

# National Chlamydia Screening Programme Outreach Guidance

*Recommendations for NHS commissioning organisations considering  
outreach testing*



## National Chlamydia Screening Programme (NCSP) recommendations for NHS commissioning organisations considering outreach testing

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The following guidance combines experience from NCSP implementation, analysis of NCSP data and highlights from the published literature.

The NCSP recommends that local NHS organisations base local testing within existing core services (general practice, pharmacy, sexual and reproductive health clinics, GUM and termination of pregnancy clinics).

However, in cases where outreach testing is deemed necessary after careful consideration, it should be targeted to hard-to-reach groups that have limited access to sexual health services, based on local needs assessment, and built into wider health initiatives in order to provide value and sustainability.

## 1. Introduction

### Definition of outreach

Although there is no single definition of outreach in the literature, for the purpose of consistency, the NCSP is using the following:

***Outreach testing can be defined as a community oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health channels.\****

Outreach testing may involve NHS staff taking the testing service to a different location for a limited time. Commissioners may also contract external organisations to offer tests in non-healthcare settings on behalf of the local programme.

Certain testing locations, such as schools, may be classed as outreach in some circumstances but not others. For example, a school with an established sexual health service (e.g. a nurse who routinely offers tests to the target population within the school) is not classified as performing outreach testing. However, clinical or non-clinical staff visiting the school for ad-hoc sessions which include the offering of tests, may be classed as outreach.

In the NCSP remote testing is not considered as outreach.

Consistent, high quality practice across all screening venues is fundamental to the success of the NCSP in achieving its aim of preventing and controlling chlamydia infection.

The NCSP recommends that local NHS organisations base local testing within existing core services (general practice, pharmacy, sexual and reproductive health clinics, GUM and termination of pregnancy clinics). This has proven to be the most cost effective way of reaching young people and of diagnosing and treating Chlamydia infections: [NCSP Recommendations on Costings for Chlamydia Screening](#)

Outreach activity in the NCSP to date has shown to be an approach that does not provide value for money, is relatively ineffective in identifying infections and has a higher rate of reported serious incidents compared with other settings. However, there are circumstances where carefully considered outreach testing, based on a local needs assessment, may help reach groups of young people who may otherwise not access testing.

This document has been developed as a guide for local NHS organisations whose needs assessments recognise outreach as the most appropriate intervention to target their most at risk and hard to reach young people who are not accessing testing in traditional healthcare settings.

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\* Effective Interventions Unit, Substance Misuse Division, Scottish Executive, St. Andrew's House, Edinburgh EH1 3D, citing Hartnoll (1990):

## 2. Potential pitfalls of outreach testing

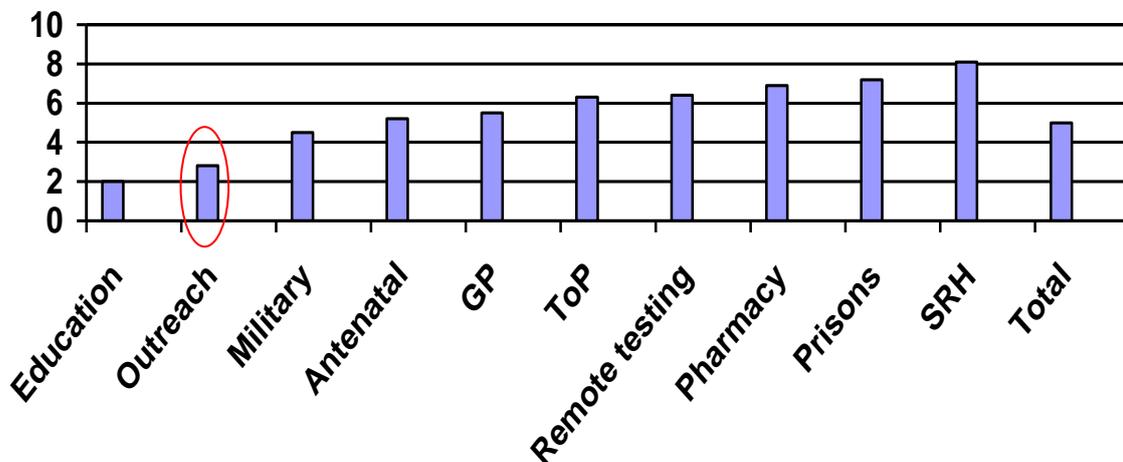
### 2.1 Identifying and treating chlamydia infections in young people

Compared to other settings outreach testing has resulted in a relatively low percentage found to be infected. Many outreach initiatives have not been targeted at hard-to-reach groups or those most at risk.

