



Public Health  
England

Protecting and improving the nation's health

# **NCSP 2017 audit report**

## **Audit of standards: turnaround times, partner notification and re-testing**

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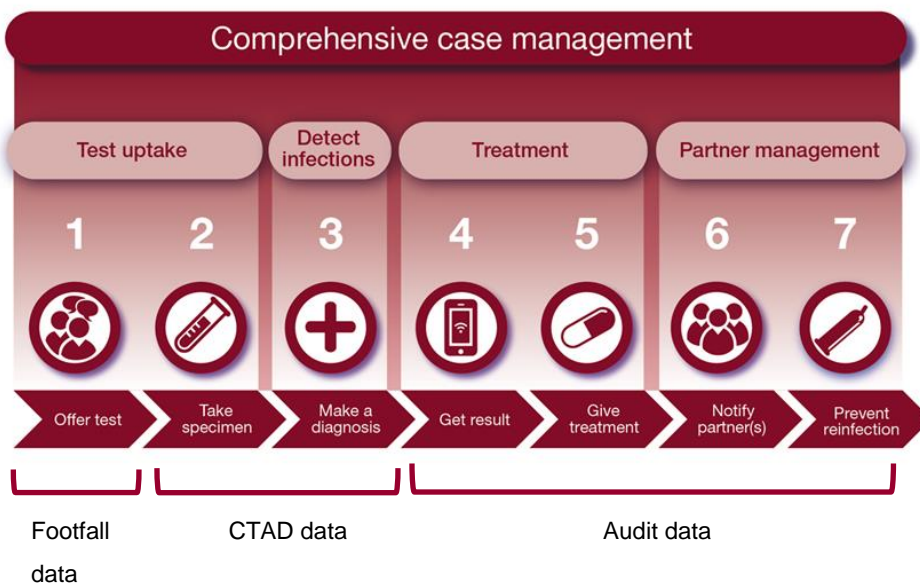
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# Introduction

The NCSP audit programme aims to ensure that chlamydia screening services are delivered to a uniform, high standard to ensure that young people get the best available care, and that the programme is able to fulfil its aims to prevent the harms of chlamydia infection. This report contains the findings of the 2017 audit that measured performance against standards in components 4 to 7 of the National Chlamydia Screening Programme (NCSP) Chlamydia Care Pathway: result notification (component 4), time to treatment (5), partner notification (PN) (6) and re-testing (7), see figure 1. When audit data is combined with data from the CTAD surveillance system for components 2 and 3, and local footfall data for component 1, a complete dataset can be created to review the entire local chlamydia care pathway.

**Figure 1: NCSP Chlamydia Care Pathway**



The NCSP runs a regular national audit programme as part of its Quality Assurance framework. We support local areas to review their local chlamydia screening activities and improve the quality of care throughout the care pathway. To do this, the NCSP facilitates local workshops where delegates work through their local data (local and audit data where available, and CTAD data). Action plans are developed to address any bottlenecks in the care pathway.

## Methodology

Previously, the components of the care pathway were audited separately. In 2017, for the first time, the NCSP used a single combined audit to simplify data collection and reduce the burden on providers, while at the same providing results for all 3 standards simultaneously.

An excel based audit tool was developed and subsequently piloted in 3 areas across England. The tool collected anonymised data and, once completed, was submitted using PHE's secure drop box. More details on the audit tool and the audit process are presented in [Appendix 1](#). The audit tool collected data on each of the auditable outcomes of each of the 4 components (table 1).

**Table 1 Auditable outcome measures**

Component	Auditable outcome measure	Standard
<b>Result notification<sup>1</sup></b>	Proportion of those tested that receive their result within 10 working days from the date of test	95%
<b>Time to treatment<sup>1</sup></b>	Proportion of young people found to be positive that received treatment within 6 working weeks from the date of test	95%
<b>Partner notification<sup>2</sup></b>	The proportion of index cases that were offered a PN discussion	97%
	The number of contacts per index case that were reported as having attended a sexual health service within 4 working weeks of date of PN discussion	0.6
<b>Re-testing<sup>3</sup></b>	The proportion of young people with chlamydia that re-turned for a re-test around 3 months after treatment	NA

Invitations to participate in the audit were emailed to a distribution list of providers of chlamydia screening, that PHE collates through its network of sexual health facilitators who are linked to each of the 9 PHE centres across England. The facilitators also copied the invitation to participate in the audit to sexual health commissioners in their centres to enable them to forward it to providers they have contracted to provide chlamydia screening. In addition, the British Association of Sexual Health and HIV (BASHH) National Audit Group members also distributed the invitation across its network of regional audit chairs.

The audit data was collected between 19 July and 15 September 2017.

<sup>1</sup> NCSP Standards 7<sup>th</sup> edition, 2014

<sup>2</sup> BASHH Standards for the management of STIs, 2014

<sup>3</sup> NCSP [Guidance on re-testing](#), 2013

A total of 50 records, comprising 40 consecutive positive patients and 10 consecutive negative patients (for whom not all data fields were required) from 31 January 2017, going back in time until 50 records were found, was requested from participating providers.

The completed audit tools that were returned, were checked for data quality prior to being collated into a single national audit dataset. The results in this report are based on the analyses of that data set. [Appendix 2](#) contains additional data on the testing service types that comprise the national dataset.

## Findings

This section reports on the response rate and the performance against the auditable outcome standards. It presents the results against the standards and compares these to previous audit findings.

### Response rate

Across England, it is estimated that more than 120 invitations were sent out. This is estimated, as we do not know how many commissioners or BASHH members may have forwarded the invitation to take part, and to how many providers this may have been sent. Out of 152 upper tier local authorities (UTLAs), audit returns that were included in the national data set covered just over half (51%) of UTLAs. 5 returns could not be included in the national data set: 3 choose a different audit period, one only submitted online test turnaround time (ie no PN or re-testing data), and one with 33% of result notification dates missing. Table 2 shows the variation in local authority (LA) coverage by PHE Centre, which ranged from 91% in East of England to 21% in West Midlands.

