Meeting Date	**27 April 2021**	**Agenda Item**	
Report Title	**Primary Care Contracted Services – Measures and Data**		
Report Author	Sam Page Head of Primary Care Sharon Miller, Associate Service Director		
Report Sponsor	Brian Owens, Service Group Director		
Presented by	Sharon Miller, Associate Service Director; Sam Page Head of Primary Care		
Freedom of Information	Open		
Purpose of the Report	This report is intended to be a series of reports that provide the Health Board Performance and Finance Committee with information on the available measures and data for primary care contracted services to enable the development of a meaningful suite of performance measures and data that can provide the Performance and Finance Committee with assurance on contracted services.		
Key Issues	This first report will provide an explanation of the available information to the Health Board that provides an indication on the quality and performance of access to primary care contracted services. This information is reviewed and monitored by the primary care team within the Primary Community and Therapies Service Group (PCTSG). The focus of this first report will be on access to primary care contracted services and will include: • General Medical Services Access Standards • GP Sustainability • GP and Community Pharmacy Escalation Levels • Access to General Dental Services • Patient Feedback		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☐	☐
Recommendations	The Performance and Finance Committee are asked to consider the information presented on access to primary care contracted services and discuss the level of assurance that it provides to the Committee and the ongoing reporting requirements.		

Primary Care Contracted Services – Measures and Data

1. INTRODUCTION

This report is intended to be a series of reports that provide the Health Board Performance and Finance Committee with information on the available measures and data for primary care contracted services to enable the development of a meaningful suite of performance measures and data that can provide the Performance and Finance Committee with assurance on contracted services.

The focus of this first report will be on access to primary care contracted services.

2. BACKGROUND

Swansea Bay University Health Board (SBUHB) is responsible for the commissioning of primary care services for the local population. Over 90% of patient contacts take place in General Medical Practices which are responsible for providing General Medical Services [GMS] from 0800 to 1830, Monday to Friday with urgent cover outside these hours provided by SBUHB Urgent Primary Care Service. There are 49 GP Practices across the SBUHB footprint of which one is a directly managed practice. The Health Board also contracts with 93 Community Pharmacies, 72 Dental practitioners (including two Orthodontic and two oral surgery specialists) and engages with 31 Optometry practices who provide on behalf of NHS Wales enhanced eye care services, there is currently no national contract for optometry.

This first report will provide an explanation on the available information to the Health Board that provides an indication on the quality and performance of access to primary care contracted services. This information is reviewed and monitored by the primary care team within the Primary Community and Therapies Service Group (PCTSG).

2.1 General Medical Services Access Standards

In September 2019 Access to In-Hours GMS Service Standards guidance was released. The access standards strive to improve access to services, which is a key strategic priority for Welsh Government and is central to the Primary Care Model for Wales. The standards aim to provide practices with clear expectations to work towards, with a need to better understand the barriers people face in accessing GP services.

To take account of the changes in working practice as a consequence of the Covid-19 pandemic, it is important to highlight that the GMS access standards and guidance from 2019/20 has been amended. Later guidance is supplementary to the original access standards published in September 2019. In addition, with agreement between Welsh Government, GPC Wales and NHS Wales additional amendments have since been decided of which have been referenced within the latest release of guidance. A list of the updated access standards issued in January 2021 can be found in **Appendix 1**.

It should be noted by the Committee that achievement of the Access standards are not contractual and GP practices are required to self-report quarterly to Health

Boards using the agreed digital access reporting tool developed by NHS Wales Informatics Service (NWIS). This tool has the provision for the uploading of evidence to support validation of year-end achievement to enable authorisation of funding linked to achievement. The deadline for practices to report year-end achievement using the tool is the 23rd April 2021; at this stage evidence will be used by Health Boards for verification purpose.

It is proposed by the PCSTG to report the year end position by cluster to the Committee against each of the standards and provide a quarterly position report. Due to the sensitives around achievement and income, it is proposed to report practice level data at in-committee only should this information be requested.

A summary of the standards and the total % achievement reported by practices at December 2020 is outlined below.

Group 1 Access Standards

Standard 1 – Phone Systems

In order to achieve Standard 1, Practices were asked to confirm the following:

- Does your phone system have a recording function for incoming and outgoing lines?
- Does your phone system have the ability to stack calls?
- Are you able to interrogate your telephone system to analyse data on calls?

