Public Health England

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Local Government Association

HIV, sexual and reproductive health: current issues bulletin

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Bulletin 2: Commissioning sexual health services from primary care
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This bulletin has been developed by Public Health England and the Department of Health, with input from and the support of the Local Government Association, the Association of Directors of Public Health and the English HIV and Sexual Health Commissioners Group. Recommendations and questions for future issues of the bulletin can be submitted to: sexualhealthenquiries@phe.gov.uk.

Purpose of this bulletin

Department of Health (DH) has issued a range of guidance and other supporting documentation over the last year to support commissioning of sexual health services by local authorities. In February 2013, the Local Government Association (LGA) published the Sexual Health Commissioning – Frequently Asked Questions with Public Health England (PHE) and the Association of Directors of Public Health (ADSPH) to further support the transfer of responsibilities from PCTs to local authorities.

However, there is a recognition that situations continue to arise where further clarity about how to operate under the new arrangements is required. This bulletin is intended to address these issues in a timely manner.

This is the second monthly bulletin. The series will focus on 'live' issues and will provide further guidance and suggestions for solutions that can be used at local levels.

The bulletin is intended to address queries from all those responsible for commissioning sexual health services (that is, contraception and reproductive health services, GUM services, HIV testing or treatment services and abortion services), whether they are local authorities, NHS England and Clinical Commissioning Groups. The bulletin is also intended to provide information for provider bodies. PHE will work with DH, NHS England, the LGA, the ADsPH and the National Commissioners Group to provide timely responses.

This bulletin will not be a source of new formal guidance, but will help with the interpretation of existing policy and guidance. Where issues are raised that require a policy response they will be raised with the DH policy team.

Focus on: Commissioning sexual health services from primary care

Overview

General practice and community pharmacy represent an important part of the provider landscape for sexual health services. General practice is the largest provider of contraception[1]; and community pharmacy, with its long opening hours and high street presence, can provide good access to services especially in rural areas.

Prior to April 2013, Primary Care Trusts (PCT) used a variety of 'enhanced service' arrangements to commission sexual health and other public health services from general practice and community pharmacy. These arrangements, including Local Enhanced Services (LES), National Enhanced Services (NES) and Directed Enhanced Services (DES), were all contracting mechanisms linked to the contracts that the PCT held with each practice or pharmacy.

Examples of services that have typically been commissioned through enhanced services agreements, and for which local authorities now hold responsibility, include long acting reversible contraception (LARC), in particular sub dermal implants (SDI) and intrauterine contraceptive devices (IUCD); chlamydia screening and treatment; emergency hormonal contraception (EHC); STI & HIV testing.

As the main contract for general practice and community pharmacy services is now held by NHS England, it is not possible for local authorities to use the 'enhanced service' form of contracting when commissioning public health services from primary care.

This does not, of course, mean that local authorities cannot commission services from primary care. However, as the contracting mechanism is no longer a LES or other enhanced service, local authorities wishing to commission services from primary care will need to agree a new contracting mechanism.

Whilst the contracting mechanism will change, it is important to note that the approach to determining whether services are best delivered by primary care or other providers (or a combination of both) should not have changed. Local Authorities will be expected to ensure that the services they commission deliver the best quality and outcomes for patients, provide value for money, give patients choice wherever appropriate, and adhere to procurement rules.

The Local Government Association has produced a useful document on the role of community pharmacy with case studies of existing practice.

Commissioning

As with any public health service that the local authority is looking to commission, there is a need to identify the level of need locally and commission the service accordingly, both in terms of the type of service being commissioned, who needs the service, and the best type of provider to meet the identified need.

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[1] Department of Health (2013) A Framework for Sexual Health Improvement in England

Service specifications

All elements of the service to be commissioned need to be clearly specified, including detailing links with other services in the area in relation to onward referral, clinical governance arrangements, and training.

Where the needs of the population were well met by the services previously commissioned through LES arrangements, the current service specification may still be fit for purpose, or require minimal alteration prior to appending to the new contracting mechanism.