**Table 2: Audit participation by PHE Centre**

<b>PHE Centre</b>	<b>No of LAs</b>	<b>No of LAs in audit</b>	<b>Proportion participating</b>
<b>East of England</b>	11	10	91%
<b>Yorkshire and Humber</b>	15	13	87%
<b>South West</b>	16	11	69%
<b>North West</b>	23	11	48%
<b>East Midlands</b>	9	4	44%
<b>North East</b>	12	5	42%
<b>London</b>	33	13	39%
<b>South East</b>	19	6	32%
<b>West Midlands</b>	14	3	21%
<b>England</b>	152	78	51%

### Overall results

The audit results show that the standards of the auditable outcome measures have not been met overall. When compared to the previous audit results, performance against the standards show a mixed picture, with 2 out of the 4 standards improving (treatment standard, proportion of index cases offered a PN discussion) and 2 deteriorating (result notification and the number of contacts per index case that attended a sexual health service). The proportion of young people with chlamydia that returned for a re-test after

the recommended 3 months after treatment has also slightly reduced. This has been presented in table 3.

**Table 3: Overall audit results**

Component	Auditable outcome measure	Standard	Previous audit results (year of previous audit)	2017 result
<b>Result notification<sup>1</sup></b>	Proportion of those tested that received their result within 10 working days from the date of test	95%	94% (2014)	90%↓
<b>Time to treatment<sup>1</sup></b>	Proportion of young people found to be positive that received treatment within 6 working weeks from the date of test	95%	91% (2014)	92%↑
<b>Partner notification<sup>2</sup></b>	The proportion of index cases that were offered a PN discussion	97%	92% (2015)	94%↑
	The number of contacts per index case that were reported as having attended a sexual health service within 4 working weeks of date of PN discussion	0.6	0.53 (2015)	0.42↓
<b>Re-testing<sup>3</sup></b>	The proportion of young people with chlamydia that re-turned for a re-test around 3 months after treatment	NA	8% (2015)	7%↓

The audit sample contains 2880 young people (80%) who tested positive for chlamydia and 720 (20%) who tested negative. For result notification, all 3600 records have been used for the analysis. Whereas for the time to treatment, partner notification and re-testing, the data relating to young people with chlamydia have been used.

### Audit sample: Demographics

The audit sample comprises nearly twice as many tests from females (2401, 67%) as males (1197, 33%), and 1422 (40%) tests were from the 15-19 age group and 2169 (60%) from the 20-24 age group.

The proportions for gender are broadly split in line with those of the national CTAD data 2016: 70% of tests were for females and nearly 30% tests were for males. The audit sample contains slightly more tests from the younger age group compared to the



national age split: 40% compared to 35% nationally, and 60% are in the older age group compared to 65% nationally.

The age and gender split in the audit sample is presented in table 4.

**Table 4: Age and gender split of the audit sample**

Age \ Gender	Male		Female		Gender not recorded		Total	
	n	%	n	%	n	%	n	%
<b>Age not recorded</b>	2	<1	7	<1			9	<1%
<b>15-19</b>	370	10.3	1051	29.2	1	<1	1422	39.7
<b>20-24</b>	825	22.9	1343	37.3	1	<1	2169	60.2
<b>Total</b>	1197	33.2	2401	66.7	2	<1	3600	100

In the following 3, more detailed analysis is presented for each of the standards around turnaround time (result notification and time to treatment), partner notification and re-testing.

## Turnaround time standards

### Result notification (component 4)

90% of young people received their result within 10 working days of the test being taken. This does not meet the NCSP standard of 95% and represents a deterioration compared to the 2014 audit (94%).

91% and 89% of young people with a positive and negative test result received results within 10 working days, respectively.

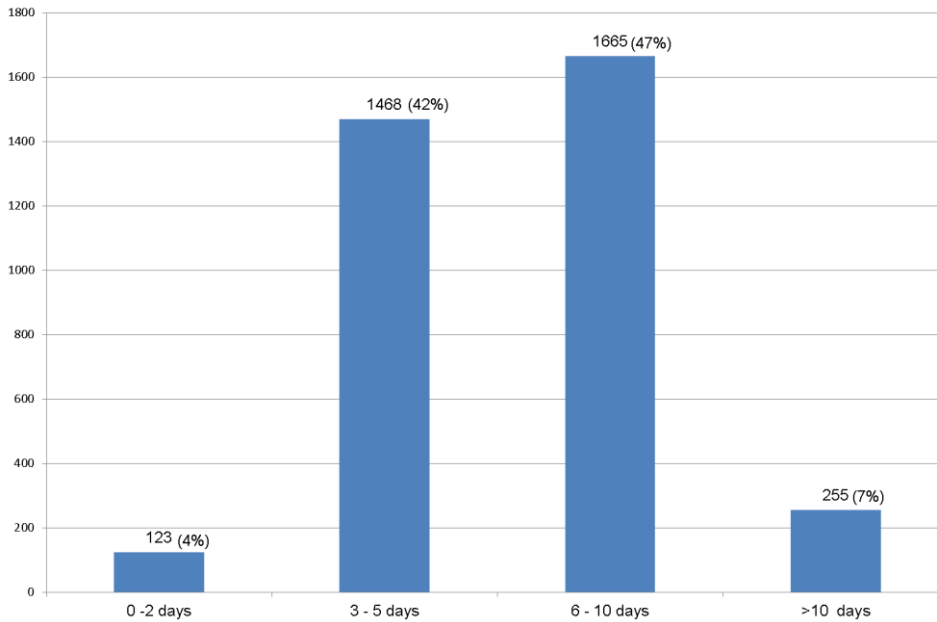
For 89 young people (2%), the result notification date was missing, these were considered as 'standard not met'.

