Public Health England

National Chlamydia Screening Programme

Information to support the commissioning of chlamydia screening in general practice and community pharmacies

October 2014

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1. Introduction

Purpose of the guidance

1.1 This guidance aims to support both commissioners and service providers in achieving high quality chlamydia screening services for the population they serve. It is hoped that it will support consistent high quality of commissioning, collaboration between Local Authorities (LAs), equity of service provision, and flexibility for local development. Information included is considered generic and would therefore be appropriate for all specifications. It is likely that LAs will want to supplement this information with requirements relevant to their local area based on detail that will be identified from local Sexual Health Needs Assessment including local priorities, local models of service provision and the resultant care and referral pathways.

1.2 This document aims to provide additional guidance specifically to assist the commissioning of chlamydia screening in general practice and community pharmacies. The advice provided can be adapted to suit local circumstances and provides suggested sections that commissioners may wish to include in their contracts with providers of chlamydia screening. The wording can be used in conjunction with the national service specifications for integrated sexual health services (June 2013)[1].

1.3 The importance of controlling and preventing onward transmission of chlamydia infection has been recognised in the Public Health Outcomes Framework[2.] The chlamydia detection rate is one of the Health Protection indicators and is a measure of chlamydia control activity in England, aimed at reducing the incidence of reproductive sequelae of chlamydia infection. PHE recommends that commissioners work toward a detection rate of 2,300 diagnoses per 100,000 15 to 24 year olds in their local authority. Higher detection rates reflect improved chlamydia control and are likely to result in a continued reduction in chlamydia prevalence. When working to achieve this detection level, it is important to recognise that genito-urinary medicine (GUM) services are unlikely to provide sufficient diagnoses on their own. Community services such as GP and pharmacy can play a crucial role in achieving this rate when commissioned in an integrated fashion with clear clinical pathways and links between services.

1.4 Maximising the capacity of general practice and community pharmacies to deliver chlamydia testing, treatment and partner management as part of core sexual health services is an effective strategy, as outlined in the NCSP guidance Integration into

core services (October 2014). Young people have widespread access to GPs and community pharmacies, and these services can provide diagnoses in areas where specialist sexual health services are not easy to access.

1.5 The NCSP's Standards 7th edition[3] states that at least 70 per cent of chlamydia screening should take place in core services. Core services consist of primary care (General Practitioner (GP) and community pharmacy), sexual reproductive health (SRH), GUM, and abortion services. In 2013, integration of chlamydia screening as measured through the proportion of screens undertaken in core services reached 69.5 per cent[4]. There is scope to further increase this proportion, particularly in primary care including general practice and community pharmacies. This is offered as a tool to help local authorities and their providers increase the proportion of screens undertaken in core services.

The contribution of general practice and community pharmacies

1.6 The role of general practice in providing chlamydia screening, treatment and partner notification is well established. Since the launch of the programme general practice and, to a lesser extent, pharmacies have generated increasing proportions of annual screening numbers. However, it is clear that in most areas the potential of these services to provide screening, treatment and partner notification is not being fully utilised. Chlamydia screening is not part of the GP contract (not part of Quality Outcomes Framework). The Department of Health's (DH) 'Framework for sexual health improvement (2013)[5] states: "However, many general practice staff have not had specific sexual health training and are often reluctant to raise or discuss issues due to a fear of causing offence, the sensitivity of the subject matter and constraints around time and expertise. Training, including e-learning courses, can support GPs and practice nurses in enhancing their skills and confidence in sexual health issues."

1.7 General practice and community pharmacies have a crucial role to play in promoting sexual health. Most young people visit their GP at least annually[6,7]. The Sexual Health Framework reports that "Access to services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice[5]." The Chief Medical Officer's Annual Report[8] 2012 'Our children deserve better: prevention pays' also states that 'Commissioners may maximise value by commissioning appropriate sexually transmitted infection (STI) screening services through opportunistic health contacts such as general practice, sexual health services, abortion services, pharmacies and existing resources'.

1.8 Community pharmacies have played an increasing role in the delivery of sexual health services building on the success of pharmacy-based emergency hormonal contraception (EHC) programmes. In recent years, commissioners across the country have commissioned chlamydia testing services alongside EHC, condom distribution and other sexual health services from community pharmacies. The 2008 Pharmacy White Paper includes a range of specific proposals on the contribution that pharmacies can make to sexual health services nationally. More recently in 2013, both the Local Government Association and the NHS Confederation published documents that clearly outlined the increasing role of community pharmacies in delivering public health services, including chlamydia screening.[9,10] Including chlamydia screening in a pharmacy setting is an important way of 'making every contact count'.