The Pharmaceutical Services Negotiating Committee (PSNC) – an organisation that promotes and supports the interests of all community pharmacies in England, and the recognised body that represents pharmacy contractors – has a useful website. This website has a range of resources, including template service specifications. The National Chlamydia Screening Programme website also has example service specifications which are in the process of being updated.

As with any commissioned service, the specification should include qualification and training requirements for staff who will be undertaking procedures, as well as the requirement to maintain competency. This is of particular importance for IUCD and SDI procedures and details of relevant service standards can be found on the Faculty of Sexual and Reproductive Health website.

Commissioning models

Commissioners may choose to commission directly from a number of independent primary care providers (i.e. general practices and community pharmacies), or may wish to explore other arrangements, such as a 'lead provider model' or 'Any Qualified Provider' model. Both the lead provider model and the 'any qualified provider' framework agreements are contracts to which the EC procurement rules apply and should be treated in the same way as any other contract.

The 'lead provider model'

In this model one, or small number of, specialist sexual health providers are commissioned to provide services, including sub-contracting with other local providers, such as primary care, to provide the services required across a local area. This model has the advantage of ensuring that smaller primary care services can plug into the clinical leadership and governance arrangements which should be in place in specialised services, as described in the recently published clinical governance document.

Any Qualified Provider Model

When a service is opened up to choice of 'Any Qualified Provider', patients can choose from a range of providers all of whom meet certain standards and price. Providers must pass a standard qualification process to ensure they meet the appropriate quality requirements. Commissioners will own the service specification and will confirm if the provider can deliver that specification. There is no guarantee of activity or minimum payments.

Whilst local authorities are not able to use, or be an associate to, the current general practice and community pharmacy contracts, it would be beneficial for local authority sexual health commissioners to discuss their intentions with colleagues in NHS England and local Clinical Commissioning Groups to ensure all parties working with primary care have a good understanding of the range of services primary care is being commissioned to deliver. Likewise, any concerns regarding quality are best addressed in conjunction with other commissioning organisations, for example through the NHS England Area Team Quality Monitoring Groups.

Contracting

In the majority of cases, current enhanced service contracts were novated over from PCTs to local authorities in April 2013. Going forward local authority commissioners will need to discuss the appropriate contracting mechanism with their contracting/procurement teams. Some local authorities have chosen to use the DH Non-Mandatory Public Health Services Contract, amended as necessary to take account of the services to be provided by primary care; others may choose to use standard contract forms in use by the local authorities with any necessary additional clauses for public health services; and others may feel that a contract which used a modified version of their current LES terms and conditions best fits their needs. In some cases, individual local authorities have agreed to waive the need to tender for these services for the forthcoming year (2014/15), but this is a local decision.

Indemnity cover in the contract

Enhanced services were part of the main general practice or community pharmacy contract and as such benefited from the indemnity terms and conditions in the main contract. Commissioners will need to ensure that new contractual arrangements include requirements for appropriate levels of indemnity insurance, especially if the services include invasive clinical procedures such as IUS/IUD services.

The existing GMS (general medical services) contract doesn't contain details of the levels of insurance needed; rather it contains a number of clauses, such as 'The Contractor shall at all times hold adequate insurance against liability arising from negligent performance of clinical services under the Contract.'

The DH Public Health Services Contract (see above) does not refer directly to 'negligent clinical practice', but does include a clause on indemnity:

B1.1. The Provider shall indemnify and keep indemnified the Authority against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses whatsoever, whether arising in tort (including negligence), default or breach of this Contract, or breach of its statutory duty or breach of an obligation under the DPA, save to the extent that the same is directly caused by or directly arises from the negligence, breach of this Contract or breach of statutory duty or breach of an obligation under the DPA by the Authority.

As part of agreeing the appropriate contracting mechanism, local authorities may find it useful to take advice on the nature of the indemnity clauses within whichever contract is to be used. In addition, ensuring that policies, such as safeguarding and incident reporting are incorporated into the contract should be considered. (The Non-Mandatory Public Health Services Contract allows for this through inclusion of local information in the appropriate Appendices.)

