Department of Health & Social Care

Sexual Health Services: Key Principles for Cross Charging

Updated guidance for commissioners and providers of sexual and reproductive health services in England

August 2018

DH ID box
Title: Sexual Health Services: Updated Guidance on Key Principles for Cross-Charging for Commissioners and Providers of Sexual and Reproductive Health Services in England
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Document Purpose: Guidance
Publication date: August 2018
Target audience: Commissioners of sexual and reproductive health services Providers of sexual and reproductive health services
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Published to gov.uk, in PDF format only.

www.gov.uk/dh

Contents

1. Introduction

1.1. The Department of Health and Social Care (DHSC) issued guidance, endorsed by Local Government Association, Public Health England (PHE) and Association of Directors of Public Health on cross-charging Sexual Health Services: Key Principles for Cross-charging in August 2013. The guidance was produced to support local authorities and providers following transition to local government commissioning of sexual health services to promote a consistent, fair and transparent approach.

1.2. Since 2013, the commissioning landscape for sexual health services has changed and become more complex as set out in Sexual Health, Reproductive Health and HIV: A Review of Commissioning published by PHE in September 2017. The majority of local authorities have now competitively tendered services in contrast to the situation prior to 2013, when long term NHS contracts were generally in place. The outcome of tendering has resulted in a more modernised 21st century service and integrated with improved access and innovative digital approaches for the sexual and reproductive health programme.

1.3. Local authority commissioning arrangements have evolved since 2013 and local areas have adapted their own policies and approaches to how cross-charging for sexual health services can work across their local footprint. While different approaches and arrangements are in place, it is important to maintain some general principles including an equitable approach to cross-charging and billing for out of area (OOA) service users from both a commissioning and provider perspective. This refreshed guidance is aimed at both Commissioners and Providers to support the development of fair and transparent cross charging approaches across footprints in England. It also includes examples of cross-charging agreements from local authorities. This document reinforces the key principles set out in the earlier 2013 guidance around open access sexual health services and restates the obligations placed upon local authorities in this regard by Regulations. This guidance will be reviewed annually.

2. Background

Legal Position

2.1 Local authorities have a legal duty to commission open access services for the provision of contraception and detection and treatment of sexually transmitted infections (STIs).

2.2 Since 1 April 2013 the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (the 2013 Regulations) require that each local authority "shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area":

- For preventing the spread of sexually transmitted infections (STIs);
- For treating, testing and caring for people with such infections;
- For notifying sexual partners of people with such infections, and
- Advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and
- Advice on preventing unintended pregnancy.

The full text of the requirements in the 2013 Regulations on local authorities is in Annex A.

3. Key principles

3.1. In 2013, the Advisory Committee for Resource Allocations (ACRA) published its view that cross-charging is the best way to handle service use by OOA service users applicable to sexual health. Experience has shown that using these mechanisms lead to fair payments, stabilisation of services, and promotion of innovation.

Integrated services and care

3.2. The integration of service provision in many areas and the fact that the open access mandate applies equally to STI and contraception care indicates that having the same payment mechanisms in place is beneficial, particularly when it is the same episode of care for the same patient being provided. In this situation, there are unique challenges if separate charging arrangements are in place. However, there are historical differences for charging STI and contraception care and ultimately it is for local determination how payment arrangements work and solutions found that meet legal requirements, the needs of local areas and local populations. However, as set out earlier, the principles set out in the DH 2013 guidance remain relevant. We strongly advise both commissioners and providers adhere to these principles and the approaches set out in this updated guidance.

Patient Flows

3.3. Cross-charging arrangements for OOA attendances remain in place in most areas for STI testing and treatment. Cross border flows vary significantly. This can create a significant burden and in areas where there are large patient flows, LAs are investing in dedicated staff time to administer invoices. Data from PHE showed that for Genitourinary Medicine (GUM) attendances at the level of upper tier LAs in 2016:

- 34% of first attendances were by out of area residents
- 29% of follow up attendances were by out of area residents

3.4. The Sexual and Reproductive Health Activity Data (SHRAD) set for 2016/17 shows that for contraception attendances, 21% of attendances were by out of area residents.

