Performance Measures for the National Chlamydia Screening Programme

Guidance Notes

Health Protection Agency and Department of Health (England)

In consultation with the local programme area chlamydia screening coordinators and the National Chlamydia Screening Steering Group

1st edition, October 2005
Background

The National Chlamydia Screening Programme (NCSP) in England was established as a mechanism to control the spread of this largely asymptomatic disease through comprehensive screening, treatment and partner follow-up services. Critical to the success of any programme is an active engagement in performance assessments to ensure the service is achieving its goal. To date there are no published standards for performance specific to chlamydia screening.

The national team, in consultation with experts in sexual health, have developed a set of performance measures to help guide local programmes in evaluating their own service. These measures are not prescriptive; rather, they should be used as a general tool for local programmes to use. Primary Care Trusts will be performance managed by the Strategic Health Authority as to their achievement of Local Delivery Plan (LDP) targets for acceptance of chlamydia screening by the target population. This LDP line is included in this guidance document, as well, to place it within the context of the entire service delivery package of the NCSP.

How to use this guide

This guide is laid out in four different sections: local programme, clinical, laboratory and data. Within each section, structural, process and outcome performance measures are listed with an explanation for each. Each measure has a target, data sources, measurement specifications, and definitions of the numerator and denominator (where appropriate).

Because this is the first attempt to define performance standards for chlamydia screening, the targets set were chosen through a consultative process with local coordinators and experts in the field, as well as a review of the published literature for standards in GUM clinics. Therefore, targets should be viewed as an optimal goal to strive for, but local programmes will not be penalised for not achieving the target.

A worksheet is provided at the end of this guide for use by local programmes when making their annual review of their performance at the end of each financial year.
LOCAL PROGRAMME

Structural Performance Indicators – Local Programme

**PS1 – Local programme area has an agreed upon chlamydia screening plan.**

Target: All programme areas should have a screening plan on file in the local screening office, which should be reviewed against progress at the beginning of each financial year.

**PS2 – Local programme area has a central screening office or coordinating body to oversee screening efforts in their area.**

Target: All programme areas should have accommodation for the central screening office/coordinating body and ensure this location is widely known throughout the local area.

**PS3 – LCSSG has at least one representative from all of the following specialties: local screening office, laboratory/microbiology, family planning/contraception, GU medicine, primary care/general practice, young person’s services (e.g., Brook), sexual health lead at PCT or SHA level, IT staff or manager from either PCT or laboratory, finance from either PCT or SHA, and women’s services (e.g., termination, gynaecology, etc.)**

Target: All programme areas should have a membership list on file in their local screening office, which should be reviewed annually.

**PS4 – Local programme has a functioning local chlamydia screening steering group (LCSSG) with a designated chair/lead.**

Target: All programmes should have a description of the functions of their LCSSG on file in the local screening office.

Data sources: Programme areas should consider establishing ‘terms of reference’ for their LCSSG.

**PS5 – Local programme area has set annual screening uptake goal for women and men aged less than 25 years, to facilitate achieving local delivery plan (LDP) benchmark for chlamydia.**

Target: At the discretion of local programmes. The uptake target should consider local capacity, existing testing among <25 year olds occurring in specialty clinics such as GUM clinics, and attending behaviour of women and
men <25 years old in the area to assess what additional uptake of opportunistic screening is required to achieve 50% coverage targets outlined in the LDP line from the government.

Data sources for measure: Population estimates of sexually active 16-24 year olds by sex and PCT. Number of people tested for chlamydia at GUM each year, number of <25 year old women and men who attend non-specialist settings (e.g., contraceptive clinics, young person’s services), and proportion of <25 year old women and men who attended GP surgeries in the last year.

Process Performance Indicators – Local Programme

**PP1 – LCSSG meets at least twice yearly**

Target: At least twice yearly.

Data sources for measure: Meeting records of the LCSSG.

**PP2 – Number and percentage of chlamydia positive results notified to the patient by CSO within 2 working days of receiving result from the laboratory.**

Target: At least 90%.

Data sources for measure: Programme database or records within the CSO. Use date of result from the lab and date of first notification (letter/phone call/text) by the CSO.

Numerator: total number of chlamydia positive results notified to the patient by the CSO within 2 working days of receiving the result from the laboratory.

Denominator: total number of chlamydia positive results received by the CSO from the laboratory.

**PP3 – Number and percentage of chlamydia negative results notified to the patient by CSO within 5 working days of receiving result from the laboratory.**

Target: At least 90%.

Data sources for measure: Programme database or records within the CSO.

Measurement specifications: Use date of result from the lab and date of first notification (letter/phone call/text) by the CSO.
Numerator: total number of chlamydia negative results notified to the patient by the CSO within 5 working days of receiving the result from the laboratory.

Denominator: total number of chlamydia negatives received by the CSO from the laboratory.

Outcome Performance Indicators – Local Programme

**PO1 – Number and percentage of venues assigned clinic ID numbers who have performed screening of the target population**

Target: at least 75%.

Data sources for measure: HPA NCSP database.

Measurement specifications: HPA will provide this information on a regular basis.

Numerator: total number of unique clinic ID numbers within the programme area with at least one reported opportunistic screen during the past financial year.

Denominator: total number of unique clinic ID numbers in the programme area on record at the HPA during the past financial year.

**PO2 – Number and percentage of GP practices within the programme area that have performed screening of the target population, compared to the total number of GP surgeries in the programme area.**

Target: at least 50%.

Data sources for measure: NHS list of GP practices within the local programme area, and the NCSP database at the HPA.

