

National Chlamydia Screening Programme

Core Requirements

Name of Document	NCSP Core Requirements
Edition	Fifth Edition
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Revisions

This document is the 5th edition of the Core Requirements. Previous editions were published as shown below

Edition 1	June 2003
Edition 2	July 2004
Edition 3	September 2006
Edition 4	January 2008

Please replace all previous editions.

Summary of the Main Changes since the 4th Edition

Section		Summary of Changes
All	Overall format	Document edited to simplify the text and format, and to update
All	Overall format	Supporting information has been moved into another document, to shorten the Core Requirements document and signpost to key points
All	Overall content	Content is less prescriptive as to how programmes should be provided, to reflect the fact that the programme can be successfully provided in a number of ways.
All	References to Chlamydia Screening Offices	Document changed to remove necessity for a centralised Chlamydia Screening Office. The local programme coordination can be delivered through a variety of models, and many functions devolved to providers
All	Standards	Standards are highlighted throughout the document, and at the beginning, to make it clear what is necessary. In addition the sections are linked to the BASHH standards for ease
All	Commissioning implications	Sections are highlighted for commissioners at the end of each section
6	Commissioning arrangements	Section added with information on costing and other guidance specific to commissioners
3.2	Consent	Removal of "The NCSP test form has been completed", inclusion of competence. Now reads <i>Consent is implied if:</i> <ul style="list-style-type: none"> • <i>The young person has been given the NCSP patient information leaflet and given time to read and understand it prior to participating; PLUS</i> • <i>A sample has been provided; PLUS</i> • <i>The client has competence to consent</i>
7	QA and Governance	Sections added on Serious Incident reporting, child protection issues, risk assessment and records management
9	Information requirements	Updated information as to frequency, content and method of data collection and submission

Amendments

Any changes made to the document will be shown in RED text, and shown on the last page of the document.

NCSP Core Requirements Quick Reference Sheet for Providers

To be used in conjunction with the NCSP Core Requirements 5th ed.

<p>NCSP criteria</p> <ul style="list-style-type: none"> • Opportunistic testing of sexually active under 25 • Includes partners regardless of age • Asymptomatic* • Test annually or with every change of partner 	<p>Test</p> <ul style="list-style-type: none"> • Must be NAATs • Self taken swab, urine or cervical swab if cervical examination already taking place
<p>Offering the test</p> <ul style="list-style-type: none"> • Offer test at every opportunity • Add chlamydia to other 'call' opportunities, e.g. asthma check • Test during routine medicals, EHC consultations, etc 	<p>Consent</p> <ul style="list-style-type: none"> • NCSP patient information leaflet, PLUS • Sample provided PLUS • Competent to consent – Under 16s must be 'Fraser' competent
<p>Local delivery</p> <ul style="list-style-type: none"> • Programme Lead responsible for local programme • LCSSG to monitor progress and support programme • The programme may be delivered by a chlamydia screening coordinator, or chlamydia screening office or as part of a more generic sexual health role. • Local testing plan • Ongoing quality assurance monitoring 	<p>Testing venues</p> <ul style="list-style-type: none"> • At least 60% of tests through existing core services (GP, pharmacy, sexual and reproductive health, abortion clinics) • Additional venues may also be used (e.g. remote tests via a website, youth services, military bases, etc). These should be carefully targeted to reach those who do not use core services • Staff at testing venues can be trained to provide the result, treatment and initiate PN where appropriate
<p>Providing results</p> <ul style="list-style-type: none"> • Young person chooses how they will be notified • Three attempts to contact the young person if test positive • Text – most cost effective method 	<p>Treatment</p> <ul style="list-style-type: none"> • Treatment is free for the young person • Azithromycin 1gm stat or • Doxycycline 100mg bd seven days • If pregnant – see BASHH guidance for options
<p>Management of positives</p> <ul style="list-style-type: none"> • Take sexual history • Advise full STI screen • Arrange treatment • Discuss PN • Agree arrangements for partners to be managed • Give safe sex advice • Follow up 2 weeks post treatment 	<p>Partner management</p> <ul style="list-style-type: none"> • Offer test • Empirical treatment – do not wait for test result • Ask about partners of partners and encourage them to attend for a test • Most partner notification will be patient led with the opportunity for provider led PN as back up if required

* Genital symptoms- ineligible for NCSP but consider testing via local care pathways and referral to clinical service for management

NCSP Core Requirements Quick Reference Sheet for Commissioners

To be used in conjunction with the NCSP Core Requirements 5th ed.

<p>NCSP criteria</p> <ul style="list-style-type: none"> • Opportunistic testing of sexually active under 25 • Includes partners regardless of age • Asymptomatic* • Test annually or with every change of partner 	<p>Test</p> <ul style="list-style-type: none"> • Must be NAATs • Self taken swab, urine or cervical swab if cervical examination already taking place
<p>Offering the test</p> <ul style="list-style-type: none"> • Offer test at every opportunity • Add chlamydia to other 'call' opportunities, e.g. asthma check • Test during routine medicals, EHC consultations, etc 	<p>Consent</p> <ul style="list-style-type: none"> • NCSP patient information leaflet, PLUS • Sample provided – PLUS • Competent to consent – Under 16s must be 'Fraser' competent
<p>Local delivery</p> <ul style="list-style-type: none"> • Programme Lead responsible for local programme • LCSSG to monitor progress and support programme • The programme may be delivered by a chlamydia screening coordinator, or chlamydia screening office or as part of a more generic sexual health role • Local testing plan • Ongoing quality assurance monitoring 	<p>Testing venues</p> <ul style="list-style-type: none"> • At least 60% of tests through existing core services (GP, pharmacy, sexual and reproductive health, abortion clinics) • Additional venues may also be used (e.g. remote tests via a website, youth services, military bases, etc). These should be carefully targeted to reach those who do not use core services • Staff at testing venues can be trained to provide the result, treatment and initiate PN where appropriate
<p>Providing results</p> <ul style="list-style-type: none"> • Young person chooses how they will be notified • Testing venues, laboratories, or the coordinator may provide this service 	<p>Treatment and Partner notification</p> <ul style="list-style-type: none"> • Treatment is free for the young person • Commission venues to provide treatment and PN initiation as a minimum for clinical venues • Offer test and provide empirical treatment • Include partners of partners
<p>Contracts and SLAs</p> <ul style="list-style-type: none"> • Specify NCSP core requirements and standards in the contract • Review regularly • Commission to exceed the national target • Service specification for GP/Pharmacy available on the NCSP website 	<p>Value for money</p> <ul style="list-style-type: none"> • Consider joined up commissioning locally and regionally where possible • Integrate chlamydia testing within wider sexual health provision and develop capacity for testing, treatment and PN in core services • An estimated cost of £33 per test should be achievable as volumes increase, integration improves and opportunities for collaborative procurement are maximised.

* Genital symptoms- ineligible for NCSP but consider testing via local care pathways and referral to clinical service for management

NCSP Standards

Standard	Target
Standard 1 – Diagnostics	
The laboratory has full capacity to perform high volume (at least 20 000 tests per year) NAATs on non-invasive specimens	The NAAT platform should run at least 90% efficiency, i.e. laboratories receiving samples from NCSP programmes should process at least 90% of the maximum number of samples that can be processed in a year
% of samples processed (test result known) within 5 days of receipt	>90%
% of samples where the result was reported by the laboratory to the programme staff within 7 working days of receipt of the sample in the laboratory.	>90%
% of samples where the sample is inhibitory.	<5%
% of samples where the test result is equivocal after the second test.	<5%
Standard 2 – Notification of Results	
% of positive results notified to the young person within two working days of the programme receiving the result from the laboratory.	>90%
% of negative results notified to the young person within five working days of the programme receiving the result from the laboratory.	>90%
Standard 3 – Treatment	
% of positive people treated within 14 days from the date of specimen collection.	>50%
% of positive people treated within 30 days from the date of specimen collection.	>90%
Percentage of positive index patients who received treatment	>95%
Standard 4 – Partner Notification	
Number of contacts per index patient who have attended a health care site for testing and epidemiological treatment within 90 days of the first PN discussion.	>0.4 contacts per index case within a large city (London, Manchester, Birmingham) or >0.6 contacts per index case elsewhere
Standard 5 – Access to Care	
% of tests offered through core services	>60%

The programme has set an annual screening uptake goal, with quarterly trajectories, in line with the national target. Details of the current national target are available at: http://www.chlamydia-screening.nhs.uk/ps/data/data_tables.html

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1. Introduction

1.1 Document purpose

This document has been prepared by the National Chlamydia Screening Programme (NCSP) to provide guidance for the delivery of a local testing programme. This document is available at: <http://www.chlamydia-screening.nhs.uk/ps/publications/core.html>

This guidance is consistent with an evidence-based and cost-effective approach. It outlines the minimum specifications for local implementation of chlamydia testing, and should form the basis for local chlamydia testing plans. The text contains relevant NCSP standards to help programmes set out requirements in local service level agreements and contracts, and to facilitate quality assurance procedures and monitoring. However the text allows flexibility so that programmes can be set up to suit local infrastructure and demographics.