1.9 Table 1 presents the number and proportion of all tests carried out in general practice and in community pharmacies in 2008/09 and in 2012. While there is an increase of screening in actual numbers of tests in both testing service types (particularly in general practice), there is scope to raise their numbers and proportions further.

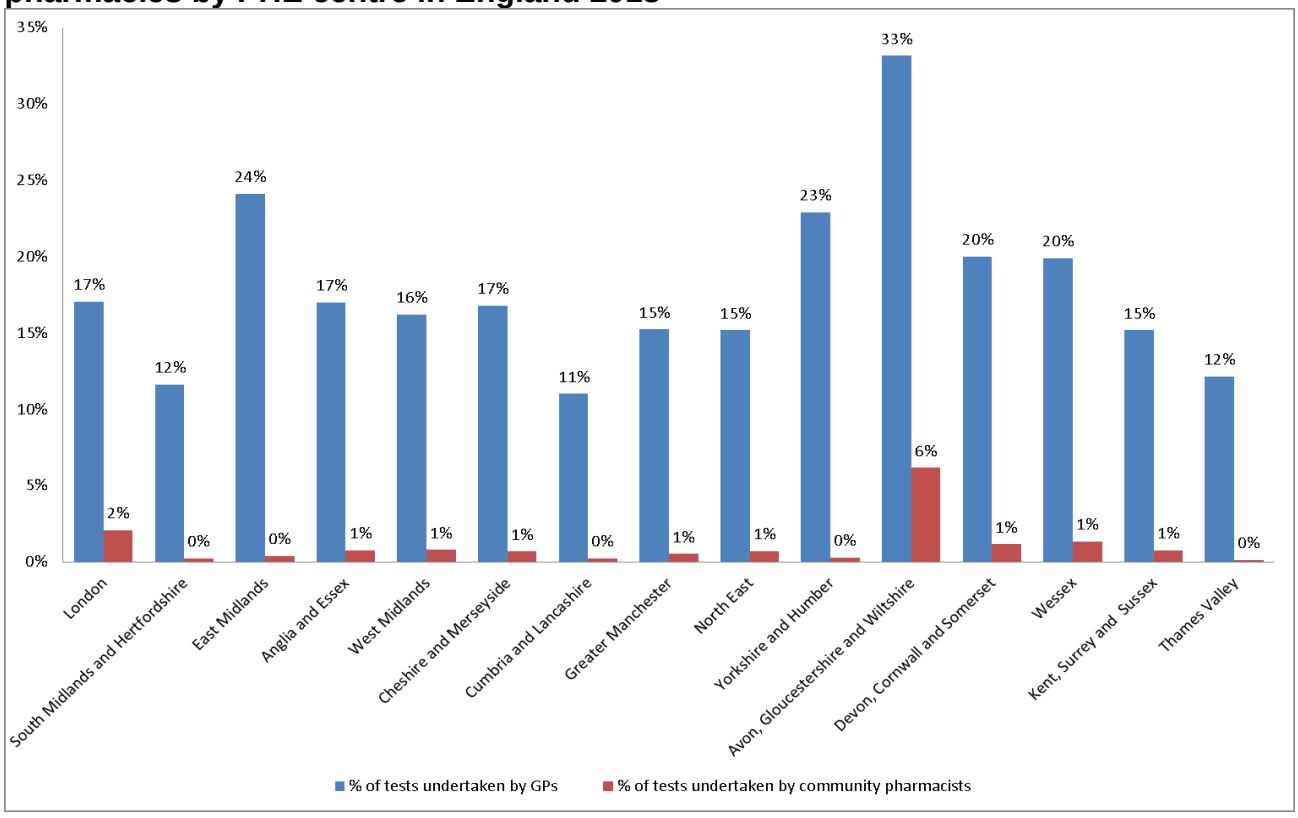
In recognition of this potential to increase screening for chlamydia in general practice, the NCSP is piloting a programme to support basic sexual health provision in GP surgeries, called '3Cs and HIV'. This programme is designed to support general practices to deliver a basic sexual health offer consisting of a **c**hlamydia screen, provision or signposting to **c**ontraceptive advice, and free **c**ondoms, as well as HIV testing in over 16 year olds where indicated. Across England, a number of practices are taking part in this pilot and the impact on the chlamydia screening rate and other sexual health activity will be evaluated to inform further development. Further information can be found on the NCSP's website.