Research in the UK and internationally shows that some testing in non-clinical venues is feasible and could add to existing screening in healthcare venues. (Morris 2010; Kang 2010; Johnson 2010; Rietmeijer 2008). However, it finds a low uptake (Sacks-Davis R, 2010), poor return rates for kit distribution through outreach (Rose SB, 2010, Austr.), and very low proportions of people infected compared to other settings (Henricus E, 2010). Commissioners should therefore consider the potential value of any outreach activity carefully.

The number of NCSP tests performed via outreach in 2010/11 was **326,059** (19 per cent of all tests). NCSP data also shows that the overall percentage found to be infected through outreach testing was lower in comparison to other services (**2.8** per cent percent infected in outreach compared to 5 per cent for all tests). This suggests that outreach testing is not generally an effective means to identify those at high risk of infection.

Percentage infected by setting 2010/11



### 2.2 Value for money and sustainability

At a time when budgets are already extremely tight, outreach testing initiatives may require separate funding streams and are therefore vulnerable.

Some outreach programmes have tested thousands of young people with only a few infections identified, leading to high costs per infection identified. In order to

diagnose and treat as many infections as possible, programmes need to target resources to settings where testing is more likely to identify infections.

The National Audit Office report ([link](#)) highlighted that local NHS organisations have to focus on delivering the programme in a more cost effective way, and outreach testing must link to other initiatives and become more sustainable.

### 2.3 Quality assurance

A significant proportion of serious incidents (SIs) reported to the NCSP have involved outreach testing and some common themes and learning points have emerged. The SIs include a number of governance issues relating to contracted providers and complaints about the way young people have been approached by outreach staff. For example:

- Allegations that young people were coerced into taking the test
- Allegations that tests were taken in unsuitable locations and initiated by staff without visible ID
- Allegations of false data and/or of multiple tests being taken by test initiators

Learning points from these incidents have been incorporated in this guidance and [NCSP lessons learnt reports](#) are available on the NCSP website. Reports summarising SIs reported to the NCSP are available at: [NCSP Serious Incidents](#).

The NCSP conducts regular audits to support continual monitoring and service improvement. During March and April 2011 the NCSP surveyed outreach testing practices for testing that took place during 2010/11 ([QA audits](#)). The survey was undertaken to address several issues that arose from analysis of SIs.

**According to the NCSP outreach survey (March 2011):**

**Only 70 of all 127 responding PCTs regularly reviewed their existing outreach contracts during 2010/11.**

**47 out of 127 responding PCTs did not specify in contracts that any serious incidents that occur in relation to outreach testing must be reported to the PCT.**

Review of data and of serious incidents reported to the NCSP suggests that in some cases outreach has been undertaken primarily to quickly maximise testing coverage in response to targets, at the expense of quality. Some initiatives also involved offering disproportionate or inappropriate incentives to young people such as providing vouchers or paying young people to recruit friends, which the NCSP advises against.

[The NCSP Core Requirements](#) include a set of quality standards that local programmes should meet and which should be monitored. The NCSP also has example key performance indicators (KPIs) for a provider contract, available from NCSP programme facilitators.

### 3. Good practice – Ensuring outreach testing is effective

In this section, we set out key requirements that apply to outreach testing and provide good practice examples from across the country. These have been developed from a combination of NCSP data, literature review and good practice collated by NCSP Facilitators.