Young people without a result notification date were included in the audit sample, but considered as standard not being met. This also applied to 2 services without any result notification dates. One operated a 'no news is good news' policy (not recommended practice by NCSP or BASHH). The other used an automated telephone service that clients call for result. This telephonic system does not record the date that a patient calls. Therefore, a specific date for results notification is unknown. Both services were in the process of changing these practices.

Of those notified of their result, 4% of young people were notified within 2 days, 42% between 3 and 5 days and nearly half (47%) of young people were notified between 6

and 10 days. Just over 250 young people (7%) received their results after 10 days, see chart 1.

**Chart 1: Frequency distribution in number of days to result notification**

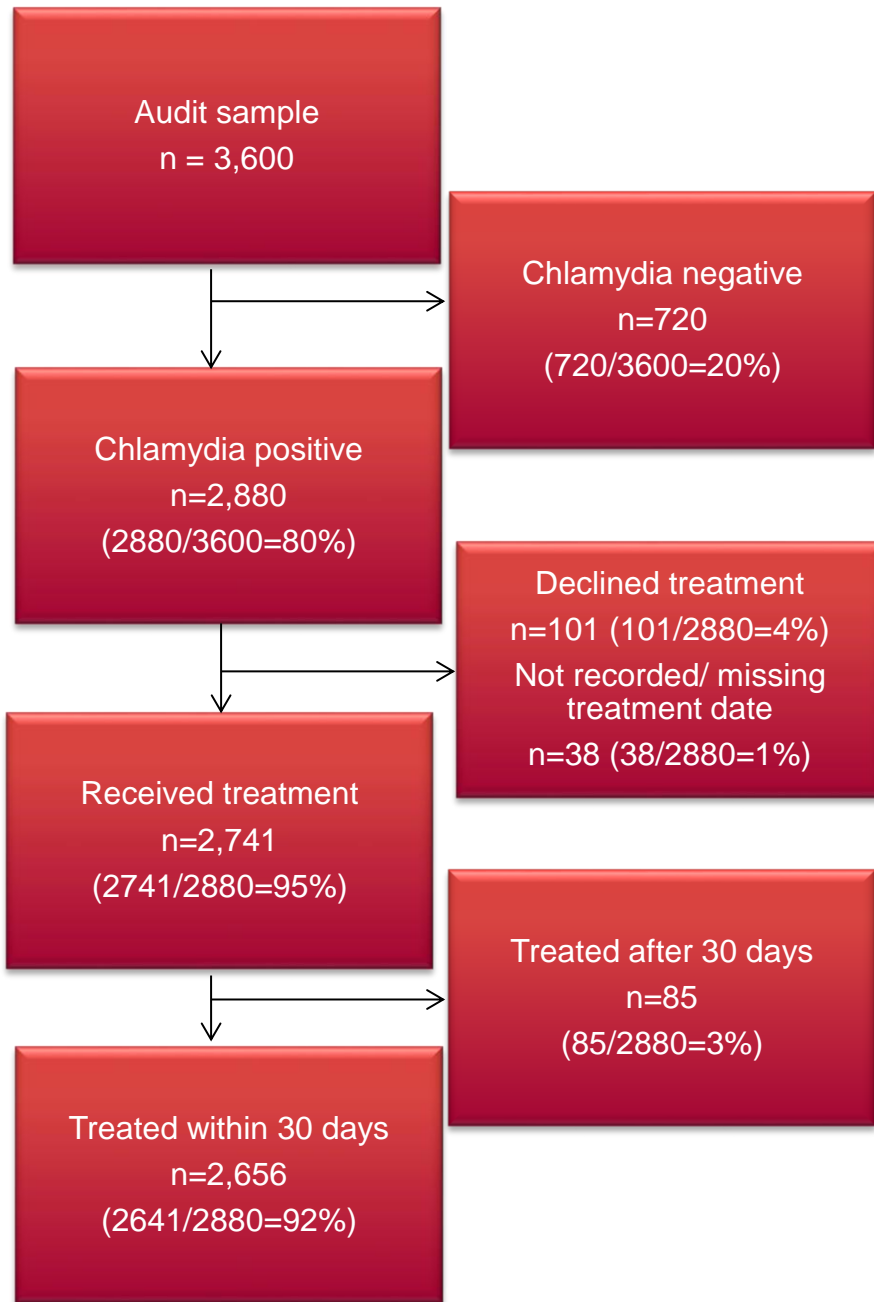


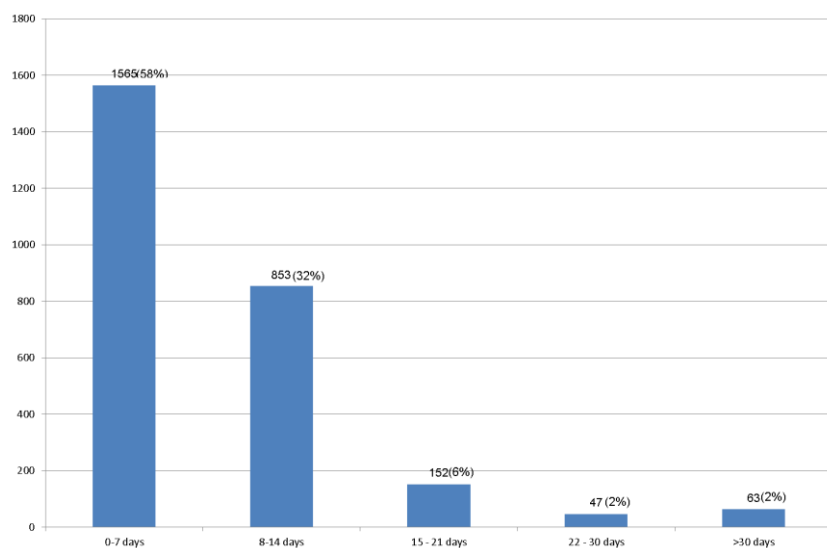
### Time to treatment (component 5)

92% of individuals testing positive for chlamydia were treated within 6 weeks (30 working days) of the test date. This is below the standard of 95% but a slight improvement compared to the last audit result of 91%.

