

# **Partner Notification for Chlamydia in Community Settings**

## **Recommendations on process and outcome standards in English practice.**

Effective control of transmission of sexually transmitted infections requires the identification and treatment of the sexual partners of those diagnosed with such infections. This process is known as partner notification. In England, ensuring partner notification (PN) is available to all persons diagnosed with a sexually transmitted infection is the responsibility of the local primary care trust.

The document recommends interventions based on the current evidence base of UK and world practice to deliver effective partner notification for genital chlamydia infections within the National Chlamydia Screening programme (NCSP).

This document is directed to commissioners, senior clinicians and service providers working in sexual health services.

This working group report began to consider these issues solely for NCSP, but it soon became apparent that all community settings have similar needs for consistent access to PN for all chlamydia diagnoses in community settings. The logical case for a single PN bureau serving GU medicine and community settings was compelling as we considered the processes needed. Evidence from Scotland<sup>1</sup>, where community PN offices have been operating for some time, supports the practical effectiveness of this approach.

### **Background**

The public health review by NICE on interventions to reduce under 18s conceptions and sexually transmitted infections identified partner notification (PN) as an essential part of the management of sexually transmitted infections (STI) irrespective of healthcare setting<sup>2</sup>. Partner notification includes a range of supportive interventions at the time of diagnosis and treatment initiated by a health professional intended to help patients with an STI to get their partners tested and treated. This support should be tailored to meet the client's individual needs.

Partner notification may be undertaken by the client or by the health professional, supported by specialist advice. In England, this support may come from health advisers working in the community, GU medicine (GUM) or via a Chlamydia Screening Office. Outcome measures for PN include numbers of partners traced and treated as soon as possible.

### **The National Chlamydia Screening Programme and Partner Notification**

The skills associated with achieving effective PN have been concentrated in GUM services in the UK, based around the role of the Health Adviser (HA). With the advent of the National Chlamydia Screening programme in England, where opportunistic screening of those under 25 years old is encouraged in non-GUM settings, the logical extension of service is to devolve treatment and PN activities also into novel settings. Chlamydia Screening offices and

community health advising services have developed, but the effectiveness of these services to date is known to be variable<sup>3</sup>. The increasing volume of screening in general practice and community pharmacies is uncovering a lack of capacity and training to offer comprehensive PN. An integrated system of community and clinic based PN, such as that working within the Glasgow Health Board, can offer continuity of care and removes a barrier to GP participation in screening.

As with all expansion of healthcare into new settings, it is essential to maintain client safety and a minimum quality of service delivery, based wherever possible on best practice guidelines and research evidence.

A working group of community based healthcare professionals and NCSP representatives met to consider the optimal development of PN processes in the programme with a view to standard development within a unified model of service delivery.

### **The working group recommendations**

- All clients diagnosed with Chlamydia should have access to partner notification support at the time of diagnosis and treatment from a healthcare professional supported by a health adviser, irrespective of the venue of testing:
- All clients diagnosed with Chlamydia should be offered follow up contact at two weeks from initial treatment to confirm treatment and PN success:
- Provider notification, where a Health adviser completes the PN process on behalf of a client, should be available to all clients (young, vulnerable, abused) who require more intensive support:
- A unified care pathway for partner notification of all Chlamydia diagnoses should be agreed with all provider venues for Chlamydia testing in a healthcare network:
- All commissioners of such care pathways should consider unifying health advising resources within a common Bureau. This team of Health Advisers and support staff would receive all positive chlamydia results and coordinate the care pathway for managing the PN activities. They would offer telephone support to clients and frontline staff, and be responsible for the recording of outcomes and for provider notification:
- Since this model recommends merging GU Medicine, Chlamydia Screening programme and community HA resources, standards for practice should be consistent with accepted professional practice:
- Outcomes recorded should be those partners believed screened and treated as revealed at follow up interviewing. Formal verification of partner treatment from venues would be sought at sentinel sites to monitor the validity of this outcome measure.

# Developing Community based Partner Notification

## The Working Group

Representatives from general practice, CASH services, BASHH, NCSP, SSHA, RPSGB and the NCSAG met to form a consensus on developing PN for chlamydia in community settings. Further consultation of draft materials was sought from researchers prominent in the field and the voluntary sector. Final recommendations were to be seen as pragmatic advice awaiting a change in the evidence base.

## Inclusions

The settings considered were pharmacy, general practice and community contraceptive services, where professional healthcare staff are available. These venues may be part of NCSP but the guidance can be generalised to all settings.

