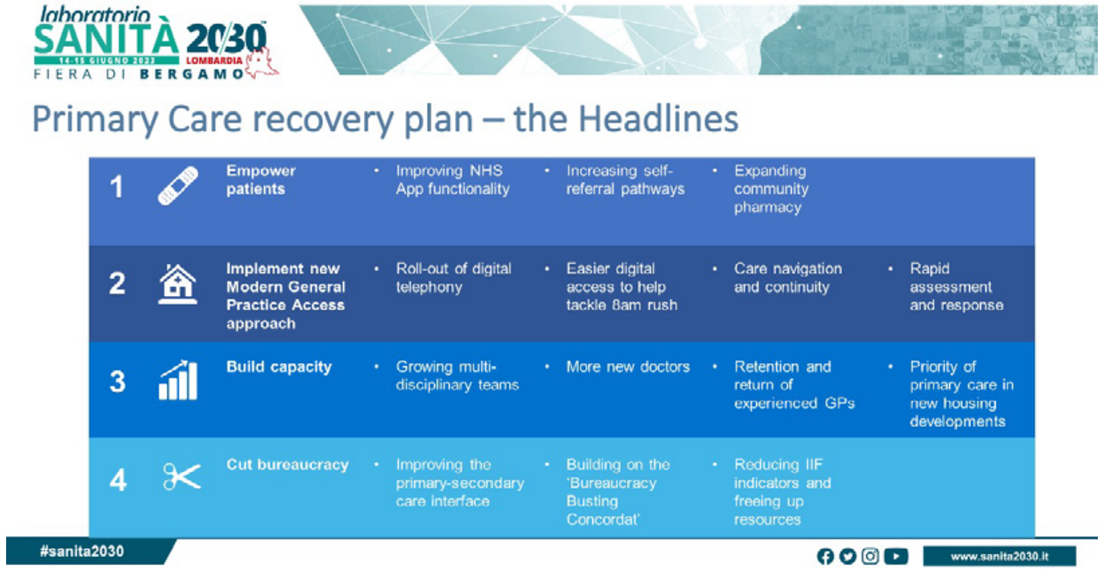
Improve data flow and embed digital transformation in holistic care

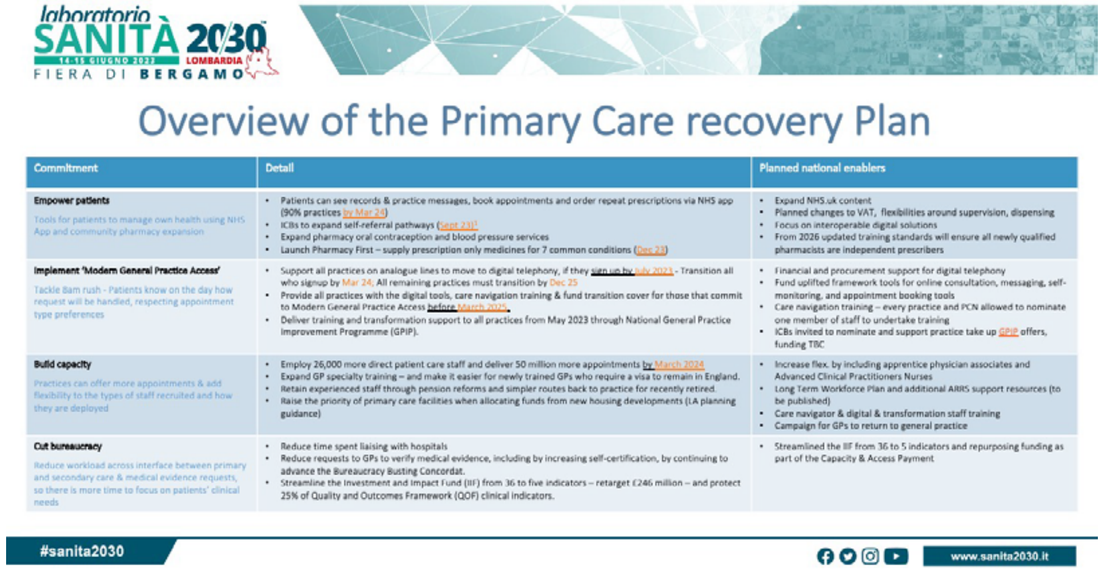
- Address **patient data sharing** challenges to **improve co-ordination of care**
- Develop **digital transformation** that **focuses on patient experience and outcomes**, made in **partnership with staff and patients** whilst **addressing barriers to digital tools**