Table 1 Proportion of chlamydia screens in general practice and community pharmacies in 2008/09 and 2012

Proportion of chlamydia screens in	2008/09		2013	
	Number	%	Number	%
General practice	113,854	15%	312,687	18%
Community Pharmacies	15,180	2%	18,932	1%

Figure 1 shows the variation across England in the proportion of chlamydia tests undertaken in general practice and in community pharmacies. For GPs the lowest proportion is 11 per cent, and the highest 33 percent. For community pharmacies the proportion of screens range from 0 to 6 percent.

Figure 1 Proportion of chlamydia screens undertaken in general practice and community pharmacies by PHE centre in England 2013



1.10 Commissioning services in General Practice and pharmacy can make a significant contribution to raising a local area's diagnostic rate. The positivity of tests carried out by GPs in 2012 was six per cent, for community pharmacies this was eight per cent[4]. Screening at these venues may be very effective given the high proportion of young people who attend these services annually.

2. Developing service specifications

2.1 In order to support local authorities (LAs) commission chlamydia screening in general practice and community pharmacies this document contains information that commissioners may wish to include in their service specifications.

2.2 The DH suggested standard service specification for integrated sexual health services[1] can be used with the non-mandatory contract or other contracting mechanisms.

2.3 Chlamydia screening should be commissioned as part of a wider sexual health pathway. The service should be offered to any sexually active under 25 year olds, regardless of their reason for attending a general practice or community pharmacy. In addition, there are some services already provided in general practice and community pharmacies that may act as a trigger for offering a chlamydia test, such as provision of contraception and emergency hormonal contraception (EHC), C-card scheme, general adolescent/youth issues, and provision of long acting reversible contraception (LARC). The paragraphs below contain suggested wording that may be copied or amended for inclusion in service specifications, as appropriate to local circumstances.

2.4 Young people presenting to General Practice with symptoms of a sexually transmitted infection should have a clinical assessment which may require referral to GUM. Pharmacy should refer all symptomatic young people to GUM or other appropriate services for clinical assessment.

Aims and outcomes

2.5 The aims and service outcomes of chlamydia screening in general practice and community pharmacies can be defined as:

a) increase access to screening opportunities by providing additional locations where asymptomatic young people can access testing and treatment for chlamydia;
b) increase access for young people, to sexual health advice and referral on to specialist services where required;
c) increase young people's knowledge of the risks associated with STIs, and
d) strengthen the network of contraceptive and sexual health services to help provide easy and swift access to advice.

Objectives

2.6 A number of objectives of commissioning services for chlamydia screening in general practice and in community pharmacies can be identified. These include:

a) an increase in opportunistic testing of asymptomatic patients under 25 years of age consulting for unrelated conditions in general practice and community pharmacy;
b) an increase in early detection and treatment of chlamydia and therefore reducing transmission and complications associated with it;
c) an increase in understanding and awareness of the importance of chlamydia and other sexually transmitted infections;
d) reaching sexually active young men and women who are not accessing specialist sexual health services, and
e) reducing the burden on specialist services by diagnosing, treating infections and providing partner notification in the community.

2.7 Ideally providers offer the full pathway in chlamydia screening and treatment including testing, provision of health advice and promotion, treatment and instigation of partner notification (PN), but this will vary dependent on local arrangements and may not be feasible in all settings. However, it is essential that the specification is explicit and clear about which elements of the pathway are being commissioned, how the local pathways work and how a range of providers need to work together. When a GP is the test initiator, they should be able to access the test results. Where PN has also been commissioned, testing and epidemiological treatment of partners should take place regardless of age.

Quality

2.8 The NCSP standards 7th edition[3] set out the mandatory programme requirements plus additional screening recommendations. The standards outline the NCSP's quality requirements that need to be met in the course of opportunistic screening for chlamydia. Table 2 below summarises these requirements into the various elements of the screening pathway.

Table 2 Quality requirements in the course of chlamydia screening

Element	Quality requirements
Testing venue	• Healthcare and associated staff at all venues should be trained to provide results, treatment and initiate partner notification or be aware of PN services in their area • The contractor will maintain a safe and suitable environment for patients and staff and comply with all relevant statutory requirements, legislation, Department of Health Guidance and Professional Codes of Practice, Health and Safety regulations, Consent and Chaperone policies. • In line with good practice, the testing venue and the offer of a chlamydia test should comply with the national 'You're Welcome' criteria for young people friendly services.