3.5. The GUMCAD STI Surveillance System is used to monitor trends in STIs, but can also be used to monitor service provision, attendances, and patient flows. Therefore, providers should ensure that coding of attendances for both GUMCAD and SHRAD is as accurate as possible given this data is used to analyse patient flows and determine funding arrangements.

STI Testing, Treatment and Care

3.6. Re-charging by the provider for the costs of GUM services for testing, treatment and care for STIs, back to the area where the user is normally resident has been in place for many years and prior to the transfer of sexual health commissioning to local authorities in 2013. A mandatory NHS tariff was in place for GUM services prior to transition which became non-mandatory for local authorities. The last published NHS tariff was in

2015/16 and was set as £131 for a multi-professional first attendance and £103 for a multi-professional follow up attendance. Payment of a Market Force Factor (MFF) used in the NHS tariff, is NOT mandatory for local authorities.

3.7. Cross-charging supports health protection and the prevention of onward transmission of infectious diseases, open access and patient choice. However, cross-charging agreements should be equitable, fair and transparent and to achieve this, the following is strongly advised:

- For the purposes of transparency, providers must make sure the price list for OOA charges is disclosed to all local authorities prior to the start of each financial year. Any changes in price must be agreed with the local commissioner.

- The price charged by providers to all local authorities should not be more than the rate agreed for attendances by local residents. This means that the provider charges all commissioners the same price regardless of residence of the patient. For example, if a patient from Sunderland attends a service in Bedford; Sunderland will be charged the price agreed between the provider and Bedford.

- If the provider is funded through a block contract, it should be explicitly stated whether the cost of OOA attendances is covered by the block contract for GUM and/or contraception. If OOA attendances are not funded by the block contract, there needs to be agreement that the provider will invoice other local authorities for that activity.

- Local Authorities can also support this process by publishing the locally agreed prices that they pay for their residents with their locally contracted service providers.

- Commissioners and providers may wish to work together to negotiate an agreed tariff or price where there are long established patient flows. There are examples where this is working well.

- If there is a broadly predictable patient flow between two areas which is of a similar level, and therefore ‘cancels each other out’, commissioners may wish to reach reciprocal arrangements whereby activity is not invoiced, particularly where the administrative burden outweighs the marginal differences in patient flow between the two areas. The arrangements should be reviewed each year to ensure that the patient flows remain in balance. Commissioners may wish to set a trigger for early discussions where the pattern changes significantly between areas. The views of the provider should also be sought.

- If a provider includes an additional geographical allowance due to increased costs of providing a service, for example, in an urban area, this must be clearly stated in the price list at the start of each financial year and must be in line with the geographical allowance agreed and charge to their local commissioner.

3.8. When invoicing for OOA service use, consideration must be given to protecting patient confidentiality, while providing sufficient information to the home local authority to verify the activity. Information on the patients registered GP is not sufficient to confirm LA of residence. A backing information template to provide this information was developed by the English HIV and Sexual Health Commissioners Group (Annex C). This template has

been risk assessed and it is considered that either individually or in combination, the data does not present a risk to patient confidentiality.

3.9. For the small number of users (2.7% in 2016) who wish to remain anonymous and decline to provide identifiable information, the cost should be assigned to the local authority in which the provider is based.

Contraception

3.10. Traditionally, cross-charging arrangements have not been in place for attendances at sexual and reproductive health services for contraception care and these costs have generally been absorbed by the host commissioner for contraception. Funding was allocated to local authorities during the transition to local authorities in 2012/13 on the above basis of continued host funding for contraception.

3.11. Commissioning arrangements for contraception are also more complex given user dependent methods of contraception are primarily supplied by general practice as part of General Medical Service (GMS) contracts with NHS England (in some areas this has been devolved to CCGs) and the provision of long acting methods of reversible contraception (LARC excluding injectable contraception) are primarily commissioned by Local Authorities via general practice and specialist sexual and reproductive health services. The majority of contraception care (around 80%) continues to be provided by general practice across England and they have a significant role to play in terms of reproductive health across the life course. SRH services tend to see women in younger age groups, in 16/17, women aged 18 to 19 were most likely to use an SRH service, with 18 per cent of women in this age group having at least one contact.