Legislative, contractual, commissioning and funding frameworks

- DHSE and NHSE **enable and support new models of integrated primary care**, provide **practical support** and **build ICS estates expertise**
- Consider how to **improve equity in resource distribution** and **improve health outcomes**
- Ensure **primary care estates** is central in the next **Health Infrastructure Plan**

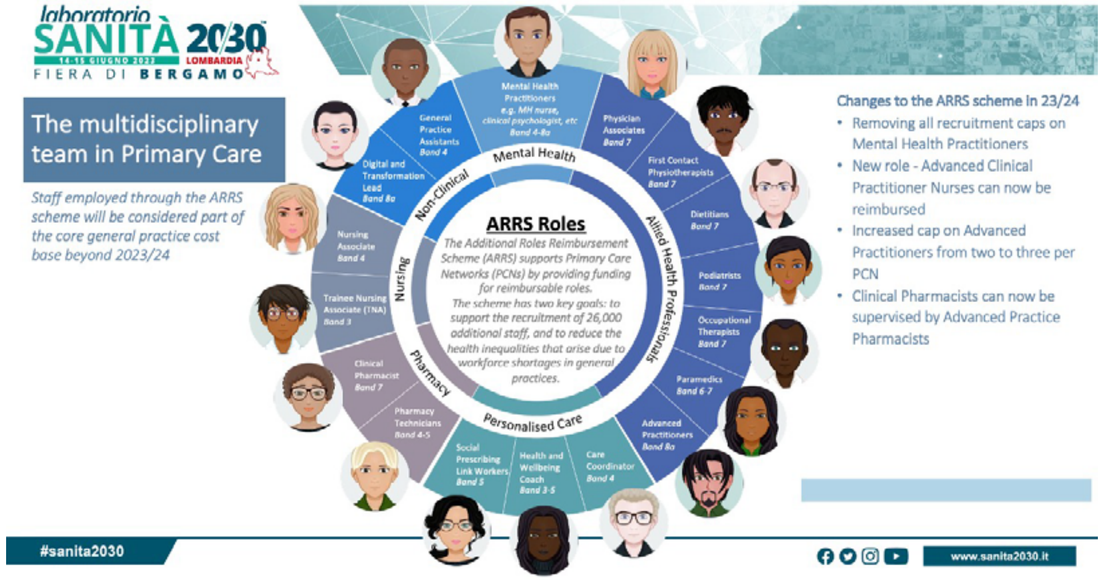






Overview of the Primary Care recovery Plan

Commitment	Detail	Planned national enablers
Empower patients Tools for patients to manage own health using NHS App and community pharmacy expansion	• Patients can see records & practice messages, book appointments and order repeat prescriptions via NHS app (90% practices by Mar 24) • ICBs to expand self-referral pathways (Sept 23) • Expand pharmacy oral contraception and blood pressure services • Launch Pharmacy First – supply prescription only medicines for 7 common conditions (Dec 23)	• Expand NHS.uk content • Planned changes to VAT, flexibilities around supervision, dispensing • Focus on interoperable digital solutions • From 2026 updated training standards will ensure all newly qualified pharmacists are independent prescribers
Implement 'Modern General Practice Access' Tackle 8am rush - Patients know on the day how request will be handled, respecting appointment type preferences	• Support all practices on analogue lines to move to digital telephony, if they sign up by July 2023 - Transition all who signup by Mar 24. All remaining practices must transition by Dec 25 • Provide all practices with the digital tools, care navigation training & fund transition cover for those that commit to Modern General Practice Access before March 2025. • Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme (GPIP).	• Financial and procurement support for digital telephony • Fund uplifted framework tools for online consultation, messaging, self-monitoring, and appointment booking tools • Care navigation training – every practice and PCN allowed to nominate one member of staff to undertake training • ICBs invited to nominate and support practice take up GPIP offers, funding TBC
Build capacity Practices can offer more appointments & add flexibility to the types of staff recruited and how they are deployed	• Employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 • Expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England. • Retain experienced staff through pension reforms and simpler routes back to practice for recently retired. • Raise the priority of primary care facilities when allocating funds from new housing developments (LA planning guidance)	• Increase flex. by including apprentice physician associates and Advanced Clinical Practitioners Nurses • Long Term Workforce Plan and additional ARRS support resources (to be published) • Care navigator & digital & transformation staff training • Campaign for GPs to return to general practice
Cut bureaucracy Reduce workload across interface between primary and secondary care & medical evidence requests, so there is more time to focus on patients' clinical needs	• Reduce time spent liaising with hospitals • Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat. • Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.	• Streamlined the IIF from 36 to 5 indicators and repurposing funding as part of the Capacity & Access Payment