The calculation has been shown in figure 2.

**Figure 2: Proportion of young people treated within 6 working weeks**



**Chart 2: Frequency distribution in number of days between test and treatment**

### Turnaround times by testing and treatment service type

The proportion of young people that received their results within 10 days is highest when they test through GUM clinics (97%) and lowest when tests are undertaken in integrated sexual health services (87%) and the 'other' category (84%).

The proportion of young people that accepted treatment and that were treated within 6 working weeks is highest when they were treated through a chlamydia screening office (CSO, 99%, but low numbers: 76/77 that were treated), followed at 98% by integrated sexual health clinics (983/1001), and SRH/CASH clinics (382/390). 97% of young people treated by GPs met the treatment standard (197/204).

Of the following testing service types, 96% of young people were treated within the 6 weeks: GUM clinics (653/680), Outreach and education (44/46), and the 'other' (106/110) category. At 95%, this was followed by being treated through a community pharmacy (155/164). 94% of those treated by post achieved the treatment standard (16/17). For 52 young people, the treatment service type had not been recorded but for 44 (85%) of these young people, the treatment standard had been met, see table 5.

For 139 out of the 2880 positive young people, the treatment status had either not been recorded (38), or young people had not accepted treatment (101). Therefore, it is not known whether the treatment standard has been met for young people without a known treatment service type. This means that the overall percentage of young people being treated within 6 working weeks is 92% (2656/2880). Lower than the range found in those with a known treatment service type (94% to 99%), see table 5. The main reasons for not accepting treatment, or why it is not known/not recorded whether or not the patient accepted treatment, are lost to follow up (58), and young people reported they

were treated elsewhere (52, combination of 'unconfirmed' by the service (36), 'confirmed' by the service (16)).

**Table 5: Turnaround standards by test result and testing or treatment service type**



	<b>Component 4: Result within 10 days 95% Standard</b>			<b>Component 5: Treatment within 30 days 95% Standard</b>		
	<b>Number of young people tested (a)</b>	<b>Number notified within 10 days (b)</b>	<b>% (b/a)</b>	<b>Number of young people treated/not treated (c)</b>	<b>Number treated within 30 days (d)</b>	<b>% (d/c)</b>
<b>Audit sample:</b>	3600	3257	90			
<b>Negative result</b>	720	639	89			
<b>Positive result</b>	2880	2618	91			
<b>Audit sample:</b>	3600	3257	90	2880	2656	92
<b>GUM clinic</b>	485	470	97	680	653	96
<b>SRH/CASH clinic</b>	487	434	89	390	382	98
<b>ISH service</b>	958	837	87	1001	983	98
<b>GP</b>	348	315	91	204	197	97
<b>Community Pharmacy</b>	124	117	94	164	155	95
<b>Remote testing</b>	506	470	93	17	16	94
<b>Outreach and education</b>	308	284	92	46	44	96
<b>CSO</b>	158	140	89	77	76	99
<b>Other*</b>	220	185	84	110	106	96
<b>service type not recorded</b>	6	5	83	52	44	85
<b>Treatment not accepted</b>				101	NA	
<b>Treatment status not recorded</b>				38	NA	

\*'Other' comprises: prison/YOI, military, ToP, gynae, A&E/MIU, antenatal etc.

## Partner notification

Partner notification comprises component 6 of the chlamydia care pathway. 94% of individuals who tested positive for chlamydia had the offer of PN discussion documented in their records. While it does not meet the standard of 97%, it is an improvement from the previous PN audit (92%). The number of contacts per index case that were reported as having attended a sexual health service within 4 working weeks of the date of PN discussion was 0.42. This does not meet the standard of 0.6 contacts per index case and is a deterioration from the previous audit (0.53), see table 6.

**Table 6: Partner notification<sup>4</sup> standards measured in this audit**

Measure	Standards	Previous audit results (2015)	2017 Result
The proportion of index cases that were offered a PN discussion	97%	92%	94% 
The number of contacts per index case that were reported as having attended a sexual health service within 4 working weeks of date of PN discussion	0.6	0.53	0.42 

## Offer of PN

For 43 index cases (43/2880, 2%) offer of PN was unknown/not documented, and 121 (121/2880, 4%) index cases were recorded as 'no PN offered'. The reasons for not offering PN are presented in table 7. The main reason being 'patient lost to follow up before PN could be initiated' (52/121, 43%).

**Table 7: Reasons for not offering PN**

Reason	Number	Proportion
Lost to follow up before PN initiated	52	43%
Other	22	18%
No documented evidence of PN	20	17%
Blank/not documented	13	11%
Patient transferred care	6	5%
Documented that PN performed elsewhere	6	5%
Patient routinely seen for SH care elsewhere	2	2%
Total	121	

<sup>4</sup> BASHH Standards for the management of STIs, 2014

## PN standard

There were a total of 3882 contacts for the 2880 young people with chlamydia, of which 2620 (67%) were 'contactable'. 1213 contacts (31% of all contacts and 46% of contactable contacts) had an attendance at a sexual health service within 4 weeks following the PN discussion date with the index patient. A PN ratio of 0.42 contacts per index case. This does not meet the standard of 0.6 and represents a deterioration since the 2015 PN audit (0.53).

