UK Health Security Agency

# Standards

## English National Chlamydia Screening Programme

Eighth edition 2022

# Contents

# National Chlamydia Screening Programme (NCSP) standards 2022: quick reference sheet

For all steps in the delivery of chlamydia screening, relevant standards for the management of chlamydia such as British Association for Sexual Health and HIV (BASHH) Standards for the Management of Sexually Transmitted Infections (STIs), BASHH Clinical guidance for the management of chlamydia, BASHH Standards for Children and Young People apply. The table below contains a summary of the main elements.

**Table 1. NCSP quick references to the standards**

| Standard or care pathway component | Quick reference |
|---|---|
| 1. Offer of a test | 1.1. All sexually active women and other people with a womb or ovaries under the age of 25 accessing a sexual and reproductive health service (including online), any service offering contraception, termination of pregnancy service, GP or pharmacy should be offered a chlamydia test.<br>1.2. Services should promote testing at partner change, or annually if no partner change.<br>1.3. All sexual partners of individuals who are diagnosed with chlamydia, should be offered a test. This should be delivered in line with BASHH national guidelines for the management of chlamydia, regardless of their age.<br>1.4. All those offered a test should be provided with health promotion and advice.<br>1.5. All testing environments should meet Young People Friendly quality criteria. |
| 2. Take specimen | 2.1. The NCSP follows national guidelines on the testing and clinical management of Chlamydia as produced by the British Association for Sexual Health and HIV and the UK Standards for Microbiology Investigations<br>2.2. Standard laboratory test forms can be used and should contain the relevant fields to ensure data for surveillance purposes is captured. |

| Standard or care pathway component | Quick reference |
|---|---|
| 3. Make a diagnosis | 3.1. The NCSP follows national guidelines on the testing and clinical management of chlamydia as produced by the British Association for Sexual Health and HIV.<br>3.2. Increasing the identification and re-testing of people with chlamydia will help to minimise the health related harms of untreated infections. This will assist local areas in achieving the detection rate indicator as published in the Public Health Outcomes Framework. |
| 4. Get result | 4.1. The NCSP follows national guidelines on the testing and clinical management of chlamydia as produced by the British Association for Sexual Health and HIV: 95% of young people should receive their result within 8 days.<br>4.2. Prompt notification of test results is essential for the index patient to begin treatment at the earliest opportunity to increase the likelihood of reducing harm, and to stop onward transmission. |
| 5. Give treatment | 5.1. The NCSP follows national guidelines on the testing and clinical management of chlamydia as produced by the British Association for Sexual Health and HIV: 85% of young people should receive treatment within 3 weeks.<br>5.2. Treatment must be administered by either medical practitioners or other clinical staff legally covered to work under patient group directions (PGDs), per NICE guidance. Treatment should be free of charge.<br>5.3. Young people receiving treatment must also receive information on treatment, the potential for re-infection, safer sex advice, offer of a full STI screen, partner notification and offer of a re-test. |
| 6. Notify partner(s) | 6.1. Effective partner notification benefits the patient through preventing re-infection and subsequent harm, facilitates treatment of partners and reduces the spread of chlamydia.<br>6.2. Partner notification is an effective way of identifying new infections because the positivity rates of partners who get tested for chlamydia is generally very high. This can contribute to the aim of the programme to reduce harm from infection, and support achievement the recommended detection rate indicator. |
| 7. Prevent re-infection | 7.1. Local areas should focus on increasing the re-testing rates of those found to be positive for chlamydia as there is evidence of higher rates of health harms from subsequent infections and the |

| Standard or care pathway component | Quick reference |
|---|---|
| | positivity rates of those returning for a re-test are generally higher compared to those having an initial test.<br>7.2. The NCSP follows national guidelines on the testing and clinical management of chlamydia as produced by the British Association for Sexual Health and HIV: re-testing should happen between 3 and 6 months after initial treatment. |
| 8. Data collection and submission | 8.1. Complete and high quality data capture on chlamydia tests and diagnoses is essential to accurately measure screening activity which in turn inform service planning at local level.<br>8.2. Providers, laboratories and commissioners each have responsibilities to ensure all required data is captured in a timely manner and to high quality standards whilst ensuring confidentiality requirements are met. |

Note: Sexually active women and other people with a womb or ovaries include transgender men, and non-binary people assigned female at birth, and intersex people with a womb or ovaries.