This document is the 5th edition NCSP Core requirements, published in June 2010. Please replace all previous editions.

The supplementary text “NCSP Core Requirements Accompanying Information”, available on the NCSP website, will be referenced throughout this document, and provides additional information.

This guidance will be updated as required and reviewed annually.

1.2 Context

The British Association for Sexual Health and HIV (BASHH) *Standards for the Management of Sexually Transmitted Infections*¹ cover all aspects of the management of STIs including diagnosis, treatment and the broader public health role of infection control. Chlamydia is one of the STIs covered by the BASHH standards. This document contains further detail specific to chlamydia. Where the guidance here relates to the BASHH standards this will be highlighted in order to make it easier for cross-referencing.

The BASHH standards are available at: http://www.bashh.org/news/435_bashh-standards-for-the-management-of-sexually-transmitted-infections

Background information on chlamydia, epidemiological data and the evidence base for the NCSP is available at: <http://www.chlamydia-screening.nhs.uk/ps/default.html>

1.3 Aims and Objectives

The NCSP aims to:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection
- Reduce onward transmission to sexual partners
- Prevent the consequences of untreated infection
- Ensure all sexually active men and women under 25 are aware of chlamydia and its effects, and have access to services providing testing, prevention and treatment

1.4 Criteria for testing

The programme includes:

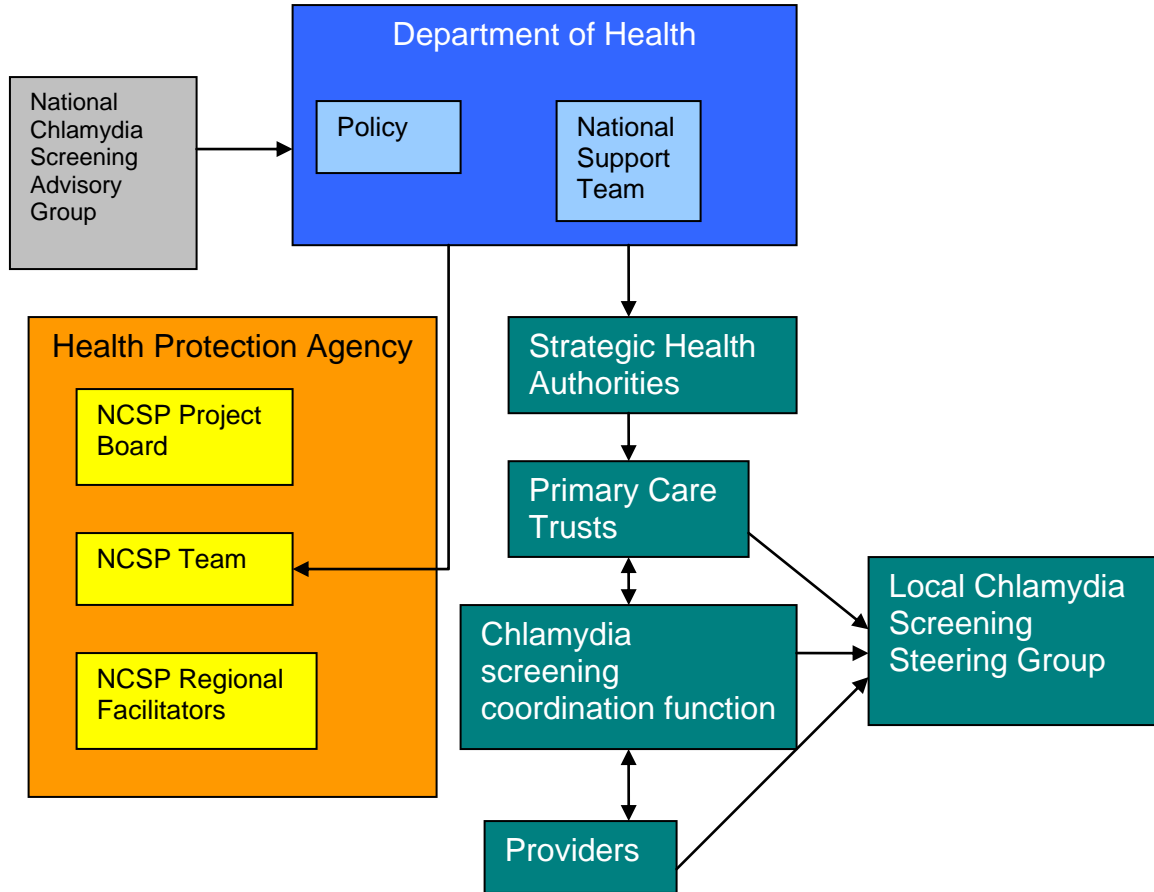
- Men and women under 25 who have ever been sexually active and who are offered, or request, a chlamydia test
- Under 16s who are deemed 'Fraser' competent to consent
- Contacts of test positives, regardless of age

The NCSP does not include those who cannot give consent, anyone unwilling to give any means of contact for the result, and under 16s not deemed 'Fraser' competent.

Young people should be encouraged to be tested annually or whenever there is a change in sexual partner². Additional repeat testing may be required according to risk assessment by clinical staff.

2. Roles and Responsibilities

2.1 National Programme Structure



The **Department of Health** (DH) prioritises the NCSP as part of the *National Strategy for Sexual Health and HIV*^{8,4,5} and is responsible for implementation via the Strategic Health Authority performance management framework. The DH also provides a strategic policy lead for the NCSP.

The **National Support Team (NST) for Sexual Health** provides support to PCTs to help them achieve the national target for chlamydia testing.

PCTs are responsible for funding and delivering the programme locally and are performance managed by the SHAs.

The **National Chlamydia Screening Advisory Group** advises the DH in its role and advises on procedures, standards and development of the programme.

A service level agreement exists between the DH and the **Health Protection Agency** (HPA) which hosts the NCSP national team. The **NCSP project board** coordinates delivery of the service level agreement.

The **NCSP national team** oversees operational management of the programme. This comprises development of the programme at a strategic level, providing guidance and support to programmes, and collating and analysing data. The team includes a network of **Regional Facilitators** who work closely with local programme areas. Contact details for the NCSP are available at:

<http://www.chlamydia-screening.nhs.uk/ps/contact/contact.html>

2.2 Local programme structure

Programmes may be delivered by individual PCTs or consortia of two or more PCTs. In deciding the structure PCTs should consider local demographics, the geographical area, existing collaboration between PCTs and opportunities for joined up work with potential for cost efficiencies. Wherever possible the NCSP should be linked with other elements of sexual health service planning and delivery.

Benefits of delivering the programme through a consortium include opportunities to maximise resources, and to develop a single brand and system covering a large area.

However, some consortia have had difficulties managing a single programme over a large area containing many providers, and communication lines between the PCTs must be excellent in order for the programme to succeed. The consortia PCTs will also need to agree on a consistent structure and future vision for the local programme.