#### 3.1 Legal requirements

Contracts with outreach providers or local policies and procedures must ensure that:

- Patient information is provided to all clients prior to taking the test.
- Consent is obtained from all clients prior to taking the test (i.e. the young person has been given the NCSP information leaflet and had time to read and understand it, a sample has been provided, and they have competence to consent).
- Fraser competence is assessed in line with local protocols and national guidance if under 16s are offered the test.
- All staff are Criminal Records Bureau checked.

Additionally, requirements for the safe handling of samples must be referred to. ([Safe handling](#))

#### 3.2 Managing contracts and ensuring sustainability

Commissioners should review lessons learnt from incidents reported to the NCSP both when preparing contracts with third party organisations, and when considering outreach initiatives delivered by in-house staff [NCSP lessons learnt](#).

Outreach testing should be commissioned through a well defined service level agreement (SLA), detailing how testing should be implemented. Avoid 'payment per test' arrangements.

Contracts should ensure that all staff involved in offering the test have been trained with regard to local and national procedures and requirements, and in terms of how data is managed including local checks to detect any falsified tests. All training should be documented and regularly updated. Staff references should be followed up.

All staff involved in outreach testing should be made aware of the responsibility to be accurate, honest and work within the NCSP guidelines. The impact of falsifying data and the legal consequences should be explained. Staff should work in pairs and wear ID that links them to their organisation. Tests should only be offered in appropriate locations with suitable toilet facilities nearby.

To ensure that young people can be contacted to receive their result, and to provide treatment and partner notification (PN) as necessary, staff should ensure test forms are completed as fully as possible. This includes ensuring that mobile numbers have 11 digits and seeking a second method of contact where possible. Staff should not pre complete the form.

Consider asking test initiators to initial test forms so that tracing can take place if necessary.

A record of training given to staff who will be undertaking outreach testing should be kept.

**Out of 127 PCTs that responded to the 2011 QA outreach survey**

**80 had contracts specifying that all outreach staff received training specific to the national and local programme prior to offering tests**

**57 PCTs had training covering fraud and required their staff to wear an ID badge.**

Where third party organisations may be involved in providing treatment they must be registered with the Care Quality Commission (CQC). For more information please see the [NCSP position statement](#) on how CQC registration impacts providers.

Outreach work should be planned at the onset of the year as part of the trajectory for the full year, rather than as a measure to make up testing numbers at year-end.

Clear KPIs should be built into contracts. The NCSP has example KPIs for a provider contract, available from your NCSP programme facilitator. Contracts should be reviewed annually, and performance against work plans closely monitored at least on a quarterly basis to ensure requirements are being met and that the initiative is delivering in terms of positive cases identified and value for money.

Building testing into existing sexual health services will build capacity and offer a service that is more likely to foster change in the behaviour of young people.

#### **Partnership working to maximise effectiveness**

NHS Lincolnshire commissioned a third sector provider to provide an outreach service for chlamydia screening towards the end of 2009. From the start, the third sector provider's core team was based within the chlamydia team, in order to maximise a collaborative approach. Close working encouraged a culture of sorting issues out as they arose, ensuring staff got to know each others roles and everyone knew what everyone else was doing. Planning meetings were held regularly and day-to-day conversations took place, which wouldn't have been the case if the teams were in separate buildings. Incidents were dealt with jointly and learning points disseminated.

**Contact NCSP service development lead Jozef Bartovic for more details.**

### **3.3 Key principles**

The key principles underlying any intervention in a non-clinical venue should be:

- **Easy access** – for those who can't access sexual health services or would normally not choose to access services.

- **Respond to local needs** – any community-based intervention needs to respond to local needs assessment and feedback from young people.
- **Integration** – chlamydia testing should be offered as a part of wider sexual health promotion or as part of a general young peoples' health offer.
- **Value for money** –With the proposed new diagnosis rate indicator programmes will have to focus on finding and treating infections, rather than just population coverage (an acceptable range for the percentage infected amongst those tested is 6 to 7 per cent, please see [NCSP FAQ document](#) on diagnosis).

The case studies in this document demonstrate how outreach testing has been used to identify significant numbers of infections, and increase access in areas where certain populations may not otherwise access sexual health services.