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Professional perspective

Dr Helene Brown

NHS England

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Shaping the future

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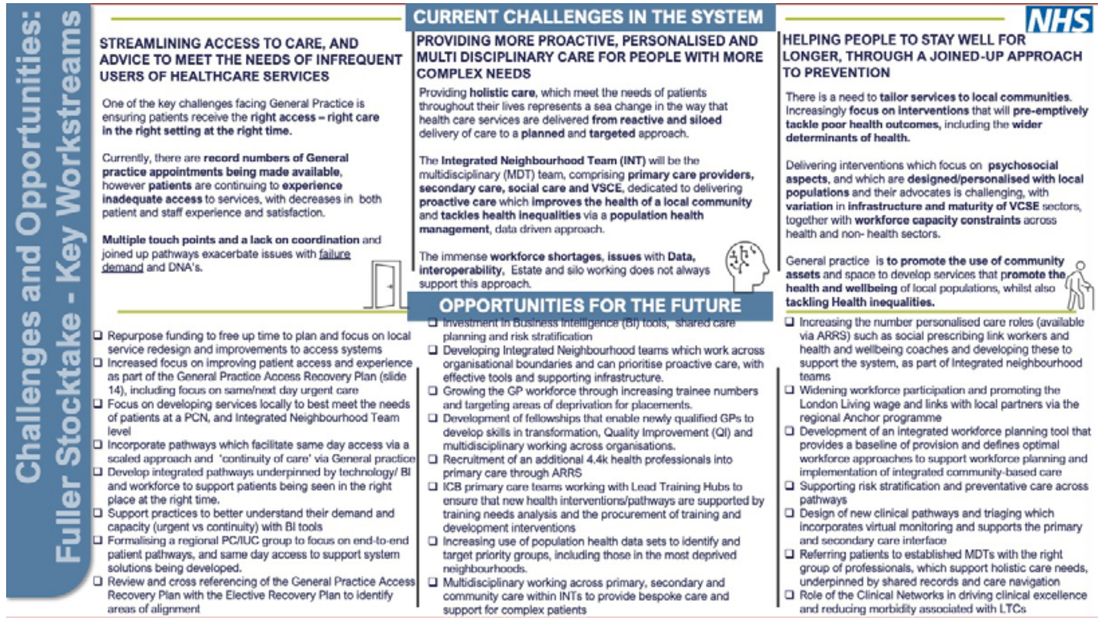
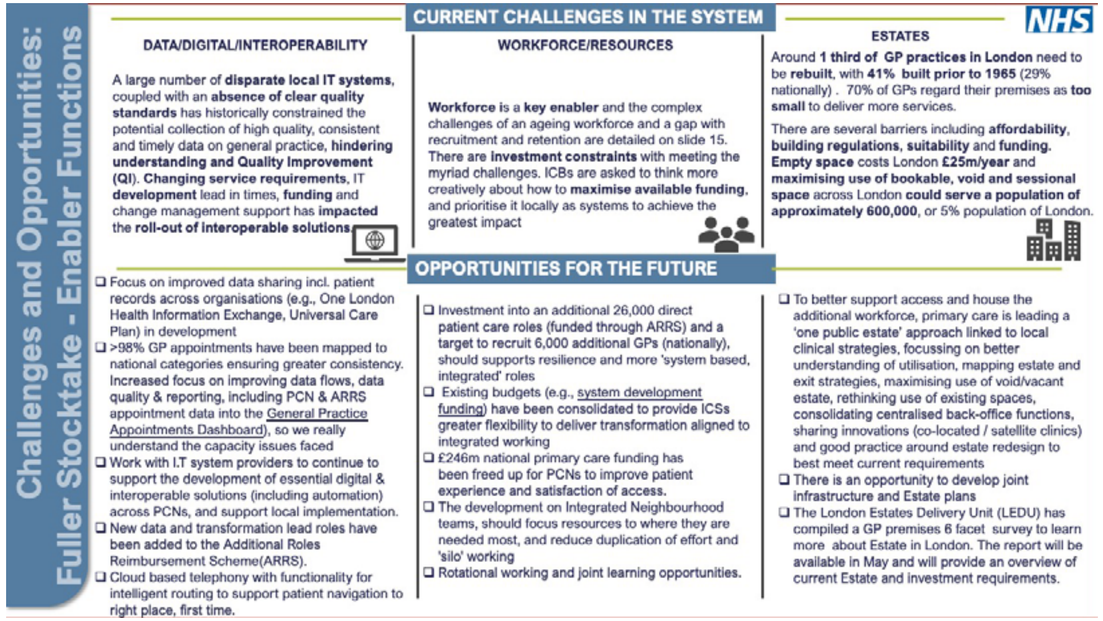
- New models of care/delivery
- New models of contracting/commissioning
- Integrated neighbourhood teams – key role for CPs
- Primary/secondary care interface
- Digital front door/NHS App
- Data on primary care – presenting diagnoses/outcomes
- Workforce: recruitment and retention