# Auditable outcome standards

Three of the standards include auditable outcome measures to inform local programme improvement and performance monitoring. These are aligned with outcome measures from BASHH Standards for the Management of STIs.

**Table 2. NCSP auditable outcome standards**

| NCSP standard | Outcome measures | Key performance indicator |
|---|---|---|
| Time to result notification (NCSP standard 4) | All those tested notified of their result within 8 working days from date of test* | 95% |
| Time to treatment (NCSP standard 5) | All those testing positive to be treated within 3 weeks | 85% |
| Partner notification (PN) (NCSP standard 6) | Percentage of index cases documented as offered ≥one PN discussion (including telephone discussion) with a healthcare worker with the appropriate documented competency | At least 97% of cases |
| | Percentage of index cases for whom outcome of agreed contact action(s), or decision not to contact, documented for all contacts | At least 97% of index cases |
| | 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 4 weeks of first PN discussion** | At least 0.6 contacts per index case for all clinics and documented within 4 weeks of date of first PN discussion |

*Test date assumed as date on the test form. Notification date assumed as date provider sent text or left verbal message.

**This is the first discussion between the index case and a HCW (including telephone) for the purpose of PN, with the appropriate documented competency.

# Introduction

## Background

This document contains updated standards to support the delivery of the National Chlamydia Screening Programme (NCSP) in England. This eighth edition supersedes the seventh edition (May 2014 and updated in November 2018). For all steps in the delivery of chlamydia screening, relevant standards for the management of chlamydia apply, such as BASHH STIMs, BASHH Clinical guidance for the management of Chlamydia trachomatis, BASHH Standards for Children and Young People.

## Screening for chlamydia

Chlamydia is a major public health concern as infection can lead to serious and costly health problems including pelvic inflammatory disease, chronic pelvic pain, tubal factor infertility, and ectopic pregnancy. In 2019, 49% of new diagnoses for sexually transmitted infections in sexual health services (SHS) were for chlamydia. The prevalence of infection is highest in young sexually active people (15 to 24 year olds) (1, 2).

The NCSP focuses on reducing reproductive harm of untreated infection in young women and other people with a womb or ovaries. This includes transgender men, and non-binary people assigned female at birth, and intersex people with a womb or ovaries.

## NCSP aims and objectives

The principal aim of the programme is:

- to prevent the adverse consequences of untreated chlamydia infection

With secondary aims:

- to reduce re-infections and onward transmission of chlamydia
- to raise awareness of good sexual health

This is achieved by opportunistic screening (that is the proactive offer of a chlamydia test to young people without symptoms) of women and other people with womb or ovaries under the age of 25 years, combined with reducing time to test results and treatment, strengthening

partner notification and re-testing after treatment. In practice this means that chlamydia screening in community settings, such as GPs and pharmacies, will only be proactively offered to sexually active young women and other people with womb or ovaries. Services provided by sexual health services remain unchanged. Further information on the changes to the NCSP can be found in the policy paper on ‘Changes to the National Chlamydia Screening Programme’ published on 24 June 2021 (3).

