Department of Health


Evaluation of Public and Professional views

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1. Summary Of Main Findings

1.1 Introduction
This report summarises the overall key findings from all stages of independent qualitative and quantitative research with the general public, the screened population and professionals involved in the Chlamydia Screening Pilots in Portsmouth and the Wirral. The research was conducted by University of Liverpool, with NOP and Conway Smith Rose. Summary reports (including full details of the research approach) for each of these groups are appended.

1.2 Awareness of chlamydia
The general level of awareness held by those targeted for opportunistic screening is integral to the success of an initiative such as this one. Opportunistic screening for Chlamydia was launched at a time when roughly half of the general population were aware of Chlamydia as a condition. The target populations in the Wirral and in Portsmouth had broadly similar levels of awareness as the general population before the pilot screening actually began. However, it was clear that as the pilot initiative was rolled out the general level of awareness of chlamydia increased beyond that demonstrated in the general population sample. Once the pilot had begun, approximately three quarters of the target group in the Wirral and Portsmouth were aware of Chlamydia compared with just over half of the general population sample. The operation of the pilot screening therefore had a clear effect on the levels of awareness of Chlamydia in the target population of 16-24 year olds. Perhaps because of the focus of screening on women, it is not surprising that twice as many women as men had heard of this initiative.

There can be no doubt that the urine test for Chlamydia was found to be universally acceptable from the start of the pilot initiative. Once individuals had been given the information about Chlamydia and the potential consequences of an infection, the simplicity of the urine test enabled people to accept the test and to encourage their friends to take the test. Perhaps paradoxically, accepting the test did not reflect a detailed understanding of the consequences of receiving a positive test result.

All professionals involved in the screening initiative considered Chlamydia to be an important public health issue. Over the course of the pilot (between waves one and two of data collection) the proportion who considered it very important rose from 55 to 65 per cent. Nine out of ten respondents in the survey considered Chlamydia screening important because of the impact on health.

As with all new pilot initiatives health professionals identified particular teething problems with the implementation of the opportunistic screening model. Just over half of professionals had experienced some problems in the first few months although most of
these difficulties were resolved quite quickly and by the end of the initiative the majority of these problems had been resolved.

Ongoing problems included comments that the screening process was time-consuming and that staff forgot to give young people the forms.

At the beginning of the pilot over three-quarters of professionals surveyed reported enthusiasm about being involved in the pilot. Of those who were less enthusiastic (almost a fifth) receptionists represented the single most important group (half of all receptionists surveyed). The majority (89%) of those people not enthusiastic from the outset had concerns about the amount of extra work involved. Almost one quarter (mainly receptionists in the Wirral) worried about discussing Chlamydia with patients and around one fifth had concerns about whether they would be able to answer patient queries.

In reality, half of the professionals in the self-completion survey said the workload was very much as they had anticipated. Only a minority of professionals at both waves (about a sixth) said their workload had increased a lot. Doctors were least likely to report an impact on workload. Very few clinics said they employed more staff to cope with the pilot.

1.3 The opportunistic model of screening
While the quantitative survey revealed widespread satisfaction with the opportunistic screening model, the detailed qualitative interviews revealed problems with particular aspects of the process. We do not have the data to quantify the extent to which these concerns are representative of all those screened in the pilot. However, the views elicited from the qualitative interviews with the screened population and the professionals operating the screening initiative revealed common concerns with the process.

1.3.1 Screening in the community
There were particular problems arising from the reliance in the opportunistic model in General Practice on receptionists. Receptionists were centrally involved in the identification of young people for screening and for handing out information about the screening initiative. The fundamental problem arising from their involvement related to the public space within which receptionists operate.

The pilot initiative model required receptionists merely to hand out information to those young people who were identified as being in the target age range. The model did not require receptionists to talk to the young people about the test or their decision to have the test. However, there were many instances in which the young people themselves (and/or their accompanying parent) asked receptionists direct questions about the pilot. Receptionists varied in their response to direct questions; some referred the young person to the doctor while others felt comfortable providing some preliminary basic information.
In the early stages of the pilot there were specific concerns on the part of young people that being invited to take the test conveyed the impression that they were thought of as sexually active or promiscuous. For some young people therefore being invited to take part in the screening was not a neutral act. In addition, it was impossible for receptionists to hand out the leaflet on Chlamydia in the certain knowledge that they would not be asked questions and receptionists reported both the fear of being asked questions and instances in which they had been asked for further information. Not all felt equipped to deal with these questions. Some young people felt that their confidentiality had been compromised by the very visible way in which they were handed a leaflet bearing the same colours and logos as the large posters on the surgery walls.