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General Practice/ Trust interface

Good organisation of care across the interface between general practice and secondary is crucial in making the best use of clinical time and resources in both settings. The **Health and Social Care Select Committee report (Oct 22)** into the **Future of General Practice** states: "GP retention needs to be improved" adding "…GPs are facing unsustainable workloads, which increase burnout and make GPs more likely to leave the profession. This creates a vicious circle of workforce and workload pressures for the GPs who remain…". In stemming the spiralling attrition rates for GPs **we need to work closely with and collaborate with general practice**.

Whilst the visions and direction within the Fuller Stocktake provides strategic direction, there are practical issues, which if resolved effectively in the short term, could help with accelerating transformation, these include:

- Reducing the bureaucracy and shift of workload from secondary to Primary care, building on the Bureaucracy busting concordat
- Making referral pathways simple and easy to navigate
- Timely discharge summaries/clinic letters with immediate care needs met
- Develop systems for appropriate information exchange to and from general practice care
- Effective communication flows across settings, allowing for relationships to develop and more streamlined care
- Clear Shared Care Protocols
- Facilitate team building across the interface and incorporate joint learning and development
- Assess and reduce the amount of work that is inappropriately transferred from secondary care to primary care
- Co-development of secondary care role within integrated neighbourhood teams
- Collaborative design of innovative pathways to reduce inappropriate referrals into secondary care, improve case finding and optimise prevention
- Self-service processes for patients and public where appropriate

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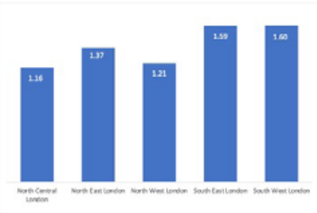
Workforce

Rate of FTE GPs per 10k population, March '23

- The **number of GPs across London has increased** from March ' '20 to '23 by 149 (FTE)
- The **better resourced boroughs** have **66% more GPs per 10k population** than under-resourced areas of the capital
- NHS London are working with ICBs to understand the factors that drive this variability and address them through national and **local recruitment and retention schemes**

Rate of FTE Practice Nurses per 10k population, March '23



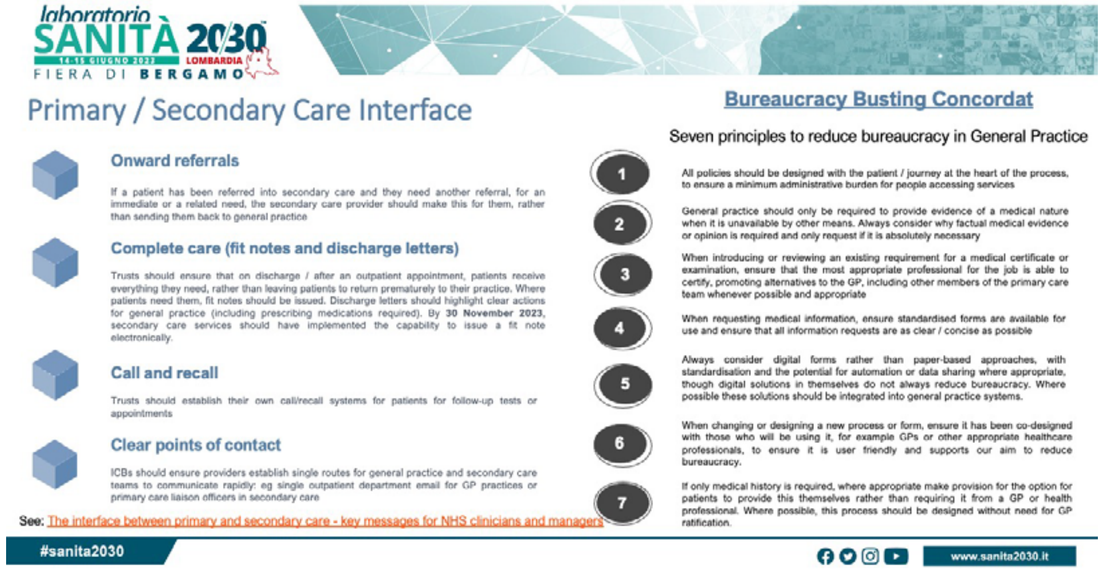
- The number of **Practice Nurses** across London **has decreased** from March '20 to '23 by 48 FTE
- The **better resourced boroughs have over 100% more practice nurses per 10k population** than under-resourced areas of the capital
- The regional vision and delivery plan for practice nursing is **focussed on growing the next generation, enhancing their role and career prospects** and use them as a catalysts for change