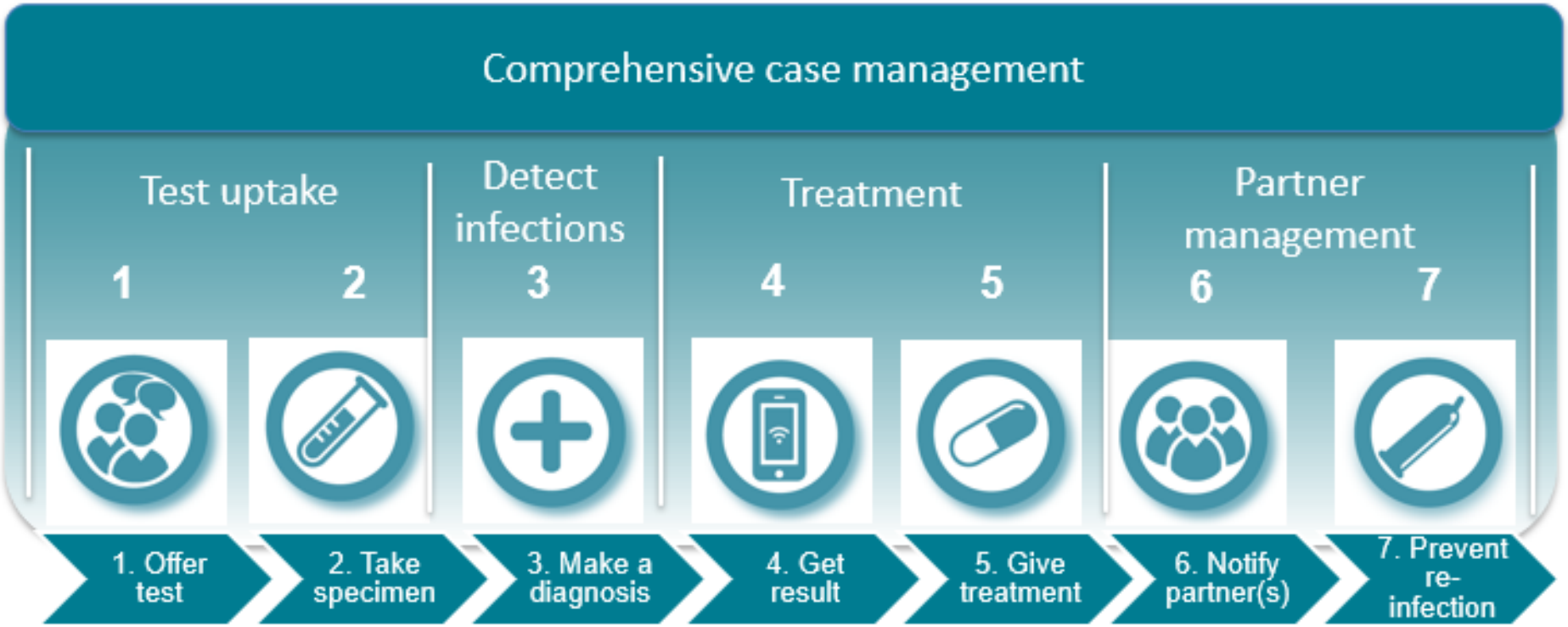
People with symptoms should be assessed by an appropriate healthcare professional. Non-specialist sexual health services should have robust referral and signposting routes to ensure that this happens. People with STI concerns should have a medical and sexual history taken and appropriate management given within a competent clinical service, as per clinical guidance published by the British Association for Sexual Health and HIV (BASHH) (4).

Anyone of any gender who is concerned they might be at risk of chlamydia or other STIs should contact their local sexual health service or GP for health advice about whether to get tested.

Online sexual health services are expected to continue to test for chlamydia as part of full sexual health screening. If providing online opportunistic chlamydia screening (that is not directly requested or as part of a full STI screen), this should be in line with NCSP policy.

The standards in this document support the implementation of the changes to the NCSP which were announced in June 2021, and form part of the NCSP's updated Quality Assurance and Quality Improvement Framework. The standards also reflect the BASHH 2019 Standards for the Management of STIs (4), and the UK national guideline for the management of infection with Chlamydia trachomatis (5). The structure of this standards document follows the 7 care pathway components that comprise the NCSP chlamydia service care pathway, presented in Figure 1. The section on Quality Improvement contains more information on the chlamydia care pathway.