### 3.3.1. Involving young people and responding to their needs

Participation of young people and relevant patient groups in the planning and design of interventions such as outreach is key in order for policies and service design to reflect patients' needs and preferences, and lead to a more effective healthcare system.

The NCSP recommends that if local NHS organisations are considering an outreach initiative, they involve young people in the design, planning and delivery, or require the provider to demonstrate how they have or will do so.

#### *Integrated sexual health outreach to provide wider sexual health provision and promotion*

In summer 2008, North East Lincolnshire Care Trust Plus (CTP) invited local clinical providers to deliver an outreach contraceptive and sexual health service to 'hard-to-reach' and vulnerable young people under 25. This initiative aimed to impact the problem of rising teenage conceptions.

To evaluate young peoples' needs, the sexual health outreach team SHOUT worked with a number of agencies including Teen Parenting Team, CSH, TOPs Follow Up Clinic, Grimsby Institute of Further and Higher Education, YMCA, Women's Refuge and Young Mums Group and other local organisations.

The SHOUT team offers advice and support on all aspects of contraception and sexual health. SHOUT also offers pregnancy testing and referral into the midwifery and termination services. The team also provides a rolling programme of sexual health educational sessions to groups of young people.

SHOUT has been successful in targeting the most hard-to-reach and vulnerable members of their local population. The ability to work with clients on a 1:1 basis and to provide rapid and responsive home visits has been a key factor in this success. From November 2009, SHOUT has seen 846 clients and fitted 301 LARC devices (all other clients are provided with contraception). On average, the team performed 15 chlamydia tests per month finding 15% of those tested to be infected.

To measure the impact of SHOUT and provide more details about the needs of partner agencies and young people locally, a comprehensive needs assessment of local population is being conducted by the young people consultation worker.

**Contact NCSP facilitator Sharron Ainslie for more details.**

### 3.3.2 Targeting hard-to-reach groups

Outreach has to be targeted specifically at those hard-to-reach groups who have limited access to sexual health, for example, homeless young people, looked after young people, vulnerable people and those leaving care and sex workers or where young people don't have a way into open access sexual health services. The key aim of setting up an outreach initiative should be to respond to an unmet need, rather than simply trying to maximise testing numbers.

#### Research Highlights

##### Homeless adolescents

*Van Leeuwen 2002, USA*, found that chlamydia and gonorrhoea urine testing could be incorporated into existing outreach programmes for homeless youths, with a high percentage of those tested being found to be infected (12%).

*Solorio et al 2006, USA*, identified homeless as a high risk group for Chlamydia infection with 46% of girls in the study found to be infected for an STI and 9% of boys.

*Henning et al 2007, Australia* (interviews with homeless young people), reported a poor knowledge of chlamydia and barriers to being screened. The study recommends culturally-specific education and health promotion programmes.

*Debattista et al 2002, USA*, suggested street outreach activities needed to be brief, gender focused, specific to their needs and accessible.

##### Commercial Sex Workers (CSW)

*Macaulay et al 2009, UK*, evaluated chlamydia and gonorrhoea testing within an existing outreach service for CSW. Most of this group of women were knowledgeable about sexual health and were already having regular check-ups, but a significant minority did not know how to access STI care. Offering STI testing via outreach was feasible and cost effective.

##### Injecting drug users (IDUs)

*Bradshaw et al 2005, Australia*. Street outreach workers targeted IDUs, offering testing for range of STIs. High rates of STIs were identified; 6% of those tested had chlamydia infection.

##### Men who have sex with men (MSM)

MSM STI testing in a sauna found high rate of STIs (37%). Sauna as an acceptable setting for screening. (*Arumainayagam et al 2009, UK*.)

*Currie et al 2006, Australia*. MSM identified as high risk group for Gonorrhoea and Chlamydia.

*Lister et al 2005, Australia*. Demonstrated feasibility of outreach STI testing clinic in male sauna. High prevalence of STI.