3.12. The same legal requirements for open access services apply to local authorities who are required to provide “reasonable access to a broad range of contraceptive substances and appliances” (as per the 2013 Regulations) and accordingly payment arrangements for contraceptive services should also be transparent, fair and equitable. As an increasing number of services are providing integrated sexual and reproductive healthcare care, it has become more challenging to identify who should pay if an attendance is related to both STI testing and contraception. In recognition of the integrated sexual and reproductive health service offer, some areas now have cross-charging arrangements for contraception in place. In other areas locally agreed arrangements are in place to deal with cross boundary flows.

3.13. These arrangements have been established where the majority of patient flows are within the same geographical region and LAs have worked together to agree the same payment terms and conditions and a transparent and consistent payment system in place of cross-charging arrangements.

3.14. It remains a matter for local agreement as to whether cross-charging or host funding is used for out of area contraception provision, however it is important that there is a consistent approach to this issue across a geographic footprint that has identified and assessed patient flows in and out of area. The provider should have a clear understanding as to the funding arrangement that is in place and which local authority should be invoiced for contraception attendances. If cross-charging is used then the principles set out above for STI care should be followed. If cross-charging is not in place and an LA has a large flow of residents to a service out of area consideration should be given to negotiating a price for these attendances with the provider.

On-line services

3.15. The use of on-line services is increasing and offers an additional service choice with the option of ordering self-testing kits and contraception through the internet. An on-line option is generally offered as an additional service for residents of the local authority commissioning the service only. This is in line with sexual health services commissioned from primary care and existing online options for chlamydia screening and HIV self-sampling which have been established for some time. LAs must still ensure that appropriate walk in and or appointment only physical services are available to anyone present in their area to continue to meet their open access mandate.

Students

3.16. Providers should seek information from students as to where they are currently residing. In term time this will be the local authority in which they are living and payment should be made by that authority. When the student returns to their "home" area outside of term time, it is that home LA that should be invoiced.

Looked After Children

3.17. Where Looked After Children are placed out of area, it is the LA of residence that should be charged for any attendances and not the LA who has placed the young person out of area.

Pre-exposure Prophylaxis (PrEP)

3.18. PrEP is a new use of HIV drugs and has shown clinical effectiveness in research trials at preventing HIV in people at high risk of acquiring HIV. Access to PrEP in sexual health services in England is through the PrEP Impact Trial. The trial is open to residents of England only.

3.19. The PrEP Impact Trial aims to answer key questions about the use of PrEP by those at high risk of HIV acquisition. The trial began in October 2017 and is planned to last three years and enrols up to 10,000 participants at high risk of acquiring HIV.

3.20. The trial research costs, and the cost of the trial drug, will be covered by the trial budget regardless of the place of residence of the trial participant (as long as the participant is ordinarily resident in England). Service costs of attendances out of area are anticipated to be dealt with by local authorities as they are now, that is, by cross-charging.

Attendances by people living outside England

3.21. Guidance issued by the DHSC in October 2017 on overseas visitors charging sets out that family planning services and diagnosis and treatment of sexually transmitted infections remain exempt from charges.

3.22. Overseas visitors should be funded by the LA in which the service provider is based, unless joint commissioning and risk sharing agreements are in place locally.

3.23. The legal position on charging is set out in the National Health Service (Charges to Overseas Visitors) Regulations 2015 which came into force on 6 April 2015 and have subsequently been amended, most recently by the NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017 (together "the Charging Regulations"). The Charging Regulations place a legal obligation on any organisation providing relevant services to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges.

3.24. Cross-charging does not extend to the devolved administrations. A patient registered in the devolved administrations treated in an England sexual health clinic is paid for by the host commissioner in England, and vice versa. As with overseas visitors, provision of services to people who are residents of Scotland, Wales and Northern Ireland should be funded by the LA in which the provider is based, unless local risk sharing arrangements are in place.

4. Way forward

4.1. It is unlikely that there will be a one size fits all model for cross charging. Increasingly, areas are finding solutions that work for them. These arrangements will inevitably vary according to local need and circumstances, particularly where numbers of cross border flows are high. We will review this document every year, sharing examples of practices and relevant updates.

4.2. Every effort should be made for local resolution of disputes. We encourage local authority commissioners to engage in early discussions as soon as problems arise. The English HIV and Sexual Health Commissioners Group can provide information and advice for commissioners on issues around cross-charging.