**Figure 1. NCSP Chlamydia Care Pathway**



# Standard 1: Offer of a chlamydia test

## Offer of a test

The NCSP recommends that all sexually active women and other people with a womb or ovaries (this includes transgender men, and non-binary people assigned female at birth, and intersex people with a womb or ovaries) under the age of 25 accessing a sexual and reproductive health service (including online), any service offering contraception, termination of pregnancy service, GP or pharmacy should be offered a chlamydia test.

Services should promote testing at partner change, or annually if no partner change. If a patient is found to be positive for chlamydia, partners of any age should be offered a test.

Targeted outreach screening can be considered for groups not engaged by healthcare services if there is evidence of unmet need. BASHH has produced standards for outreach services (6).

Gay, bisexual, and other men who have sex with men should be advised to obtain a full STI screen, in line with national clinical guidelines (7).

## Testing for gonorrhoea

Population screening for gonorrhoea where prevalence is low is of limited public health benefit, as where prevalence is below 1%, most initial positive test results (using a single target NAAT) are likely to be false positives, and confirmation of all gonorrhoea reactive tests is essential. Any gonorrhoea-testing service, including online services, should include a specific care pathway that sets out how to gain consent for the test, how and when to notify the patients of the results, what is the appropriate treatment and how partner notification should be performed. If services delivering chlamydia screening are using dual NAATs then consent to test for both organisms should be gained (guidance for the detection of gonorrhoea in England (8)).

## Sexual health advice

In line with good practice and to raise awareness of good sexual health, service providers should ensure that they have appropriate mechanisms in place to provide health promotion and prevention. More on this can be found for example at the BASHH Standards for the Management of STIs (4), and the BASHH guide to safer sex (9).

In addition, guidance from the National Institute for Clinical Excellence and Care (NICE) on one-to-one interventions with Prevention of STIs and under 18 conceptions (10), on condom distribution schemes (11), and on behaviour change (12) is also available.

# Standard 2: Take specimen

The NCSP follows the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and the BASHH Standards for the Management of STIs 2019 (NCSP standard 3) (4), and the UK Standards for Microbiology Investigations (13).

These guidelines and standards include elements around taking a specimen such as contracting with accredited laboratories, how to test, sites to be sampled, algorithms to follow for different test results, laboratory standards, and turnaround times.

It is recommended to use standard laboratory test forms, which contain the necessary items for the CTAD Chlamydia Surveillance System (see NCSP standard 8). In non-clinical settings where the standard lab form is not employed, test request forms should be formatted to facilitate easy self completion and it is recommended staff complete venue specific details. Service providers must ensure that all relevant information is passed on to the laboratories to assist CTAD reporting.

# Standard 3: Make a diagnosis

The NCSP follows the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and the BASHH Standards for the Management of STIs 2019 (NCSP standard 4) (4).

These guidelines and standards include elements around making a diagnosis, including which test to use as indicated by clinical assessment, presence of inhibitors, knowing how to interpret invalid results, window period, and recommended further investigations.

The number of diagnoses per 100,000 of the 15 to 24 year old population in a local area is referred to as the chlamydia detection rate. This number reflects the number of cases found through screening and is not a measure of local prevalence. The higher this rate per 100,000 15 to 24 year olds in a local area, the better the likely prevention of harm from chlamydia though appropriate treatment and management of the diagnosed infections.

Increasing the number of chlamydia diagnoses made leads to a higher detection rate indicator (DRI). People who have been treated for chlamydia have a higher chance of testing positive again than those who initially test negative. Therefore, improving re-testing rates can help to increase the number of diagnoses made and help local areas in achieving the DRI. Given the change in the NCSP programme aim the Public Health Outcomes Framework (PHOF) DRI benchmarking thresholds have been revised and will be measured for females only from January 2022 – please see this document for more details. The section on Quality Improvement contains more information on this topic.