### 3.3.3 Integration with wider health initiatives

Combining with other aspects of sexual health and / or with wider health needs of young people makes both practical and economic sense. A whole system approach to young peoples' health is the optimal model to prevent disease or improve health. For example, links between alcohol consumption and risk taking sexual behaviour have been well documented and using this knowledge in designing outreach

interventions in many programme areas has proven to be very effective. For example if outreach is used to access young men, additional health promotion that could go alongside with chlamydia testing should be considered; likewise integration with SRE (sex and relationships education) sessions can be a particularly effective way of accessing young people in education settings in combination with offering SRE and health promotion.

**Integrated sexual health provision to provide a sustainable service in the East Midlands**

The service provides an integrated and peer-led approach to chlamydia screening, offering this as a part of a wider package of sexual health education and awareness.

The peer education programme is an established outreach initiative that provides sexual health education, information, campaigns and resources to young people aged 15 to 25. Chlamydia screening was introduced as part of this programme in 2008 and is seen as a practical application of sexual health promotion in addition to the existing programme, rather than as a stand-alone activity.

Using the peer-led model has proven successful in breaking down barriers to accessing screening, supporting young people to see this as a normal part of their health and wellbeing. Young people acting as peer educators in Derbyshire are provided with in-depth sexual health training across a wide variety of subjects including chlamydia, thereby allowing them to interact with young people across a range of issues in order to meet their needs.

To ensure quality, the service has clear procedures and protocols for each outreach session. This ensures that clients, workers and the organisation are all protected. Close relationships with the chlamydia co-ordinator and commissioner are key to successful delivery of the programme.

From the start of the scheme, the Service has delivered a total of 16,870 tests and the percentage infected for chlamydia tests done through this service was above national average for outreach.

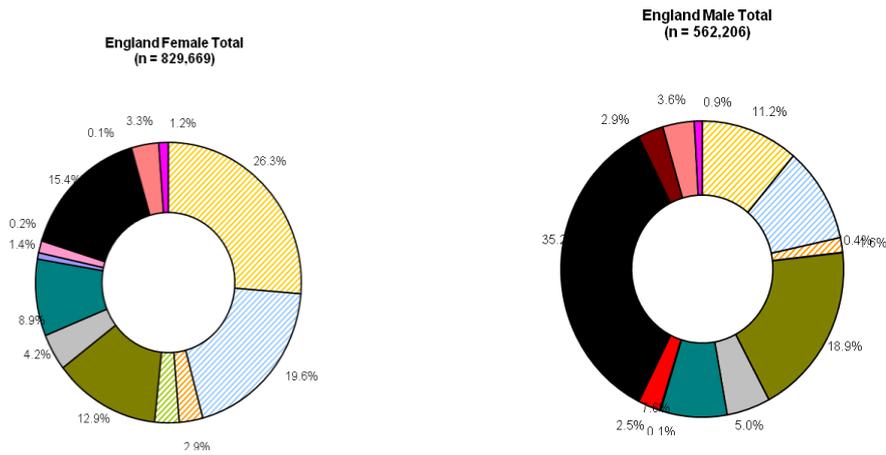
***Contact NCSP service development lead Jozef Bartovic for more details.***

### **3.3.4. Improving access: testing men**

NCSP data shows that a significant proportion of men continue to access testing through outreach. Although the percentage infected is still low, tests performed in outreach account for 35 percent of all male tests (more than 197,000 tests in total) and outreach is considered as an acceptable setting for many young men. If local NHS organisations are struggling to reach men through other settings, they may consider outreach as a means to offer testing to young men.

NCSP 2010/11 data shows that:

- More than 50 percent of females accessed testing through core services while only 15 percent were tested through outreach
- Only 25 per cent of males tests were through core services while more than 35 per cent used outreach to access testing.