Annex A - Legislation

Extract of Regulation 6 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

Sexual health services

(1) Subject to paragraphs (4) and (5), each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area –

(a) By exercising the public health functions of the Secretary of State relating to the provision of contraceptive services under paragraph 8 of Schedule 1 to the Act (further provision about the Secretary of State and services); and

(b) By exercising the public health functions of local authorities pursuant to section 2B of the Act in the provision of open access services -

(i) for preventing the spread of sexually transmitted infections; and

(ii) for treating and caring for persons with such infections; and

(iii) for notifying sexual partners of persons with such infections.

(2) In paragraph (1), references to the provision of open access services shall be construed to mean services that are available for the benefit of all people present in the local authority's area.

(3) In exercising its functions in relation to the provision of contraceptive services under paragraph (1) (a), each local authority shall ensure that the following is made available-

- advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and
- advice on preventing unintended pregnancy.

(4) The duty of the local authority under paragraph (1)(a) does not include a requirement to offer to any person services relating to a procedure for sterilisation or vasectomy, other than the giving of preliminary advice on the availability of those procedures as an appropriate method of contraception for the person concerned.

(5) The duty of the local authority under paragraph (1)(b) does not include a requirement to offer services for treating or caring for people infected with Human Immunodeficiency Virus.

Annex B - Examples of Practices/Protocols

These are examples of some areas that have either singularly or collectively reached agreement to address some of the challenges faced on cross-charging.

Case study 1: Manchester

Collaborative commissioning of sexual and reproductive health services in Greater Manchester

The ten local authorities of Greater Manchester have taken a collaborative approach to the commissioning of integrated sexual and reproductive health services. The approach was agreed in order to address a number of identified issues including:

- Desire to provide integrated sexual and reproductive health services across all areas of Greater Manchester
- Requirement to reduce the costs of providing sexual and reproductive health services
- Requirement to reduce the risk of unanticipated or increasing spend – (on our commissioned services and from out of area charges from non-contracted providers)
- Requirement to maintain open-access arrangements
- The local authorities agreed a number of principles including:
- Integrated sexual and reproductive health services will be commissioned using a shared specification and block contracts, and delivered on a cluster basis (4 clusters)
- Local areas were responsible for funding both sexual and reproductive health services used by their residents
- Providers will be funded to offer services to all residents of Greater Manchester. This will be achieved through a commissioner-to-commissioner funding agreement, rather than through provider recharges to local areas,
- The local authorities, working in clusters and on a phased basis, have now procured a number of integrated sexual and reproductive health services for Greater Manchester. Our services operate on an open-access basis and offer the full range of sexual and reproductive healthcare provision.
- Integrated services in most of our areas are now commissioned on a block-contract basis; each block has been calculated to include a payment from the host council and payments from the other councils. The host council receives funding from the other councils to pay for services provided for their residents. This is calculated using a standard ‘cost per attendance’ fee, rather than separate amounts for contraception and GU.
- In the absence of a national tariff for contraception services, the local authorities took the decision that blocks would be calculated to include funding to pay for all attendances for contraception regardless of area of residence of the patient. On this basis, the councils do

not accept bills for contraception services provided for our residents from non-contracted providers and our providers do not bill other councils for contraception services provided for their residents. Commissioners continue to accept bills for attendances for STI testing and treatment (using the non-mandated tariff) and our providers continue to bill out-of-area commissioners.

Our collaborative commissioning arrangements have proved to be an effective solution for Greater Manchester. We have reduced the overall spend on sexual and reproductive health services. In addition, we have removed any incentive for providers to classify patients as attending for GU rather than CASH; and through paying for CASH services used anywhere in GM we have encouraged local areas not to disinvest in local areas.

Case Study 2: Yorkshire and Humber

Yorkshire and Humber Directors of Public Health adopted the following principles for cross-charging to ensure a fair approach ensuring all invoices are treated consistently which other areas are also now following:

- Authorities will only pay for invoices for Genitourinary Medicine activity within using the 2014/15 tariff cost envelope.
- Authorities will not reimburse invoices for contraception activity
- Authorities will not pay charges for market forces factor (MFF)
- Before making payment invoices and supporting data will clearly provide all the required information

Case study 3: Northumberland

Northumberland Local Authority went through a procurement cycle last year, which resulted in recommissioning our incumbent provider Northumbria Healthcare Foundation Trust (NHFT).