The Additional Roles Reimbursement Scheme (ARRS)

- The number of **Direct Patient Care roles** including those funded through ARRS **has grown to 4,460** (FTE).
- **London's share of the national target of 26k is approximately 4.4k above baseline** meaning that the workforce would need to grow to 5,346 fte by March 2024. Local plans show that PCNs expect to achieve this target although **turnover rates of 14%** highlight the recruitment and retention challenges they face.

WORKFORCE PRIORITIES FOR 23/24

- Supporting the development and planning of **Integrated Neighborhood Teams** to facilitate London's response to the Fuller Stocktake
- Working with ICBs and at scale providers to **develop innovative models of care** and associated workforce models that make the most **effective and flexible use of our existing workforce** resources
- Promote **SPIN fellowships** for all newly qualified GPs and Practices Nurses
- Promoting **mentoring,** enabling experienced GPs to gain portfolio working opportunities by supporting newly qualified GPs
- Working in partnership with NHSE colleagues to implement the regional **primary care workforce strategy** including to ensure that primary care provides **training, education and continuing professional development** for all members of the **multidisciplinary team**
- Support the development of **communities of practice** to support workforce in **deprived areas**
- **Addressing Discrimination and Harassment** through the implementation of the WRES primary care employer's framework



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Primary / Secondary Care Interface

Onward referrals

If a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice

Complete care (fit notes and discharge letters)

Trusts should ensure that on discharge / after an outpatient appointment, patients receive everything they need, rather than leaving patients to return prematurely to their practice. Where patients need them, fit notes should be issued. Discharge letters should highlight clear actions for general practice (including prescribing medications required). By **30 November 2023**, secondary care services should have implemented the capability to issue a fit note electronically.

Call and recall

Trusts should establish their own call/recall systems for patients for follow-up tests or appointments

Clear points of contact

ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: eg single outpatient department email for GP practices or primary care liaison officers in secondary care

See: The interface between primary and secondary care - key messages for NHS clinicians and managers

Bureaucracy Busting Concordat

Seven principles to reduce bureaucracy in General Practice

1. All policies should be designed with the patient / journey at the heart of the process, to ensure a minimum administrative burden for people accessing services
2. General practice should only be required to provide evidence of a medical nature when it is unavailable by other means. Always consider why factual medical evidence or opinion is required and only request if it is absolutely necessary
3. When introducing or reviewing an existing requirement for a medical certificate or examination, ensure that the most appropriate professional for the job is able to certify, promoting alternatives to the GP, including other members of the primary care team whenever possible and appropriate
4. When requesting medical information, ensure standardised forms are available for use and ensure that all information requests are as clear / concise as possible
5. Always consider digital forms rather than paper-based approaches, with standardisation and the potential for automation or data sharing where appropriate, though digital solutions in themselves do not always reduce bureaucracy. Where possible these solutions should be integrated into general practice systems.
6. When changing or designing a new process or form, ensure it has been co-designed with those who will be using it, for example GPs or other appropriate healthcare professionals, to ensure it is user friendly and supports our aim to reduce bureaucracy.
7. If only medical history is required, where appropriate make provision for the option for patients to provide this themselves rather than requiring it from a GP or health professional. Where possible, this process should be designed without need for GP ratification.