**NCSP venues by sex, 2010/11, outreach in black**

Research highlights:

- Two linked studies from Glasgow found testing in non-clinical settings to vary by gender, with men demonstrating a higher acceptance than women (Lorimer 2009a, 2009b).
- Department of Health commissioned outreach guidance based on an outreach clinic set up to target men under 25 in an area with high rates of STIs. This showed there was 98 per cent chlamydia and gonorrhoea test uptake and high percentage infected with chlamydia (12 per cent). (*Lewis et al 2004, England*). [Sexual health outreach, why, what and how](#)

**Third sector provider of community based chlamydia outreach in Oldham and Salford**

In Oldham and Salford, a third sector provider was commissioned to take chlamydia screening services out to young people in the community. This was a response to high rates of chlamydia, and particular groups of young people (for example young men) who were less likely to visit sexual health services. Taking services to this group of young people meant that the programme could reach young people who would not otherwise have been screened.

In Oldham, a 'themed shop' was opened in the town centre on a quarterly basis to provide screening and sexual health promotion. This approach was very successful. Outreach staff were located in the town centre, but were also linked in with local community events and campaigns.

The aim was to create awareness of chlamydia and how easy it is to test and treat, as well as raising awareness of local sexual health services. It also helped to remove some of the stigma around testing - making young people feel more comfortable about being tested and more likely to visit a sexual health service in the future.

In Oldham, 898 young people were screened between July 2010 and June 2011, with a percentage infected of around 7%. This has been primarily due to the success of the themed shop. A significantly higher proportion of young men attended, with an increased uptake among young Asian men.

In Salford, 402 people were screened by outreach from April 2010 to March 2011, with percentage infected of 4.5%.

**Contact NCSP facilitator Patrick Lenehan for more details.**

## Improving NCSP outreach interventions: Top ten tips for commissioners

The NCSP recommends that commissioners base local testing within existing core services (general practice, pharmacy, sexual and reproductive health clinics, GUM and termination of pregnancy clinics). This has proven to be the most cost effective way of reaching young people and identifying chlamydia infection.

The NCSP experience has shown that, in general, outreach testing does not provide value for money, is not effective in identifying infections and has a higher rate of serious incidents compared to other settings. However, carefully considered outreach testing, based on a local needs assessment, may help reach groups of young people who may otherwise not access testing, for example, homeless, commercial sex workers, injecting drug users or looked after young people.

Commissioners contracting outreach organisations to offer the test to young people should consider the following:

- 1. Needs assessment** – in order to be effective, outreach testing has to be targeted specifically for hard-to-reach groups with limited access to sexual health services, and those who choose not to access mainstream services. Ensure any outreach initiative responds to your local needs assessment.
- 2. Value for Money** – consider how your outreach activity can be located and targeted in order to maximise your impact in terms of identifying infections and providing access to testing and other services.
- 3. Sustainability** - plan outreach work at the onset of the year as part of the trajectory for the full year, rather than as a measure to make up number of tests at year-end. Use the outreach initiative as a driver to build links with partner organisations and look for ways to embed testing into existing services.
- 4. Integration** – build chlamydia testing into wider outreach initiatives by offering the test alongside other sexual health testing, education, sign posting and health promotion to offer a comprehensive holistic service.
- 5. Training** - a significant proportion of serious incidents linked to outreach and reported to the NCSP are a result of poor or inadequate training. Training of staff performing outreach work is essential. Training records for all staff must be maintained.
- 6. Contracts** – ensure the contract or service level agreement with your provider is robust and monitor performance regularly. The NCSP has example KPIs for a provider contract, available from your NCSP programme facilitator. The performance management process needs to be built in to your local programme work plan and take place at least quarterly. Contracts should be reviewed regularly.
- 7. Legal requirements** – contracts or local policies and procedures must ensure that staff CRB checks have taken place, provision of patient information, consent, and Fraser competence assessment (where testing is offered to under 16s).
- 8. Safe handling of samples** – contracts or local policies and procedures should refer to regulations for safe handling of samples in the contract ([link](#))
- 9. Consult young people** – engaging young people to help you in developing and delivering outreach to the targeted population is vital to a successful initiative.

**10. Take advantage of shared learning** - work with the NCSP team and your NCSP Facilitator to determine whether outreach testing is appropriate in your area. Review lessons learnt reports from the serious incidents relating to outreach testing that have been reported to NCSP team ([link](#)).