



23 May 2008

Gateway: 9952

To: SHA Chief Executives

Dear Colleagues

### **Monitoring the uptake of chlamydia screening - Vital Signs indicator 2008/09**

This letter sets out how local performance of chlamydia screening will be monitored and how the chlamydia 'Vital Signs' indicator will be measured in 2008/09. As set out in the technical note to support the Vital Signs Indicator, from April this year **all** chlamydia screens/tests undertaken outside of genitourinary medicine clinics (GUM) on 15-24 year olds will count towards calculating screening coverage in residents of each Primary Care Trust (PCT) (see attached Technical Annex).

When monitoring the 2007/08 LDP target, only screens recorded on National Chlamydia Screening Programme (NCSP) forms were included. Following feedback from PCTs indicating that many other community-based screens/tests for chlamydia than was reported to the NCSP are occurring, a survey of laboratories was undertaken. This has shown a substantial amount of chlamydia testing of young adults also taking place outside of GUM clinics that is not recorded within the programme. The importance of identifying all non-GUM screening/testing is recognised and this testing will now count towards the measurement of the Vital Signs performance indicator. Some regions and areas have already undertaken work in this area and are already able to identify non-GUM, non-NCSP testing and screening by PCT. Case studies on how this work was carried out will be circulated to support others.

Whilst this non-NCSP activity will make an important contribution to screening/testing uptake in the target age group at present, the longer term strategy is that as the NCSP rollout continues many of these testing sites will be incorporated into the programme. Increased screening volumes by the NCSP is essential if the 2008/09 Vital Signs target of screening 17% of the target population is to be achieved.

Guidance on removing duplicate reports is provided in the Technical Annex. PCTs should make arrangements to capture aggregate data on these other screens/tests where an NCSP approved form has **not** been used. Quarterly reporting of aggregate data on other chlamydia tests should be in place in all areas by the third quarter of 2008/09.

National data will continue to be collated by the Health Protection Agency, which will issue quarterly progress reports that distinguish NCSP screens from other chlamydia screens/tests. The HPA will also produce data by local authority area for the Local Government Indicator Set. Tests undertaken at GUM clinics will be monitored separately through the new clinical activity data set ([NHS Dataset Change Notice \(DSCN\), reference DSCN 04/2008](#)).

The NCSP aims to control chlamydia infection in young adults through opportunistic screening of sexually active under-25 year olds in a variety of healthcare and non-healthcare settings, at least annually. It is estimated that for chlamydia transmission to fall in this population, the screening/testing rate (including tests at GUM clinics) must be sustained above 35%, together with effective partner notification and management. The 2008/09 Vital Signs target of 17% uptake is a milestone towards higher uptake in subsequent years. Local Chlamydia Screening Offices should continue to work at engaging services and sites throughout PCTs with chlamydia screening, and at ensuring that both a co-ordinated care pathway for those testing positive and partner notification arrangements are in place.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alan Hall', written in a cursive style.

**Alan Hall**  
**Director of Performance**

cc: SHA Directors of Performance

## Technical Annex:

### Monitoring the uptake of chlamydia screening Vital Signs indicator 2008/09

The Department Health has commissioned the National Chlamydia Screening Programme (NCSP) to collate **all** data on chlamydia screening/testing of 15-24 year olds in the community to monitor the Vital Signs indicator Chlamydia Prevalence (2008/9 to 2010/11). For the first year of the Vital Signs indicator, the emphasis is on counting and increasing all community testing. In the following years all community data will count along with GUM tests in monitoring progress towards reducing chlamydia prevalence in each PCT.

This section outlines briefly the mechanisms for collecting chlamydia screening/testing in the community not currently counted through the NCSP Core data set.

Mechanisms for collecting all chlamydia screens/tests by PCT of the patient include:

- 1) 'NCSP' approved test request forms (for which disaggregate data will be collated in the usual way),
- 2) Aggregate data from Community or Primary Care settings,
- 3) Aggregate data from Laboratory Information Management Systems

It is a matter for PCTs working with Local Chlamydia Co-coordinators to decide the best mechanism for collecting this data and to identify and collate data from all settings undertaking chlamydia screening/testing and this data will be returned to the National Chlamydia Screening Programme.

Aggregated data will be returned to the NCSP on a voluntary basis and all data collected will be counted towards PCT's Chlamydia Vital Signs indicator. Validation the aggregated data will be done by the HPA.

It is important that duplicate reports **within** data sources and overlapping reports **between** data sources be removed (currently done within the 'NCSP' core data set).

#### Data collection and collation

##### **1 –'NCSP' approved test request forms (for which disaggregate data will be collated in the usual way).**

All data for a programme area will be compiled via the Chlamydia Screening Office (CSO) and sent to the HPA. All data collected via this route should have the minimum data set collected within the NCSP Core data set (in a CSV or text file format) and be consented for inclusion in the NCSP via the patient consent leaflet (for more details see [www.chlamydia-screening.nhs.uk](http://www.chlamydia-screening.nhs.uk)).