Not surprisingly, some young people felt that the public reception area was not the appropriate location for being introduced to the test.

Although receptionists in the survey represented the largest single group of people who were not enthusiastic about their involvement in the pilot, only 15 per cent of receptionists were against continuing screening for Chlamydia. Concerns about the running of the pilot, however, led to many practices operating the protocols for the offering of the test very differently. In particular, receptionists were likely to be selective about who was approached and how the test was offered.

A screening programme that is solely opportunistic in nature does not distinguish between people who have had the test from those who have not. The principle being, that on each occasion an individual attends a surgery they should be given the Chlamydia testing information and invited to take a test. Individuals in the qualitative interviews reported annoyance at being repeatedly asked whether they wanted to take the test and a few young people thought that because they had been approached more than once they were viewed as promiscuous. Changing sexual partner is one of the criteria for having a Chlamydia test.

1.4 Impact of receiving a positive test result

Although the survey revealed that there was a widespread understanding of the process by which people would receive their test results, there was a much lower level of understanding about what would happen if the test result were positive. In reality the majority of those interviewed who had received a positive test were shocked and distressed at their result.

Those people testing negative were relieved and felt assured that appropriate action had been taken.
1.5 Partner notification
The principle of partner notification was generally felt by all the respondents to be important. Differences existed between the pilot sites and types of location as to how this was handled. In some places there was a policy that those people who tested positive should get in touch with all their partners using a partner notification/tracing form. In other places there appeared to be a more flexible approach which allowed young people to choose those individuals they would tell, leaving the others to be traced by the clinic. While young people wanted to inform their current partners, there were concerns about how this news would be received. Among those people who were interviewed and who tested positive there were, however, no reported repercussions within the relationship as a result of the positive test result.

1.6 Responses to support from the pilot research team
The majority of the professional respondents valued the help and support of the pilot team, in particular that received from the research nurses – about two-thirds of the respondents considered visits and other verbal instructions from the pilot nurses to be useful.

In both waves of data collection, nine out of ten respondents said that they found all aspects of the written material useful, particularly the written information provided for staff. The publicity materials produced by the pilot teams received a warm response.

1.7 Overall conclusions
Although screening for Chlamydia is acceptable among the target group, it is clear that some elements of the model need refining.
2. Study of Professionals Involved in the Pilots

2.1 Background

The Department of Health commissioned an evaluation of the ‘Opportunistic model of screening for Chlamydia among 16-24 year old women’. The report summarises the findings of the data collected from the professionals involved in the administration of the Chlamydia screening pilot in both Portsmouth and the Wirral. It integrates the data collected at the beginning of the pilot (wave one) with that collected at the end of the pilot (wave two) and includes both quantitative and qualitative research methods. The aim of this stage of the research was to investigate the impact on health professionals and their workload of conducting an opportunistic screening programme for the detection and treatment of Chlamydia.

Overall, there were relatively few differences in response between waves one and two (either qualitative or quantitative). Any points of difference are reported below. There were, however, more substantial variations between the survey data and the qualitative data. In part these may be attributed to the restricted nature of the questions that can be posed using the self-completion method.

2.2 Quantitative research

NOP Social and Political carried out two self-completion quantitative surveys among a sample of health professionals in Portsmouth and Southeast Hampshire and on the Wirral. The two waves of data collection took place at the beginning and at the end of the pilot initiative.

Questionnaires were despatched to pilot co-ordinators in Portsmouth and the Wirral. In the Wirral they were distributed to GP surgeries, Wirral Drugs Service, BPAS, Brook Advisory Centre, Family Planning Clinics, Women’s Services and GUM. In Portsmouth the questionnaires were distributed to GPs, Family Planning Clinics, Antenatal/Gynaecology and GUM.

In the first wave of research 532 questionnaires were distributed in the Wirral and 577 in Portsmouth. A total of 143 (27%) completed questionnaires were sent back from the Wirral and 302 (52%) from Portsmouth. In the second wave at the end of the Pilot Programme, 486 were distributed in the Wirral and 577 again in Portsmouth with 157 (32%) and 249 (43%) received back respectively.

It should be noted that the self-completion approach, while very cost-effective, involves a restricted questionnaire length and tends to be accompanied by relatively high levels of missing values.
2.3 Qualitative study

The qualitative component of this evaluation mirrored the quantitative design; two waves of interviews with health professionals were carried out at the beginning and end of the screening initiative. A total of 83 qualitative depth interviews (43 stage one and 40 stage two) were conducted - the majority with GP primary care teams and family planning services (including The Wirral Brook Advisory Centre and Sex Sense clinics). There are in addition, a small number of interviews with other professionals and the screening pilot team.