2.3 LCSSG

It is expected that a local chlamydia screening steering group (LCSSG) is established in each programme area, chaired by the Programme Lead or another suitable senior representative.

The LCSSG is responsible for devising and implementing the local chlamydia testing plan. The group will report to the PCT chief executive and SHA with regards to local coverage, monitoring and progress towards local and national targets.

The LCSSG should steer, guide and advise on all aspects of the local programme activity. The individual responsible for coordinating chlamydia screening locally should report to this group.

Suggested membership and key responsibilities of the LCSSG are available in the Accompanying Information document, page 1.

2.4 Local Chlamydia Screening Programme Lead

The Programme Lead is responsible for delivery of the service at local level, and will chair the LCSSG. The Programme Lead may be a consultant/associate specialist or a specialist commissioner, though variation will exist depending on local accountability structures. Further details are available in the Accompanying Information document, page 2.

2.5 Local Chlamydia Programme Coordination Function

There should be an individual responsible for coordinating chlamydia screening locally. This role may be integrated with a more generic responsibility for the coordination of primary care sexual health services. This person should work closely with the Programme Lead and Regional Facilitator. The main functions of this role will be core services venue engagement, training and support, data collection and reporting and quality assurance.

Since the inception of the NCSP the Coordinator role has shifted from operational running of the Chlamydia Screening Office and provision of the service towards strategic management and development across the local programme. Details of the key responsibilities of the above roles are available in the Accompanying Information document, page 2.

IMPLICATIONS FOR COMMISSIONNERS

- a) Commissioners should have in place clear plans to meet current targets and expand services. Robust treatment, partner notification and sexual health promotion should be a part of these plans
- b) Commissioners should investigate the benefits of provision of the service by a consortium
- c) PCT senior executive commitment and direction is required to support local chlamydia control and prevention strategies. Commissioners should ensure that the programme works with a strong LCSSG and that the PCT works with performance leads in the SHA to provide ongoing monitoring.
- d) Review job descriptions of the Coordinator(s) to ensure that inappropriate functions are not being carried out

3. Chlamydia Testing

BASHH: Standards 1 and 3

3.1 Screening venues

Screening can be carried out in a number of venues. These include

- **Core services** (GP surgeries, community pharmacies, sexual and reproductive health services, abortion clinics)
- **Additional venues** such as schools, youth services, military bases etc. Where testing is provided here it should be carefully targeted to reach specific groups who are hard to reach through core services
- **Remote testing** – testing kits can be requested by young people through websites, which can be posted to them

Chlamydia testing needs to be integrated with sexual health provision. The NCSP is not a stand alone service and testing should be normalised within existing consultations. However patients should be able to have a choice of testing and treatment venues. Guidance for maximising testing through core services is available at: <http://www.chlamydia screening.nhs.uk/ps/sharing/index.html>

Patients have a right to confidentiality regardless of the setting.

3.2 Consent for testing

The test is voluntary and young people must be given information to assist them in making an informed choice. This should include the fact that data collected as part of the programme will be used for national programme monitoring.

Consent is implied if:

- The young person has been given the NCSP patient information leaflet and given time to read and understand it prior to participating; PLUS
- A sample has been provided; PLUS
- The client has competence to consent (see below)

The NCSP information leaflet is available at:

<http://www.chlamydia screening.nhs.uk/ps/publications/marketing.html>

The NCSP leaflet may be supplemented with, but not replaced by, local information on chlamydia testing, or other sexual health services including gonorrhoea testing.

3.3 Specific consent issues

The test initiator is responsible for ensuring that any under 16s offered a test are competent to make an informed decision. Staff should adhere to national and local guidance on consent for the under 16s^{6,7,8}. Further information is available in the Accompanying Information document, page 3.

Internet testing and tests from 'grab bins' should not be offered to under 16s, since there is no way for a professional to ascertain whether they are competent to make an informed decision. In cases where it appears that an under 16 has accessed a test

through these routes a suitably trained professional must liaise with the young person in line with local and national guidelines.

The NCSP does not support the use of incentives for young people to encourage testing: http://www.chlamydia-screening.nhs.uk/ps/assets/pdfs/statements/formal/NCSP_FormalPositionStatement_on_the_use_of_incentives.pdf

3.4 Screening for other sexually transmitted infections

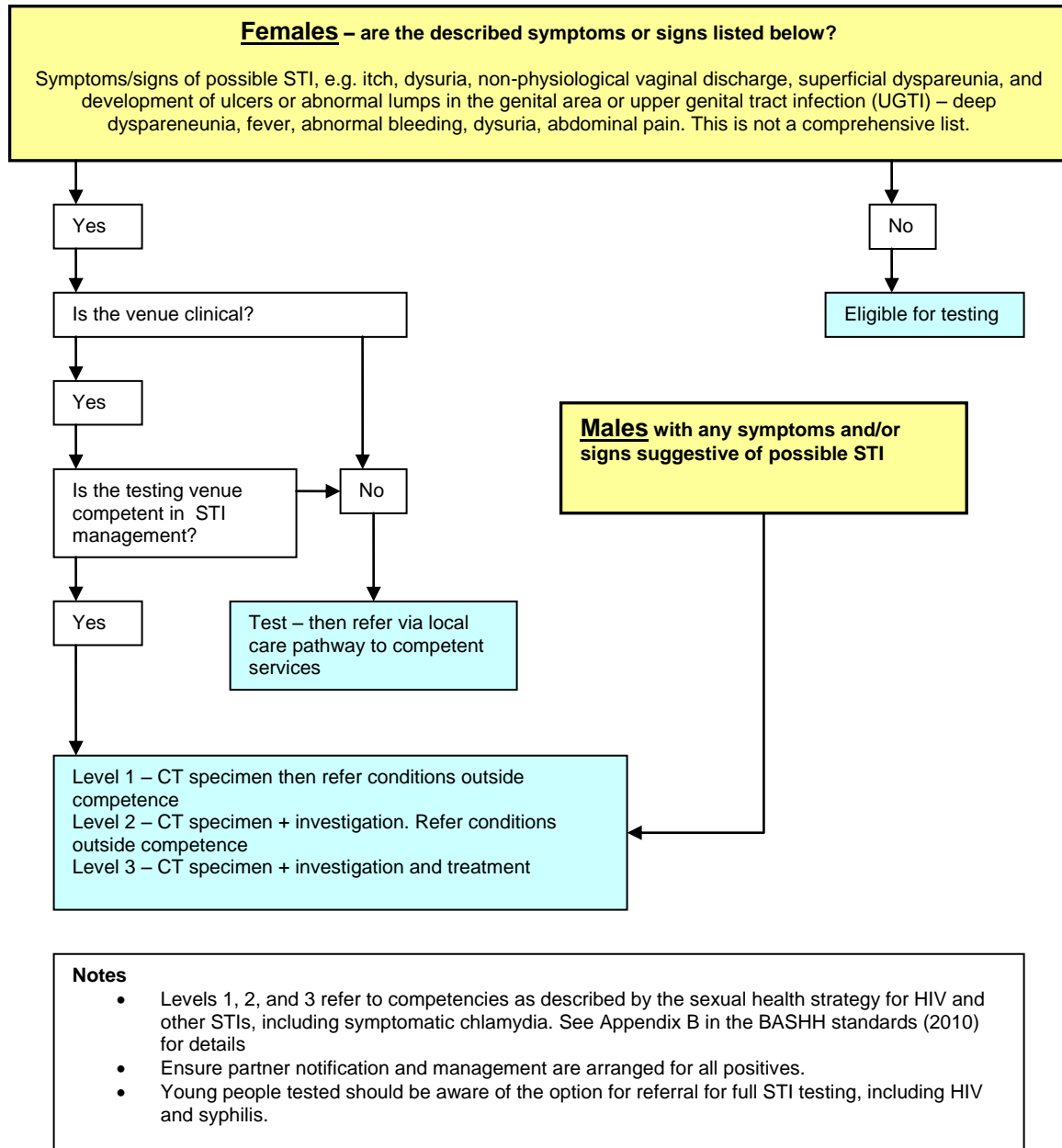
A number of programmes are now offering dual testing for chlamydia and gonorrhoea (GC). In these cases specific information must be provided to patients and consent obtained for gonorrhoea testing. Staff involved in offering tests, providing results, treatment and PN must be trained as appropriate^{9,10}. Further NCSP guidance on the considerations that should be taken is available in the Accompanying Information document, page 4.