Invoicing and monitoring

Local authorities will wish to find mechanisms that support payment of invoices and monitoring of activity in a way that does not place undue administrative demand on both providers and commissioners. This is likely to include aggregated reporting of activity in an agreed format, based on agreed criteria, for example "Number of women aged 16-25 fitted with an implant in the last month". The exact form of information required will need to be agreed locally. Disaggregate data is unlikely to be necessary or appropriate, and any request for disaggregate patient level data must be in line with information governance requirements.

Prices attached to contracts with primary care providers are for commissioners and providers to agree, but commissioners may find it helpful to obtain a feel for appropriate rates to be applied by holding discussions with other local commissioners, or sharing of price information through the National HIV and Sexual Health Commissioners online forum which is a commissioner-only space.

Prescribing

Patient Group Directions

A Patient Group Direction (PGD) is 'a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment'[2]. A PGD allows a named, regulated health professional to supply and/or administer a named medicine to anyone who fulfils a pre-determined set of criteria described in the PGD, without the need for a specific prescription for a specific patient.

Commonly these directions are used by pharmacists in the delivery of emergency contraception as well as other sexual health services. More detailed information on PGDs can be found in the recently published document Sexual Health: Clinical Governance and the National Institute for Health and Care Excellence (NICE) good practice guidance on PGDs[3].

Current legislation for PGDs is included in The Human Medicines Regulations 2012 (amended in April 2013). This legislation requires that a PGD:

- must be signed by a Doctor (or Dentist) and a pharmacist
- must be signed on behalf of the authorising body (CCG'S, Local Authorities, NHS Trusts or Foundation Trusts, Special health authorities, the NHS Commissioning Board).

In addition to being signed by the authorising body (then the PCT), practitioners using PGDs have in the past been required to present signed copies to the PCT for approval. Some local authority areas are including a form of words within the new service specifications that states that providers are required to ensure they sign and work within any relevant PGDs and retain copies for inspection upon the request of the commissioner. They are working with their Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC) to negotiate and implement this change which allows doctors, nurses and pharmacists to

[2] Health Service Circular HSC 2000/026
[3] http://www.nice.org.uk/mpc/goodpracticeguidance/GPG2.jsp.

take professional responsibility for their prescribing practice, reduces the administrative burden and thereby reduces the time required to approve new providers. An example local authority PGD policy can be found in appendix 1.

Prescribing costs

As of April 2013, local authorities have taken on responsibility for commissioning public health services. Some of these services will involve the supply of medicines and devices using NHS pharmaceutical services (FP10s).

In the process of developing the public health allocations the Department of Health surveyed PCTs on their public health expenditure. PCTs were asked to reflect the full costs of services in their returns, including the costs of all medicines supplied to patients whether on prescription or not, and any associated prescribing costs. The public health allocations therefore are intended to cover the full costs of supplying medicines via prescription forms. This means that where a local authority commissions a service which includes prescription medicines/devices as part of a public health intervention, the cost of the prescription should be met from their public health allocation.

Where a GP prescribes an item in response to an identified clinical need (e.g. nicotine replacement therapy outside a commissioned smoking cessation programme) the drug costs should be attributed to the practice's indicative prescribing budget and the costs will be met from the Clinical Commissioning Group's prescribing budget.

NHS Business Services Authority has recently published a factsheet on Supply of medicines for public health commissioned services. This document, developed in conjunction with NHS England, Public Health England and Department of Health, provides detailed information for local authorities and providers. It also provides details of information that can be accessed from NHS Prescription Services including ePACT data.

Access to free treatment for chlamydia

The National Chlamydia Screening Programme Standards state that 'treatment should be free of charge'. This position is restated in the recently published document from NHS Business Services Authority – section 10.2 (see above). Whilst this can be managed simply through the use of a PGD for community pharmacies, it can be more complex for general practice to deliver this. Where the patient would normally be required to pay for their prescription, some local area have developed voucher systems whereby the patient is issued an FP10 by the GP, but are not required to pay the dispensing pharmacy as the pharmacy reclaims the cost direct from the commissioner (See appendix 2).