Number of practices achieving standard 1:

45 of 49 (92%) practices confirmed in December 2020 that telephone systems are able to record calls, stack calls and analyse call data.

Standard 2 - Calls Answered

In order to achieve Standard 2, Practices were asked to confirm the following:

- Are you able to demonstrate that 90% of your calls are answered within 2 minutes of the introductory message ending?
- Are you able to demonstrate if less than 20% of calls are reported as abandoned?

35 of 49 (71%) practices confirmed in December 2020 that they are able to demonstrate that 90% of their calls are answered within 2 minutes of the recorded message ending.

This standard has been relaxed as per guidance issued in March 2021. Achievement for this Standard at the end of March 2021 will be carried forward with achievement being counted as the same as at March 2020, with practices retaining the ability to evidence achievement if they didn't last year.

Standard 3 – Bilingual Message

In order to achieve Standard 3, Practices were asked to confirm the following:

- Are you able to confirm if your telephone introduction message is recorded bilingually and lasts no longer than 2 minutes?
- if yes, please confirm if you have used the national bilingual message

38 of 49 (78%) practices confirmed in December 2020 that their telephone introduction message is recorded bilingually and last no longer than 2 minutes.

Standard 4 – My Health Online

In order to achieve Standard 4, Practices were asked to confirm the following:

- Can you confirm if your practice offers patients access to order repeat prescriptions through a digital solution e.g. MHOL?
- Can you confirm if your practice offers care homes access to order repeat prescriptions through a digital solution?

43 of 49 (88%) practices confirmed in December that they offer access to order repeat prescriptions for both patients and Care Home residents.

Standard 5 – Email

In order to achieve Standard 5, Practices were asked to confirm the following:

- Can you confirm if your practice offers an email facility for patients to request non-urgent appointments or a call back?
- Does the practice have the necessary governance arrangements in place for this process?

35 of 49 (71%) practices confirmed in December that they offer an email facility to request non-urgent appointments/call backs and have the necessary governance arrangements in place.

Standard 6 – Informing Patients

In order to achieve Standard 6, Practices were asked to confirm the following:

- Can you confirm that your practice publicises information for patients on how to request an urgent, routine and advanced consultation?
- Can you confirm that your practice publicises information for patients on how to request a consultation via the practice leaflet and practice website?
- Can you confirm that your practice displays information on Standards of Access?

44 of 49 (90%) practices confirmed in December that they publicise information on how to request advanced consultation and display information on Standards of Access.

Standard 7 – Appointments

In order to achieve Standard 7, Practices were asked to confirm the following:

- Does your practice use a triaging system?
- Does your practice offer same day consultations for children under 16 with acute presentations?
- Does your practice offer same day consultations for patients clinically triaged as requiring an urgent assessment?
- Does your practice offer pre-bookable appointments within 2/3 weeks and up to 6 weeks in advance?
- Does your practice actively signpost queries to alternative cluster based services, health board wide and national services?

42 of 49 (86%) practices confirmed in December that they offer a triage system, offer same day appointment for under 16 year olds, offer pre bookable appointment 2/3 weeks in advance and actively sign post to alternative cluster based services which could include direct access to alternative clusters services if available without the need for triage.

Standard 8 – Patients Needs and Demands

In order to achieve Standard 7, Practices were asked to confirm the following:

- Can you confirm that your practice has undertaken an annual patient survey, reflected on the findings and an action plan discussed at cluster level?
- When was the date of the last survey?
- When was the date the last survey was discussed at a Cluster meeting?
- Can you confirm that your practice has undertaken a demand and capacity audit and considered the findings?

23 of 49 (47%) practices confirmed they have undertaken an annual patient survey.

This standard has been relaxed as at 22nd January 2021 according to the latest guidance issued.

2.2 GP Sustainability

In common with other parts of the UK / Wales sustainability issues are being experienced in general medical practices within SBUHB. The National GP Sustainability Framework is a mechanism for assessing the sustainability of GP practices and has been in place since April 2015. The sustainability assessment criteria identify the potential for practices at risk of closure within 12 months and / or those at risk of a reduction in the range of services provided through external factors which may impinge on the sustainability of the practice. The Primary Care Team work closely with practices experiencing sustainability issues and this Framework also provides a mechanism for formal support.

To date there has been 19 local sustainability assessment panels, these are attended by both the Community Health Council and Local Medical Committee for consideration of 15 applications which have been formally made by practices. Panels have granted a range of additional practical or financial support on a case by case basis.