The PN rate ranged from 0.29 contacts per index case in integrated sexual health clinics, to 0.51 contacts per index case in GUM clinics. GPs, GUM clinics and remote/online testing service types had the highest number of contacts meeting the standard per index case, see table 8.

**Table 8: PN standards contacts by testing service type**

	<b>Component 6: Partner notification</b>			Contacts seen/index case 0.6 Standard	
	Proportion of index cases that offered a PN discussion 97% Standard			Contacts attending SHS within 4 weeks of PN discussion (c)	PN Ratio (c/a)
	No of index cases (a)	Documented offer of a PN discussion (b)	% (b/a)		
<b>Audit sample</b>	2880	2716	94	1213	0.42
<b>Testing service type</b>					
<b>GUM clinic</b>	388	376	97	196	0.51
<b>SRH/CASH clinic</b>	399	371	93	169	0.42
<b>Integrated sexual health     service</b>	754	712	94	219	0.29
<b>GP</b>	259	239	92	148	0.57
<b>Community Pharmacy</b>	102	98	96	47	0.46
<b>Remote testing</b>	432	413	96	212	0.49
<b>Outreach and education</b>	234	225	96	84	0.36
<b>CSO</b>	134	130	97	61	0.46
<b>Other*</b>	172	146	85	76	0.44
<b>Not recorded</b>	6	6	100	1	0.17

\*'Other' comprises prison/YOI, military, ToP, gynae, A&E/MIU, antenatal etc

Those contacts that have an attendance date at a sexual health service within 4 working weeks, usually attend within one week of the PN discussion with the index patient: the mean number of working days between date of PN discussion with the index and date of attendance of the contact is 4 days.

## PN outcomes and positivity

For 3191 contacts (3191/3882, 82%) of the total 3882 contacts, a PN outcome had been recorded. This is presented in table 9 in order of frequency from high to low. The most frequent was 'recorded that contact informed of risk of chlamydia infection, but not known to have had a chlamydia test' (825/3191, 26%), the least frequent was 'contact had a negative test in another service' (69/3191, 2%), after 'other' at less than 1%.

**Table 9: PN outcomes of the contacts**

PN outcome	Number	Proportion
Recorded that contact informed of risk of chlamydia infection, but not known to have had a chlamydia test	825	26%
Contact not known to have been informed of risk of chlamydia infection	603	19%
Contact had a positive test in the same service (a)	534	17%
Contact treated but not tested	322	10%
Contact had a positive test in another service (b)	271	8%
Contact already known to have chlamydia infection	266	8%
Contact had a negative test in the same service (c)	146	5%
Contact had a chlamydia test, but result not known (e)	144	5%
Contact had a negative test in another service (d)	69	2%
Other	11	0%
	3191	100%

From the above table, it can be deduced that a total of 805 new positive contacts (a+b) were found, out of a total of 1164 (a+b+c+d+e) that proceeded to have a test as a result of PN, a positivity of 69%.



## Re-testing

While there is no standard for re-testing (component 7 of the chlamydia care pathway) after an initial positive test. The NCSP recommends that all young people with a positive test are offered a re-test at 3 months after the date of treatment due to the high rates of re-infection<sup>5</sup>. 77% (2218/2880) of young people with chlamydia were offered a re-test, but only 210 (7%) were re-tested around 3 months after treatment (NCSP recommendation). When extending the time period to 3 to 6 months after treatment (BASHH recommendation), the proportion re-testing increased to 17%. 991 (34%) re-tested at any time following treatment (range from the same day to 302 days). The overview is presented in table 10.

**Table 10: Re-testing by time since treatment**

	Retest around 3 months (NCSP)	Retest between 3 and 6 months (BASHH)	Re-test at any time
Number retesting (%)	210 (7)	502 (17)	991 (34)
Of which number positive (%)	30 (14)	79 (16)	147 (15)

### Offer of a test

The majority of young people with chlamydia (77%) were offered a re-test; 17% (n=477) were not offered a re-test and for 185 cases (6%) this was unknown/not recorded.

### Positivity at re-test

Positivity was 14% and 16% in those retesting around 3 months and between 3 and 6 months following treatment, respectively. Positivity was 15% in those who retested at any time following treatment. This means that positivity at re-test is relatively high as the national percentage for those testing positive for chlamydia in 2016 was 9.1%.

### Re-testing by testing service type and recall method

Integrated sexual health services and SRH/CASH clinics had the largest proportions of young people with chlamydia returning for a re-test at 24% and 20% respectively. In GUM clinics, GPS and remote testing, the re-testing rate was 11%, whereas CSOs, Outreach and education, Community Pharmacies and 'Other' ranged from 7% to 4%.

<sup>5</sup> NCSP Re-testing recommendation 2014

A number of different methods were used to recall young people for re-testing. Text messaging was most frequently used (34%), and 8% of these came back around the recommended 3 months. Another quarter of positive young people were informed of the need for a re-test at the time of result notification without a further reminder, 10% of these came back around 3 months after treatment. While the return rate of issuing testing kit is higher at around 26%, the number of times that this method is used is less than 1% of all the recall methods.

For integrated sexual health services, SRH/CASH clinics, GUM clinics, remote testing, outreach and education, GPs, community pharmacies and CSOs, most young people with chlamydia return to their initial testing service type. Whereas, for the 'unknown' and the 'other' category, the return testing service types are more varied.

Table 11 presents the numbers re-testing around 3 months by testing service type and by recall method, as a proportion of all re-tests at 3 months (n=210) and as a return rate by testing service type.