Offering the test	• Test to be offered:
	  • annually and on every change of partner
	  • via routine medicals, contraceptive / emergency hormonal contraceptive consultations
	  • after referral for abortion, and
	  • at 'call' opportunities (e.g. asthma check)
	• People should be provided with information about chlamydia and other sexual health promotion including the benefits of testing, how to access contraception advice, specimen collection, management of results and access to free treatment.
	• People declaring symptoms suggestive of sexual ill health should be risk assessed and managed appropriately. This may include referral to specialist sexual health services.
	• Contact details should be requested and preferably two methods of contact recorded and verified.
	• Samples and forms should be collected for analysis in a timely manner, as defined by local operational guidance.
	• People should be signposted to other sexual health services as appropriate.
	• Free condoms should be available and appropriate sexual health advice provided.

Test consent	• Obtain consent for test and use of data; • Careful consideration should be given to any commissioning of services for under 16s due to the medico-legal implications. The test initiator is responsible for ensuring that any young person under 16 being offered a test is competent to make an informed decision, using the Fraser guidelines. Test venues must adhere to national and local guidance and ensure competency is assessed and documented.

Element	Quality requirements
Testing practice	• Self taken swab or urine sample, or cervical swab if cervical examination taking place • Nucleic Acid Amplification Tests (NAAT) must be used
Providing results	• Young person to select preferred notification method • If test is positive, three contact attempts to be made (using more than one notification method) • If the test is negative one documented attempt can be made to report a negative result. No further action is required
Screening kits	All providers of postal chlamydia screening kits should deliver the services identified below: • Advice on how to utilise the kit, how to return it for testing, and what will happen following completion of the test including how people will be notified of results. • Provide information signposting people to other sexual health services.
Management of positives	• Advise full STI screen • Arrange treatment • Discuss partner notification • Agree arrangements for partners to be managed • Give safe sex advice • Follow up two weeks post-treatment • Offer a re test at around 3 months following a positive test
Treating chlamydia infections*	• Azithromycin (1gm) stat or doxycycline (100mg bd) seven days • Treatment is free for the young person • See BASHH guidance for treatment during pregnancy
Partner management	• Patient-led PN (provider-led offered as required) • Offer testing • Empirical treatment (do not wait for test result) • Ask about partners of partners and encourage testing

*People requiring treatment for STIs should receive this free of any prescription charge or, if this is not possible (e.g. where FP10 prescriptions are used) and the service user is not exempt, they should be offered access to another provider if they wish. Medication for the treatment of STIs should ideally be dispensed at the time of diagnosis[11].

2.9 The standards for the management of STIs of the British Association for Sexual Health and HIV (BASHH)[11], and the standards for the management of STIs in primary care[12] also need to be considered when commissioning sexual health services from general practice and community pharmacies.

Re-testing

2.10 The NCSP recommends that the case management of those testing positive for chlamydia should include a routine offer of re-testing around 3 months after treatment. The available evidence describes that after a positive chlamydia test the rate of a subsequent positive test is around two to three times higher than in those with an initial negative test, and around 10-15% of young adults diagnosed with chlamydia also test positive at their next test.[1-10]

This aspect of case management would ideally be built into the care pathway at as early a stage as possible i.e. raised when the young adult is first screened.

2.11 Commissioners and providers need to be aware of the implications of introducing re-testing. Specifically obtaining consent to re-contact young people, the additional resources that might be required and providing clarity on the clinical pathway for management of positive cases. Further information and supporting materials can be found on the NCSP website.

Clinical Governance

2.12 Clinical governance describes the structures, processes and culture needed to ensure that healthcare organisations - and all individuals within them - can assure the quality of the care they provide and are continuously seeking to improve it. In October 2013, the DH published guidance on clinical governance in sexual health services and the principles outlined in that document need to be adhered to (DH Clinical Governance guidance)[13]. Elements of this guidance have been referred to in the sections below.

2.13 Practices must ensure that

- it has a partner or employee who has the necessary skills and experience to carry out the contracted procedures. Only those trained for the opportunistic Chlamydia screening services should carry out the services. Medical and nursing staff registered with the GMC and NMC are considered qualified to undertake chlamydia screening, however, they will need to keep appropriate training and skills up to date. Only those who are registered healthcare

[1] Batteiger BE, et al. J.Infect.Dis. 2010;201:42-51; [2] Gotz HM, et al. STI.2013;89(1):63-9; [3] Götz HM, et al. BMC Infect Dis. 2013 May 24;13(1):239; [4] LaMontagne DS, et al. STI. 2007;83:292-303; [5] Rietmeijer CA, et al. STD. 2002;29:65-72; [6] Turner KM, et al. STI. 2013 Feb;89(1):70-5; [7] Walker J, et al. PLoS.One. 2012;7:e37778; [8] Woodhall SC, et al. STI. 2013 Feb;89(1):51-6; [9] Hosenfeld CB, et al. STD. 2009;36:478-89; [10] Fung M, et al. STI. 2007;83:304-9;

professionals, and have undergone appropriate training, should administer treatment under the Patient Group Directive