## Exclusions

The key principles of offering PN at the time of diagnosis prior to treatment was seen as applicable to all settings where screening and treatment take place. Non-clinical settings may be part of opportunistic outreach initiatives through distribution of postal teaching kits with clear care pathways for positives into central Chlamydia screening offices, offering options for treatment and PN.

Third sector providers were not specifically considered since their staffing and services vary widely, but any commissioned screening services could be included in a locality network for PN.

Commercial and private medicine settings were not included. The impact of over the counter provision of azithromycin through the Clamelle<sup>®</sup> licensing in 2008 is yet to be assessed; the protocol suggests treatment only for partners with no requirement for testing contacts<sup>4</sup>.

## Applicability and common themes

Most basic activities for partner notification in all STIs are identical; outcome measures, timescales of look back and treatments will vary.

### Quality and equity

Underlying the discussion was the principle of equity. The group agreed that a common baseline standard of service should be available to a client no matter where they choose to access sexual health services. Expert services should be available via clear care pathways for complex management and would be expected to offer training, support and quality assurance for the local network.

## Evidence base

The systematic review by Trelle and Low<sup>5</sup> of partner notification for patients with sexually transmitted infections concluded that, despite selection bias and methodological flaws in studies, involving index patients in shared responsibility for the management of sexual partners improves outcomes. Stronger evidence of benefit was seen in studies of counselling interventions to support clients to disclose to their sexual partners. A randomised controlled

trial and economic evaluation of partner notification for chlamydia in primary care was undertaken within ClaSS<sup>6</sup>. This demonstrated that partner notification can be undertaken effectively by trained practice nurses supported by a health adviser. Although not part of the intervention, a follow up telephone interview was required to reliably assess outcome. In addition, proformas were used at the initiation of partner notification, and during follow-up to record details. The study was co-ordinated centrally.

Health professionals should consider the following sources of guidance for the management of individual clients:

- The BASHH guideline for the management of *Chlamydia trachomatis*<sup>7</sup>.
- Guidance on partner notification by the Society of sexual health advisers<sup>8</sup>.
- Swedish key observations re improved effectiveness of a centralised system and value of telephone call from a skilled practitioner at 2 weeks<sup>9</sup>.

#### **Interventions under investigation at present**

- Client delivered partner therapy (APT),
- Home sampling for partners
- Providing additional information for partners.
- A study on accelerated partner therapy in England is to report shortly.
- A large randomised controlled trial has recently been commissioned in England to evaluate the most effective method of partner notification in primary care.

## Model of service

- Partner notification should be undertaken by trained staff.
  - If not available on-site, a telephone-based interview by a trained health adviser is a suitable alternative. Clients opting for screening should be informed of the process should they test positive. The need for an agreed method of rapid communication with a client, such as text or mobile telephone access, should be emphasised.
- A central resource of health adviser expertise within each health economy accessible to all venues providing screening and treatment services.
  - They should act as a centralised resource coordinating partner notification, receiving positive results, undertaking the follow-up telephone call at two weeks and keeping records of outcomes for each client.
- Written information must be available for the screen positive index patient and for their partners.
- At the initial PN interview, the number of partners in the past six months should be recorded.
- All clients should have access to provider notification, if indicated.
- All clients should receive a follow up telephone interview at two weeks to assess outcomes

## The central health adviser resource- The Bureau

The key recommendation is that every venue offering treatment for Chlamydia has immediate access to expert PN services. A centralised bureau of sexual health advisers, supported by clerical staff, would be an efficient model of care. Commissioners should consider merging CSOs, community health advising services and GUM HAs to exploit the skill base in a given community.

### Staffing the Bureau

- Community/GUM health advisers performing provider notification and supervising telephone PN services.
- Trainee HAs and call handlers could perform telephone PN within supervision protocols.
- Support workers in administrative roles to process PN referrals.

The staff numbers and skill mix required for each Bureau would vary by size of caseload offered from the local network (see below).

## Practical considerations for partner notification

- Initial testing discussions and literature should touch on the process of what happens when a test is found.
- All index clients found positive should be given infection specific information and detailed information for partners on accessing services.
- Where screen positive clients are returning in person for their result, the venue should have facilities for private discussion and initial contact history recording before dispensing treatment.

Treatment without PN is not good practice; divorcing the two processes in time leads to poor PN outcomes.

- Patient information leaflets about positive results should be available in every venue. They should include clear explanation about the importance of telephone follow-up after treatment.
- Venues should have communication facilities allowing prompt contact with the HA bureau – via fax, email via NHSnet or other agreed method.

Exchange of third party information is permissible for public health purposes; non-clinical settings may wish simply to indicate the number of contacts declared and this prompt is expanded upon by the Bureau.