All interviews were audiotaped and transcribed verbatim. However, all verbatim quotes used in this report have been anonymised to ensure confidentiality and respondent anonymity. No individuals have been identified at any stage.

2.4 Summary of findings

2.4.1 Overall satisfaction with the pilot programme

The majority of respondents were satisfied with the pilot programme both in the early stages of the pilot and looking back after it had finished.

Professionals considered Chlamydia to be an important public health issue in both of the pilot sites. Nine out of ten respondents in the survey considered Chlamydia screening important because of the impact on health. Over the course of the pilot (between waves one and two of data collection) the proportion who considered it very important rose from 55 to 65 per cent. The reasons for this were explored in the in-depth work. First, its prevalence was believed to be rising among young people in the UK. Second, a significant proportion of infections are thought to be asymptomatic so reducing the likelihood of symptoms prompting young people to seek a test. Third, the consequences of long-term infections are known to be potentially serious (including infertility, ectopic pregnancy, etc).

As with all new pilot initiatives health professionals identified particular problems with the opportunistic screening model. Just over half of professionals had experienced some problems in the first few months although most of these difficulties were resolved quite quickly and by the end of the initiative the majority of these problems had been resolved.

Ongoing problems included comments that the screening process was time-consuming and that staff were forgetting to give young people the forms.
2.4.2 Enthusiasm about being personally involved in the pilot
In the beginning (wave one) over three-quarters of respondents said they had been enthusiastic about being involved in the pilot. However, almost a fifth said they were not enthusiastic (including almost half the receptionists and a third of family planning staff in Portsmouth). Almost all of this group (89%) had concerns about the amount of extra work involved. Almost one quarter (mainly receptionists in the Wirral) worried about discussing Chlamydia with patients and around one fifth had concerns about whether they would be able to answer patient queries.

Receptionists were central to the opportunistic model of screening in General Practice. Their experiences of being involved in the pilot are therefore important. Receptionists across both sites shared many concerns, which will be fully explored later on. However, a significant proportion of receptionists were dissatisfied with the opportunistic model. A third of receptionists in the Wirral were initially dissatisfied. At the start of the pilot these ranged from a lack of information and training to an increased workload and lack of full involvement in how the pilot procedures would be managed. By the end of the pilot the reasons for dissatisfaction arose from the extra work, time consuming procedures, and the difficulty in operating a complicated system. Despite these criticisms only 15 per cent of receptionists were against continuing screening for Chlamydia.

2.4.3 Usefulness of support provided
The majority of the professional respondents valued the help and support of the pilot team, in particular that received from the research nurses – about two-thirds of the respondents considered visits and other verbal instructions from the pilot nurses to be useful. Fewer than 10% actually said that this kind of support was not useful. The team was considered knowledgeable, approachable, and easy to contact. After the initial training had taken place it was more common for professionals to receive support on the basis of having asked for it. For instance, requests for additional supplies and answers to particular questions about the forms.

Other types of support professionals thought might have been useful included more training sessions, a telephone help-line and more visits from the research nurse. A third of professionals in both waves of the quantitative research said no additional support was needed.

2.4.4 Publicity materials
In both waves of data collection, nine out of ten respondents said that they found all aspects of the written material useful, particularly the written information provided for staff.
The publicity materials produced by the pilot teams received a warm response. Most professionals were happy to use them. Youth specialists involved in Sex Sense Clinics and the Wirral Brook Advisory Centre were more likely to state that they could have been more user-friendly. HEA and FPA materials were sometimes preferred by professionals and used as an adjunct to their information and advice giving.

There was some disappointment in Portsmouth, however, that there had not been an associated publicity or health promotion campaign. In the Wirral there had been a lot of publicity by the pilot team about the screening. Professionals thought this might have helped young people to formulate informed consent and to challenge misconceptions about screening. For example, there was concern that some young women might think that Chlamydia screening covered them for all sexually shared infections (SSIs). However, professionals across the different health settings in Portsmouth said that they would not have been able to cope if the numbers of young people screened had been much higher.

2.4.5 Impact on workload
Concerns about the impact of the screening pilot on workload were responsible for the minority of people who were not enthusiastic about the pilot.

In reality half of the professionals in the self-completion survey said the workload was very much as they had anticipated. Only a minority of professionals at both waves (about a sixth) said their workload had increased a lot. Doctors were least likely to report an impact on workload. Very few clinics said they employed more staff to cope with the pilot.