**Table 11: Re-testing by testing service type and recall method**

	Number of index cases (a) (% of all positive cases)	Number retesting around 3 months (b)	% of total re-tests (n=210)	Return rate (%) (b/a)
<b>Testing service type</b>				
Audit sample	2880 (100)	210	7	
GUM clinic	388 (13)	23	11	6
SRH/CASH clinic	399 (14)	42	20	11
Integrated sexual health service	754 (26)	51	24	7
GP	259 (9)	23	11	9
Community Pharmacy	102 (4)	8	4	8
Remote testing	432 (15)	24	11	6
Outreach and education	234 (8)	14	7	6
CSO	134 (5)	16	8	12
Other (incl prison/YOI, military, ToP, gynae, A&E/MIU, antenatal etc)	172 (6)	8	4	5
TST not recorded	6 (<1)	1	0	17
<b>Recall method</b>				
Audit sample	2880 (100)	210		7
Sent text message when you should test again	968 (34)	73	35	8
Conversation about re-testing when given your test result and no further reminder	680 (24)	67	32	10
Retesting advised at follow up call - text message will be sent at 3 months	341 (12)	32	15	9
Invited by phone call when you should test again	91 (3)	4	2	4
Appointment to be re-tested made when given your result	41 (1)	4	2	10
Testing kit posted to an address of your choice when you should test again	34 (1)	8	4	24
Given testing kit when given your test result and later reminded when you should test again	18 (1)	5	2	28
Other (4 other methods, <5 each)	8 (<1)	1	<1	13
Method not recorded:	699 (24)	16	8	2
Of those not recorded, those not offered a re-test	470			
Of those not recorded, offer of re-test 'unknown'	179			
Those offered a re-test but recall method not recorded	50	16		

# Summary, discussion and recommendations

## Introduction

The NCSP audit programme aims to ensure that chlamydia screening services are delivered to a uniform, high standard to ensure that young people get the best available care and that the programme is able to fulfil its aims to prevent the harms of chlamydia infection. The Chlamydia Care Pathway can be broken down into 7 steps and audit is required to quality assure 4 of these. Previously, the NCSP ran national audits on each standard separately. As many required data items were the same for each standard, it was decided to run one single combined audit to simplify data collection and reduce the burden on providers, while at the same providing results for all three standards simultaneously.

Performance against the following standards was measured:

Component	Auditable outcome measure	Standard
<b>Result notification</b>	Proportion of those tested that receive their result within 10 working days from the date of test	95%
<b>Time to treatment</b>	Proportion of young people found to be positive that received treatment within 6 working weeks from the date of test	95%
<b>Partner notification</b>	The proportion of index cases that were offered a PN discussion	97%
	The number of contacts per index case that were reported as having attended a sexual health service within four working weeks of date of PN discussion	0.6
<b>Re-testing</b>	The proportion of young people with chlamydia that re-turned for a re-test around 3 months after treatment	NA

The audit results show that the standards of the 4 auditable outcome measures have not been met nationally. However, when compared to the previous audit results, performance against the standards show a mixed picture, with 2 out of the 4 standards improving (treatment standard, proportion of index cases offered a PN discussion), and 2 deteriorating (result notification and the number of contacts per index case that attended a sexual health service). The proportion of young people with chlamydia returning for a re-test after the recommended three months after treatment has also slightly reduced.

The data showed that meeting standards varied based on the type of service that testing is happening in. The following sections provide the summary results, discussion and recommendations for each of the standards. It is important that providers and commissioners review their local data as well as these national results to help drive service improvement. Where results appear good, please share these and the practice behind the data in local provider and commissioners' networks.

## Turnaround times

### Summary of results:

- 90% of young people were notified of their results within 10 working days, against a standard of 95% (deterioration compared to 94% in 2014)
- 92% of young people with chlamydia were treated within 6 working weeks of date of test against a standard of 95% (improvement compared to 91% in 2014)
- when notified and treated, most young people are notified or treated quickly but a small number of cases took much longer

### Discussion

A fast result notification is essential to enable quicker access to treatment and minimise the time the infection can be transmitted. Where notification dates were missing in the audit data set, it was assumed that the standard was not met. Therefore, this includes missing notification dates due to not being able to contact the young person, operating a telephone result notification system, or using a 'no news is good news' policy.

SRH/CASH clinics, ISH, CSOs and those testing in 'other' testing service types (TSTs), or those without recorded TSTs, have a result notification proportion that is below 90%. Clinics need to ensure they can record the date of result notification and ensure results can be notified within 10 working days. For those with a known treatment service type, only 'remote treatment' is below the standard at 94%. Services should ensure that when postal treatment is used, this is despatched in a timely manner.

Local commissioners should use these data to identify services, which they can learn from to improve turnaround time across all of their services.

### Recommendations:

- ensure that services do not use a 'no news is good news' policy (in line with NCSP and BASHH standards)
- ensure systems are in place to record a specific date for date of test and result notification to allow standards to be measured

- services with lower turnaround times (ISH in this audit sample) can learn from systems and processes in place in those TST with highest turnaround times (GUM clinics in this audit sample)
- ensure systems are in place to assure that postal treatment is despatched in a timely manner
- local service providers should seek input from local provider networks or their PHE Sexual Health Facilitator on areas which have achieved good results

## Partner notification

### Summary of results:

- 94% of young people had a documented offer of PN, an increase from the previous audit (92% in 2015). Of young people without a PN offer, 43% (52 of 121 young people with chlamydia) was because they were lost to follow up
- the ratio of contacts attending a service within 20 days deteriorated, audit results are 0.42 contacts per index case, compared to 0.53 in 2015
- the range in PN ratio by TST was from 0.29 in ISH to 0.57 by GPs
- when contacts do attend a service, they do it relatively quickly: there was an average of 4 working days between date of attendance and date of PN discussion
- for 45% of all contacts (1428 out of 3191) it was not known whether they had either:
  - been informed of risk of chlamydia infection (603/3191, 19%), or
  - if they had been informed, it was not known whether they proceeded to have a test (825/3191, 26%)
- PN outcomes for contacts show that positivity of contacts that proceed to have a test is high (69%)

### Discussion

To calculate the PN standard, contacts were counted if they attended a sexual health service within 20 days following the date of PN discussion with the index patient. Any contacts seen before the PN discussion date, or after 20 days, are excluded as meeting the standard. Therefore, a number of contacts may in fact be accessing sexual health services, but are not counted as part of the PN ratio in this audit.