# Standard 4: Get result

The NCSP follows the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and the BASHH Standards for the Management of STIs 2019 (NCSP standard 4) (4).

All those that take a test must be notified of their result. The NCSP does not endorse a policy of 'no news is good news'.

Prompt notification of test results is essential for the index patient to begin treatment at the earliest opportunity to increase the likelihood of reducing harm, and to break the chain of onward transmission.

The young person taking the test should be offered a minimum of 2 methods for test notification and be asked for their preferred method. If they test positive, 3 attempts should be made to contact them (using more than one notification method). All results should be reported confidentially. Positive results should be provided by staff with appropriate clinical competencies. Where appropriate and agreed in local care pathways, the test result should be accessible to the test initiator for further action if required.

## Auditable outcome measure

Ninety-five percent of patients are provided with their test result within 8 working days of the date of the sample.

# Standard 5: Give treatment

The NCSP follows the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and the BASHH Standards for the Management of STIs 2019 (NCSP standard 4) (4), and treatment must be in accordance with these published clinical guidelines and standards. Treatment must be administered by either medical practitioners or other clinical staff legally covered to work under patient group directions (PGDs), per NICE guidance (14). Templates for PGDs for uncomplicated chlamydia treatment are available from the NHS Specialist Pharmacy Service (15).

Young people with chlamydia should be managed in line with national clinical guidance (4, 5).

This includes:

- information on treatment and the potential for re-infection
- safer sex advice including details of local services that can support this
- offer of a full STI screen (chlamydia, gonorrhoea, syphilis, and HIV)
- partner notification
- offer of a re-test – this re-test should occur between 3 and 6 months after treatment (5) (see NCSP standard 7)

Treatment should be free of charge. Individuals suspected of clinical treatment failure should be referred to appropriate sexual health services or managed according to the BASHH guidelines (4).

## Auditable outcome measure

Eighty-five percent of patients are treated within 3 weeks.

# Standard 6: Notify partner(s)

Partner notification (PN) is the process of identifying, testing, and treating sex partners of a person diagnosed with a STI and is an essential component of STI control. PN benefits the index patient through preventing re-infection and subsequent harm, and it also facilitates the treatment of their partners and helps to reduce the spread of STIs in their sexual network. The proportion of people testing positive through PN is high and increasing the proportion of partners notified and treated is an effective way of identifying new cases and would reduce the

cost per case identified. It can contribute to the aim of the programme to reduce harm from infection and support the achievement of the recommended DRI.

All patients identified with chlamydia should have partner notification (PN) discussed at the time of diagnosis by a trained healthcare professional. Method of PN and PN outcomes should be documented and all sexual partners should be offered and encouraged to take up full STI screening, see the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and BASHH Standards for the Management of STIs 2019 (NCSP standard 4) (4). These guidelines also include elements such as contact tracing and treatment, look-back period, and PN follow up.

## Auditable outcome measures

Individuals provided with written information about their diagnosis and management (performance standard 97%).

PN performed and documented according to BASHH Statement on PN for sexually transmissible infections (see BASHH guidelines) (performance standard 97%).

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 4 weeks of first PN discussion (performance standard: at least 0.6 contacts per index case for all clinics and documented within 4 weeks of date of first PN discussion. This is the first discussion between the index case and a healthcare worker (including telephone) for the purpose of PN, with the appropriate documented competency).

# Standard 7: Prevent re-infection

The NCSP follows the 2015 UK national guidelines on the testing and clinical management of chlamydia (5), and the BASHH Standards for the Management of STIs 2019 (4). The NCSP recommendation for when to re-test for chlamydia is aligned with the time period within the UK national guidelines: 3 to 6 months after initial treatment (5).

Local areas should focus on increasing the re-testing rates of those found to be positive for chlamydia. This is because there is evidence of higher rate of health harm from subsequent infections and the positivity rates of those returning for a re-test are generally higher compared to those having an initial test (5, 16), indicating this is an effective way of identifying new infections, which will contribute to achieving the recommended detection rate indicator.

