

Primary Care Service Framework: Management of Sexual Health in Primary Care

- This 'enhanced service' framework should be read in conjunction with the **supportive statements for commissioning** on the Primary Care Contracting website – www.pcc.nhs.uk – and the **additional supportive notes** at the end of this document to help commissioners, providers and other stakeholders with contextual planning and local service design and development. They offer further implementation pointers and have been developed with the help of those currently commissioning or providing primary care services.
- The document itself can be adapted and used as a basis for an enhanced service via a primary care contract or Service Level Agreement. This will hopefully avoid duplication of effort and speed up the commissioning process. It would be appropriate to adapt or include local information in the relevant sections. Legal advice or support for local contractual arrangements may need to be considered.
- NHS Primary Care Contracting kindly requests feedback from PCTs or Practice Based Commissioners following implementation of this Framework via the brief feedback questionnaire on their website – www.pcc.nhs.uk. This will assist in its on-going development and sharing of good practice across the NHS.
- The Department of Health and NHS Primary Care Contracting would like to thank all those individuals, departments and organisations who have contributed to the development of this Primary Care Service Framework as well as Steering Group members. Thanks also go to Dr Jeff Anderson of Primary Care Unlimited – www.primarycareunlimited.com – for coordinating the development of each Framework.

Primary Care Service Framework: Management of Sexual Health in Primary Care

- 1. Purpose of this Primary Care Service**

The purpose of this Primary Care Service Framework is

 - to equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to safely deliver a high quality, integrated sexual health service in primary care.
 - as a means of improving patient's health and quality of life by providing patient-centred, systematic and on-going support.

- 2. Period of Service**

This service will run for a period of twelve months from 1st April 2007 – 31st March 2008 (extended subject to satisfactory annual review).

- 3. Scope and Definition of service**

The service is open to male and female patients and can be provided either at individual practice level, or on a locality or PCT basis. It is open to all types of providers for example, GP practices, Community Pharmacists, community and specialist nurse-led services, voluntary sector, the independent sector or other alternative providers.

This primary care service should not be confused with (and sits outside of) essential and additional GMS or PMS services already provided, current Quality and Outcomes (QOF) indicators covering Emergency Hormonal Contraception and provision of pre-conceptual advice, and any Nationally for more specialised Sexual Health Services.

- 4. Parties to the agreement**

Insert names of any accountable individuals and organisation details.

- 5. Background**

NICE guidance (October 2005) highlighted that women requiring contraception should be given information about and offered a choice of all methods including long-acting reversible contraception (LARC).

The National Strategy for Sexual Health and HIV (2001) highlighted the rising trend of sexually transmitted infections, the link between sexual ill health, poverty and social exclusion, and the varying standards of service provision. The subsequent implementation plan in 2002 introduced the Independent Advisory Groups for Sexual Health, HIV and Teenage Pregnancy and the National Chlamydia Screening Programme - an opportunistic screening programme targeting sexually active adults aged under 25.

There is a national Public Service Agreement target to reduce the under 18 conception rate by 50% by 2010. The 'Our Health Our Care Our Say: a new direction for community services' White Paper (2006) publication identified the need to improve sexual health provision as a key priority for primary care and the 'Choosing

Health' White Paper (2004) also included a commitment to ensure that the full range of contraceptive services is available, good practice is spread and services modernised. Sexual health and GUM services were re-emphasised as one of the six national priorities outlined in 2006 by the Department of Health as part of NHS System Reform and the 2006-07 Operating Framework, in particular the provision of appointments to GUM services within 48 hours.

The Medical Foundation for AIDS and Sexual Health (MedFASH) recommended standards for sexual health services (2005) and NHS HIV services (2003) were developed to enable people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare. They are not setting-specific and serve as a recognised tool for planning, developing and evaluating local services, as well as for local performance management.

6. Summary of Local Need

Commissioners should outline or reinforce a summary of local health and social care or service need drawn from a Joint Strategic Needs Assessment, done with Local Authority partners. Suggested options to include here can be found in the additional notes below.

7. Service Objectives and Intended Health Outcomes

Joint working between sexual health service providers is critical to achieving the following list of service objectives and intended health outcomes for the local population:

- To reduce the number of teenage pregnancies
- To reduce the number of terminations
- To reduce the number of new cases of Sexually Transmitted Infections (STIs) and HIV by providing better sexual health promotion and improving access to GUM services
- To improve the uptake of Chlamydia screening through local implementation of National Chlamydia Screening Programme
- To encourage partner notification where possible through GUM services
- To ensure the full range of contraceptive methods is offered and prescribed accordingly
- To improve the referral and signposting to other integrated sexual health services, Eg. Psychosexual or erectile dysfunction services
- To improve the management of HIV+ patients as having a long term condition and reduce stigma and discrimination
- To reduce health inequalities by providing better access, better range of services, more integrated services, delivered by the most appropriate member of the primary health care team.

