



Public Health
England

Protecting and improving the nation's health

Developing integrated chlamydia screening provision locally

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Introduction

Purpose

1.1 This document provides guidance on how to integrate chlamydia screening into core primary care and sexual health services. It is for local authorities responsible for commissioning and providers of chlamydia screening, and replaces the National Chlamydia Screening Programme's (NCSP) March 2012 guidance on integration. For the purpose of this document, we define integrated chlamydia screening as screening offered opportunistically to sexually active young people under 25, as part of routine appointments in primary care, sexual health and other relevant settings.

NCSP

1.2 The NCSP is an opportunistic screening programme that was implemented in 2003 to control the transmission of chlamydia in sexually active asymptomatic women and men under 25 years (the age group where chlamydia is most present and mostly without symptoms). Screening should be delivered locally, to ensure young people have easy access to services. Screening delivered by a variety of providers, such as general practice (GP), sexual and reproductive health clinics (SRH), community pharmacy and over the internet, ensures that barriers to uptake are minimised and that young people can access services that suit them.

1.3 Since 2003 more than ten million chlamydia tests have been undertaken, of which more than 1.7m in 2013. Public Health England (PHE) has a regional network of sexual health facilitators to help and support improvements in sexual health, including local implementation and expansion of screening. In recent years chlamydia screening has become increasingly integrated into core healthcare services, such as GPs, SRH clinics, genito urinary medicine (GUM) clinics, termination services and community pharmacies.

Benefits of effective chlamydia screening

1.4 Achieving a higher detection rate reflects improved control of chlamydia infection. Identifying and treating more infections means individuals will have a reduced risk of serious sequelae and will no longer be infectious to others. This will reduce spread in the population and will prevent subsequent healthcare costs for sequelae, such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal factor infertility (TFI). Effective screening, when combined with good sexual health improvement messages, contributes to young people having better sexual health, as the offer of a test normalises testing behaviour for STIs (sexually transmitted infections), does not increase risky behaviour, and provides a gateway to more comprehensive sexual health services.¹

¹ The "Components of chlamydia screening & the impact of screening on behaviour: 2014 National Chlamydia Screening Programme web survey report" is available online at:
<http://www.chlamydia screening.nhs.uk/ps/resources.asp>.

Chlamydia detection rate, public health outcomes framework and testing service type

- 1.5 To reflect the importance of controlling chlamydia infection among under 25s, the chlamydia detection rate is one of the health protection indicators within the public health outcomes framework (PHOF). It is a measure of chlamydia control activity in England, aimed at reducing the spread of infection and the incidence of reproductive sequelae of chlamydia infection (PID, ectopic pregnancy, and TFI).
- 1.6 In June 2013, in consultation with PHE, the Department of Health (DH) published the recommended chlamydia detection rate of $\geq 2,300$ chlamydia diagnoses per 100,000 15 to 24-year olds. The NCSP advises that local authorities work toward achieving this level. Modelling suggests that achieving this level is likely to result in a continued reduction in chlamydia prevalence and sequelae. To achieve this level of diagnoses local authorities will need to ensure they commission screening in a variety of settings within the community and prioritise those services that have high rates of diagnoses. Further guidance on achieving the chlamydia detection rate can be found on our website [here](#).
- 1.7 A whole-system approach should be considered for commissioning sexual health services that integrate contraception with the diagnosis and management of sexually transmitted infections, and has close links to other services for young people. To support this, PHE recently published guidance: 'Making it work, a guide to whole system commissioning for sexual health, reproductive health and HIV' which can be found [here](#). The NCSP's vision is that all sexually active young people should be offered chlamydia screening as a routine part of every primary care and sexual health consultation.
- 1.8 The benefits of integration are presented in table 1.