High proportion of records indicated that it was unknown if a contact had been informed, or if they were informed whether or not the contact acted upon this knowledge. GPs, GUM clinics and remote/online testing service types had the highest number of contacts meeting the standard per index case, 0.57, 0.51 and 0.49 respectively. It was lowest for ISH at 0.29 contacts/index and outreach services at 0.36 contacts per index case.

The increase in the offer of PN is encouraging, as it will assist in the detection of more infections. Contact tracing remains essential as the audit data shows a high positivity of

69% in contacts that went on to have a chlamydia test. Therefore, partner notification is effective at finding people at high risk of infection.

### **Recommendations:**

- ensure that record keeping in clinics is fit for purpose including at least 2 methods of contacting young people and ensure they are able to make contact
- ensure record keeping is accurate and retains relevant information on PN
- services with lower PN rates (ISH in this audit sample) can learn from systems and processes in place in those TST with higher PN rates (GUM clinics in this audit sample)
- ensure effective pathways to provide PN for services provided on an outreach basis, for example, through linking with local GUM services (BASHH Outreach Standards 2016)

### **Re-testing**

#### **Summary of results:**

- 77% of young people with chlamydia had a record of an offer of a re-test
- a small proportion (7%) of young people with chlamydia return around 3 months after treatment, a deterioration compared to 8% in 2015
- positivity at re-test is relatively high at 14%, compared to NCSP national positivity in 2016 of 9.1% of all those tested
- there are low cost options to recall young people

### **Discussion**

While 77% of index cases were offered a re-test, few come back around 3 months; therefore, uptake of the offer needs to improve. ISH, and SRH/CASH clinics had the highest return rates. To improve re-testing rates, other TSTs with lower return rates may learn from the processes in place in these clinics.

These audit data show that there are relatively low or no additional cost recall methods, for example, text messaging (return rate 8%), or even just a conversation about re-testing at time of result notification with no further reminder (return rate 10%), as does giving an appointment at result notification (return rate also 10%). These can easily be implemented in a range of TST.

Of those that return for a re-test: 14% are positive again, compared to a national positivity rate of 9%: re-testing is therefore an effective way of identifying infections. In addition, most young people return to their initial testing site, indicating a good opportunity to stress the importance of re-testing.

**Recommendations:**

- improve uptake of offer to re-test, for example, services with lower re-test rates (GUM, outreach and remote testing in this audit sample) can learn from systems and processes in place in those TST with higher retest rates (ISHS and SRH/CASH clinics in this audit sample)
- consider using low/no additional costs recall methods such as automated SMS messages, re-testing conversations, or giving appointments, at result notification
- evaluate local recall methods to inform which ones are most effective to increase re-testing
- agree local re-testing targets between commissioners and providers

Table 13 presents all recommendations for each of the 3 standards as discussed above.



**Table 13: Summary of recommendations**

Topic	Recommendation
Turnaround times	<ul style="list-style-type: none"> <li>• ensure that the date of result notification is recorded and that services do not use a ‘no news is good news’ policy (in line with NCSP and BASHH standards)</li> <li>• ensure systems are in place to record a specific date for date of test and result notification to allow standards to be measured</li> <li>• services with lower turnaround times (ISH in this audit sample) can learn from systems and processes in place in those TST with highest turnaround times (GUM clinics in this audit sample)</li> <li>• ensure systems are in place to assure postal treatment is despatched in a timely manner, local service providers should seek input from local provider networks or their PHE Sexual Health Facilitator on areas which have achieved good results</li> </ul>
Partner notification	<ul style="list-style-type: none"> <li>• ensure that record keeping in clinics is fit for purpose including at least 2 methods of contacting young people</li> <li>• ensure record keeping is accurate and retains relevant information on PN</li> <li>• services with lower PN rates (ISH in this audit sample) can learn from systems and processes in place in those TST with higher PN rates (GUM clinics in this audit sample)</li> <li>• ensure effective pathways to provide PN for services provided on an outreach basis, for example, through linking with local GUM services (BASHH Outreach Standards 2016)</li> </ul>
Re-testing	<ul style="list-style-type: none"> <li>• improve uptake of offer to re-test, for example, services with lower re-test rates (GUM, outreach and remote testing in this audit sample) can learn from systems and processes in place in those TST with higher retest rates (ISH and SRH/CASH clinics in this audit sample)</li> <li>• consider using low/no additional costs recall methods such as automated SMS messages, re-testing conversations, or giving appointments, at result notification</li> <li>• evaluate local recall methods to inform which ones are most effective to increase re-testing</li> <li>• agree local re-testing targets between commissioners and providers</li> </ul>

## Appendix 1: Audit methodology

The following data items were required for the audit on a sample of 40 patients found to be positive per provider, going back in time from 31 January 2017:

- name of commissioning authority
- name of service provider
- type of service provider (choice of GUM clinic, SRH/CASH clinic, Integrated sexual health service, GP, Community Pharmacy, remote testing, CSO, outreach and education, 'other' (incl prison/YOI, military, ToP, gynae, A&E/MIU, antenatal clinic etc.))
- index patient number (1 to 50)
- date of test
- gender
- age
- type of test site (choice of GUM clinic, SRH/CASH clinic, Integrated sexual health service, GP, Community Pharmacy, remote testing, CSO, outreach and education, 'other' (incl prison/YOI, military, ToP, gynae, A&E/MIU, antenatal clinic etc.))
- date of result notification
- test result (positive, negative)
- date of treatment
- type of treatment site (choice of GUM clinic, SRH/CASH clinic, Integrated sexual health service, GP, Community Pharmacy, remote testing, CSO, outreach and education, 'other' (incl prison/YOI, military, ToP, gynae, A&E/MIU, antenatal clinic etc.))
- offered PN? (yes, no, unknown)
- date of PN discussion
- if no PN offered, why not? The drop down offered the following choices:
  - no documented evidence of PN
  - patient routinely seen for SH care elsewhere
  - patient transferred care
  - documented that PN performed elsewhere
  - lost to follow up before PN initiated
  - other
- total number of contacts
- total number of contactable contacts
- date of index patient or HCW reported attendance for testing and treating contact 1, up to 5 contacts
- PN outcome, drop-down list offered one of the following choices:
  - contact already known to have chlamydia infection
  - contact had a negative test in your service

- contact had a negative test in another service
- contact had a positive test in your service
- contact had a positive test in another service
- contact had a chlamydia test, but result not known
- record made that contact informed of risk of chlamydia infection, but not known to have had a chlamydia test
- contact not known to have been informed of risk of chlamydia infection
- other
- offered re-test? (yes, no, unknown)
- method used to re-call patient, drop down list offered one of the following choices:
  - a. Conversation about re-testing when given your test result and no further reminder
  - b. Reminder card when given your test result and no further reminder
  - c. Appointment to be re-tested made when given your test result
  - d. Given testing kit when given your test result and no further reminder
  - e. Given testing kit when given your test result and later reminded when you should test again
  - f. Sent text message when you should test again
  - g. Invited by phone call when you should test again
  - h. Invited by post when you should test again
  - i. Sent email when you should test again
  - j. Testing kit posted to an address of your choice when you should test again
  - k. Retesting advised at follow up call - text message will be sent at 3 months
- date of re-test
- re-testing service type (choice of GUM clinic, SRH/CASH clinic, Integrated sexual health service, GP, Community Pharmacy, remote testing, CSO, outreach and education, 'other' (incl prison/YOI, military, ToP, gynae, A&E/MIU, antenatal clinic etc.))
- result of re-test (positive, negative, equivocal/inhibitory, insufficient, unknown)

Upon completion of the data entry, the tool showed the results of the audit straightaway in each of the areas of turnaround time, partner notification and re-testing. The results were presented on the main auditable outcome measures in a 'Results overview' sheet, and in more detail for each of the 3 standards.

To calculate whether a standard was met that involved a time period (such as in result notification within 10 working days, treatment within 30 working days, or partners attending a sexual health service within 20 working days), the following excel formula was used: = network days (date of test, date of result notification).

An initial email was sent to a range of chlamydia screening providers (or in some cases to commissioners) on 19 July 2017 to invite them to take part in the audit. The initial deadline for submissions was 26 August 2017. Due to services asking for extension due to annual leave, this was extended until 15 September 2017. The response rates have been reported in the main body of the report.

Table 1 presents the reasons given for declining to take part in the audit upon receiving the invitation (7 services, some reporting more than one reason). Lack of capacity, combined with current re-design of services or computer system renewals/upgrades were the main reasons for not being able to take part.

**Table 1: Reasons for declining to take part in the audit**

<b>Reason</b>	<b>Number</b>
Redesign and computer system renewal	1
No longer running NCSP/patients not just screened for chlamydia	2
Redesign and lack of capacity	2
Audit period run by a different provider	1
Computer system renewal	1
Lack of capacity	6
<b>Total</b>	<b>13</b>

## Appendix 2: Audit data set by testing service type

The majority of audit records (27%) originated from Integrated sexual health services, followed by contraceptive and sexual health services/sexual and reproductive health (CASH/SRH) services at 14% and Level 3 genito-urinary medicine (GUM) services at 13% of the audit data. Tests taken in outreach and education settings and those in the category 'other' (prison, youth offender institutions, military settings, termination of pregnancy services, A&E/MIU, antenatal and gynaecology clinics), make up 15% of the audit sample, and remote or online testing 14%. The remaining categories are General Practice (GP, 10%), Chlamydia Screening offices (CSO, 4%, and Community Pharmacy (3%). Compared to the national Chlamydia tests taken in England in 2016 (n=1,407,952) the proportion of tests from GPs is less (10% v 19%), whereas those tests requested from the internet are higher (14% v 8%). The other categories are broadly similar in proportion. Compared to earlier topic audits, the proportion from GUM clinics and Integrated sexual health clinics has increased. The overview is in table 1.

**Table 1: Audit data set by testing service type of index patient**

Testing service type	Proportion in national audit data set (%)				
	Turnaround time audit 2014 (n=54488)	Re-testing audit 2015 (n=2853)	PN audit 2016 (n=2439)	Combined audit 2017 (=3600)	chlamydia tests England 2016 (n=1,407,952) <sup>6</sup>
SRH/CASH clinic	23	29	34	14	13
GUM clinic	2	10	7	13	
Integrated SH clinic	Not a separate category	Not a separate category	6	27	41
Remote testing	7	13	15	14	8
GP	13	12	11	10	19
Community pharmacy	3	4	7	3	1
Chlamydia Screening Office	5	8	2	4	
Outreach and education	27	12	9	9	17
Other	8	8	8	6	
Blank/not recorded	12	4	1	<1	1

<sup>6</sup> Chlamydia Testing Activity Dataset (CTAD) 2016