8. Service Outline

This specification is generic and should be tailored to suit the scale of provision at either practice or PCT Providers will be required to:

1. Identify and record those individuals who present with a sexual health issue (with particular consideration for the under 25's)
2. Provide a robust outreach service within the local community to identify and support those in more vulnerable groups such as Black and Minority Ethnic groups, deprived groups, lesbian and gay men
3. Provide the relevant aspect of service described in this outline to patients who may have been referred locally through other primary care referral pathways
4. Identify partners, where possible, who may benefit from services and advise or treat accordingly
5. Provide a sexual health programme of care including sexual health history taking and risk assessment, examination with specimen collection, diagnosis, treatment and follow up and, where possible, partner notification
6. Provide access to opportunistic Chlamydia screening and treatment of young men and women, with partner notification where possible, in accordance with the National Chlamydia Screening Programme, or refer to the local screening service provider
7. Provide 'on-the-spot' pregnancy testing with management of post-result follow-up
8. Provide up-to-date, comprehensive and non-discriminatory sexual health advice and information through a variety of media which is specific to patients needs, such as:
 - advice on how to obtain condoms locally alongside the offer of information/guidance on correct use
 - offering a condom distribution scheme if available
 - sexuality and reproductive system issues
 - offering pregnancy options and non-directive support so patient can make an informed choice
9. Where appropriate, discuss and provide (or signposting to) the full range contraceptive methods including reversible, emergency and long-acting reversible contraceptive (LARC) methods with follow-up
10. Identify formal links to termination of pregnancy providers to ensure provision of contraceptives, including LARC, at the time of termination
11. Provide pre/post termination counselling and liaison with other statutory and voluntary services as required
12. Refer to an appropriate primary care or other care pathway eg counselling services, GUM clinic screening and management services for STI's and HIV, psycho-sexual health within local networks
13. Signpost to care pathways when specific services are not provided at that location

14. Facilitate the client with planned or unplanned pregnancy, accessing other services with clear pathways to maternity services and/ or other statutory and voluntary services as required
15. Provide comprehensive sexual health promotion, supported by the primary mental health care team, with identification and management of risk taking behaviour other than sexual health i.e. drugs, alcohol, diet and nutrition, psychosocial behaviours.

Providers should be in a position to identify those individuals who would benefit from additional support for self care and enable these individuals to access the four main areas of self care - Skills and Education; Information; Tools and Devices; Self Care support networks. Additional detail around support for self care can be found in a parallel Primary Care Service Framework which can be found at www.pcc.nhs.uk.

9. Location of Service

Commissioners will need to re-assure themselves that the service is provided from premises that are fit for purpose in a modern and integrated way and address issues of service uptake, particularly in communities with poor health outcomes. Details should be included here.

10. Integrated Governance

Any commissioned service must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health (updated April 2006 www.dh.gov.uk). These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Compliance with NICE guidance www.nice.org.uk is also required.

Clinical Governance arrangements must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner.

Professional competency, education and training

All healthcare professions delivering the service will be required to demonstrate their professional eligibility, competence, and continuing professional development in order to remain up-to-date and deliver an effective service. Staff appraisal on an annual basis and at an appropriate level will also be required. Commissioners may wish providers to hold one or more of the following:

- Competency certificate gained following training with a Genito-Urinary Medicine service or other specialist training provision
- Diploma of the Faculty of Family Planning from the Faculty of Family Planning and Reproductive Healthcare www.ffprhc.org.uk
- Diploma from the Royal College of Obstetricians and Gynaecologists (DRCOG) www.rcog.org.uk
- Certificate from the British Association of Sexual Health (BASHH) STIF course www.bashh.org

- Practice of Family Planning and Reproductive Sexual Healthcare (formally ENB 8103) or equivalent
- *Implanon* training certificate or letter of competence for IUD/IUS insertion

Training and educational opportunities are also available from the Genito-Urinary Nursing Association website www.guna.org.uk or locally accredited courses should be available through specific professional representative bodies.

Providers should ensure optimum staffing capacity which may be achieved through 'managed sexual health networks' which make better use of local skill mix, such as health advisors, local nurse consultants, or the voluntary sector. Providers should ensure appropriate caseloads are encouraged at all times. Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment as required.