- the partner or employee carrying out the contracted procedures maintains up to date and appropriate membership of a recognised Medical Defence Organisation or its equivalent
- the partner or employee carrying out the contracted procedures is able to provide satisfactory evidence on demand of their qualifications, registrations and membership of appropriate professional bodies
- the contractor will indemnify the commissioner against all acts of medical negligence arising from their acts or omissions in providing the service. Such indemnity will be limited to the amount of indemnity provided by the partner or employee's Medical Defence Organisation
- the contractor will agree that access to records and documents containing information relating to individual patients treated under the terms of this Service Level Agreement will be restricted to authorised personnel and that information will not be disclosed to a third party. Both parties will comply with the Data Protection Act, Caldicott Guardian and any other legislation covering access to confidential patient information

Representatives of the commissioner have the right to visit the practice at any reasonable time, having regard for the provision of services and the patient's right to privacy and dignity.

2.14 Providers of sexual and reproductive health services are required to register with the Care Quality Commission (CQC) as providers of 'regulated activities'[14]. CQC is the statutory regulator for health and adult social care in England and it is an offence not to register if a 'regulated activity' is being provided. A service provider can be an individual, a partnership or an organisation. Further information can be found on the CQC website and a useful statement on CQC registration for providers of chlamydia screening and treatment can be found on the NCSP's website. From April 2013, GPs need to be registered with CQC. In relation to pharmacies, the scope of registration states that "Primary pharmacy services (for example, high street pharmacists) or pharmacy services that are of the same kind as those provided by high street pharmacy services" are exempt from registering with CQC. If this applies in this case, the service in question will not need to register as they are classed as "out of scope", but it is a provider's responsibility to check what service it provides exactly and whether or not registration is required. The decision tree on page 44 of the scope of registration document may be a useful tool to assess the need for registration. Community pharmacies are regulated by the General Pharmaceutical Council.

2.15 The DH Clinical Governance guidance[13] suggests that "when commissioning smaller, independent providers such as GPs and pharmacies, commissioners need to assure themselves that there are appropriate structures, systems and capacity in place to support these providers to deliver high quality care". The guidance (paragraph 49) states that commissioners should consider a variety of approaches to achieving this which might include combinations of the following arrangements:

- undertake an annual audit of independent providers possibly in conjunction with colleagues from the local CCG or CSU;
- Commission the local level 2/3 specialist provider(s) to provide clinical leadership, including clinical governance and training, to primary care providers, and
- use a lead provider model (commission one, or small number of, specialist providers who then sub-contract with other local providers, including primary care), to provide the services required across a local area, with the lead provider responsible for ensuring appropriate clinical leadership, including clinical governance is in place

Education and training

2.16 In relation to education and training, commissioners will want to assure themselves that staff working in sexual and reproductive health service have the appropriate qualifications, expertise and experience. All professionals should be competent to deliver their service, and competence should be assessed and maintained. Details of appropriate qualifications have been published by the Faculty of Sexual and Reproductive Health (FSRH)[15], and the British Association of Sexual Health and HIV (BASHH), and the Medical Faculty for Sexual Health and HIV (MedFASH) [9].

Audits

2.17 The Provider is expected to actively participate in local, regional and national clinical networks, relevant trials, training, research and audit programmes where applicable to ensure regular update of skills and expertise. Commissioners should ensure that audit activity is monitored as part of an annual chlamydia screening audit plan and that action is taken based on audit findings where appropriate.

Adverse incidents

2.18 In the event of an adverse incident occurring, the provider is required to report this using their local clinical governance procedures. The non-mandatory public health services contract allows for commissioners to agree processes and procedures for reporting incidents, including serious untoward incidents (SUI).

2.19 The DH Clinical Governance Guidance should apply[13.] This states that "Commissioners will want to ensure providers share reports on incidents and near misses, as well as reports on complaints and complements and other patient feedback. This should form part of the contract monitoring process. However, there is a role for reporting which goes beyond contract monitoring. Providers should share information about all incidents that occur in their services, regardless of whether these relate to the commissioners' specific population or not, as this allows broader lessons to be learned. Contracts should therefore ensure that they contain reporting mechanisms to allow the prompt reporting of all incidents."

2.20 According to the guidance the "Directors of Public Health need to assure themselves that there are appropriate incident management systems in place for the services they commission, from all providers, including escalation, notification and management of such incidents. Therefore, they must work closely with the provider organisation to ensure that this is the case."