By the end of the screening pilot, the in-depth interviews revealed that the enthusiasm and motivation for the pilot screening had waned. Many respondents found involvement in the pilot over a one-year period taxing. In contrast concerns among family planning staff faded away over the duration of the pilot.

2.4.6 The operation of opportunistic screening
When asked to what extent they agreed with various statements, three-quarters of respondents said they disagreed that they found it embarrassing to raise the subject of Chlamydia with patients. Receptionists as a group were less confident about raising the subject of Chlamydia. As can be seen later on this may have had a direct impact on the way in which the pilot initiative was operated in both of the sites.

Nine out of ten of the overall sample agreed that they were generally able to answer patients’ queries and nearly as many felt that they had a good understanding of the issues surrounding Chlamydia.
2.4.7 Acceptability of the urine test
Nearly all respondents said they thought the screening was acceptable to women. There was less certainty about men, with only a quarter reporting that they thought men found it acceptable. Interestingly this was not because they thought that men would refuse the test but simply because they felt unable to give an answer on the basis of the largely women-only pilot.

The availability of urine testing for Chlamydia (instead of swabs) was thought to make opportunistic for Chlamydia widely acceptable. The test was considered quick, non-invasive and accurate. In line with the findings from the quantitative study, most professionals assumed the test to be acceptable to young people. This was because very few explicitly rejected the test on the first offer. Those offering screening to men (Sex Sense clinic, Brook Advisory Centre and GUM staff) believed the test was equally acceptable to young men.

Swabs were not considered a viable alternative for opportunistic screening, because they were too time-consuming and invasive.

2.4.8 Targeting women
Some professionals were concerned about focusing the screening on women only. They understood that the CMO’s report had identified this approach as the most cost effective. However, they worried that it might have a negative impact generally on young women’s self-esteem. They also thought it sent out the wrong message to young men (for example, perpetuating societal views of women as vectors of infection).

Some professionals believed that targeting women was appropriate because young women were more likely to attend general practice and family planning services. They were also believed to be more likely to comply with the screening regimen. By stage two, several professionals felt strongly that young men should have been screened alongside women in all the health care settings involved in the screening pilot.

Several GP primary care teams and family planning staff said they had little experience of providing sexual health services for young men, because they rarely attended these settings. The survey of the general population, however, seems to contradict this impression. This survey identified a smaller but still relatively large number of young men who had seen their general practitioner in the six months prior to the survey - 55% of young men (aged 16-20) had visited their GP in the last six months. This figure increased to 72% when extended to include those people who had visited their GP in the last year.
2.4.9 Informed consent
During stage one interviews, professionals raised concerns about whether young people could be said to have given informed consent. The underlying concern related to the apparent willingness of young people to sign up for a test even though they were not fully aware of the consequences of receiving a positive test. Although all young people taking the test had been given the leaflet and request form by reception staff before seeing a clinician it was not clear how extensive their understanding of the process actually was.

However, by stage two, professionals were aware that the pilot screening exercise had become a talking point among young people within both pilot sites. Such discussions were felt to have motivated some young people (especially women, but also some young men) either to accept opportunistic offers of screening or actively to seek out and request screening themselves. These young people were thought to believe that it was worth taking the urine test to discover whether or not they had Chlamydia and to gain appropriate treatment to protect their future fertility.

Professionals believed that most of those who took the test expected to receive a negative test result and that few had actively considered the implications of testing positive. However, few clinicians considered this problematic as they had a firm belief that it was generally best to screen for and treat Chlamydial infections. Few professionals had considered the possible psychosocial impact of Chlamydia screening (e.g. on relationships, etc).

2.4.10 Efficiency of the pilot procedures
About one fifth of respondents thought that the pilot procedures were very efficient with a further two thirds believing them to be fairly efficient. An increasing proportion across the two waves of the survey said that the test results usually arrived on time. It is important to highlight that the Portsmouth lab was inundated with samples in the early stages of the pilot, which led to significant delays in dispatching test results to patients during the first few months. Over time the situation improved.

2.4.11 Impact on fertility
There was some concern that it was not possible to assess the long-term impact or outcomes of Chlamydial infection (i.e. impact on fertility). Although those people testing positive and presenting at GUM for treatment were given a full sexual health screening, young people could not be assessed for the impact of Chlamydia on their future fertility. A small number of professionals were concerned about the psychosocial impact this might have on patients.
Opportunistic screening in different settings

2.5 Screening in the community

The working model was broadly similar in general practice and family planning services, including Sex Sense Clinics and the Wirral Brook Advisory Centre.