Patient, public and staff safety – Providers will be required to demonstrate that evidence based clinical protocols are being used. Providers should have in place appropriate health and safety and risk management systems and that premises are safe and young person friendly. They should also ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website www.npsa.nhs.uk.

Clinical audit and review – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service.

Information management – Any strategy or practice should be coherent with and follow local policies and the Department of Health Code of Confidentiality, local child protection procedures, and should outline the mechanisms to safeguard patient information when shared within an integrated service.

Patient and public involvement – Providers will be required to demonstrate active engagement with patients in developing services, care plans or in supporting patients to utilise self care opportunities. Providers should demonstrate how systematic patient feedback is being used to shape and improve services.

Managing complaints – Responsive protocols and procedures should be in place for managing patient complaints. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

Continuous quality improvement – a set of indicators should be selected or developed and then agreed which defines the key quality requirements of the service. The service should also identify how it uses these measures and others to ensure that the quality of the service is continuously improved.

11. Information management/requirements

Information needs may be different depending on the scale of service provision PCT-wide or at individual practice level. The following describe a selection of key quality requirements and measurable indicators which could be used to demonstrate service effectiveness and provider performance.

- The number and percentage of patients who have had a sexual health programme of care in the last 12 months
- The number and percentage of women (aged 25 and under) who had a termination of pregnancy in the last 12 months
- The number and percentage of patients offered the full range of (and prescribed) contraceptive methods in the last 12 months
- The number and percentage of people under 25 accepting screening for Sexually Transmitted Infections (STIs) and HIV in the last 12 months
- The number and percentage of people under 25 with syphilis, gonorrhoea, HIV, chlamydia, genital warts and/or herpes in the last 12 months
- The number and percentage of people under 25 accepting chlamydia screening and treatment in the last 12 months.
- The number and percentage of MSM who have been offered and accepted HIV testing
- The number and percentage of MSM who have been offered serology for Hepatitis A and B immune status with implementation of the full course of immunisation and follow up
- A Common Data Set for sexual health services has been developed which meets the information standards required for the national IT programme, is agreed by clinicians and is applicable to all service providers. The common data set can be found at www.cdssexualhealth.org.uk. The common data set will generate all the key information requirements for complete patient information – demographics, treatment, referral and data gathered from behavioural questions. Providers should be aware of the Department of Health policy around handling and disclosing patient information. ‘Confidentiality – NHS Code of Practice’ can be found at www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf. There is also a specific confidentiality code of practice for GMS, PMS and APMS providers at www.dh.gov.uk/assetRoot/04/10/73/04/04107304.pdf.
- *You’re Welcome* quality criteria for young people’s services (2005) www.dh.gov.uk/assetRoot/04/12/15/64/04121564.pdf and the Medical Foundation for AIDS and Sexual Health (MedFASH) www.medfash.org.uk recommended standards for sexual health services and NHS HIV services should be used as a basis for measuring overall service quality, effectiveness and

performance.

- A local basket of indicators also exists for Health Inequalities and can be found at the London Health Observatory www.lho.org.uk

12. Service Monitoring and Evaluation

Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. The process by which this evaluation is achieved can also be used to show the outcomes of the service to other interested stakeholders such as patients and other joint providers. Service evaluation should cover, as a minimum, the following areas:

Service activity – Volume of work against agreed activity levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies

Clinical Outcomes - Regular analysis and interpretation of GUM clinic data as well as regular analysis and interpretation of PPA data for prescribing and Family Planning KT31 returns (see www.ic.nhs.uk/pubs/nhscontraceptiveservseng2005to06/csbulletin/file)

Quality and Governance – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year. EQIA data should be used to underpin local integrated service provision.

Patient Experience – Patients views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients in a way that supports them. This process should be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, females etc) and any resultant service changes (planned or achieved) should be highlighted.

Value for Money – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care. Such measures could include attendance rates, waiting times, length of stay. Other possible analyses include: - Prescribing costs; Quality Adjusted Life Years (QALYs); Savings due to reductions in days off work; benefits of increase in social capital and active citizenship; Staff and non-staff costs of running the service; Capital costs; Potential supplementary costs to patients eg time off work, travel and transport or other in-direct costs such as cost of loss of production to society.