3.5 Men Who Have Sex With Men (MSM)

Men who have sex with men (MSM) should be advised, even if asymptomatic, to have a full STI screen, including a test for hepatitis B as required. There are concerns that urine testing alone will miss possible asymptomatic rectal infections in MSM. Non-clinical venue providers should ensure that MSM presenting for testing are aware of the need to attend a local clinical venue for appropriate testing¹.

3.6 Young people reporting symptoms

The following diagram details the pathway for managing young people reporting signs or symptoms suggestive for an STI:



This flow chart has been designed to ensure that all those with symptoms see a clinician. Non clinical venues should ensure that this happens. For example, websites who offer test kits should advise those with symptoms to see a clinician, but may still offer testing as per the flowchart above.

3.7 Specimen Collection

Testing may be undertaken using¹¹

1. Vulvovaginal swabs (for women) or
2. First-void urine samples (for men and women), or
3. Cervical swabs *if a speculum examination is being carried out as part of routine clinical care*

Information on collection, transport, storage and handling of specimens should be provided to both participants and healthcare professionals.

Manufacturer's recommendations, including specimen type, volume and minimum time since last urine passed, should be adhered to. Further details are available in the Accompanying Information document, page 5-9.

A minimum of five weeks is recommended between tests. Repeat testing before this time may miss delayed therapeutic reaction to treatment or may detect non-viable organisms¹². A series of clinical FAQs concerning the timing of tests is available in the Accompanying Information document, page 10.

3.8 Point of care tests

Point of care Tests (POCTs) are not currently used within the NCSP. This position will be reviewed following evaluation of POCTs within the programme, should a suitably specific and sensitive POCT become available.

NCSP Standards:

- 1) Percentage of tests offered through core services.
Target: At least 60%

IMPLICATIONS FOR COMMISSIONERS

- a) Chlamydia testing should be integrated with sexual health provision, and the majority of screening done through core services.
- b) Commissioners should be clear about which elements of care are to be provided by which service providers to ensure that there is comprehensive cover of the local area. This should be laid out in contracts
- c) Testing should be offered in a range of services and locations
- d) Commissioners should review access to services for hard to reach groups
- e) Commissioners should ensure that a capacity analysis of services supports service planning and incorporates the views of young people
- f) Commissioners should ensure that services which are offering dual testing meet additional consent and information standards
- g) Suitable facilities for specimen collection, and appropriate space for consultations, should be provided at each testing venue appropriate
- h) There should be clear pathways and signpostings for symptomatic patients, under 16s and those not deemed Fraser competent towards appropriate services

4. Laboratory testing procedures

BASHH: Standard 4

- All tests must be nucleic acid amplification tests (NAATS)¹¹.
- Laboratories must be appropriately accredited with a nationally agreed accreditation scheme such as Clinical Pathology Accreditation (UK) Ltd¹³.
- To avoid delays, laboratories should not process any test where the information on the test request form is illegible or incomplete so that a result cannot be issued. The laboratory can refer these to the person responsible for coordinating chlamydia screening locally for resolution and monitoring.

When contracting a laboratory programmes are advised to perform a baseline assessment of laboratory capacity and infrastructure across all PCTs in the area. Existing transport networks should be factored into any decision. It is recommended that regional laboratory procurement is considered in order to minimise cost.

August 2010 – text deleted, see p41

4.1 Confirming positive results

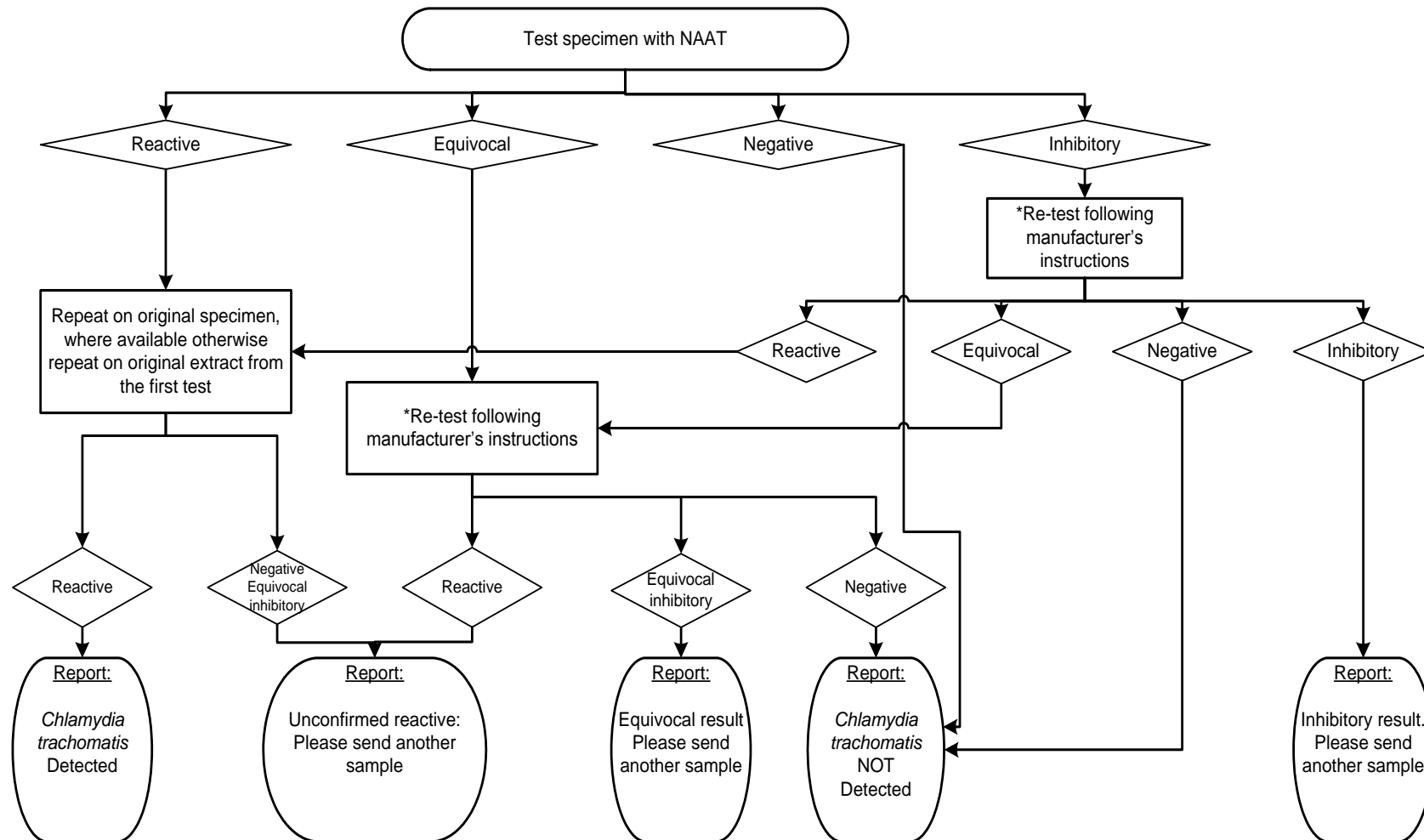
Testing should be carried out according to the algorithm below. Repeat testing will cause a slight reduction in sensitivity (some low positives will not repeat due to low nucleic acid load), but this has to be balanced against the consequences of false positive results.

Samples that do not repeat should be reported as 'equivocal' or 'unconfirmed positive' with a recommendation for a repeat sample to be tested, allowing the need for treatment and/or the possibility of further samples to be discussed with the young person¹⁴.