The sustainability position was last formally recorded in 2019 and in total there were 5 ‘red’ practices and 10 ‘amber’ within SBUHB. Red indicates a high sustainability risk, amber a medium risk and green a low risk, this positions indicates that 31% of GP practices across SBUHB are experiencing sustainability issues a copy of the sustainability risk matrix is included at **Appendix 2.** This is reflected on our risk register and a number of actions taken to mitigate the sustainability risk have been undertaken by the primary care team, including proactive advice and support. Consideration is currently being given to repeating the sustainability risk matrix exercise and this position alongside the number of sustainability panels held could be reported to the committee on a regular basis.

2.3 GP and Community Pharmacy Escalation Levels

The use by all 49 GP practices of the national escalation tool also enables regular assessment of GP practice risk and sustainability. We have seen a broadening scope of threats to the sustainability of General Practice, including stability of the wider practice workforce. Action cards have been developed to guide the contact and support discussions with practices at various levels of escalation. Significant work has also been undertaken to review and support practices with the strengthening of their Business Continuity Plans.

Levels 1 and 2 indicated the practice position is sufficient to maintain practices services, Level 2 noting that contacts are higher than expected.

Level 3 represents increased demand, coupled with workforce issues or business continuing issues impacting on service delivery, patient safety and / or practices processes.

Level 4 represents further escalation of the Level 3 position with significant impact on service delivery, patient safety and / or practices processes.

Level 5 indicates a closed practice.

Diagram 1 below shows practice escalation levels, using the national escalation tool for GMS, over a 60-day period. This shows an improved position from the previous quarter Diagram 2, where a number of Practices were reporting escalated levels due to these challenges, which also coincided with increased escalation within the community and care home services. The PCTSG played an integral role in ensuring relevant support, advice and guidance was provided to these services to limit further escalation and avoid unnecessary pressure within our hospital services.

Diagram 1

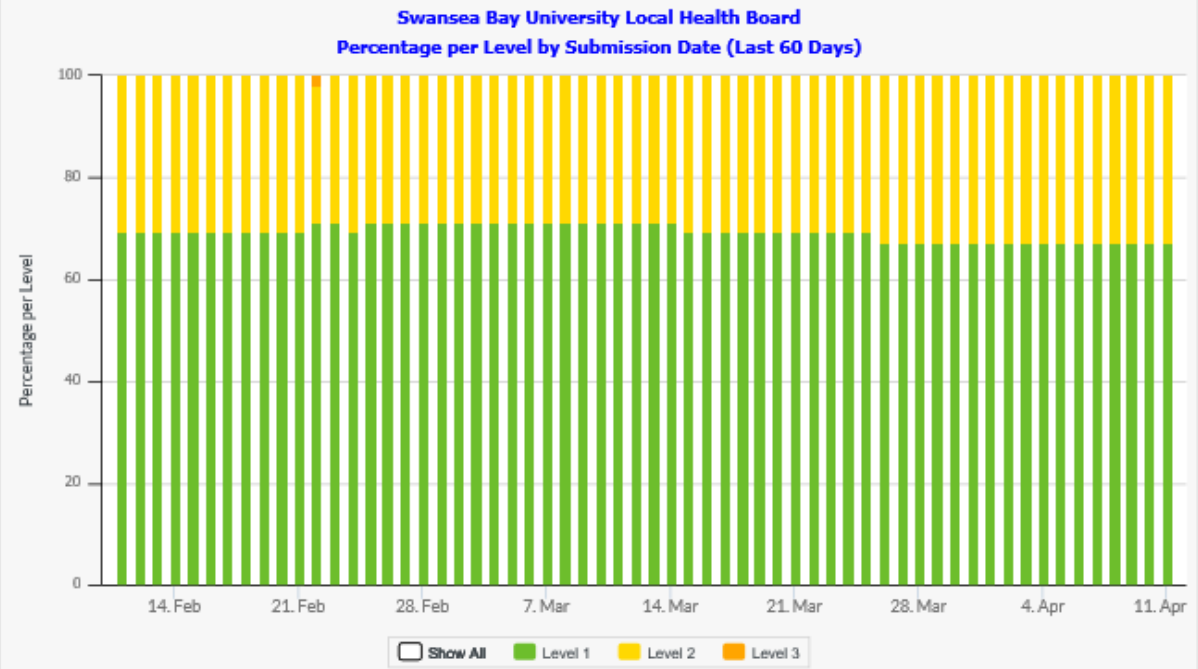
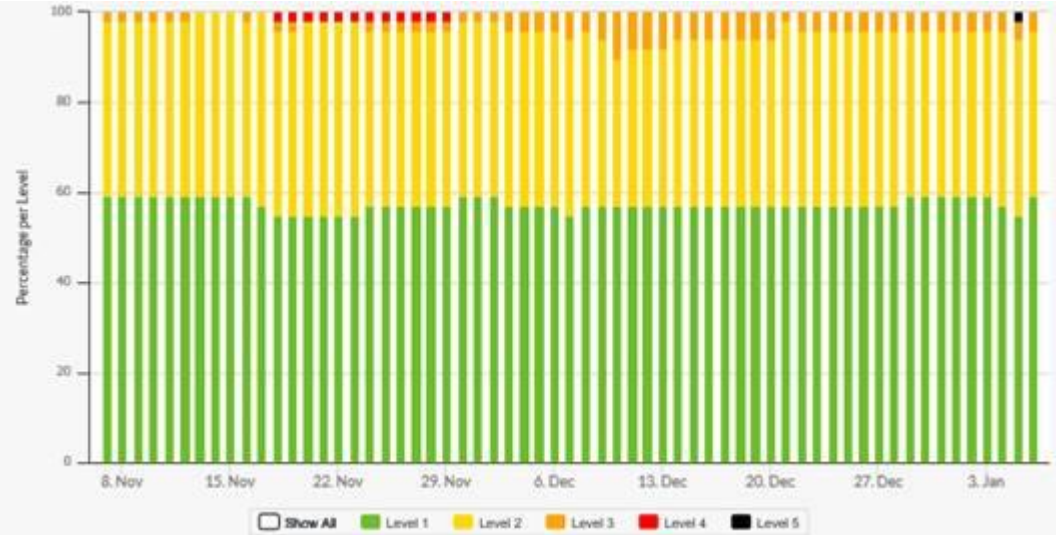