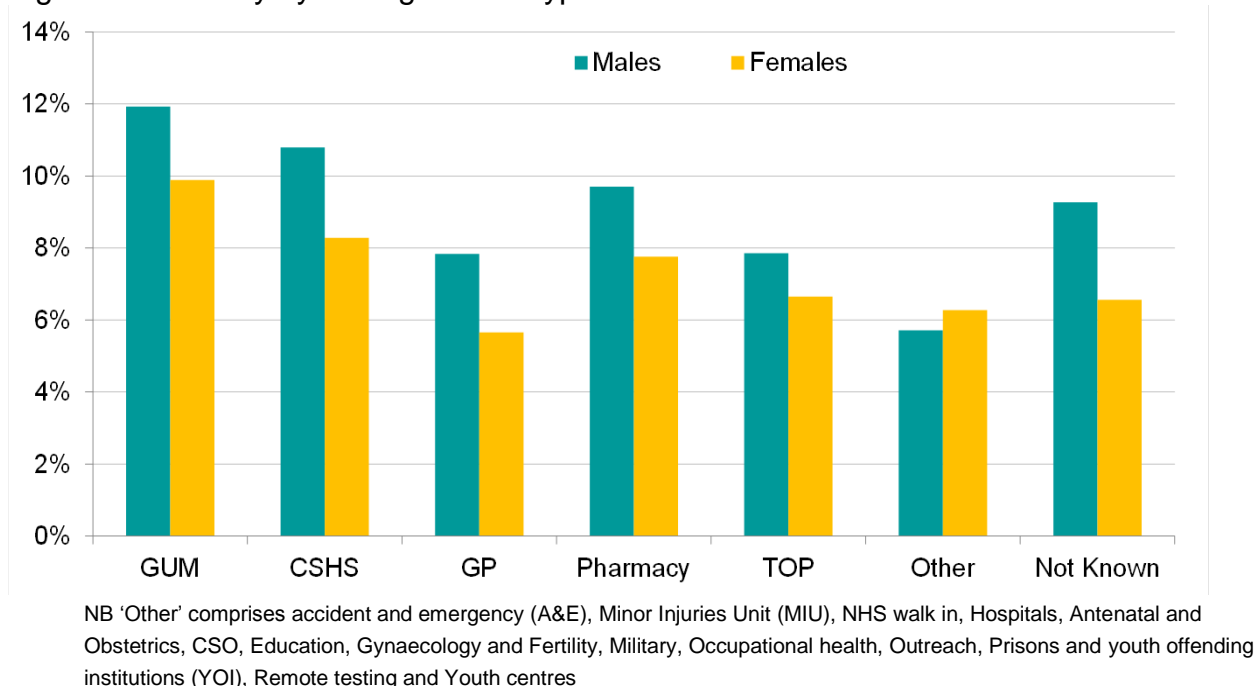
Table 1. Benefits of integrating chlamydia screening in sexual health and primary care services

Benefits	Client	Provider	Commissioner
A whole-system approach is needed to ensure people receive seamless and appropriate care that is also cost effective	✓	✓	✓
Integrated service is more sustainable as standalone chlamydia screening offices (CSOs) are vulnerable to disinvestment		✓	✓
Provides opportunity to use existing infrastructure and resources in primary care and sexual health services (for example using existing microbiology forms used in existing services rather than separate NCSP forms and processes)		✓	✓
Further normalises the opportunistic offer of a test and discussing sexual health	✓	✓	✓
Easier access to other sexual health services such as contraceptive and reproductive health, combining chlamydia screening with other sexual health packages such as prevention work or condom distribution is cost effective	✓	✓	✓
Integration offers the opportunity to address sexual health needs in a wider health context (for example, combined with asthma checks or travel consultations)	✓	✓	✓

1.9 In addition, the full roll out in 2012 of the chlamydia testing activity dataset (CTAD), which is a unified surveillance system for the reporting of all chlamydia testing to PHE directly from laboratories, removes the need to distinguish NCSP testing from other activity. This facilitates integration of chlamydia screening in existing sexual health services and primary care.

1.10 Primary care and sexual health services continue to be key stakeholders in the NCSP. Young people attend SRH clinics, termination of pregnancy (TOP) services, GP services, and community pharmacy services, and these venues continue to generate, on average, a higher proportion of chlamydia tests with a positive result than, for example, outreach and educational settings (included in 'other'). This is presented in figure 1.

Figure 1. Positivity by testing service type CTAD 2013



1.11 **'Achieving the diagnostic rate'** – gives examples on how chlamydia screening can be effectively commissioned from the various testing service types.