Table 1 outlines the variables that are collected within the NCSP Core data set. All items in bold are compulsory and a screen/test without one or more of these items will be rejected by the HPA.

**Table 1: Core data items**

Demographics	Testing items	Risk factors
<b>1. Clinic ID code (assigned by HPA)</b> <b>2. Patient unique ID number)</b> <u>OR</u> <b>3. NHS number</b> <b>3. Sex</b> <b>4. Date of birth</b> 5. Postcode of residence	7. Ethnicity <b>8. Date of attendance</b> 9. Reason(s) for test 10. Specimen type 11. Type of laboratory test <b>12. Chlamydia test result</b>	13. New sexual partner in last 3 months 14. Two or more sexual partners in last 12 months

Standardised de-duplication of reports will be undertaken by the HPA before summary information is published.

## **2 – Aggregate local Community or Primary Care Information Management Systems:**

Community and primary care providers carrying out chlamydia screens/tests not currently completed on an NCSP approved test request form are invited to report aggregate data to their respective CSO who will then forward the data to the HPA (see Table 1), after removing duplicate records.

The minimum data required to count towards the NCSP is the number of chlamydia screens/tests by PCT of residence of the patient with a separate breakdown on the number of positive cases of chlamydia for 15-24 year olds

**Table 1: Minimum data collection template to be used: Provider X**

PCT of residence	*Sex	*Age group (years)	Number of screens/tests	Number of positives
PCT X	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total**	15-19		
		20-24		
PCT Y	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total**	15-19		
		20-24		

*(\* Please Note that Sex and Age Group breakdown are not part of the minimum data set necessary to measure the indicator. However it is advisable to return this data if available to ensure adequate monitoring of target populations)*

**\*\*Total includes those with unknown or unspecified sex. Therefore, male + female will not necessarily equate to total.**

### **3 – Aggregate data from Laboratory Information Management Systems:**

Alternatively, aggregate data of chlamydia screens/tests undertaken may be reported by laboratories following exclusion of screens/tests reported on NCSP approved forms, and at GUM clinics. Once duplicates and overlapping records have been removed, data may be reported to the respective CSO on a six monthly basis in the format outlined in Table 2 below. The CSO will then forward the data to the HPA where it will be compiled and formatted accordingly.

#### **Removing Duplicate Reports of Chlamydia Screens/tests**

Removing duplicate reports **within** one data source:

For multiple records of a chlamydia screen/test **for the same patient within the same service within a seven day continuous period**, the duplicate record should be removed and a single test retained.

Duplicates are defined where records match according to patient identification, sex, date of birth, service or clinic with date of attendance within seven days.

If the test results of duplicate reports are different and the date of attendance of each is within seven days, the positive result should be retained.

Removing overlapping (duplicate ) reports **between** data sources

To prevent the counting of duplicates screen/tests between services when reporting aggregate data to the NCSP (most likely through laboratory data) , then NCSP reporting data and GUM data should be identified and excluded from aggregated data returned to the NCSP

Aggregate data based on screens/tests not recorded on an NCSP approved form will be accepted if reasonable efforts have been made to remove duplicate reports within the data source and screens/tests reported do **not** overlap either with screens/tests performed and recorded on NCSP approved forms or with screens/tests performed within local GUM clinics.

One method that may be helpful in identifying overlapping reports is to keep a simple local database of all chlamydia screening sites and the primary method of reporting their data to the NCSP, and whether the site refers patients elsewhere for treatment (including the name of the referred to site). This will allow for adjustment in the number of screens where patients are tested at multiple sites and help the NCSP in estimating a measure of duplication for each PCT.

**Table 2: Sample data collection template for aggregate laboratory reporting**

<b>Service type: General Practice</b>				
<b>PCT of residence</b>	<b>*Sex</b>	<b>*Age group (years)</b>	<b>Number of screens/tests</b>	<b>Number of positives</b>
PCT X	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total*	15-19		
		20-24		
PCT Y	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total**	15-19		
		20-24		
<b>Service type: Community contraceptive service</b>				
<b>PCT of residence</b>	<b>*Sex</b>	<b>*Age group (years)</b>	<b>Number of screens/tests</b>	<b>Number of positives</b>
PCT X	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total**	15-19		
		20-24		
PCT Y	Male	15-19		
		20-24		
	Female	15-19		
		20-24		
	Total*	15-19		
		20-24		

*(\* Please Note that Sex and Age Group breakdown are not part of the minimum data set necessary to measure the LDP. However it is advisable to return this data if available to ensure adequate monitoring of target populations)*

**\*\*Total includes those with unknown or unspecified sex. Therefore, male + female will not necessarily equate to total.**