Types of services provided by primary care, and commissioning responsibilities for these services

As mentioned above, general practice and community pharmacy are well placed to provide a range of sexual and reproductive health services. Typically these have included a combination of provision of emergency hormonal contraception, chlamydia screening and treatment, long acting reversible contraception (LARC), and level 1 and 2 sexual and reproductive services.

One particular area where clarity has been requested relates to commissioning responsibility for contraception for non-contraceptive services.

In many instances, whilst enhanced services for LARC were primarily for contraceptive services, the agreements did allow (either explicitly or implicitly) general practice to provide, and be funded for, IUS fittings for non-contraceptive reasons such as menorrhagia. From 1st April 2013 commissioning of IUS and other contraceptives for contraception purposes has been the responsibility of local authorities, but commissioning of gynaecology services, including the use of contraception for non-contraceptive purposes, is the responsibility of Clinical Commissioning Groups.

In many instances the funding identified to the Department of Health for sexual health services as part of the process of identifying public health allocations will have included the full cost of enhanced services for LARC. As such, the identified budgets may have included the existing level of provision of IUS fittings for therapeutic reasons. If this is in case for any local authorities, we suggest that these authorities hold discussions with their local Clinical Commissioning Group on issues of contracting and payments to determine the best way of ensuring that these therapeutic services are able to continue.

Surveillance data for sexual health services provided through primary care

STI diagnoses and services provided by GUM clinics and other commissioned non-GUM sexual health services are collected through GUMCADv2. Submission of GUMCADv2 is mandatory for all Level 3 (GUM clinics) and commissioned Level 2 sexual health services, including enhanced General Practices. Level 1 services, such as General Practices, that are not commissioned to provide an enhanced sexual service do not need to submit GUMCADv2, although they can do so on a voluntary basis. The data collected will help contribute to the understanding of service use and need in local areas. We encourage all commissioners to include a clause in their contracts with services to facilitate collection.

Currently, SRHAD (sexual and reproductive health activity dataset) is only collected by community sexual and reproductive health services.

Although CTAD (chlamydia testing activity dataset) is collected from laboratories rather than services, chlamydia screening and diagnosis data is presented by ‘testing service type’ including separately for general practice and community pharmacy.

Future editions of the bulletin

This bulletin is for you, and can only work if it is responding to the issues that are currently concerning you. Each monthly edition will therefore focus on a ‘live’ issue, or issues. These issues will be identified by assessing the questions raised on the commissioners’ group forum; questions that have come direct to PHE, LGA or DH, and questions that have been raised through our dedicated inbox:
sexualhealthenquiries@phe.gov.uk

Appendix 1: Example local authority PGD policy

Policy for authorisation of Patient Group Directions
XXXX County Council

Directorate for Adult Services, Health and Wellbeing

Definition of Patient Group Directions
A Patient Group Direction (PGD) is defined as ' *Written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment*.' (Health Service Circular 2000/026). They provide a legal framework that allows the supply and/or administration of a specified medicine(s), by named, authorised, registered health professionals, to a pre-defined group of patients needing prophylaxis or treatment for a condition described in the PGD, without the need for a prescription or an instruction from a prescriber. (NICE GPG2, 2013).

Purpose of PGDs
The majority of clinical care should be provided on an individual, patient-specific basis. PGDs are used in cases where they offer an advantage for patient care, without compromising on safety. The purpose of using a PGD is to;

- Deliver effective patient care that is appropriate in a pre-defined clinical situation, without compromising patient safety
- Offer a significant advantage to patient care by improving access to appropriate medicines
- Provide equity in the availability and quality of services when other options for supplying and/or administering medicines are not available
- Provide a safe legal framework to protect patients
- Reduce delays in treatment
- Maximise the use of the skills of a range of health professionals

Legal Framework
Current legislation for PGDs is included in The Human Medicines Regulations 2012 (amended in April 2013). This legislation requires that;