A significant footfall of residents attended Newcastle and North Tyneside services, and Northumberland had been paying a large amount of the ring fenced allocation for to those providers, despite also having a block contract for GUM and CASH in place with NHFT.

Within the new arrangement from August 2016, Northumberland bundled up the expected expenditure (for GUM only OOA payments) into the allocation for an Integrated Sexual Health Service and included a responsibility for the provider (NHFT) to pay for all OOA GU attendances across the two border areas to their relevant Trusts.

This resulted in Northumberland LA no longer needing to pay NHFT additional OOA charges for clients who crossed the border into NT as this was all now one block allocation. Also whilst recognising that clients have choice of where to attend and that there would be those who attended Newcastle services due to proximity of work, there were also those who attended because opening hours and locations were more accessible than those provided in Northumberland.

What has happened is that NHFT have radically reviewed the service previously provided and increased opening hours and provision nearer the border to Newcastle, as now they have a greater- incentive to attract clients. Previously on a block contract there was no impact on NHFT if Northumberland residents attended Newcastle services, other than the whole envelope of funding for SHS was reduced.

Northumberland will be reviewing numbers 'lost' to Newcastle over the coming months to see if they have fallen.

The LA continues to pay OOA charges for GU clients for all other areas.

Case Study 4: Derbyshire

Contraception

Under local Terms and Conditions, Derbyshire will:

- Pay for OOA contraception where there is a reciprocal agreement in place between respective commissioners. Where such an agreement is in place, the Local Authority will pay up to the locally agreed rate (excluding market forces factors/MFF) provided the required backing data is supplied. The Local Authority advises OOA providers to contact their commissioner to ascertain if a reciprocal agreement for contraception is in place prior to invoicing
- Pay OOA charges for GU clients within the 2014/15 tariff envelope (excluding MFF).

Case Study 5: South East

Under the terms of the Policy the Local Authority will reimburse:

- Provider invoices for out of area Genito-Urinary Medicine (GUM) activity at the locally agreed tariff for this activity (up to the non-mandatory national Department of Health GUM tariff cost envelope) excluding market force factors (MFF). This should be at no more cost than the tariff paid to the Provider by their local Commissioner.
- Provider invoices for contraception activity only when this activity forms part of GUM activity tariff for example, provision of emergency hormonal contraception (pill or IUD), pregnancy test or an initial starter pack of oral contraception as part of a GUM consultation.

Under the terms of the Policy the Local Authority will not reimburse:

- Provider invoices for standalone contraceptive activity, unless there is a prior formal agreement
- Market force factors (MFF) which are not applicable to Local Authorities
- HIV treatment and care activity which is the responsibility of NHS England
- Telephone or virtual support only
- Self-sampling or remote testing services at maximum locally agreed tariff or national non-mandatory tariff

Case Study 6: London Sexual Health Programme

The London Sexual Health Programme is a unique collaborative of 30 councils in London working together to transform sexual health services across the capital. As part of the programme, councils have worked in sub-regional groups to procure new services based on an agreed London Integrated Sexual Health Service specification. The specification fulfils the mandated requirements for open access sexual health services.

In support of the new service model, councils have worked together to update and agree an Integrated Sexual Health Tariff (ISHT) for the new procurements. The tariff covers the provision of services for HIV testing and diagnosis; testing, diagnosis and treatment of STIs; the full range of contraception; and other related services.

The new service model and tariff delivers significant efficiencies as part of the transformation, and is rolling out across London over 2017/18 and the first few months of 2018/19 as procurements are concluded and new services mobilised. The ISHT forms the agreed basis for cross-charging within London, and the basis on which London providers, in line with cross-charging guidance, bill areas outside London.

Annex C: National Template for Out of Area Sexual Health Activity

Provider organisation:		Period From:	
Host Commissioning Organisation:		Period To:	
Payment Terms: Invoices should be raised within 30 days of attendance supported by the following backing information			

Specialty	Attendance Date	Attendance Type or Activity Currency	Clinic Location/ID	LSOA Code of Residence (2011 Codes)	Local Authority of residence	Locally Agreed Tariff	Total Cost