2.21 Providers are also encouraged to inform the NCSP of the incident. The NCSP does not get involved in local incident management, however it will keep record of incidents nationally and will be able to issue lessons learned reports to help prevent similar incidents from happening elsewhere. Reports should be sent to: NCSPteam@phe.gov.uk as soon as key details of the incident become clear.

Safeguarding

2.22 Providers should have evidence that policies, training and staff checks for safeguarding children and vulnerable adults are in place and current. In relation to child protection, providers should ensure the following procedures are being adhered to (NCSP Standards 7th edition[3]):

- anyone under 16 who has a test should be assessed as Fraser competent,
- any cases of a child under 13 should be discussed with a nominated professional responsible for safeguarding in that service or locality, and
- staff involved with regular, substantial and unsupervised contact with young people or vulnerable adults must be CRB checked.

It is recommended that all sexually active young people under 16 should have a risk assessment for sexual abuse or exploitation, providers can use the national pro forma that has been developed for this purpose, it can be found here.

Care pathways

2.23 Commissioners should ensure that clear care pathways between services are established and articulated. Development of these could be supported by local sexual health networks and agreed between all relevant commissioners. Care pathways should focus on ensuring appropriate clinical management for people accessing services and support healthcare professionals in delivery of high quality care. They should be explicit, agreed, documented and utilised by all providers of chlamydia screening and treatment. Further information and guidance can be found in the BASHH guidelines on the management of STIs[11].

2.24 There is no evidence base to support widespread screening for gonorrhoea in the community[16]. Where this is in use though, the provider must ensure separate information and consent processes are in place, care pathways must be used to ensure confirmatory processes and appropriate treatment are provided, see here for the relevant guidance[17].

2.25 The care pathways must include appropriate provision for partner notification (PN), and options may include provision of PN through a central SRH/GUM service. If PN is not part of the requirement for GPs then commissioners need to ensure that care pathways exist between sexual health services and primary care so that PN can be undertaken by appropriate sexual health service. Commissioners may wish to add a performance indicator to monitor this.

2.26 Appendix 1 contains the sections in a care pathway, as an **example** of existing practice we have come across. It is not based on any recognised best practice and individual authorities may follow their own care pathways. It is an example to illustrate some of the key stages that could be included in a care pathway.

Key performance indicators

2.27 The NCSP standards[3] set out the mandatory programme requirements plus additional screening recommendations. For four of the standards, auditable outcome measures are also defined, as key considerations to inform local programme design and performance monitoring: table 3 contains the auditable outcome measures for chlamydia screening as part of the NCSP.

Table 3 NCSP Standards 7th edition Auditable Outcome Measures

Standard 1 – offering chlamydia testing
• **Key performance indicator:** At least 70% of tests delivered in primary care, sexual and reproductive health (SRH) and Genitourinary Medicine (GUM) services (per PCT or upper tier/ unitary Local Authority from April 2013).* * Primary care includes GP surgeries and community pharmacies. SRH includes sexual health clinics and abortion providers.
Standard 4 – notification of results
• **Auditable outcome measure:** All those tested notified of result within 10 working days (from date of test on the test form).* • **Key performance indicator:** At least 95% of those tested notified of result within 10 working days. * Notification date assumed as date provider sent text / left verbal message.
Standard 4 – Turnaround time for treatment
• **Auditable outcome measure:** All those testing positive offered treatment within six weeks of test date (date on the test form). •**Key performance indicator:** At least 95% of those testing positive treated within six weeks of test date.
Standard 4 – Partner Notification
• **Auditable outcome measure:** Percentage of index cases documented as offered ≥one PN discussion (including telephone discussion) with a healthcare worker with the appropriate documented competency. • **Key performance indicator:** At least 97% of index cases. • **Auditable outcome measure:** Percentage of index cases for whom outcome of agreed contact action(s), or decision not to contact, documented for all contacts. • **Key performance indicator:** At least 97% of index cases. • **Auditable outcome measure:** Number of all contacts whose attendance at a Level 1, 2, or 3 sexual health service was documented as reported by index case or healthcare worker (HCW), within four weeks of first PN discussion.* • **Key performance indicator:** at least 0.6 contacts per index case for all clinics (in and outside London) and documented within four weeks of date of first PN discussion.

3. Further suggested elements of the contract

3.1 In addition to the objectives, description and required quality standards of the service, we suggest some additional elements are included in the contract between the commissioner and the provider. This section elaborates on issues around payment structure, reporting, monitoring of activity, and confidentiality.

