Department of Health

Sexual Health Services : Key Principles for Cross Charging

Key principles to assist service commissioners and providers to develop fair payments systems

August 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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1. Guidance issued by the Department of Health, *Commissioning Sexual Health Services and Interventions, Best Practice Guidance for Local Authorities (March 2013)*[1], highlighted that further information about payment systems for open access sexual health services would be issued in due course. This document provides further information and recommends key principles for local authorities and their advisers to consider.

Background

2. Since 1 April 2013, local authorities are mandated to ensure that comprehensive, open access, confidential sexual health services are available to all people who are present in their area (whether resident in that area or not). The documentation issued to accompany the Department of Health allocations to local authorities in January 2013 noted that local authorities' ring-fenced public health budgets are, in part, derived from the historic spend of the PCT's in 2011/12. A council is only funded under the terms of the grant to support its residents, and the grant does not therefore cover the use of sexual health services by residents of other local authorities under open access arrangements.

3. The Advisory Committee on Resource Allocation (ACRA) worked with the Department of Health to provide input to the local authority allocations formula. Their letter of 17th October 2012[2] to Jeremy Hunt, Secretary of State for Health recommended the development of a system of "cross-charging" for these circumstances. It is for local determination how these arrangements work and solutions that meet the needs of local areas and local populations should be in place. However, these key principles have been endorsed by the Department of Health, the Local Government Association, the Association of Directors of Public Health and Public Health England to encourage a consistent and equitable approach to cross-charging and billing for out of area service users from both a commissioning and provider perspective.

Key Principles

4. Many councils already collaborate to commission services across a larger footprint than a single authority. Councils may wish to consider the use of contracts procured, let and managed by more than one commissioning authority to take a joined up approach and, where possible, share risk and manage demand.
5. If it is not possible or feasible to enter into collaborative commissioning arrangements, and where there is a broadly predictable patient flow from an authority's area to a specific service, it is suggested that contractual arrangements be put in place between the LA and provider. This will aid planning and budget management for both LAs and providers.

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[1] https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190648/DF-letter-to-SoS.pdf.pdf

6. It is recommended that the provider of the service (rather than the local authority that hosts the service) invoices the patient's local authority of residence. Providers can use the facility on DirectGov to search for a patient's local authority of residence based on their postcode[3]. The invoice should be sent in the first instance to the Director of Public Health in the local authority of residence and a list of Directors of Public Health is available from the Association of Directors of Public Health.

7. When invoicing for out-of-area service use, consideration needs to be paid to protecting patient confidentiality while providing sufficient information to the home authority to verify activity. There is an expectation that providers will make every effort to obtain information regarding residence to enable charges to be billed correctly. In the majority of cases patients are likely to be happy to provide their residence details. Partial post-code data at lower super output level, prescribing information or GP registration is not identifiable and should be supplied with invoices so that commissioners can make sure that providers' charges relate to their residents.

8. For the small number of patients who wish to remain anonymous and decline to provide identifiable information (3% of attendances in 2012) the cost should be assigned to the authority in which the provider is based.

9. Every effort should be made for local resolution of disputes which may arise. In the event of a dispute, commissioners will need to be able to audit data to verify attendances. To aid this process, authorities can request and retain activity data from their host provider(s) to help resolve disputes in the verification of both local and out-of-area provider activity.

10. Public Health England is considering whether activity data could be collected nationally alongside the statutory Genito-urinary Medicine Activity Dataset (GUMCAD) quarterly data return. In addition, Public Health England produces data on the number of first and follow-up attendances made by GUM clinic patients within and outside of their lower tier Local Authority (LA) of residence. Data are also presented by Upper Tier Local Authority (LA-UT), PHE Centre and PHE Region of residence. Commissioners and providers may find these data useful if they are considering cross-boundary charging. Data for 2012 are available in Table 12 of PHE's annual STI data tables, available here: http://www.hpa.org.uk/stiannualdatatables. These data will be updated quarterly and will be available from the PHE HIV & STI Web Portal from September 2013. Access to the Web Portal is available on request to gumcad@phe.gov.uk.

11. Many local authorities have now moved from previous NHS contracts covering all service attendances based either on local prices or NHS tariffs, to local contracts covering attendances by their own residents. To avoid confusion, when cross-charging for non-residents, it is recommended that the price charged by providers is not more than the rate agreed for attendances by local residents. This might be a flat-rate price per attendance or a locally agreed price for the actual package of care received which reflects the additional costs faced in different areas of the county (such as those covered

[3] http://local.direct.gov.uk/LDGRedirect/Start.do?mode=1

by the Market Forces Factor which applied to NHS PbR tariffs). Or it could be based on the integrated sexual health developed in, for example, London or some other formula. Any tariff price or formula used can be flexed to include agreed quality incentives, but it should be noted that the Commissioning for Quality and Innovation (CQUIN) quality scheme relates only to services commissioned by NHS England or CCGs and should not be used in respect of services for which LAs are responsible.

12. The integrated sexual health tariff developed within London is designed to deliver a transparent, evidence based approach for sexual and reproductive health charging. A number of areas across England are undertaking "road testing" exercises for this integrated sexual health tariff. As feedback becomes available, local authorities, directors of public health and providers will be able to take a view on whether a tariff approach for both GUM and sexual and reproductive health services offers a cost-effective solution for promoting equitable high quality outcomes for sexual and reproductive healthcare.

13. Standardisation of contracts between authorities may help, and the Department has recently published a service specification for integrated sexual health services which authorities can use if they wish to do so[4].

Attendances by people living outside England

14. Regulation 6 of the National Health Service (Charges to Overseas Visitors) Regulations 2011 specifies those services which exempt from charges and are free to everyone (including those not ordinarily resident in the UK. The current list includes:

    - family planning services, which means services that supply contraceptive products and devices to prevent establishment of pregnancy.

    - treatment for sexually transmitted diseases.

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

16. In the NHS, guidance has highlighted that cross charging does not extend to the devolved administrations, which means that a patient registered in the devolved administrations treated in an English 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 local authority in which the provider is based, unless local risk sharing arrangements are in place.

[4] https://www.gov.uk/government/publications/public-health-services-non-mandatory-contracts-and-guidance-published