2.5.1 Offering screening to symptomatic attendees
All clinical staff interviewed had been involved in screening women with suspected symptoms for Chlamydia before the pilot’s launch using swabs. None had any concerns or embarrassment about offering urine testing for symptomatic attendees or answering patient queries.

2.5.2 Offering screening opportunistically to asymptomatic attendees
There was broad support, in principal for screening asymptomatic patients for Chlamydial infection in community settings (especially via GP practices), because of the broader range of young people using such services compared to hospital-based GUM clinics.

Family planning and GP primary care team staff agreed that it was easier to offer screening in the context of sexual health and family planning services, because the clinician could assume that service users were sexually active. Offering screening in general practice to someone seeking general medical services was sometimes considered problematic, because there was thought to be a risk of offending some patients.

Most believed that the majority of patients had been screened opportunistically. However, several also noted that people were requesting screening, including young men and women over the age of 25.

Most clinicians believed that the offer of screening had not affected the quality of care delivered in response to the original reason for attending. Almost all said they set the issue of screening to one side until the original reason for the consultation was dealt with.

2.5.3 Frequency of offer
Although the rate of acceptance of the first offer of screening was believed to be high, many acknowledged that subsequent offers of screening were frequently turned down. This view was more pronounced during stage two interviews at the end of the screening pilot’s life span.

GP practice and family planning clinic receptionists were particularly worried that repeated offers of screening caused irritation and offence (i.e. suggesting that young women were regularly changing sexual partner).
2.5.4 The involvement of clinical staff
The involvement of clinical staff was broadly similar in both GP primary care setting, family planning clinics, The Wirral Brook Advisory Centre and Sex Sense clinics. Primarily, they responded to young women’s queries, handed out test kits and completed patient request forms. Some clinicians seemed more comfortable about offering screening and tried to recruit participants more actively than others.

All women GPs interviewed actively supported the screening pilot. Many were providing clinical sessions at local family planning clinics. The family planning doctors (all female) consulted were invariably GPs themselves. However, some older male GPs were said to be reluctant to get involved and some refused altogether. Some were said to shy away from providing sexual health services for women in general (including family planning services). Others were thought to believe that screening would have too great an impact on workload within the practice or that remuneration was insufficient to make participation in the pilot worthwhile.

2.5.5 GP practice managers
Practice managers generally had little involvement in the screening pilot, unless they covered reception duties.

2.5.6 involvement of reception staff
The screening pilot was often said to have had a significant impact on the workload of receptionists. Receptionists in GP practices, family planning clinics, Sex Sense clinics and The Wirral Brook Advisory Centre were involved in the following activities: identifying patients who fell within the target audience for the screening pilot; alerting clinical staff of the need to offer screening (usually by marking patient records or attendance lists in some way); where ever possible this was done in advance of surgery / clinic times; notifying the patient that the screening pilot was taking place; handing out leaflet and request forms; managing samples, plus associated pilot administration and paper work.

Receptionists felt that identifying patients and alerting clinical staff was within their skills. However, they were aware that they missed potential participants at reception, particularly during busy times, and during drop-in (emergency) clinics where patients attended without an appointment.

While some receptionists were keen to get involved in the screening pilot, there were widespread concerns about handing out leaflets and request forms to patients at reception. Receptionists frequently reported that the act of giving out this literature prompted young people to ask the receptionists questions.
Reception staff usually said that they declined to answer any such queries. They said they usually asked patients to speak to a doctor or nurse. There was also concern that young women might feel that patient confidentiality had been compromised if they were asked in an open-plan reception area, especially if they were attending with a parent or partner.

Some clinicians shared receptionists’ concerns and several GP practices adapted the working model accordingly (see note below). However, many clinicians supported the involvement of receptionists. They believed that giving out leaflets and the consent form at reception saved valuable consultation time. If reception staff were involved, they estimated that around three minutes was added to consultation time. If a patient was missed at reception, it was believed to take up to 10 minutes to run through the necessary details. They were confident that reception staff had the training and skills to handle the offer of screening sensitively.

2.5.7 Adaptation of the working model
Some practices adhered to the suggested working models as far as possible. However, there were adaptations, usually around the involvement of reception staff.

Many receptionists offered screening selectively and used their own personal judgement about whether or not it was appropriate to offer screening. For example, several would not make an offer if a young woman was attending with someone else (e.g. her partner or a parent).