Payment structure

3.2 Commissioners will want to determine local payment structures and mechanisms. The following factors will be important to consider:

1) It is highly recommended that payments are only made for samples that reach the laboratory and that are tested. Payment for handing out kits can lead to very low return rates which in turn lead to high levels of wastage in terms of kit supplies. Also, handing out kits does not support the approach of using chlamydia testing as a way to initiate wider conversations with young people about sexual health.

2) Sites will need to ensure the screens that originate from their service can be identified as such in order to provide an audit trail and evidence on which invoicing can be based.

3) The NCSP does not support or encourage the payment of different fees for tests that have a positive rather than a negative result. This is because the NCSP advocates offering a screen to all sexually active young people and not targeting specific groups. However, the extra work involved in managing a positive diagnosis should be reflected in the payment structure through the fee for patient management and/or partner notification.

4) Whether or not to use existing general practice laboratory arrangements. Where chlamydia testing is undertaken by a different laboratory than the existing one used by the general practice for non-STI testing, this may have implications for laboratory transport costs.

5) The National Chlamydia Screening Programme Standards state that 'treatment should be free of charge'. This position is restated in the document from NHS Business Services Authority – section 10.2. 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.

Reporting

3.3 It is the responsibility of the service provider to ensure correct and complete details on the test request form are provided to the laboratory for each chlamydia test, in particular, postcode of residence of the patient and testing service type.The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for all public sector commissioned chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through measurement of population screening coverage, proportion of all tests that are positive and detection rates. Guidance for commissioners on CTAD completion can be found on the NCSP's website.

3.4 Incomplete or incorrect *patient residence postcode* and *testing service type* would result in discrepancies in regional detection rates (as testing from some local authorities would be allocated to the local authority in which their clinical service resides in the absence of postcode of residence/testing service type).Reporting high quality data is vital to informing local sexual health service planning, monitoring the impact of the NCSP and assessing progress towards the *Public Health Outcomes Framework*[6] chlamydia diagnoses rate indicator.

Monitoring

3.5 The NCSP undertakes national monitoring of the chlamydia detection rate per local authority as well as positivity, testing by service type, age and gender, and re testing rates. Providers are encouraged to undertake local monitoring of turnaround times, re-testing rates, and partner notification rates where applicable. The NCSP has developed a tool to use locally for this purpose, available here.

Confidentiality

3.6 Information which identifies patients should not be shared between authorities without the patient's consent, except in certain defined circumstances, for example if a criminal offence is involved or if there are safeguarding concerns. There is specific legislation which provides a greater level of protection for patients with regard to STI testing and treatment. Work is underway in the Department of Health and Health and Social Care Information Centre to publish a new statutory Code of Practice (CoP) on confidentiality. Providers of health and social care services will be legally obliged to follow the CoP. Separate guidance on confidentiality and disclosure of information on sexual health which will form part of the CoP will be developed. The current regulations and directions will then lapse. The DH Clinical Governance guidance also has further detail in relation to confidentiality[13].