# Standard 8: Data collection and submission to UKHSA

## Surveillance systems

The UK Health Security Agency (UKHSA) collects data on all chlamydia tests undertaken in England from NHS laboratories and sexual health services to measure screening activity. The 2 main surveillance systems used for this purpose are: CTAD Chlamydia Surveillance System (CTAD, introduced as a mandatory return in April 2012) and the GUMCAD STI Surveillance System (GUMCAD, introduced as a mandatory return in April 2008, current version v3 was introduced in April 2019). For CTAD, laboratories are required to submit data on chlamydia tests and diagnoses on a quarterly basis, whereas for GUMCAD specialist and non-specialist sexual health services are required to do this. Both use the secure HIV and STI Data Exchange to submit their data.

## Data quality and completeness

UKHSA encourages commissioners, providers, and laboratories to work together ensure that CTAD data is complete and of high quality. Data substitution is performed by UKHSA to reduce duplicate copies of records between CTAD and GUMCAD STI surveillance systems. It is essential that specialist sexual health services can be identified to allow the data substitution process to be carried out to a high standard and to reduce the risk of under or over counting data on chlamydia testing and diagnosis.

It is particularly important that the following fields are completed and are accurate: postcode of residence, venue code, postcode of testing service, and testing service type.[1]

Providers of chlamydia testing must ensure that:

- screening forms (electronic or paper) allow for the collection of all the mandated CTAD data fields
- staff ensure that the screening form (electronic or paper) is completed in full and that information is accurate

[1] The venue code is used to attribute data on tests and diagnoses to the correct service type, for example general practice. The postcode of residence is required to ensure that the data is attributed to the correct area of patient residence.

- the laboratory can attribute tests and diagnoses to the correct service, location, and service type

Laboratories must ensure that:

- CTAD data is submitted to a high standard, on time, and in accordance with the CTAD specification and technical guidance
- systems are in place to ensure that tests can be attributed to the correct service (Venue Code), service location (Postcode of Testing Service) and service type (Testing Service Type)
- specialist sexual health service (Level 3 GUM) ensure Testing Service Type data item is recorded as 01 GUM with the correct corresponding Venue Code populated
- data quality and completeness issues are identified, investigated, and resolved

Commissioners must ensure that:

- providers and laboratories submit CTAD data to a high standard, on time, and in accordance with the CTAD data specification and technical guidance
- data quality and completeness issues are identified, investigated, and resolved

# Data protection

Testing providers are responsible for ensuring the quality of data collected and held locally. Confidential data (that is, clinic or NHS number, date of birth, and postcode) must not be disclosed to anyone other than the provider of the data, local programme staff handling the data and national STI surveillance team at UKHSA. No data may be disclosed to any other parties unless in aggregate form and with the agreement of those responsible for their provision. Additional confidentiality measures include, but are not limited to:

- while data is held locally, access to records should be restricted as part of the system security
- at no time should data be used for any purposes other than those for which they were specifically collected, unless the consent of the providers of that information has been confirmed

# Guidance and resources

Laboratories submit the data via the secure UKHSA HIV and STI Data Exchange, where guidance on completion and submission can also be found.

Commissioners, providers, and laboratories should adhere to the requirements and guidance as published in the CTAD specification and technical and implementation guidance (17, 18, 19).

# Data outputs

UKHSA publishes data on the number of chlamydia tests and diagnoses to 15 to 24 year olds in England. The data provides information on:

- tests to 15 to 24 year olds
- diagnoses to 15 to 24 year olds
- testing coverage
- positivity
- detection rate

Chlamydia tests and diagnoses to people of all ages is included in the STI annual data tables and report.

Chlamydia testing and diagnoses in 15 to 24 year olds in England is included the NCSP annual data tables and report.

Data for upper tier and lower tier local authorities can be viewed on the Sexual and Reproductive Health Profiles.