Please refer to minimum testing algorithm VSOP 37:

<http://www.hpa-standardmethods.org.uk/documents/vsop/pdf/vsop37.pdf>

4.2 Minimum testing algorithm¹⁴



Note – the BASHH guidelines for Chlamydia Testing have been out to consultation (consultation closed at time of publication, June 2010). This algorithm may be revised following the publication of the guidelines.

NCSP Standards:

- 1) The laboratory has full capacity to perform high volume (at least 20 000 tests per year) NAATs on non-invasive specimens.
Target: The NAAT platform should run at least 90% efficiency, i.e. laboratories receiving samples from NCSP programmes should process at least 90% of the maximum number of samples that can be processed in a year.
- 2) Percentage of samples received by the laboratory which are processed (i.e. the test result is known) within five working days of reception in the laboratory.
Target: At least 90%
- 3) Percentage of samples where the result was reported by the laboratory to the programme staff within seven working days of receipt of the sample in the laboratory.
Target: At least 90%
- 4) Percentage of samples where the sample is inhibitory.
Target: less than 5%
- 5) Percentage of samples where the test result is equivocal after the second test.
Target: Less than 5%

IMPLICATIONS FOR COMMISSIONERS

1. All laboratories commissioned to perform testing for the NCSP should be appropriately accredited and deliver optimal standards of laboratory services. They should be registered with a nationally recognised quality assurance scheme and have evidence of external and internal quality assurance
2. Commissioners should ensure that there is a contingency plan should the laboratory be temporarily unable to provide the service
3. Commissioners should consider economies of scale when commissioning laboratory services and consider regional laboratory procurement
4. Commissioners should consider the issues around communication and consistency caused by having multiple labs providing services
5. Existing transport links should be taken into account when commissioning laboratory services
6. Contracts should include the NCSP turnaround times standards, and regular audits should be used to monitor these
7. Commissioners should consider the information flows possible between laboratories, clinical services and data management at PCT level and ensure rapid and effective communication is possible with laboratories from all parts of the patient pathway.

5. Results and Treatment

BASHH: Standards 1, 4, 5 and 7

5.1 Reporting results

Reporting Procedures

- At the time of testing, young people should be asked how they wish to receive their result, choosing from a **text message, telephone call** (mobile or landline), **letter** (posted to any address of the young person's choice) or **email**. It is helpful if two methods of contact are provided. Programmes considering emailing results should take appropriate advice from their PCT Caldicott Guardians and data protection leads.
- A test should not be taken if there is no way of contacting the young person.
- Staff involved in giving results should be aware of the possibility of false negative and false positive results.
- There must be documented procedures and care pathways for patient management. Accountability structures for managing test negative and test positive young people must be clear.
- All participants must be notified of their result. **The NCSP does not endorse a policy of 'no news is good news'**.
- Men who have sex with men (MSM) should be advised, even if asymptomatic and test negative, to have a full STI screen, including a test for hepatitis B as required. There are concerns that urine testing alone will miss possible asymptomatic rectal infections in MSM. Non-clinical venue providers should ensure that MSM presenting for testing are aware of the need to attend a local clinical venue for appropriate testing¹.
- Women who have sex with women, like heterosexual women, should be advised, if they are symptomatic, to seek a full STI screen, even if they test negative.

Reporting Venues

- Automated text result messages may be sent direct from the laboratory to the young person. This should be in addition to being sent to the agreed service provider who is deemed responsible for providing test results in the 'follow through' care pathway.
- Results should be reported in a timely and confidential manner by suitably trained staff.
- Positive results should be provided by staff with appropriate clinical competencies.
- The clinical governance lead for the PCT holds the responsibility for ensuring that the policies and processes for the care pathway for the multiplicity of venues involved in the programme are robust. This will include the coordination of reporting, following through test results (negative and positive) to the young person, ensuring that there is a system to ensure all required data is sent back to the person responsible for coordinating testing in the area and ensuring the process has high levels of confidentiality.

NCSP standards:

- 1) Percentage of positive results notified to the young person within two working days of the programme receiving the result from the laboratory.
Target: At least 90%

- 2) Percentage of negative results notified to the young person within five working days of the programme receiving the result from the laboratory.
Target: At least 90%

5.2 Management of test negatives

One documented attempt can be made to report a negative result. No further action is required.

5.3 Management of test positives

Three documented attempts to report positive results should be made. Programmes are advised to consider sustainability of the method for managing positives as testing volumes increase. It is recommended core service providers are trained to provide results, treatment and PN. It is recommended that where possible different methods of communication are used to contact the patient.

5.4 Treatment

Data recording

Robust arrangements must be in place so that the person responsible for compiling local data to return to the NCSP is informed about the treatment of positive participants to ensure the accuracy and completeness of data for the NCSP on positives and their partners. To facilitate this, the local programme may provide a PCT-agreed 'follow through' process, contacting test positives two weeks after the result to verify that they have been treated and the PN process initiated. Programmes should ensure that roles and responsibilities are clearly defined for staff, in order to avoid confusion or duplication in workload.

Treatment Standards

Treatment and partner notification (PN) may take place at a variety of venues (e.g. contraceptive clinics, GP surgeries, community pharmacies, etc). All young people treated for chlamydia must receive sexual health advice and be advised to undertake PN^{1,12}. The treatment interview is a key opportunity for exploring the sexual history and communicating the importance of PN in relation to preventing repeat infection for the individual. At this stage it may be appropriate to offer a provider led notification process if more acceptable to index patient.

Staff responsible for treatment and PN must be suitably trained in line with the BASHH standards¹ and professional guidance. Accessibility and opening times should be considered when setting up treatment sites.

Treatment must be in accordance with published clinical guidelines and standards. The BASHH recommendations are summarised below¹²:

Men and non pregnant women	<p>Azithromycin 1g in a single dose, or Doxycycline 100mg twice daily for seven days</p> <p>For people intolerant of these regimes or for whom the treatment is contraindicated:</p> <p>Ofloxacin 200mg twice daily for seven days or 400 mg once daily for seven days. Or</p> <p>Erythromycin 500mg twice daily for 10-14 days</p>
Pregnant women	<p>Erythromycin 500 mg four times daily for seven days or 500mg twice daily for 14 days, or Amoxicillin 500mg three times a day for 7 days</p> <p>Azithromycin 1g in a single dose. (The safety of Azithromycin in pregnancy and lactating mothers has not been fully assessed, although available data indicate that it is safe. The British National Formulary (BNF) currently recommends the use of azithromycin in pregnancy and lactation only if no alternative is available.)</p> <p>Doxycycline and ofloxacin are contraindicated in pregnancy.</p>

- Young people receiving treatment must also receive¹²:
 - Information on treatment, potential for reinfection and PN should be instigated
 - Safe sex advice including details of local services
 - The offer of a full STI screen including information on clinic locations and opening times (BASHH defines the minimum tests that in combination constitute an STI screen as those for chlamydia, gonorrhoea, syphilis and HIV)
- Young people testing positive and their partners should be encouraged to abstain from sex until all have been treated; this includes the period of treatment and the next seven days for all people.
- Young women on the combined oral contraceptive pill need to be counselled about their choice of contraceptive method and its interaction with treatment. Providers may consider recommending and/or prescribing emergency contraception to women who may not have abstained from sex or used extra precautions while on antibiotics for a further seven days.
- Individuals suspected of clinical treatment failure should be managed according to the BASHH guidelines¹².

Treatment should be free of charge. PCTs will need to ensure that there are processes in place to ensure that this can be provided in all treatment locations. The NCSP will be publishing guidance shortly, which will be available on the website.

Treatment must be administered by either medical practitioners or other clinical staff legally covered to work under patient group directions (PGDs). Further information is available in the Accompanying Information document, page 12-14.

NCSP Standards:

1) Percentage of positive people treated within a) 14 days and b) 30 days from the date of specimen collection.

Target: At least 50% treated in 14 days and at least 90% within 30 days.