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Fuller review and strategic development

- **The Fuller Review is a stocktake report undertaken by Dr Claire Fuller,** Chief Executive Surrey Heartlands Integrated Care System looking at what is working well, why it's working well and how we can **accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry)** across systems
- The report provides a catalyst and opportunity to reflect and focus the direction of travel for primary care. It challenges areas to be bold and innovative in creating ***"both the conditions to enable locally led change and the supporting infrastructure to implement it"***
- Primary Care has been under considerable strain for some time – this was exacerbated by Covid-19 and the backlog created during the pandemic. A significant and growing proportion of patients require complex care co-ordination for multiple co-morbidities. While the pandemic also widened existing health disparities and points to an urgent need to focus on primary prevention, starting with Core 20+5 populations.
- **London systems are already delivering elements of the vision and the direction of travel aligns to local strategies.** Much of what was set out in London strategies such as the 'Next Steps to the strategic commissioning framework' links closely with the content of the report and a range of local and regional work such as within the Estates area is already attempting to make progress in line with the identified actions.
- There will be a requirement to take an integrated whole system approach to this. London stakeholders such as NHSE, ICSs, partners such as LA's, GLA, LMCs and national will need to consider any key thinking the report highlights and how to take forward some of the asks set out in the report if they are not already being planned for. **There is scope to consider how London can prioritise areas of work, collectively manage any challenges working with all key stakeholders and within this support progress and share good practice.**
- There is a growing consensus that providing the same degree of person-centred continuity of care to all patients, from cradle to grave is no longer sustainable. At the same time, many people – particularly those who are generally fit and well – prioritise faster access over continuity of care and have embraced 'digital first' primary care accelerated by the pandemic. The current model of care, which has largely been unchanged, requires adaption...

Delitti in materia di violazione del diritto d'autore (Art. 25-novies, D.Lgs. n. 231/2001) [articolo aggiunto dalla L. n. 99/2009]

- Messa a disposizione del pubblico, in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta, o di parte di essa (art. 171, legge n.633/1941 comma 1 lett. a) bis)
- Reati di cui al punto precedente commessi su opere altrui non destinate alla pubblicazione qualora ne risulti offeso l'onore o la reputazione (art. 171, legge n.633/1941 comma 3)
- Abusiva duplicazione, per trarne profitto, di programmi per elaboratore; importazione, distribuzione, vendita o detenzione a scopo commerciale o imprenditoriale o concessione in locazione di programmi contenuti in supporti non contrassegnati dalla SIAE; predisposizione di mezzi per rimuovere o eludere i dispositivi di protezione di programmi per elaboratori (art. 171-bis legge n.633/1941 comma 1)
- Riproduzione, trasferimento su altro supporto, distribuzione, comunicazione, presentazione o dimostrazione in pubblico, del contenuto di una banca dati; estrazione o reimpiego della banca dati; distribuzione, vendita o concessione in locazione di banche di dati (art. 171-bis legge n.633/1941 comma 2)
- Abusiva duplicazione, riproduzione, trasmissione o diffusione in pubblico con qualsiasi procedimento, in tutto o in parte, di opere dell'ingegno destinate al circuito televisivo, cinematografico, della vendita o del noleggio di dischi, nastri o supporti analoghi o ogni altro supporto contenente fonogrammi o videogrammi di opere musicali, cinematografiche o audiovisive assimilate o sequenze di immagini in movimento; opere letterarie, drammatiche, scientifiche o didattiche, musicali o drammatico musicali, multimediali, anche se inserite in opere collettive o composite o banche dati; riproduzione, duplicazione, trasmissione o diffusione abusiva, vendita o commercio, cessione a qualsiasi titolo o importazione abusiva di oltre cinquanta copie o esemplari di opere tutelate dal diritto d'autore e da diritti connessi; immissione in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta dal diritto d'autore, o parte di essa (art. 171-ter legge n.633/1941)
- Mancata comunicazione alla SIAE dei dati di identificazione dei supporti non soggetti al contrassegno o falsa dichiarazione (art. 171-septies legge n.633/1941)
- Fraudolenta produzione, vendita, importazione, promozione, installazione, modifica, utilizzo per uso pubblico e privato di apparati o parti di apparati atti alla decodificazione di trasmissioni audiovisive ad accesso condizionato effettuate via etere, via satellite, via cavo, in forma sia analogica sia digitale (art. 171-octies legge n.633/1941).

Torna all'inizio