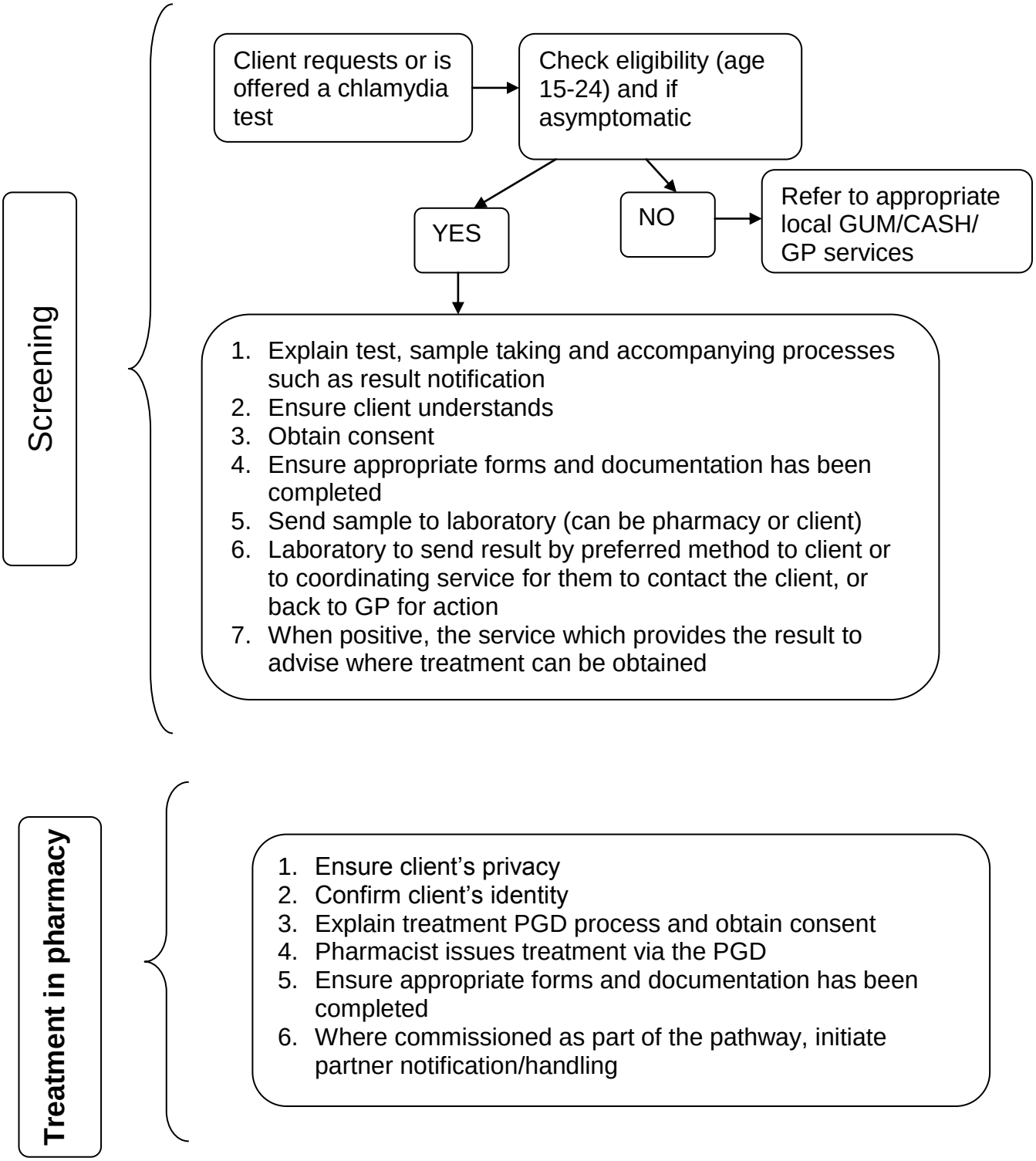
Other elements and further guidance

3.7 Two important elements of a contract for the provision of opportunistic chlamydia screening to be considered are details on 'termination of the agreement', and 'key contacts'. Supporting forms such as examples of test forms, treatment record forms, and/or 'client management treatment form', are also useful appendices to contracts.

3.8 In addition to the documents referred to in this guidance, additional support can also be found in the HIV, Sexual and Reproductive Health: current issues Bulletin, published by Public Health England (PHE), on behalf of PHE, DH, the Local Government Association (LGA) and the Association of Directors of Public Health (ADPH). Bulletin 2, December 2013, can be found here, and its main focus is commissioning sexual health services from primary care.

3.9 Where used, the requirement for advertising of the scheme is part of the provider responsibility.

Appendix 1 Example of sections in a care pathway



Please note that partner notification may not necessarily be part of the care pathway for community pharmacies, other designated providers may be commissioned to handle partner notification instead. This part below is merely an example of existing practice.

Partner handling/notification – *if applicable*

1. Ensure client's privacy
2. The pharmacist can treat the client if;
   a. The client attends at the same time as the chlamydia contact patient.
   b. The client attends on their own, but is able to provide all the chlamydia contact patient details in full.
3. If the client is unable to provide all the Chlamydia contact details in full they must contact the service the index attended or the coordinating service that notified the index of the result. The client must inform the service that they are a chlamydia contact before the pharmacist can issue the treatment.
4. The coordinating service will supply the appropriate information to the pharmacist once notified by the contact.
5. The pharmacist must ensure client privacy at all times and confirm that the client is suitable to receive the Azithromycin treatment via the PGD.
6. The pharmacist explains the Azithromycin treatment Patient Group Directive (PGD) process to the client.
7. The pharmacist must confirm with the client that they wish to continue with the PGD treatment process.
8. The pharmacist issues the Azithromycin treatment via the PGD.
9. The pharmacist fills out the Patient/Contact Treatment Report (Blue form) and returns it to the coordinating service.

During the screening process if the client opts for written contact only, there will be no opportunity for the coordinating service to initiate partner notification. Under these circumstances the pharmacist will need to complete a partner notification form and return this to the coordinating service.

Note: The above outline of possible key stages in a care pathway is not based on any recognised best practice and individual authorities may follow different care pathways and approaches. It is an example to illustrate some of the appropriate key stages.

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