2) Percentage of positive index patients who received treatment

Target: at least 95%

5.5 Partner notification

BASHH: Standards 1, 2 and 5

Partner notification (PN) is a key element in the identification, management and control of STIs and should be offered to all young people diagnosed with chlamydia. Protocols should be in place at each venue undertaking PN. Close working relationships between all services offering PN and treatment are important in order to maximise the effectiveness of the programme. All staff involved in PN must be suitably trained and work to the standards and guidelines from BASHH and the Manual for Sexual Health Advisors by the Society of Sexual Health Advisors¹⁵: www.ssha.info

The PN process should be acceptable to young people and their partners.

The PN discussion

- Partner notification should be discussed and recorded without delay, either by telephone when the result is given, or face to face when treatment is dispensed

Look back period

- There is limited understanding of the most effective look back period^{12, 15}. The NCSP recommend a look back period of six months for women and asymptomatic men; one month for symptomatic men.

Choice of PN method

- Patients should be offered the choice of informing partners themselves (patient referral) or passing contact details to staff who will notify the partner without disclosing the patient's identity (provider referral). The majority of patients prefer to notify their partners themselves, but provider referral may be more effective in certain circumstances¹⁶.

Partner management

- All partners should be offered a test and epidemiological treatment, in accordance with BASHH guidance¹²
- If partners are tested they should be reported as a 'contact' when submitting the data. If symptoms are present this should also be indicated.

Co-operation between local programme and GUM services

- Provider referral requests may be passed to the partner's local programme office, or nearest GUM, to protect index patient confidentiality
- The index patient's testing service or local programme office should be informed of partner tests/diagnosis/ treatment by phone or return of contact slip

- Further information is available in the Accompanying Information document, page 15.

Patient and partner management data

- Partner treatment should ideally be confirmed by a clinician. If this is not possible, confirmation should be sought from the index patient¹².

Local PN Pathways

- Local pathways for the management of PN should be in place to clarify roles and responsibilities for all aspects of PN, including interviews, provider referral, follow-up, verification and data reporting

Links to venues competent to treat sexually transmitted infections for care pathways for symptomatic test requesters, people testing positive or their partners need to be robust and clear to both patients and providers.

NCSP standards:

1) Number of contacts per index patient who have attended a health care site for testing and epidemiological treatment within 90 days of the first PN discussion.
Target: 0.4 contacts per index case within a large city (London, Manchester, Birmingham) or 0.6 contacts per index case elsewhere.

5.6 Follow-up

Follow up is an important part in the management of chlamydia^{1, 15}. The objectives include

- Following up partner notification
- Reinforcing health education
- Ensuring compliance with treatment and abstinence from sexual intercourse until partner(s) have completed antibiotics (if treated with azithromycin waiting seven days).
- Re-treating non-compliant and/or re-exposed individuals.

There is some evidence to suggest that follow-up by phone may be more effective than asking the patient to re-attend. It is therefore likely that the former method is more cost effective¹¹.

5.7 Test of cure

Test of cure is not routinely recommended. However, if the young person has been treated with erythromycin, test of cure should be considered five weeks after the original test date (or three weeks after the end of the 14 day course). A test of cure prior to five weeks may miss patients with delayed therapeutic reaction to treatment or may detect non viable organisms. All pregnant women are advised to have a test of cure¹².

Providers who suspect patient or partner non-compliance to therapy may consider performing a test of cure for confirmation, and direct therapy according to the results of the test.

IMPLICATIONS FOR COMMISSIONERS

- a) Test positives should be clearly signposted to a treatment centre
- b) Performance management of the number of attempts made to contact both test negative and test positive patients is useful in ensuring high standards of care
- c) Partner notification is a key part in the management of STIs to reduce risk of re-infection for the index patient and to reduce transmission risk across the community.
- d) All services that give results, treatment or partner notification should adhere to the BASHH guidelines and standards
- e) Commissioners should ensure that patient pathways, policies and guidance for testing, treatment and PN are in place, valid, and available to all involved

6. Local service delivery and development

6.1 Commissioning arrangements

BASHH: Standards 1 - 9

This document is intended for both providers and commissioners, although the focus is on service provision. Further guidance available for commissioners includes

- Quick Wins – Commissioning Chlamydia Screening, available at <http://www.chlamydia-screening.nhs.uk/ps/publications/qwins.html>
- Costing guidance¹⁷, available at <http://www.chlamydia-screening.nhs.uk/ps/commissioners/remuneration.html>
- Guidance for the development of specifications for commissioning chlamydia screening, available at <http://www.chlamydia-screening.nhs.uk/ps/commissioners/model.html>

Costing

In 2009, the NCSP conducted a costing review to encourage consistent costs nationally and reduce the cost variations observed in different PCTs. The average cost per testing episode (including follow up of positives, overheads and local coordination) was found to be £45. This average cost sits in several different funding streams (CASH block contracts, GP and community pharmacy Local Enhanced Services (LES), laboratory contracts, Chlamydia Screening Offices (CSO) support, 3rd sector provider contracts)¹⁷.

An estimated cost of £33 per testing episode should be achievable, as testing volumes increase, testing is better integrated in all community sexual health pathways, sexual health networks develop and regions move to collaborative procurement¹⁷.

The results of the review are consistent with the NCSP strategy to prioritise engagement of core services, as well as better integration of chlamydia screening within other sexual health service provision.

Payment by Results (PbR) is currently being expanded into community settings. There is currently no plan to develop a fixed or nationally agreed tariff for chlamydia screening across primary care and the community. However, this costing review and ongoing economic evaluation will support commissioners to commission local chlamydia screening services representing best value for money.

6.2 Local chlamydia testing plan

It is recommended that programmes develop, implement and monitor a local testing plan, agreed by the LCSSG. The plan should reflect the core requirements, link to the PCT sexual health needs assessment, reflect integration of the programme within the PCTs wider sexual health strategy and be publicly available.

The plan should include:

- Roles and responsibilities
- Key deliverables and timescales (note NCSP standards)
- Protocols and procedures for all operational aspects

It is recommended that there is an action plan for each service indicating how the service will meet its proportion of the target based on footfall.

NCSP Standards:

1) The programme has set an annual screening uptake goal, with quarterly trajectories, in line with the national target. Details of the current national target are available at: http://www.chlamydia-screening.nhs.uk/ps/data/data_tables.html

6.3 Staff Training

BASHH: Standard 2

Commissioners are responsible for ensuring that all staff involved in the delivery of NCSP are adequately trained and competent. This training should be refreshed/ updated on a regular basis. The type of training required will depend on the location and roles of the individuals involved.

Training should be tailored to the local programme and may be delivered by professional bodies, core service trainers/facilitators, sexual health professionals, sexual health promotion specialists, or local chlamydia testing champions, as well as generic primary care STI training courses. Regional Facilitators can also support local training and education initiatives.

IMPLICATIONS FOR COMMISSIONERS

- a) Commissioners should use the NCSP's costing review to help identify areas for potential savings.
- b) A local chlamydia testing plan should be in place to outline local policies and procedures, as well as deliverables for each testing venue
- c) Contracts should state the requirements for the expected levels of training and education for providers, and the expected assessment of competencies
- d) Providers should have workforce development plans and contingency plans
- e) Commissioners should develop performance indicators, and evaluate service delivery against contracts

7. Quality Assurance and Governance

7.1 Quality Assurance

Quality assurance (QA) is the systematic action necessary to provide confidence that a service will meet given requirements. QA covers all areas of a service that affect the quality of the end product. Quality control processes measure specific aspects of the service to ensure they meet the required standards.

The aim of QA in the NCSP is to maintain minimum standards and improve performance of all aspects of chlamydia testing, in order to ensure young people have access to a high quality service.

It is the responsibility of the Programme Lead and LCSSG to ensure that the local programme has a system for monitoring QA at least annually.

This document contains specific QA standards throughout. Programmes should use these standards when:

- Preparing SLAs or contracts with providers
- Monitoring quality at LCSSG/PCT level
- Devising measures to drive continual improvement
- Training staff involved in delivery of the service

A summary of the NCSP standards is available at the beginning of this document.