Diagram 2



Community pharmacies across Wales also engaged in business continuity planning and to ensure Health Boards were cognisant of pressures within the system; an online Escalation Tool and a supportive planning resource was developed. The tool is designed to support operational planning at times of pressure and wider engagement in terms of business continuity planning. Information is used locally as an effective escalation process.

Swansea Bay University Health Board				
Cluster	0	1	2	3
Afan	1	7	3	2
Bay Health	1	11	5	1
City Health	0	9	4	1
Cwmtawe	0	6	3	0
Llwchwr	1	6	2	1
Neath	1	5	3	1
Penderi	0	6	3	0
Upper Valleys	3	5	2	1
Swansea Bay University Health Board	7	55	25	7

2.4 Access to General Dental Services

The current General Dental Services (GDS) Contract introduced in April 2006 remunerates dentists by an annual contract value in return for providing an agreed level of Units of Dental Activity (UDAs). It is well documented that General Dental

Practitioners (GDPs) find the current contract restrictive which limits access with GDPs reluctant to accept new patients because they don't know the extent of treatment patients may require. UDAs are allocated based on courses of treatment and dental treatment is categorised in the various bandings, so for example a dentist would receive the same number of UDAs whether the patient needed 1 filling or 5 fillings. Also UDAs are the main measurement of dental performance but does not give assurance on the quality of the service. For this reasons, although since 1st April 2006 patients are also no longer required to be registered with a particular dentist, GDPs can choose to maintain a list of regular patients to whom they provide regular or ongoing treatment or care.

The Welsh Government has acknowledged the current contractual system needs reform. UDAs as a sole measure of contract performance, focusing on treatment activity only, does not encourage needs-led care, prevention, or make the best use of the skills of the whole dental team. Prior to the pandemic general dentistry was on a journey of contract reform to move away from UDA targets with a focus on improved delivery of evidence-based prevention, the implementation of needs-led dental recall intervals and an increase in the use of skill mix.