- Proformas could be used in the bureau detailing how to structure and conduct the telephone interview and to record the information, ensuring consistency across the service.
- If clients are phoned or texted by the bureau with positive results, the initial health education and contact history taking could take place during that discussion. This facility would also be available for sites dispensing treatment with either insufficient facilities for PN or no staff trained in PN.
- Everyone referred into PN would be offered a follow up phone call two weeks after the initial contact. This would be initiated from the HA bureau.

## Anticipated resource requirements

The centralisation of PN skills into a single bureau model may produce savings by merging office space and overhead costs.

Published data estimates one hour of HA time per positive offered phone results and phone follow up<sup>10</sup>. This includes all administration activities involved with recording, tracing and contacting clients. The costs could be reviewed if administration is supported by clerical staff. Scottish models<sup>11</sup> suggest costings for PN in general practice around £2 per case. More data will be available soon from the APT study.

The continued commitment to support for frontline staff, as both an expert resource and a training centre for the initiation of PN with clients should be reflected in job planning for health advisers.

### **Confidentiality and PN**

Clarification from the Department of Health confirms that the public health legislation concerning managing STIs and data confidentiality applies to all health care providers either within the NHS or contracted to the NHS.

The recording of names or aliases for follow up purposes at diagnosis where results are given face to face in a non-clinical or non- NHS setting could offer problems of storage and security. However, the proportion of such venues doing this would be very small and they may be encouraged to persuade clients to accept results from the central Bureau by text, phone or email, followed by telephone interview offering a choice of clinical venues to pick up treatment and PN activity.

### **Look back period**

All contacts within 6 months for asymptomatic Chlamydia need to be recorded and an attempt to trace made – simply looking for the current partner is not likely to result in effective control of Chlamydia infection in a population. A shorter duration for look back is suggested in symptomatic patients in accordance with BASHH guidelines.

### **Provider notification**

Provider notification is the most labour intensive option of PN, but is needed when clients cannot initiate the process at all themselves. These are often the most vulnerable service users, such as those suffering domestic violence, the very young or those with learning difficulties. All attempts to contact sexual partners are initiated by a HA, without disclosing the index patient's identity or diagnosis.

Clear guidance needs to be given to testing/treatment venues as to when provider notification is indicated. Those services providing face to face interviews need to establish rapid referral pathways- ideally within 48 hours- for those expressing a preference/ recognised as in need for the service. A minority of clients undergoing PN needs this complex intervention, with extended access to HA time, but this needs to be costed into service models.

### **Outcome standards**

Two main approaches are open:

#### **Set a standard**

This could be based on ClaSS criteria using the information from the index patient at 2 weeks:

- Cases with at least one contact treated target 60%
- Cases with all partners treated target 50%

Alternatively, the existing NCSP standards could be applied. These state that within 90 days of diagnosis:

- 0.4 contacts should be traced and treated per case in large conurbations (London, Manchester, Birmingham) or
- 0.6 contacts traced and treated per case elsewhere.

The urban/rural difference in outcome standard should be reviewed using NCSP and BASHH GUM audit data.

**Benchmark across services** by using deviation from the mean to identify those with good and poor practice and use this to inform changes in practise to improve the performance as a whole.

There is some evidence that either method may be acceptable to analyse PN activity<sup>12</sup> but whichever method is chosen should be acceptable and justifiable to all types of site.

These two approaches are not mutually exclusive, and could form the basis of powerful audit strategies and auditable outcomes.

The BASHH audit 2008 is being analysed and there are several research studies under way that may inform a change of standard.

### **Training requirements**

There will be training needs generated by this change of model. Groups such as FRSH, BASHH and RCN would be approached to amend existing competency training to reflect the approach.

The POM to P guidance on Clamelle<sup>®</sup> for community pharmacists was seen as a likely resource for use by some pharmacists. This does not assume contacts are tested and the care pathway for PN is not defined as this group recommends.

### **Further work**

Modifications of the advice in this document are anticipated after the publication of the large research projects on accelerated partner management and PN in primary care.