The national NCSP QA framework includes an annual survey which should be completed in addition to ongoing local QA measures:

<http://www.chlamydia-screening.nhs.uk/ps/standards/index.html>

7.2 Confidentiality

BASHH: Standard 1

All staff involved with testing, providing results, treatment or PN must adhere to national and professional Guidelines concerning patient confidentiality:

- British Association for Sexual Health and HIV (2010) *Standards for the management of sexually transmitted infections (STIs)*¹
- Department of Health, Caldicott Committee (1997) *Report on the Review of Patient Identifiable Information*¹⁸.
- Department of Health (2000) *NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000*¹⁹.
- Department of Health (2003) *Confidentiality Code of Practice*²⁰.

7.3 Child protection

BASHH: Standard 3

In line with the BASHH standards

- Anyone under 16 who has a test should be assessed for Fraser competency (see section 3.3)¹
- Any cases of a child under 13 should be discussed with a nominated professional¹.
- It is recommended that all sexually active young people under 16 should have a risk assessment for sexual abuse of exploitation¹

7.4 Governance leads

BASHH: Standard 8

PCTs should ensure that there is a named governance lead for the programme, and that the NCSP is aware of this person and has their contact details

7.5 Information governance

BASHH: Standards 6 and 8

Programmes must ensure that the use of websites, e-mail and data storage within their local programme has been approved by their PCT Information Governance Leads and Caldicott Guardians. The confidentiality of patient information and contact details should be maintained at all times.

PCTs should consider copyrighting the information on their websites, and should ensure there are clear privacy statements in place. Where private companies facilitate internet testing they should be fully compliant with all NHS Information Governance procedures. Further information on copyrighting is available from the Centre Office of Information, at <http://coi.gov.uk/guidance.php?page=168>

7.6 Risk assessment

LCSSGs and Programme Leads are advised to incorporate risk assessment processes to their testing plans and monitoring. Areas to be covered may include:

- Staff cover in the event of sickness or other absence
- Security of data held and transferred between venues within the programme, this may include paper, electronic and faxed data
- That there are procedures in place to ensure that all young people tested receive their result, and if necessary, treatment and PN wherever possible
- Local procedures are documented and do not rely on individual staff members
- Continuity of service provision in the event of other emergency priorities within the NHS

7.7 Records management

Test request forms and treatment and PN notes must be retained in accordance with national and local guidelines²¹.

PCTs should have a records management policy authorised by Medical Records and Governance leads (and in some cases Caldicott Guardians and safeguarding leads). All GUM and sexual health records for people over 18 must be kept for a minimum of 10 years (both positive and negative) in either paper format or electronically by scanning original paper documents securely²¹. For clients under 18 records should be kept until their 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) .

The DH Code of Practice for records management is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747

7.8 Incident Reporting

Providers are responsible for their own governance, and for investigation and resolution of incidents in order to provide assurance of governance and safety, to prevent recurrence, improve services and share learning. Commissioning PCTs should have oversight of serious incidents, and should ensure that they are managed properly. The NCSP also asks to be informed about all serious incidents related to the programme, in order to share learning, ensure that incidents are properly investigated, and maintain an overview of any issues or problems surrounding the programme.

The full NCSP Incident Reporting Policy is available on the website (www.chlamydia-screening.nhs.uk). Further information is available in

- National Patient Safety Agency (2010) *National Framework for Reporting and Learning from Incidents Requiring Investigation*²²
- UK National Screening Committee, NHS Cancer Screening Programmes, National Patient Safety Agency (2010) *Managing Serious Incidents in National Screening Programmes*²³

IMPLICATIONS FOR COMMISSIONERS

- a) Quality Assurance should be an ongoing process. Audit requirements should be specified in the SLAs, and performance managed accordingly
- b) Guidelines for confidentiality and child protection should be in place at all centres, and there should be evidence of staff training and checks
- c) Commissioners should ensure that requirements for governance and accountability are explicit in contracts with providers
- d) Commissioners should ensure that all providers comply with national requirements in relation to the recording, collection, sharing and reporting of data
- e) All providers should be registered under the Data Protection Act and have a system in place to assess requests for research and audit data

8. Communications

BASHH: Standard 9

8.1 Promotion and marketing

Local programmes should be promoted in a way that is accessible to the target population. There are national resources available for programmes to use to promote screening locally: <http://www.chlamydia-screening.nhs.uk/ps/publications/marketing.html>

Programmes may also opt to supplement this with local promotion and marketing strategies. Commissioners should consider arranging this at a regional level in order to maximise value for money and impact.

Social marketing is increasingly being used by PCTs to ensure that marketing strategies are appropriate to the target population and effective. The National Social Marketing Centre has developed social marketing benchmark criteria: <http://www.nsmcentre.org.uk/>

When devising marketing materials and patient information PCTs must adhere to NHS branding requirements. Link: <http://www.nhsidentity.nhs.uk/>

8.2 User involvement

PCTs should involve users when designing or developing services. Examples of user involvement within local programmes include seeking feedback from young people on:

- The design and content of local patient information.
- The range and access of venues available locally for receiving treatment and initiating PN.
- Their experience of being offered the test.

IMPLICATIONS FOR COMMISSIONERS

- a) Commissioners and providers should engage with the public when developing their vision and plans to ensure that service provision is appropriate for and acceptable to young people
- b) Commissioners should consider regional or national marketing campaigns in order to save resources and make messages consistent and powerful
- c) Commissioners should ensure that the local communication strategy will support current and potential service users to access services

9. Data collection and IT

BASHH: Standard 6

9.1 Data collection

There are currently three electronic data returns managed by the NCSP. Two datasets collect information on testing outside of GUM clinics (the Core dataset and non NCSP non GUM dataset). The third collects information on patient treatment and partner management (the Patient and Partner Notification and Management dataset).

All data returns are electronic and reported quarterly. Data is entered or uploaded via the secure NCSP web based application. The link to the web based application and user manual are available at: <http://www.chlamydia-screening.nhs.uk/ps/data/it.html>

Programmes should notify the NCSP Information Management team of any changes to contact details for staff involved in submitting data so that users of the web based application can be managed appropriately.

It is likely in the near future that data systems will evolve to ensure comprehensive reporting of all chlamydia tests being done in England. Further information can be found in the Accompanying Information document, page 16.

9.2 Core Dataset

This dataset consists of disaggregate data on all tests done on young people under 25 years in sites registered with the programme. There are 14 data items in the core dataset, of which seven fields are mandatory and must be completed for each test in order for the test record to be successfully imported. These seven are outlined below:

- **Clinic ID (assigned via the web based application)**
- **Patient ID or NHS number**
- **Sex**
- **Date of birth**
- **Date of attendance**
- **Test result**

All core data should be collected as completely as possible for each young person. In consultation with NCSP, each local programme should decide on the mechanism used to collect the core dataset for each test performed, based on its current or expected capacities.

All core data reported to HPA should be thoroughly checked before submission to ensure that it meets the technical specifications (Accompanying Information document, page 18). A data quality questionnaire should be completed locally each quarter and submitted to the NCSP Information Management team to ensure all data quality issues have been followed up locally.

There should always be 14 columns for the core data set in exactly the order below;

Clinic Code	Patient ID	NHS No.	Sex	D.O.B	Post Code	Ethnicity	D.O.A	Reas for Test	Spec type	New SP	2 =< SP	Lab test	Result
		Please leave blank if not provided			If post code of residence is not provided please leave blank								

If any of the data items are not collected then please leave that field blank e.g. NHS number is not collected in your programme you will still need to include the NHS column.

The full post code of residence should be also be collected. (If people of no fixed abode are tested they should be encouraged to provide the postcode of their homeless shelter if available, otherwise a temporary shelter address should be offered). It is acceptable to leave out the last digit so that the test will be allocated to the correct PCT but will not map to the specific address.

It is not acceptable for staff to complete the postcode of the test venue instead of obtaining the young person's postcode. It is advised that staff complete missing or incomplete postcodes using the Royal Mail post code facility.