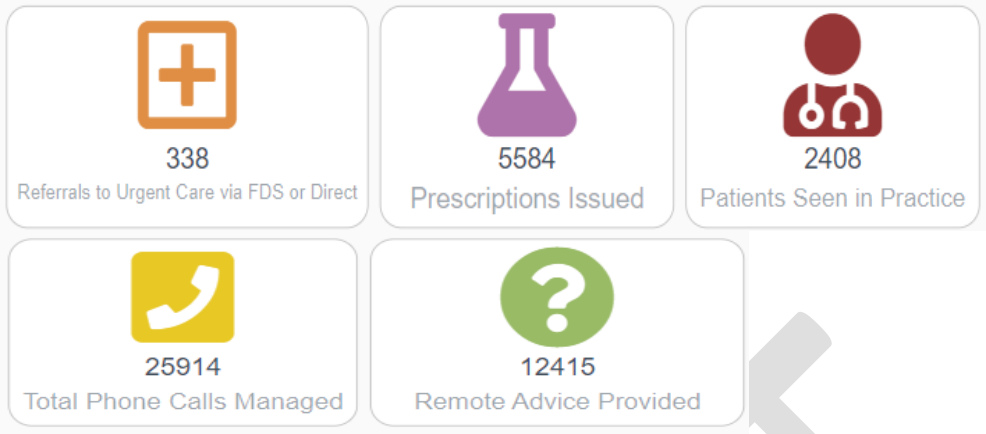
On joining the programme, practices start using a standardised risks and needs assessment toolkit, attached at **Appendix 3** called ACORN (Assessment of Clinical Oral Risks & Needs) and move away from the traditional model of dental check-ups. Practices carry out risks and needs assessment once a year instead of dental check-ups every 6 months. Practices are also expected to improve their delivery of personalised evidence-based prevention such as brief intervention on smoking cessation and referral, application of fluoride varnish on teeth, etc.

There are currently 132 practices participating in the programme across Wales, which represent over 30% of all general dental practices. The aim was to have over 50% of practices part of the reform programme by October 2020 and with 22 Practices (31%) in SBUHB part of the programme this was an achievable target for SBUHB; unfortunately, the pandemic has resulted in the suspension of the programme alongside the UDA target.

Access to dental services has been significantly impeded by the COVID-19 pandemic, on 23rd March 2020 dental services went into 'Covid-19 Red Dental Alert Level', which meant that all routine scheduled dentistry paused and all aerosol generating procedures (AGPs) e.g. those treatments that require high speed drills, needed to be undertaken in a Health Board designated Urgent Dental Centre (UDC).

It is important to note that there continued to be urgent access for dental patients. All of our local General Dental Practices, in line with this national position, were available and were triaging patients throughout, known to them or not, providing advice and reassuring patients who have a dental problem by telephone. Dentists were able to issue remote prescriptions for AAA (Advice, Antibiotics and Analgesia)

SBUHB General Dental Practice Activity during the Red Alert (23rd March – 19th June):

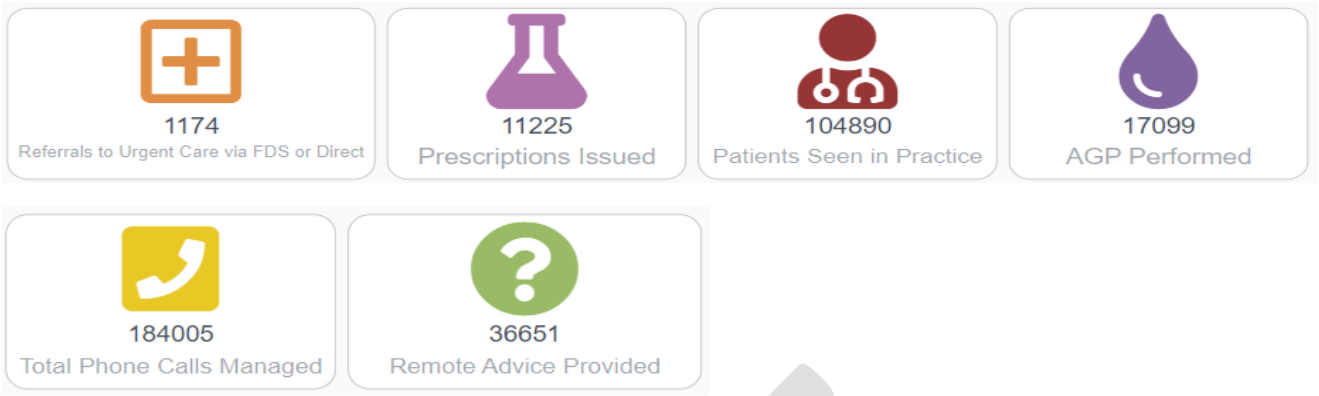


On the 19th of June 2020 dental services moved to Amber alert level and will continue to remain in Amber until at least 30th September 2021. The WG guidance asked dental practices to prioritise the most urgent patients and those with ongoing treatment needs that had been delayed due to the pandemic, releasing of the very prescriptive Red guidance of using AAA (Advice, Antibiotics and Analgesia) and allowed them to prioritise those patients with urgent routine needs and recommence AGPs from 17th August 2020.