- a PGD must be signed by a Doctor (or Dentist) and a pharmacist
- a PGD must be signed on behalf of the authorising body (CCG'S, Local Authorities, NHS Trusts or Foundation Trusts, Special health authorities, the NHS Commissioning Board)
- PGDs must only be used by the following registered health professionals; chiropodists and podiatrists, dental hygienists, dental therapists, dietitians, midwives, nurses, occupational therapists, optometrists, orthoptists, orthotists and prosthetists, paramedics, pharmacists, physiotherapists, radiographers & speech and language therapists
- Only certain controlled drugs are legally eligible to be included in a PGD
- Each PGD contains information relating to specific fields

Authorisation of PGDs
PGDs are required to be signed by an authorising body. Previously, PGDs were mainly authorised by PCTs but this needed to change when the new NHS organisational structures were implemented in April 2013. To allow this change, the Medicines and Healthcare products Regulatory Agency (MHRA) and Department of Health amended the medicines legislation to:

- enable Clinical Commissioning Groups and Local Authorities to authorise PGDs from April 2013
- ensure that existing PGDs with an expiry date after 31 March 2013 continued to be legal until the PGD either expires or is replaced.

The commissioning and/or provider organisation may be an authorising body. If the provider is an authorising body, the commissioning organisation does not legally need to authorise the PGDs for the provider. In the NHS in England, these organisations are:

- clinical commissioning groups (CCGs)
- local authorities
- NHS trusts or NHS foundation trusts
- Special health authorities

- the NHS Commissioning Board

As such, XXXX Foundation Trust and our acute trusts for example, are authorised to sign off their own PGDs. For other providers e.g. XXX, Community Pharmacy and Primary Care, they are not authorised to sign off their own PGDs.

XXXX County Councils responsibilities
XXXX County Council is the appropriate authorising body for PGDs developed by services commissioned by XCC, and not covered by their own authorising body. XCC will review the content of the PGD to ensure it contains the information recommended in the NICE Guidelines. It will not be responsible for reviewing the clinical content of the PGD.

The purpose of this policy is to;

- Document the existing contracts commissioning services which use PGDs
- Detail the process for reviewing and authorising PGDs

PGD Register
(To be completed)

Provider	Details of service provision	PGDs in place	Review date

Appendix 2: Pharmacy voucher scheme for chlamydia treatment

Management of Sexually Transmitted Infections (STIs) Local Enhanced Service
Voucher Scheme for Reimbursement of Prescription Costs

Context
From April 2013, XXXX County Council (XCC) took over the commissioning of a range of sexual health services formerly commissioned by NHS XXX. These include services promoting the assessment and treatment of asymptomatic STIs in primary care. In order to address national guidance which advises that treatment for STIs should be provided free of charge, and to ensure equity with the free treatment already provided within the county's Genito-urinary medicine (GUM) departments, the county council will continue to use the prescription voucher scheme developed by NHS XXX.

Notes for Participating Practices
The voucher is attached as a Microsoft Word template. Practices should copy this template onto their practice systems and enter the practice code in the header of the template before saving the document. The date and time will automatically update each time the voucher is printed, providing a unique identifier for each voucher.

When treating a patient with a diagnosed STI, the GP should ask whether the patient usually pays for their prescription:-

If the patient normally pays for their prescriptions, they should be issued with a voucher to take to their local pharmacy with their FP10. (Note: this voucher will only be accepted at pharmacies in XXX).

If the patient is already exempt from prescription charges, they should not be issued with a voucher.

Notes for Dispensing Practices
A voucher should be completed for patients who normally pay for their prescriptions. The patient should sign the declaration on the rear of the FP10 indicating that they have paid the prescription charge. Completed and signed vouchers should be returned by post or FAX, by the 10th of the following month, to:-

FREE TREATMENT VOUCHER

This voucher entitles you to a single course of free treatment for a specific health condition. The voucher is only valid when presented with your prescription at a pharmacy in XXXX.

For Pharmacy Use only:-
This voucher should only be accepted as payment for the prescription levy incurred for the FP10 with which this voucher is presented. The patient should sign the declaration on the rear of the FP10 indicating that they have paid the levy.

Pharmacy stamp:

Levy to pay | Pharmacist name | Pharmacist's signature

The pharmacy will be reimbursed to the sum of levy incurred. This voucher must be faxed (or a copy posted) to the following address by the 10th day of the month following receipt of the voucher:
XXXX