Reception staff at several GP practices in both Portsmouth and the Wirral stopped offering screening altogether and left it to clinicians to decide whether or not to do so (either by their own request or at the request of GPs). In contrast, entire test kits were given out at reception in one practice.

2.5.8 Facilities within the practice and clinic
GP primary care teams, family planning clinics and the Brook Advisory Centre (the Wirral) generally believed toilet facilities were adequate to enable young people to give samples on site.

Most women were able to give samples on site in family planning clinics and the Brook Advisory Centre and Sex Sense clinics, because of longer waiting times. However, young women were more likely to have urinated within an hour of attending their GP clinic and so were less likely to be able to give a sample on the day. Taking test kits home was considered problematic (see below).
Sex Sense clinics located in informal settings often struggled to provide adequate toilet facilities to enable young people (male and female) to give samples discretely. However, the informal and open atmosphere was thought to overcome any potential disadvantages.

2.5.9 Taking test kits home
GP primary care team staff said that many young women were taking test kits home, because they had not held their urine for one or more hours before attending the clinic. They were not confident that samples were subsequently being returned. Several thought that it would be preferable to ask young women to return to the practice for screening.

2.5.10 Managing samples
Professionals (including primary care team staff) had few problems collecting and dispatching samples to the lab. Reception staff in GP practices and family planning clinics, in particular, considered such tasks well within their skills. A range of collection methods was employed. Some asked patients to hand samples to the doctor, nurse or reception staff. Others asked women to leave their sample in a designated samples box or tray.

2.5.11 Patient request forms and day sheets
Most professionals said they quickly got to grips with the patient request form. However, there were several complaints that the reporting requirements were cumbersome and time consuming, especially the day sheets.

2.5.12 Treatment in the community
The original intention was for the pilot research nurses to have scope to treat test-positive patients in the community in Portsmouth. In the event, almost all test-positive patients were referred to GUM for treatment. There was much concern among GP primary care team and family planning staff in Portsmouth about the impact on workload if treatment was to take place in the community.

Some patients were treated in the community in Wirral. Several GPs interviewed during stage two were administering treatment themselves.

2.5.13 Referral to GUM clinic for treatment and secondary screening
Like survey respondents, interviewees also thought that young people who tested positive would have concerns about the referral to GUM clinics. However, Portsmouth professionals often said they had no contact with patients after the initial sample was sent to the lab.
Some thought that young people were largely unaware of GUM clinics. GP primary care team and family planning clinic staff in Portsmouth generally preferred this working model, because GUM clinics had the facilities and resources to offer full sexual health screening and the necessary contact tracing / partner notification.

The research nurses’ involvement in facilitating referral to GUM clinics was considered both important and an effective way of encouraging young people to attend GUM for treatment and full sexual health screening. Several thought that any future working model should include a designated GUM health advisers to undertake a similar role.

2.5.14 Storage of test results and statistical returns
A named GP in each practice tended to receive a copy of all test results. These were neither stored with nor recorded on patient records. Practices in the Wirral complained that the pilot team had not provided statistical returns for each practice. As discussed (see above), initial problems in Portsmouth with both the amount of samples received and the technical difficulties with the test equipment caused a backlog. Consequently, there were long delays in screening samples and issuing test result. It took some time for the lab and pilot team to catch up with the backlog.

2.6 Screening and treatment via GUM clinics

2.6.1 Introduction
GUM staff were keen to be involved in the screening pilot and had few concerns about participation. Such screening was considered well within their skills and service remit. They encountered few problems implementing the pilot. GUM staff had devised their own protocol.

In contrast to other settings, GUM receptionists only marked patient record to alert clinical staff of the need to offer screening. They were not involved in handing out leaflets and request forms. Consequently, their involvement caused no concern.

2.6.2 Full sexual health screening
There was much support among professionals across the different health care settings for linking treatment of test-positive patients to full sexual health screening via GUM clinics. GP primary care teams and family planning staff often said they lacked the facilities (and sometimes the training) to provide such a service in the community.

2.6.3 Contact tracing and partner notification
The involvement of GUM clinic staff was considered important to ensure that contact tracing and associated partner notification took place. Both GP primary care team staff and family planning staff said they lacked the resources and skills to undertake such a task.
2.7 Overall views of the pilot’s success

Most professionals interviewed in Portsmouth thought the pilot had been a success, both in terms of uptake and in terms of the number of asymptomatic positive patients discovered. Many were aware that around 1 in 10 of young people who had accepted the offer of screening had subsequently tested positive. This persuaded many to believe that Chlamydia screening was worthwhile and that a national screening programme was warranted.