If it is not possible to obtain a postcode then the post code field should be left blank and the NCSP will attribute the post code of the testing venue.

Further background information on the core dataset is available in the Accompanying Information document, page 16.

Test request form

Information reported through the NCSP Core dataset may be collected using the NCSP test request form. A template form (which programmes may adapt) is available in the Accompanying Information document, page 20.

The form should be formatted to facilitate ease of patient self completion. It is recommended that the young person completes their own personal information and staff complete venue specific details.

Programmes should use a patient unique identifier and not a test unique identifier locally. Programmes changing IT providers should ensure that the same patient unique identifiers are used in the new system.

Programmes may also use a 'virtual test request form' or collect the core data through other means providing all required data items can be submitted to the NCSP.

9.3 Non NCSP non GUM data

The Non NCSP non GUM data return collects aggregate data on number of tests by PCT, sex, age group, and result from tests done on 15-24 year olds outside of GUM but not reported to the NCSP. All data should be sent to the NCSP Information Management team with a completed accompanying de-duplication questionnaire. Further details are available in the Accompanying Information document, page 16.

9.4 Patient management and partner follow up

The patient and partner notification and management (PPNM) data return is an aggregate return consisting of two parts. The first section focuses on treatment of all under 25 year olds who were tested through the programme and had a positive test result. The second section focuses on management and treatment of partners (all ages) reported in the first section. See Accompanying Information document, page 16.

Programmes should collate treatment and partner follow up information continuously through the care pathway from notification of positive results to the completion of partner therapy. Both young person confirmed and professional confirmed treatment are acceptable.

All PPNM data should be reported via the secure NCSP web based application.

9.5 Data management

The local programme is responsible for ensuring the quality of data collected and held locally.

Confidential data (i.e. 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 the NCSP Information Management team. No data may be disclosed to any other parties unless in aggregate form and with the agreement of those responsible for their provision.

For further information, and advice on additional confidentiality measures see the Accompanying Information document, page 17.

9.6 IT

Programmes are recommended to have electronic IT systems to facilitate collation and analysis of data. Examples of the IT systems used within the programme can be obtained from the NCSP Information Management Team.

When implementing or developing the IT system programmes are advised to consider:

- Confidentiality of data must be maintained
- There should be adequate support for system maintenance and staff training
- Scanning software can increase processing times
- A virtual test request form may be used, or data collected some other way providing the tests are undertaken under the NCSP and the core data items are collected and submitted

For further information contact the NCSP Information Management team (Ncspdata@hpa.org.uk).

IMPLICATIONS FOR COMMISSIONERS

- a) Commissioners should conduct audits to ensure the accuracy of data
- b) Commissioners should ensure that there is a secure link to upload data to the NCSP
- c) Commissioners should ensure that responsibilities for the submission of data are made clear in contracts

10. Evaluation

10.1 Local monitoring and evaluation

Programme monitoring and evaluation are key to the NCSP in order to assess the impact of testing and inform development of NCSP policy. Programmes are encouraged to routinely evaluate their testing initiatives in order to review their own testing plan and to share learning regionally and nationally.

The NCSP provides a template evaluation form which programmes are encouraged to complete and submit. All evaluations received feed into the development of NCSP guidance and policy.

Further details and the evaluation template are available at:
<http://www.chlamydia-screening.nhs.uk/ps/sharing/index.html>

The LCSSG is also advised to review the local testing plan at least annually to ensure the programme model and procedures remain fit for purpose.

IMPLICATIONS FOR COMMISSIONERS

- a) Commissioners should make monitoring and evaluation a key part of the SLA
- b) Commissioners should share good practice with the NCSP
- c) The local testing plan should be updated annually

11. Glossary and table of acronyms

Contact

Sexual contacts of a person found to have chlamydia (the 'index case') through testing.

Internet testing

A PCT based service enabling young people to order a postal test kit via a website.

Point of care test

A test offered to or accessed by a person that can be carried out onsite or at home, providing a rapid result without the need for laboratory processing.

Programme

A PCT or consortia of PCTs delivering the NCSP at a local level.

Non NCSP non GUM data

Data recording chlamydia tests outside of NCSP testing venues and GUM.

Test

A chlamydia test performed on a sexually active under 25 year old man or woman who accepts the offer if, or requests, a chlamydia test from a designated testing venue.

Testing venue

A provider service that has been appointed by the CSO to provide testing under the umbrella of the local programme. The venue may also provide results, treatment, and partner notification.

BASHH British Association for Sexual Health and HIV	NST National Support Team
CSO Chlamydia Screening Office	PBR Payment by results
DH The Department of Health	PCT Primary Care Trust/Organisation
GP General Practice	PGD Patient group direction
GUM Genitourinary medicine	PIL Patient information leaflet
HPA Health Protection Agency	PN Partner notification
LCSSG Local Chlamydia Screening Steering Group	POCT Point of care test
LES Local enhanced service	QA Quality assurance
MSM Men who have sex with men	SHA Strategic Health Authority
NAAT Nucleic acid amplification test	STI Sexually transmitted infection
NCSP National Chlamydia Screening Programme	WSW Women who have sex with women

12. Supporting Documents

BASHH Clinical Effectiveness Group. National Guidelines – consultations requiring sexual history-taking (2006).

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- ⁴ Department of Health. *The National Strategy for Sexual Health and HIV – Implementation Action Plan*. London: Department of Health, 2002.
- ⁵ Sexual Health Independent Advisory Group. *Progress and priorities – working together for high quality sexual health*. 2009.
- ⁶ BASHH Clinical Effectiveness Group. *UK National Guideline on the management of STIs and related conditions in children and young people*. 2009.
- ⁷ Department of Health. *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. 2004.
- ⁸ General Medical Council *0-18 Years: guidance for all doctors*. 2007.
- ⁹ BASHH Clinical Effectiveness Group. *National Guideline on the Diagnosis and Treatment of Gonorrhoea in Adults*. 2005.
- ¹⁰ Health Protection Agency. *Guidance for Gonorrhoea testing in England and Wales* 2010.
- ¹¹ BASHH *Chlamydia Trachomatis Screening and Testing Draft Guidelines*. 2010.
- ¹² BASHH Clinical Effectiveness Group. *UK National Guideline for the Management of Genital Tract Infection with Chlamydia trachomatis*. 2006.
- ¹³ CPA accredited laboratories. (Available at www.cpa-uk.co.uk)
- ¹⁴ Health Protection Agency *Chlamydia trachomatis Infection – Testing by Nucleic Acid Amplification Tests (NAATs)*. 2008
- ¹⁵ Society of Sexual Health Advisors. *The SSHA manual for sexual health advisors*. 2004
- ¹⁶ Trelle S et al. *Improved effectiveness of partner notification for patients with sexually transmitted infections: systematic review* *BMJ* 2007; 334 (7589):354
- ¹⁷ National Chlamydia Screening Programmes. *Guidance for commissioners on the cost of providing chlamydia screening in primary care and the community: a review of costs in practice across England in 2009*. 2009
- ¹⁸ Department of Health, Caldicott Committee *Report on the Review of Patient Identifiable Information*. 1997.
- ¹⁹ Department of Health *NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000*. 2000.
- ²⁰ Department of Health *Confidentiality Code of Practice*. 2003.
- ²¹ Department of Health. *Records Management: NHS Code of Practice*. 2006.
- ²² National Patient Safety Agency *National Framework for Reporting and Learning from Incidents Requiring Investigation*. 2010.
- ²³ UK National Screening Committee, NHS Cancer Screening Programmes, National Patient Safety Agency *Managing Serious Incidents in National Screening Programmes*. 2010.

Amendments

Following review in August 2010, sections in the Accompanying Information document were updated. As such this main document was amended to keep consistency.

- Removal of the following text on p17 “A check list for use when contracting laboratories is available in the Accompanying Information document, page 11-13”. This check list was removed
- Page numbers relating to the Accompanying Information document have been updated