13. Funding

There will be no fixed or nationally agreed price for this service. Commissioners and providers should agree funding which is reflective of the level of service to be delivered locally and could include:

- Basic funding for achieving minimum requirements within the service specification
- Additional funding or financial incentive for delivering specific local patient outcomes
- Indication of national benchmark prices if available

Where the service is provided by general practice teams it is recognised that they may also gain additional reward for quality service provision relating to the clinical domains within the Quality and Outcomes Framework.

14. Contract Management

The name and contact point of the contract manager of both the commissioner and provider should be given here. Any specific local arrangements for contract management should also be stated.

15. Review, variation and re-commissioning process

A number of important contractual design and management issues will be followed throughout the period of the contract. In particular:

- Formal review of the service will be on-going and will inform the end of year service review process which will be used to determine if service is to be extended or de-commissioned.
- Any in-year contract variations will be discussed and agreed by both parties and will be included as additions to this Primary Care Service Framework.
- Following the review the commissioner will decide whether the service has been effective. If not, the commissioner will discuss with the provider any formal escalation or recovery plan with realistic timeframes for delivery.
- Appropriate notice periods and termination procedures will be agreed by both parties.

Both parties may wish to seek legal advice before agreeing any formal contractual arrangements resulting from this Primary Care Service Framework.

16. Signatories

Signatures from both parties as those accountable for the agreement

Additional supportive notes to assist the implementation of the Primary Care Service Framework: Management of Sexual Health in Primary Care

Commissioning 'business case' and Value for Money

- Commissioning this Primary Care Service will have a significant impact on the availability of commissioning resources locally. Investment in sexual health services is good value for money and can deliver significant healthcare savings through preventing unplanned pregnancies and reducing the transmission of sexually transmitted infections (STIs) and HIV. For every pregnancy the average cost to the NHS is around £1500. Approximately £165 million a year is spent on treating STIs. Despite affecting a small number of individuals HIV imposes a significant burden on healthcare resources at around £580 million a year, with a lifetime cost per case of £300,000. These figures do not include preventing onward transmission of infection. Further, a wide choice of contraceptive services and abortion services provided with minimal delay is cost saving. For every £1 spent on contraceptive services, £11 is saved.
- Commissioners should also be aware of the wider savings which would be realised through support for self care as described in a complementary Primary Care Service Framework. This can be found on the NHS Primary Care Contracting website www.pcc.nhs.uk

Practice Based Commissioning (PBC) sign off

- PCTs and Practice Based Commissioners should be aware that business case proposals for the provision of this Primary Care Service will need to meet the full requirements of any local service delivery plan and authorisation process. This may well be at PCT Board level or any delegated panel. For proposals that pertain to the provision of services for a wider population, consideration as to further engagement and sign off with the SHA may be necessary.
- The Commissioning Framework (Department of Health, July 2006) highlights how commissioners should follow EU best practice principles when considering competitive procurement of local services. This does not necessarily mean open tendering processes should be adopted in every case. The Department of Health would not normally expect tendering where practices currently under GMS/PMS contracts could provide services as a means of extending patient choice.
- In the past, there has been confusion about the role of both commissioners and providers of sexual health services and PBC provides the opportunity to re-define these roles clearly. Local community sexual health promotion and preventive services and those provided by Family Planning and GUM services should be encouraged to work jointly to develop integrated, effective local services by agreeing local need, staffing capacity and location of service. Further, the PBC system should ensure a balanced approach so that commitment of resources and successful provision in one area of the service does not have a negative effect on other essential parts of the service, for instance achieving 48 hour appointment access to GUM clinics may direct resources away from other preventive services in the community.
- PBC resources can be obtained from the Department of Health www.dh.gov.uk and NHS Primary Care Contracting www.pcc.nhs.uk. The recent PBC guidance can be found at www.dh.gov.uk/assetRoot/04/14/15/64/04141564.pdf

Contracting for the service

- This service should be considered as a 'locally enhanced service'. As such, the full range of providers and primary care contracting flexibilities should be considered, including GMS, PMS, PCTMS, APMS, and community and voluntary organisations. Once an appropriate provider has been selected, the appropriate contracting route should be adopted. Additionally, providers may wish to sub-contract part or all of the service provision. This should be made clear throughout the contract implementation process.
- NHS Primary Care Contracting has developed a simple guide for potential providers of services such as this Primary Care Service www.pcc.nhs.uk

Incentivising provision

- The recent Commissioning Framework (July 2006) www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf emphasised the options open to commissioners to support new local providers of services by offering additional quality incentives, use of local primary care premises or pump-priming loans. The Kings Fund has described some of the considerations when developing local incentives. For instance, introducing new providers into the local health economy may improve service quality and efficiency but this may be at the expense of service responsiveness, provider collaboration and sustainability of services. Also care must be taken to develop better access to services without generating extra demand within the local health system which increases pressure on other services.