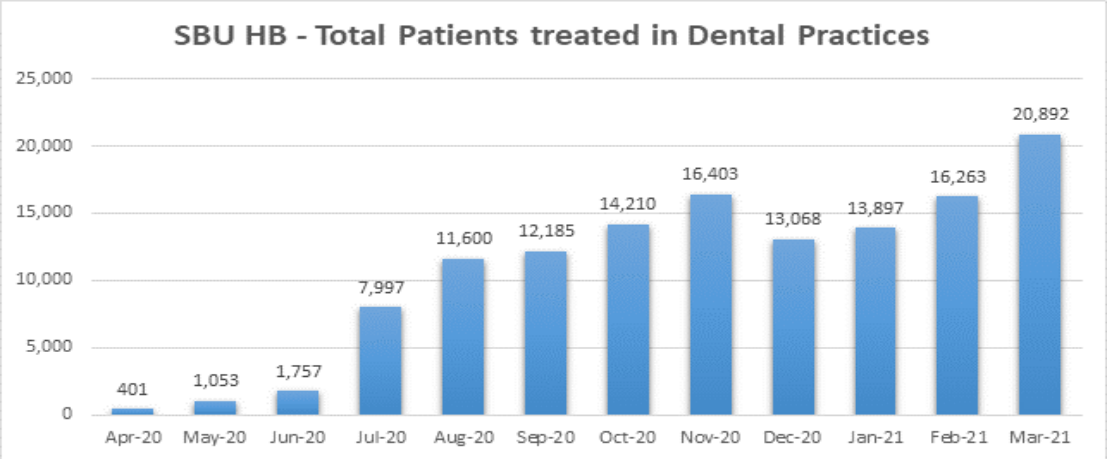
Practices were asked to prioritise those patients with urgent or ongoing treatment needs and those patients whose treatment cannot be delayed. Routine care can now be offered but only if the practice has the capacity to do so, as well as being able to offer same day urgent care to patients and treating those whose care was delayed due to the pandemic. If a practice has capacity to re-start routine care, there would still need to be a priority for any routine assessments to be carried out on patients who are known to be at risk of deteriorating oral health.

The effect of complying with all the necessary Covid-19 precautions, which requires dental practices to ensure a mandatory fallow time between patients has seen the capacity of an average NHS dental provider drop by around 80%. Hence, the vast majority of care is currently focused on the most urgent patients as outlined. However, within the last quarter practices are slowly beginning to address the routine treatment backlog, whilst continuing to implement the stringent Standard Operating Procedure (SOP) requirements necessary.

GDS Activity during Amber (19th June 20 – 19th Feb 21)



This graph below shows the increasing volume of activity being undertaken at Dental Practices within SBU HB despite the current restrictions.



The expectations for Quarter 1 and Quarter 2 for the restoration of dental services focuses on the principles of addressing priority needs and inequalities, stepping up preventive intervention and care, and making effective use of the resources. UDAs and the contract reform programme continue to be suspended as activity or performance measures. However, there are new alternative achievable measures, which will sit alongside the existing contractual requirements such as opening hours and NHS commitment. Need and risk will drive access to and priority of care delivery and assessment, treatment activity, proactive prevention and recall/assessment review intervals are expected to follow individual need assessment findings and priorities for treatment.

These measures are intended to prepare practices for a re-start of contract reform later in the year. What is expected is 'need and priority led' delivery of 'good preventive dentistry'.

These new measures for quarter 1 and quarter 2 include:

- **Aerosol Generated Procedures (AGPs)** – practices must be carrying out AGPs in accordance with the national Standard Operating Procedure (SOP) requirements. The health board would expect to see a reasonable amount of

AGPs being delivered to reflect the needs of the local population and the practice contract size.