1.12 Public health colleagues, practice nurses, pharmacists, third-sector providers and GPs have all shown to be viable and effective chlamydia screening champions in their local areas. They can:

- contribute to the strategic direction of the local chlamydia programme
- raise awareness of the NCSP and the profile of the local chlamydia screening programme among peers (other GPs, practice nurses or pharmacists)
- normalise the opportunistic offering of chlamydia testing within the set geographical parameters by training local practitioners
- promote and facilitate a 100% test offer rate to young people accessing healthcare services

1.13 The NCSP encourages programmes to continue to identify testing advocates. Champions could continue to specialise in opportunistic chlamydia testing for either local or cluster arrangements; alternatively the NCSP agenda could be cultivated alongside other health agendas, patient health checks and general sexual health.

1.14 Commissioners are encouraged to continue to target the most cost-effective community interventions yielding as high a case detection rate as possible- consistently demonstrated to be primary care settings and sexual health services (GPs, SRH, TOP and pharmacies and GUM). This is emphasised throughout this document. However, additional activities, for example, internet testing, could be commissioned to improve access to testing where a needs assessment supports this.

Integrating chlamydia screening

- 1.15 Integration is a process that could be advanced incrementally or in a single stage, and could be partial or full. A planned approach to this transition will deliver a fully integrated chlamydia testing programme – one where there are no standalone chlamydia-specific activities and NCSP testing is a mainstream part of appropriate provider services.
- 1.16 When advancing integration, ownership of operational and commissioning duties should be reviewed to reflect capacity and the service model employed. For example, commissioners may decide to handover some procurement duties to SRH and TOP providers but retain others.
- 1.17 In a fully integrated system, providers should assure the quality of their chlamydia service and demonstrate their NCSP and the British Association of Sexual Health and HIV (BASHH) standards compliance to commissioners. Where programmes are less integrated, CSOs could support commissioners by establishing activity data flows between themselves, contracted laboratories, PHE and participating venues. Table 2 presents examples of activities in chlamydia screening in a partially and a fully integrated setting.

Table 2. Examples of chlamydia screening activities in partially and fully integrated settings

Models of NCSP programme delivery	Activity examples
Model A: partially integrated chlamydia screening programmes	<ol style="list-style-type: none"> 1. Where CSOs are mainly administrative and quality control hubs for NCSP activity. The functions of a CSO are usually housed by a clinical or third party provider . 2. Limited use of local NCSP specific forms and testing kits. 3. CSOs have limited involvement in results management including the coordination of treatment and partner notification (PN). 4. Clinically competent providers treat patients and initiate PN and the CSO ensures these duties are fulfilled. 5. Providers initiating treatment are to undertake follow-up two weeks post-treatment. 6. CSOs or providers initiate treatment and recall patients for annual, repeat and re-testing. 7. Designated operational leads facilitate and deliver NCSP training to local providers following competency assessments. 8. CSOs analyse data to support the local commissioning bodies with NCSP-related performance management of providers. 9. CSOs may be involved with maintaining relations with providers through regular visits, news bulletins and over the telephone support. 10. Commissioned CSO providers oversee and monitor quality assurance across the local NCSP service. 11. All commissioned laboratories upload chlamydia testing activity data to PHE.
Model B: fully integrated chlamydia screening programmes	<ol style="list-style-type: none"> 1. No standalone chlamydia screening offices. 2. No, or limited, use of NCSP specific forms and testing kits. 3. Community providers with demonstrable competence treat patients and initiate PN as well as patient recall. 4. Providers hosting results management undertake follow-up two weeks post-treatment. 5. NCSP quality assurance is addressed within contractual agreements with providers and participation in local and national audits. 6. Providers are responsible for maintaining their staff's competence through training assessments and delivery. 7. All commissioned laboratories upload chlamydia testing activity data to PHE.

1.18 Appendix 1 presents a comparison between standalone, partially integrated and fully integrated chlamydia screening across the range of required activities in the care pathway.

1.19 Commissioners may wish to consider the issues highlighted in table 3 when commissioning chlamydia screening in partially and fully integrated settings.