By contrast, staff at only one of the GP practices included in the qualitative sample in the Wirral believed the pilot had gone really well. Others felt that uptake had been poor. Figures from the PHLS confirm that practices varied enormously in the numbers of people actually screened.

2.8 The end of the pilot

During stage two interviews, like quantitative survey respondents, many qualitative participants in both Portsmouth and the Wirral were, however, critical of the pilot’s abrupt ending. There was much concern about the lack of interim arrangements in the period before the expected launch of a national screening programme. Many also worried that patient expectations about the availability of urine testing for Chlamydia in the community (via GP primary care teams, family planning services and specialist youth clinics) may have been raised unreasonably and that neither swabs nor referral to GUM clinics were acceptable viable alternative.

2.9 Feasibility of offering Chlamydia screening routinely

Three-quarters of those who returned a questionnaire thought it feasible to offer Chlamydia screening routinely to all women aged 16-24. Six out of ten said it would be feasible to offer it to all men and women aged 16-24 and the same proportion thought it feasible to offer the screening on a routine basis to women coming for contraception or smear tests only.

2.10 Suggested improvements to the working model

When asked at the end of the pilot, the majority (eight out of ten) of respondents said they would like to see the screening continue in their practice or clinic. Notwithstanding some criticisms of the process, few professionals suggested improvements to the process. Suggestions for improvement included more publicity to create greater patient awareness,
easier and simpler forms to complete, and reducing the frequency with which screening was offered.

In the in-depth interviews, professionals outlined a number of ways in which a national screening programme might be implemented differently. Many believed screening should be offered less frequently. Several suggested linking Chlamydia screening to general sexual health services, including smears and pill checks. Many also suggested adopting a call / recall approach. Many professionals believed that this, like other screening programmes, could be nurse-led. Some suggested that the possibility of self-administered screening should be explored.

Other suggestions included:
running off lists of people within the age bracket and doing mail shots;
holding special (sexual health) clinics for young people;
treating in general practice, rather than GUM; others thought that GP primary care teams lack the time to offer health advisor services, contact tracing skills and facilities to do full sexual health screening.

3 Study of The General 16-24 Year Old Population

3.1 Summary of The Main Findings – General Population Survey

This is a summary of the key findings from the first and second surveys of 16-24 year olds in the Chlamydia pilot areas along with a control group from the rest of the country. Samples of 1500+ young adults were interviewed in the Spring of 1999, in advance of the pilot programme and the survey was repeated in the early Autumn of 2000. A third study is being conducted in March/April 2001 in connection with the re-infection work but the findings of this work were not available at the time of writing. In each wave of fieldwork, there were 500+ interviews in the two pilot areas and a similar national sample.

- The overall proportion of respondents registered with a GP remained static over the two waves (at 95%). Women were more likely than men to be registered and also to visit their doctor more regularly.

- Respondents in the National and Wirral samples were more likely to visit a Family Planning Clinic than any other specified non-GP site. Brook Clinics (Sex Sense in Portsmouth) were used by more respondents in the Wirral than in either of the other two areas.
• Overall awareness of any sexually shared infection was highest amongst the 21-24 age group and the ABC1 (white-collar) social class group.

• Although awareness of Chlamydia was at the same level (c50%) in each of the three samples before the screening began, it had significantly increased in both the Wirral and Portsmouth on the second survey (c75%). The National sample saw a more modest increase (to 47% to 52%), reflecting the growing nation-wide coverage of the issue.

• The second survey showed a general increase in understanding about Chlamydia. Most respondents realised that Chlamydia affects both men and women and that it has serious side effects. Understanding overall is highest amongst women and those from ABC1 homes and the increase in understanding was greater in Portsmouth than on the Wirral.

• In the second wave of interviewing, over half of the respondents in both pilot areas had seen or heard something about Chlamydia recently – most mentions were for posters and word of mouth.

• In both the pilot areas, four-in-ten respondents (especially women) had heard of the Chlamydia screening programme. Twice as many women as men had heard of this initiative. Male awareness was rather lower on the Wirral than in Portsmouth.

• There was little difference between the two waves in the level of willingness to have a Chlamydia test - around 90% were willing to be tested at a GP setting with slightly lower figures agreeing to tests at other sites such as GU and FP clinics. With such high levels of initial agreement, it is not surprising that there has been no significant increase in anticipated acceptance across the two waves.

• Key reasons for not being willing to have the test included embarrassment and privacy. A small number of respondents said because they only had one partner they were not at risk and a few others said that they simply didn’t like doctors.