Commissioners and providers of sexual health services can access national, regional and local data on chlamydia screening and diagnoses via the CTAD section of the HIV and STI Data Exchange.

# Quality improvement

## Chlamydia Service Care Pathway

Since 2016, the NCSP has been running Chlamydia Service Care Pathway workshops with local providers and commissioners across England. These present a combination of surveillance data, local or national data from NCSP national audits, and additional locally collected data in a logical sequential framework. The data highlight which components across the service care pathway worked well and where stakeholders could focus their service improvement planning.

## Guidance

The NCSP will continue to develop guidance (20), including to support the implementation of the changes adopted in 2021.

## Evaluation

Evaluating interventions or service delivery models is an essential component of quality and service improvement. Public Health England (PHE) developed a number of resources; more can be found on these webpages:

- Sexual health, reproductive health, and HIV services: evaluation resources – GOV.UK website
- Understanding the impact of sexual health and reproductive health service changes during COVID-19: Tools and resources – Faculty of Sexual and Reproductive Healthcare (FSRH) website
- Variation in outcomes in sexual and reproductive health in England toolkit – GOV.UK website

These resources can help in identifying existing health inequalities and acting upon the results of these analyses may contribute to reducing these.

# Quality assurance

## Audit

The NCSP continues to run a regular national audit programme (21). Audit results help provide a snapshot of performance against standards as well as informing local service improvement activities. Local results can be benchmarked against national averages and are used to inform the chlamydia care pathway. The audit tools will be updated to enable measurement against the auditable outcomes related to the NCSP changes implemented in 2021. The audit programme is expected to start from 2022.

## Incidents and lessons learned

Service improvement can also be achieved by reflecting on incidents that happen in the course of chlamydia screening. The NCSP operates an incident reporting policy and shares lessons learned where it is appropriate to do so to prevent similar events happening elsewhere (22, 23).

## Monitoring

Commissioners should ensure that indicators are included in service specifications to allow quality outcomes to be monitored and reported.

# References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2. Natsal-3. Woodhall and others (2015); Sonnenberg and others (2013)
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4. British Association for Sexual Health and HIV (BASHH). 'Standards for the Management of STIs' 2019
5. BASHH. 'BASHH Clinical Guideline for the management of chlamydia' Last updated September 2018
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7. BASHH Clinical Effectiveness Group (2016). 'UK national guideline on the sexual health care of men who have sex with men'
8. PHE. 'Guidance for the detection of gonorrhoea in England' Updated 2021
9. BASHH. 'A BASHH guide to safer sex'
10. National Institute for Health and Care Excellence (NICE) public health guideline PH3. 'Sexually transmitted infections and under-18 conceptions: prevention Published 28 February 2007, checked December 2018, plan to be updated
11. NICE guideline NG68. 'Sexually transmitted infections: condom distribution schemes' 6 April 2017
12. NICE public health guideline PH49. 'Behaviour change: individual approaches' 2 January 2014
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14. NICE. 'Pathways: Patient group directions overview – everything NICE says in an interactive flowchart'
15. NHS Specialist Pharmacy Service (SPS). 'Patient Group Directions'
16. PHE. 'NCSP: re-testing of positive chlamydia cases consultation report and evidence summary' 1 August 2013
17. PHE. 'Chlamydia Testing Activity Dataset (CTAD): specification and technical guidance'
18. PHE. 'CTAD commissioning guidance' 1 October 2015
19. PHE. 'Chlamydia: guidance on reporting in CTAD and GUMCADv2'
20. PHE. 'NCSP Commissioning and provider guidance' (being updated)
21. PHE. 'NCSP: Audit reports and tools' Last updated 24 June 2021

22. PHE. 'NCSP: Incident reporting policy' January 2020
23. PHE. 'NCSP: Lessons learned reports'

# About the UK Health Security Agency

UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

UKHSA is an executive agency, sponsored by the Department of Health and Social Care.



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