Table 3. Issues for consideration when commissioning chlamydia testing activity in partially and fully integrated chlamydia screening programmes

Pathology	<ol style="list-style-type: none"> 1. STI testing information governance and maintenance of confidentiality is paramount. 2. There is no evidence to support widespread opportunistic screening for gonorrhoea in community-based settings, and the evidence for selected screening in UK community-based settings is sparse. If considering dual testing for chlamydia and gonorrhoea, an impact assessment should take place prior to roll out. Further guidance on dual testing can be found here.
Client results notification	<ol style="list-style-type: none"> 1. Client care pathways should be both transparent and robust. 2. Consideration needs to be given whether or not additional frontline training is required. 3. Providers hosting results management should be required to demonstrate: <ol style="list-style-type: none"> ○ their protocols for the management of tests received from under 16s and under 13s ○ strong links with local services safeguarding the welfare of children 4. Protocols for uncontactable positives would also need to be agreed and formalised with all providers hosting results management.
Treatment	<ol style="list-style-type: none"> 1. Access to free treatment for those not exempt from prescription fees. 2. Providers referring young people to treatment venues should always be in possession of an up-to-date directory of local treatment venues. 3. If treatment venues are restricted to the ones managed by the provider hosting results management, patient choice may be compromised.
Partner notification	<ol style="list-style-type: none"> 1. In accordance with the NCSP standards those arranging treatment and initiating PN need to be appropriately trained and fully competent in delivering such services. 2. Patient confidentiality and choice should not be compromised when arranging treatment for contacts and index patients and when confirming treatment.
Remuneration	<ol style="list-style-type: none"> 1. Costings of the chlamydia testing pathway undertaken in 2009 ('Guidance for the commissioners on the costs of providing chlamydia screening in primary care and the community', December 2009) can be found here. These can be used to provide baseline data for payment negotiations. It specifies every component of the chlamydia testing pathway and where possible the whole pathway

should be completed by the clinical provider initiating testing. Remuneration packages can reflect this. Data on the cost of chlamydia care alone and as an adjunct to other sexual health services have been calculated with the latter shown to be a more cost effective approach. Joined up commissioning across local authority boundaries can also yield further economies of scale and savings.

Quality assurance and standards

1. Quality assurance is an essential part of NCSP delivery. The NCSP standards 7th edition published in April 2014 sets out the essential quality standards and these should be referenced in all relevant service agreements and monitored.
2. The NCSP aims to work with providers to conduct regular national audits based on selected NCSP standards and recommends participation to be specified in contracts. We also advise commissioners and/or providers to conduct regular local audits against these standards and involve CSOs in this process where they exist.
3. The quality standards for commissioning chlamydia testing including partner notification and turnaround times are set out in the [NCSP standards document 7th edition](#)

Appendix 1. Chlamydia screening activities across the care pathway in standalone, partially integrated and fully integrated settings

	Standalone	Partially integrated	Fully integrated
Testing consumables	Several NAATs platforms, urine, self-sample vaginal swabs, endocervical and male urethral specimens. NCSP specific consumables and forms are used. Patient information leaflets, local leaflets testing instructions.	Either local NCSP testing packs or standard microbiology consumables can be used in a partially integrated chlamydia screening programme. This decision should be made with reference to its suitability for the tester, the service-user, and the pathology provider. Areas wishing to employ NCSP packs across GP and non-clinical community settings could instruct either CSOs or laboratory providers to assemble and distribute packs and patient leaflets. Where large quantities are required outsourcing assembling of kits is strongly advised. Where a local tariff is paid to a provider (eg, SRH, abortion services and GUM) for completing an entire clinical pathway, contracts should be transparent concerning which parties incur costs for testing consumables. Local NCSP forms may be required for activity outside clinical services but are only advised in clinical settings where NCSP results management is centralised. All other providers are advised to continue to use their existing specimen and patient information collection systems.	GUM, GPs, abortion services, and SRH would use existing pathology pathways rather than separate NCSP routes. Consumables for chlamydia testing, including patient request forms, would be determined by the pathology provider and delivered directly to test providers via existing systems. Where test kits have been requested outside clinical services, eg, from a commissioned website, testing consumables should be determined by the pathology provider but all kit requests could be processed and posted by a hosting clinical provider, eg, SRH or the laboratory. Providers contracted to offer chlamydia testing services will need to print and manage their stock of NCSP resources such as the patient information leaflet.
Offer of a test	Chlamydia screening can be offered in a wide range of settings, but may be a discrete offer disconnected from core primary care and sexual health services.	A chlamydia test is routinely offered opportunistically to sexually active under 25s by health practitioners in a variety of settings. This routine offer can be supported by advertising and promoting chlamydia screening and other sexual health services in waiting areas. Alerts and pop-ups can be used on the health practitioner's monitors during consultations. Offering chlamydia screening on an opt-out basis should be considered in a variety of settings, in particular in CASH services. Partially or fully integrated services can facilitate audits of reasons why test and or treatment has been declined to help inform improvement in practice and uptake.	
Pathology	Either:	A hybrid of services using existing pathology arrangements or separate	GUM, GP, SRH, and abortion services are advised to