- **ACORN** (Assessment of Clinical Oral Risks & Needs) - mandatory use of ACORN, which should be completed for every patient (including urgent cases) once a year, with the 8 data points reported on FP17s (Dental providers submit forms (FP17) detailing dental activity data. The data recorded on the FP17 shows the patient charge collected, the number of units of activity performed and treatment banding information)
- **New Patients** – accepting a level of new patients defined by contract size. New patients being defined as an adult patient who has not been seen in the practice in the previous 24 months or 12 months for children.
- **Fluoride Varnish** - Fluoride Varnish should be delivered in at least 80% of all children and those adult patients with risk of (amber), or active decay (red).

These new measures, which will be monitored monthly by the Primary Care Team are also intended to support improvement to access. Practices hold their own waiting lists and are expected to address the lists of patients waiting to access dental care.

It should also be noted by Committee that the Health Board also commissions in-hours urgent access sessions, these sessions are for patients who do not have a regular dentist but have an urgent dental need. If a patient contacts this service and needs to see a dentist, they will be offered an appointment. Access is via 111 and referral to the Health Board Referral Management Centre, who will assess the patient's needs and provide an appointment at one of the dental practices offering these sessions.

It is proposed to report at the end of quarter 1 and 2 the position against the new measures for general dental services.

2.5 Patient Feedback

Patients can complain either directly to the primary care contractor (which the majority do) or to the Health Board under the Putting Things Right Policy.

In the table below is the number of complaints received by the Health Board during November, December and January.

The average number of complaints per month is just over 13.

Complaints	18	10	12
Month	Nov 20	Dec 20	Jan 21
Themes	6	5	7

Below is a thematic analysis of those complaints (to note, one complaint may have multiple themes):

	Nov 2020	Dec 2020	Jan 2021	Total
Administrative Processes (Excluding Documentation)	6	1	2	9
Communication	8	5	6	19
Diagnostic Processes/Procedures	0	2	0	2
Documentation	0	1	1	2
Medication/Biologics/Fluids	2	1	2	5
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	2	0	1	3
Total	18	10	12	40

Complaints are referred back to the related Practices to be dealt with if appropriate; however, where there are ongoing concerns complainants are routinely provided with an offer to meet to discuss these and also with the contact details of the CHC and Public Services Ombudsman for Wales.

Not all complaints are received by the Health Board; others are directed immediately to the practice. The Primary Care Team has recently reintroduced a formalised procedure for identifying how contractors review their complaint data by conducting a quarterly practice complaints audit.

3. GOVERNANCE AND RISK ISSUES

Governance is an integral part of the PCTSG contractual monitoring processes. The measures and data outlined within this report highlight the existing key areas for measuring and reviewing quality and performance specific to Contractors, which has provided a level of assurance to the PCTSG either through review of available data and information or through practices visits.

There are no significant risks or governance issues to highlight to the Committee within this report. All Primary Care related risks are reflected on the Service Group risk register and discussed at the Service Group Quality and Safety Forum.

4. FINANCIAL IMPLICATIONS

The monitoring and production of primary care data is undertaken from within the resource of the PCTSG primary care team.

All performance related payments are made within the underspent primary care contract ring-fenced budgets.

5. RECOMMENDATION

The Performance and Finance Committee are asked to consider the information presented on access to primary care contracted services and discuss the level of assurance that it provides to the Committee and the ongoing reporting requirements.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐

Quality, Safety and Patient Experience

Governance is an integral part of the PCTSG contractual monitoring processes. The measures and data outlined within this report highlight the existing key areas for measuring and reviewing quality and performance specific to Contractors, which has provided a level of assurance to the PCTSG either through review of available data and information or through practices visits.

There are no significant risks or governance issues to highlight to the Committee within this report.

Financial Implications

The monitoring and production of primary care data is undertaken from within resource of the PCTSG primary care team.

All performance related payments are made within the underspent primary care contract ring-fenced budgets.

Legal Implications (including equality and diversity assessment)

None

Staffing Implications

None

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

Briefly identify how the paper will have an impact of the “The Well-being of Future Generations (Wales) Act 2015, 5 ways of working.

- **Long Term** - The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
- **Prevention** - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.
- **Integration -** Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies.
- **Collaboration -** Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives.
- **Involvement -** The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

Report History	None
Appendices	Appendix 1 Access Standards  Appendix 1 Access Standards.docx Appendix 2 Sustainability Risk Matrix  SUSTAINABILITY risk matrix template Sept Appendix 3 – ACORN  Appendix 3 ACORN.pdf