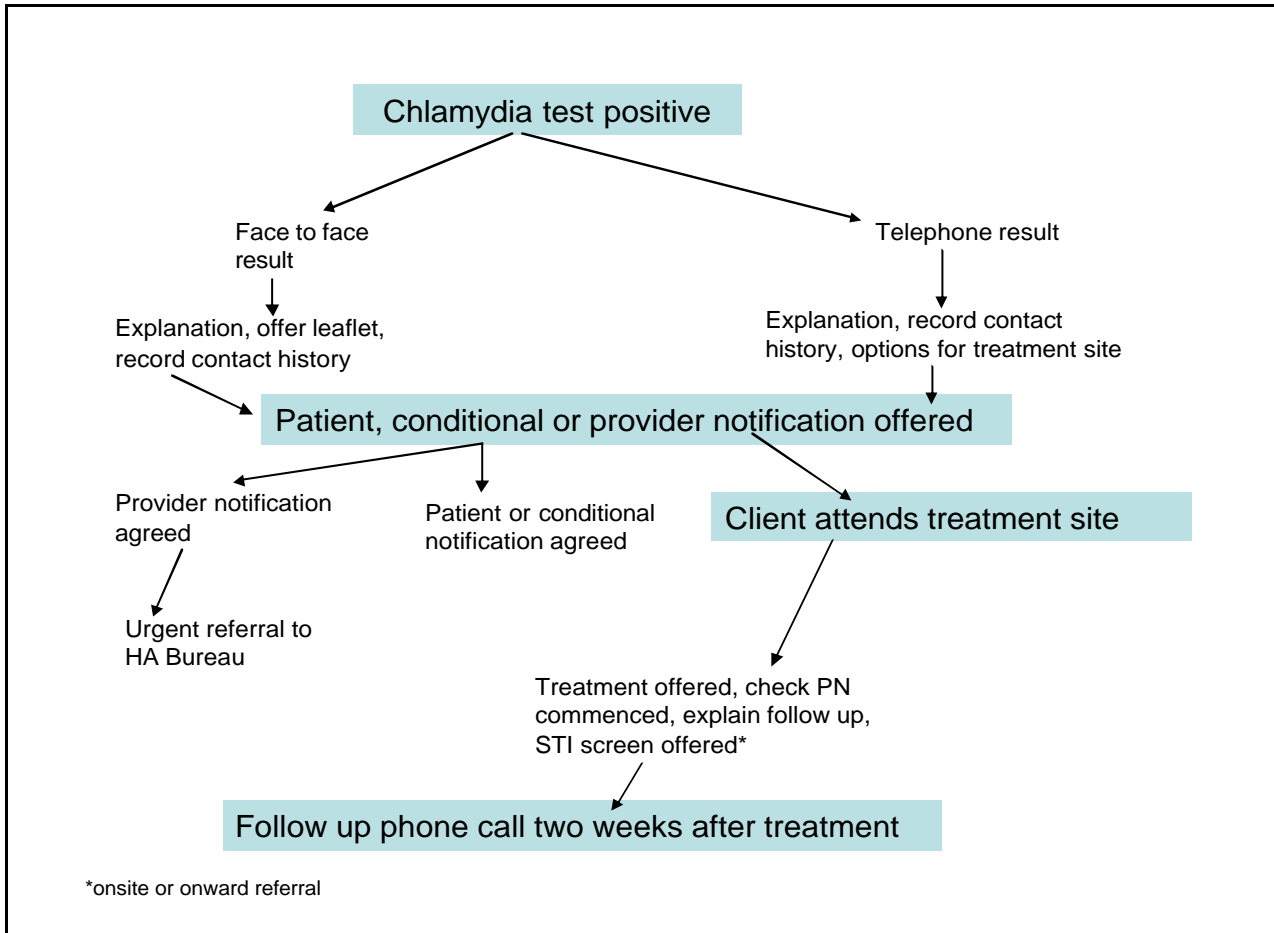
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### **Comments**

Please direct comments to Dr J Clarke  
c/o National Chlamydia screening programme  
Centre for Infections  
Health Protection Agency  
61 Colindale Avenue  
Colindale  
LONDON  
NW9 5EQ

Jan.clarke@leedsth.nhs.uk

## Flow chart for the process of Partner Notification



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**Contributors**

Jan Clarke	Chair, NCSAG*
Paddy Horner*	Academic GU clinician
Gill Bell*	Consultant Sexual Health Adviser
Hugo McClean	Consultant GU physician, BASHH
Mary Macintosh*	Director, NCSP
Paula Baraitser*	Medical Director, NCSP
Noel Gill*	HPA
Heidi Wright	RSPGB
Sebastian Kalwij	GP lead, NCSP
Peter Horne	Sexual health adviser, SSHA
Angela Wyatt	FSRH

\*Members, National Chlamydia Screening Advisory Group

**Additional comments from:**

Paul Ward	THT
Claudia Estcourt	Academic GU clinician
Chris Carne	Chair, National Audit Group, BASHH
Jackie Cassell	Academic public health clinician

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