• At wave 2, over four-in-ten women in both Portsmouth and the Wirral had been offered a Chlamydia test compared with only one-in-ten in the national sample. Few people seemed to have refused the offer of the test.
3.2 Summary of findings for the screened population: results of the survey and in-depth interviews

3.2.1 Introduction
Data from a total of 386 individuals screened for Chlamydia form the basis for this summary of findings. 386 respondents returned self-completion questionnaires and 25 of these took part in in-depth face-to-face interviews.

In general, the findings from the two types of data collected are complementary. However, owing to the detailed nature of the in-depth interviews it is often the case that a set of complex and sometimes conflicting views lie behind the quantitative data. Where the two data sets appear to produce divergent views this is highlighted in the summary.

3.2.2 General views
There can be no doubt that the urine test for Chlamydia was found to be universally acceptable. Once individuals had been given the information about Chlamydia and the potential consequences of an infection, the simplicity of the urine test enabled people to accept the test and to encourage their friends to take the test. Perhaps paradoxically, accepting the test did not reflect a detailed understanding of the consequences of receiving a positive test result.

The experimental/pilot nature of the screening initiative seemed to provide a justification for the ‘opportunistic’ nature of the screening. Young people in the early stages of the pilot did express some surprise that they were offered a screening test for a sexual health problem when they were attending primary care on unrelated matters.

The majority of young people being tested in this pilot had not previously been tested for Chlamydia. Before the pilot and its attendant publicity there was a relatively low level of knowledge about Chlamydia, its consequences and treatment. As the pilot progressed, as a result of increased publicity and by word of mouth, there was an increase in knowledge about the infection. The in-depth interviews, however, revealed some alarming misconceptions about Chlamydia, particularly about the ways in which it could be transmitted.

3.2.3 The opportunistic model of screening
While the quantitative survey revealed widespread satisfaction with the opportunistic screening model, the detailed qualitative interviews revealed problems with particular aspects of the process. While we do not have the data to quantify the extent to which these concerns are representative of those screened, similar concerns were raised by the professionals operating the screening initiative.
3.2.3 Screening in the community
There were particular problems arising from the reliance in the opportunistic model in General Practice on receptionists. Receptionists were centrally involved in the identification of young people for screening and for handing out information about the screening initiative. The fundamental problem arising from their involvement related to the public space within which receptionists are located. The young people in the in-depth interviews felt that the public reception area was not the appropriate location for having a new initiative linked to sexual activity explained to them. Indeed some individuals felt that their confidentiality had been compromised by the way in which the subject had been raised.

3.2.4 Screening in Family Planning and GUM clinics
In these settings where the reason for attendance could be said to be primarily sex-related, there was much less sensitivity about the matter being raised. There were a number of complaints about the lack of information about the screening initiative in GUM clinics.

3.3 Impact of receiving a positive test result
Although the survey revealed that there was a widespread understanding of the process by which people would receive their test results, there was a much lower level of understanding about what would happen if the test result was positive. In reality, the qualitative research showed that the majority of those interviewed who had received a positive test were shocked and distressed at their result.

3.4 Partner notification
The principle of partner notification was generally felt by all the respondents to be important. Differences existed between the pilot sites and types of location as to how this was handled. In some places there was a policy that those people who tested positive should get in touch with all their partners using a partner notification/tracing form. In other places there appeared to be a more flexible approach which allowed for young people to choose which individuals they would tell, leaving others to be traced by the clinic. While young people wanted to inform their current partners, there were concerns about how this news would be received. Among those people who were interviewed and who tested positive there were no repercussions within the relationship as a result of the positive test result.
3.5 Informed consent

It is difficult to assess accurately the extent to which this group of young people were in a position to give informed consent to take the test. The survey revealed that a small minority of young people felt pressured into taking the test, although the clear majority stated that they felt able to refuse. There were clear signals that people who accepted the test had little understanding of the consequences of a positive test. Not surprisingly particular individuals in particular settings were more responsive to different aspects of the screening process. Young people testing positive for instance felt under pressure to accept a full sexual health screening in GUM, but frequently agreed to this without full knowledge of what they were being screened for. All the tests used were invasive in nature and although unpleasant were believed to be effective.

3.6 Benefits of participating

The respondents in both samples felt that they had benefited from being screened. Most people had received and read, some if not all, of the literature which accompanied the pilot. Those people testing negative were relieved and felt assured that appropriate action had been taken.

Those people testing positive had gone for treatment and had had a test to check whether they had been cured. Some participants in the qualitative study were, however, concerned about the impact of chlamydial infection on their future fertility.