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	Standalone	Partially integrated	Fully integrated
	Separate contracts with CSO and with pathology provider, or One contract with CSO who then sub-contracts with the laboratory provider.	standalone contracts still exists.	use existing pathology arrangements where possible and aim not to establish separate chlamydia pathology arrangements. These could be with acute and private laboratory providers.
Result notification	To providers: laboratories, CSOs. To clients: laboratory providers, CSOs.	Provider result notification Ideally, results management should sit with the testing provider. Providers expected to undertake results management should routinely receive a copy of their patients' results via a secure data transfer system. Where patient consent has been obtained, testing clinical services should receive a copy of the patient's results even when they are not responsible for results management Client result notification As results management moves from the CSO to the provider, results notification will have to be consistent with both the current provider systems and NCSP guidance. No news is good news is not the recommended course of action under NCSP and BASHH guidance. Where NCSP forms continue to be employed, commissioned laboratories or CSOs can initiate all or part of client results notification irrespective of the diagnoses. For example, commissioned laboratories may send a message to the young person communicating their positive or negative result. The CSO is subsequently responsible for contacting the positive young person directly to discuss and arrange treatment. When paying local tariffs for chlamydia testing in SRH, abortion providers and GUM, the cost of client results notification may be included within the payment.	It would be the provider's responsibility to undertake client results notification in accordance with NCSP guidance and 'no news is good news' is not recommended according to BASHH and NCSP standards . Client results notification could be provided by laboratories or clinical providers. Patients with a positive result generated from non-clinical activity, for example websites, should be followed up by an appropriate provider, for example local SRH clinic, whose duties would include referring young people to their most convenient treatment venue.
Treatment	CSOs, GUM, SRH, pharmacies, GPs or at other locations	Free treatment should be made available and easily accessible to all chlamydia positives in the NCSP age range and could be arranged by providers in a timely manner through a patient group directive (PGD), signposting, pharmacy vouchers or prescription. CSOs are advised to cease administering treatment themselves and focus on referring young people to their most convenient treatment venue and confirming that treatment has taken place within two weeks of receiving a positive diagnosis.	Free treatment should be easily accessible to all chlamydia positive within the age range and could be arranged by providers in a timely manner through PGDs, signposting, prescription or voucher – depending upon the resources available in the treatment initiating service.
Partner	Index patient led, or	Providers committed to treatment interviews should also have	Providers committed to treatment interviews should also

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	Standalone	Partially integrated	Fully integrated
notification	by CSOs, GUM, SRH, pharmacies, GPs or at other locations	demonstrable competence in partner notification initiation. For further details see NCSP standards 7th edition . CSOs should be expected to liaise with treating venues or the index patient to confirm PN has been initiated with contacts of NCSP positives.	have demonstrable competence in partner notification initiation. This service could be undertaken by providers responsible for taking the test or may be outsourced. PN for all STI testing activity for all ages in the community could be subcontracted collaboratively in some settings. Each area should have clear referral pathways for this activity. For further details, see NCSP standards 7th edition .