Summary of local need

- Local demographic information along with a broad public health profile may need to be considered and made explicit. Specific details of morbidity and mortality levels, other health and well being data and condition-specific data, health inequality data and ethnicity profile are also important and should be included if available. It is essential to clarify that this service is a priority identified in the Local Delivery Plan for either the PCT or the local PBC group.
- Additional relevant information should also be considered for inclusion such as recent service user feedback, current service staffing levels and competencies, local partnership arrangements, and any planned changes to local need.

Involving patients and the public

- The White Paper 'Our Health, Our Care, Our Say' made it clear that patients and the public would be firmly placed at the centre of NHS and social care services, with a stronger local voice. Following this, the Department of Health has published a framework for creating stronger public engagement in the development of health and social care services www.dh.gov.uk/assetRoot/04/13/70/41/04137041.pdf. This will develop with patients and the public having more involvement in service planning processes where possible including design of individualised care plans and choice of services as well as involvement in decision-making processes and service evaluation mechanisms at both provider and commissioner level.
- Historically, those providing sexual health services have found difficulty gaining significant user involvement as the nature of the problems faced by users of sexual health services are generally not those that are easily shared with others. Services generally have very few formal complaints to review and act upon. Increasingly, managed networks in sexual health are looking at more innovative ways of

engaging users including making use of mystery shoppers or utilising the voluntary sector. Providers should also be aware of the possible need to seek local ethics committee approval before asking patients for sensitive information.

Skill mix and partnership opportunities

- Where there is a need to develop the GP with Special Interest role, it is important to be aware of new guidance and regulation procedures due to be published by the Department of Health at the end of 2006. This will mean greater adherence to any new special interest competency framework and more formal special interest accreditation of new practitioners.
- The Department of Health (September 2006) has published a best practice toolkit to help assess skills, knowledge and attitudes of primary care staff – ‘Competencies for providing more specialised sexually transmitted infection services within primary care: Assessment Toolkit’. This useful aid is transferable to any primary care setting and supports improving quality in managing STIs - www.dh.gov.uk/assestRoot/04/13/93/57/04139357.pdf
- The White Paper has stated the government’s desire to see more integrated health and social care services, based in the community. One option is to develop a local steering group including patient, PCT, GP, nurse, consultant, pharmacist, and other local provider input. Through more integrated service delivery and the development of managed sexual health networks, there will be greater opportunities to develop a wider skill mix among staff in the local community. Formal links should be made local contraceptive service providers and GUM specialists and other roles will develop throughout the primary health care team including pharmacists, sexual health advisers, and the voluntary sector offering outreach and support services. New targeted roles are beginning to develop to provide services to more vulnerable groups including young men’s key workers or gay men’s workers. Roles should be extended to support harder to reach communities.

Health Inequalities

- Reducing the gap in infant mortality across social groups, and raising life expectancy in the most disadvantaged areas (the Spearhead areas) faster than elsewhere are the focus for the 2010 health inequalities Public Service Agreement target. Effective, pro-active action to tackle health inequalities at local level by commissioners, providers, practitioners and other stakeholders will be key to meeting the target. To understand more about the Equalities and Human Rights agenda in the NHS, the Department of Health has recently published a useful guide for NHS Boards – www.dh.gov.uk/assetRoot/04/14/13/71/04141371.pdf
- With any provision of service, consideration must be given up front to the impact on inequalities in health which may result from service outcomes. This Primary Care Service provides an opportunity to narrow the inequalities gap by providing services not only to the mainstream population but also those in disadvantaged groups with poor health outcomes. Provision of this Primary Care Service should consider, where possible, outreach services by practitioners which offer a more flexible approach to ensure all groups in the population have good access to services.
- The first Local Authority Health Profiles covering the whole of England have been produced by Public Health Observatories and will be updated every year. These profiles, which can be used by both local authorities and the health service, are designed to show where there are important problems with health or health inequalities to help target action to improve the health of local people. The profiles can be accessed at www.communityhealthprofiles.info/

- Commissioners may also wish to consider looking at the profile of their local population against the Health Poverty Index www.hpi-org or the inequalities reports compiled by the London Health Observatory www.lho.org to help them understand the impact this service may have on local population health.
 - Further help in this area can be obtained from the National Support Team for Health Inequalities at the Department of Health.
 - Links to Health Literacy through support for self care and using health as a useful means of educating local people.
-