Measurement specifications: List of GP practices can be acquired from local PCT headquarters. List of GP practices assigned clinic ID numbers will be provided by the HPA on a regular basis.

Numerator: the number of GP practices within the programme area that have at least one opportunistic screen on record in the HPA NCSP database.

Denominator: the total number of GP practices within the programme area.
**PO3 – Number and percentage of screens among <25 year old women (a) and men (b) reported, compared to the goal set by the programme area (see PS5).**

Target: at least 50% of the original goal set for year 1, rising to >90% of the goal set for year 3.

Data sources for measure: CSO database, laboratory records, quarterly reports from the HPA, and/or the HPA NCSP database. Annual screening targets set in PS5 and in local screening plans.

Numerator: the total number of screens among women (a) and men (b) aged <25 reported to the HPA.

Denominator: the total number of screens among women (a) and men (b) aged <25 set as the programme area target in their local screening plan.

Measurement specifications for men: note that this is for opportunistic screens among men only and should not include men tested and/or screened as a part of a contact tracing/partner follow-up activity.

**PO4 – Number and percentage of screens among 15-24 year old women (a) and men (b) screened within the NCSP, compared to the estimated number of sexually active 15-24 year old women (a) and men (b) in the programme area.**

Target: the level required to achieve the LDP target of 50% coverage of the sexually active 15-24 year old female and male population.

Data sources for measure: CSO database, laboratory records, quarterly reports from the HPA, and/or the HPA NCSP database. Estimates of the total 15-24 year old sexually active women and men within each PCT distributed by the HPA to each local programme area.

Measurement specifications: this measure investigates the number screens done within the NCSP (outside GUM and other non-NCSP providers) that contribute towards the overall goal of the LDP line (see PO5).

Numerator: the total number of NCSP screens among women (a) and men (b) aged 15-24 reported to the HPA.

Denominator: the estimated total number of sexually active women (a) and men (b) aged 15-24.

**PO5 – Number and percentage of sexually active 15-24 year old women (a) and men (b) who received a chlamydia screen during the financial year (LDP line).**
This is the official LDP line and every PCT will be performance managed for progress in achieving this target. This measure includes ALL chlamydia screens that occurred among the target population, regardless of the screening location and payment source for the screen. Local programmes should strive to acquire as much information about all chlamydia screening activities within their area before embarking on calculating this measure.

Target: 50% of the total sexually active 15-24 year old male and female population.

Data sources for measure: CSO database, laboratory records, quarterly reports from the HPA, the HPA NCSP database, and other adjunct data from GUM or other facilities that have provided chlamydia screening to the target population but that are not captured within the reporting system of the NCSP. Estimates of the total 15-24 year old sexually active population within each PCT distributed by the HPA to each local programme area.

Measurement specifications: Data source availability will vary by programme area depending upon the local infrastructure, proportion of the target population that receives a chlamydia screen at GU medicine in the previous year, and the use of other clinical services by the target population for chlamydia screening not documented within the programme activities.

Numerator: the total number of sexually active 15-24 year old women (a) and men (b) who received a chlamydia test during the financial year.

Denominator: the total number of sexually active 15-24 year old women (a) and men (b) in the programme area.
CLINICAL

Structural Performance Indicators - Clinical

CS1 – Local programme has documented care pathway for offering chlamydia screening to patients at each venue participating in the screening programme.

Target: Programme area has documented care pathways for chlamydia screening that are on file at the local screening office and distributed to each venue participating in screening.

CS2 – Local programme has documented care pathway for notification of chlamydia screening results to patients screened at each venue participating in the screening programme.

Target: Programme area has documented care pathways for notification of screening results to participants in the screening programme which are on file at the local screening office and distributed to each venue participating in the programme.

CS3 – Local programme has documented care pathway for patient treatment for those screened positive at each venue participating in the screening programme.

Target: Programme area has documented care pathways for patient treatment that are on file at the local screening office and distributed to each venue participating in the programme.

Note: If local programmes are using patient group directions (PGDs) as a part of their care pathway for patient and/or partner treatment, these PGDs must also be on file in the local screening office and must be approved by the local clinical governance body.

CS4 – Local programme has documented care pathway for partner notification activities, including contacting partners, testing and treatment of partners, at each venue participating in the screening programme.

Target: All local programme areas have documented care pathways for all partner notification activities that are on file at the local screening office and distributed to each venue participating in the programme.

Note: If local programmes are using patient group directions (PGDs) as a part of their care pathway for partner treatment, these PGDs must also be on file in the local screening office and must be approved by the local clinical governance body.
CS5 – Local programme has documented plan for when a screening patient fails to respond to notification of positive results or fails to receive treatment.

Target: A documented plan for “failure to treat” is kept at the local screening office and distributed to each venue participating in the programme.

Process Performance Indicators - Clinical

CP1 – a) Number and percentage of positives who were treated within (a) 14 days and (b) 30 days from the date of specimen.

Target: At least 50% of positives are treated within 14 days, and at least 90% are treated within 30 days from when the patient provided the sample for testing.

Data sources for measure: CSO database and/or laboratory records.

Measurement specifications: Use date of when the patient provided the sample for testing and the date when the patient received treatment.

Numerator: the number of positives who were treated within 14 or 30 days from the date of the specimen.

Denominator: the total number of positives.

CP2 – Where the CSO is asked by the patient to do partner contacting, the number and percentage of reported partners treated within (a) 14 days and (b) 30 days from the date of the index patient’s treatment.

Target: At least 50% of reported partners that are requested to be contacted by the CSO are treated within 14 days of the index patient’s treatment, and at least 75% of reported partners that are requested to be contacted by the CSO are treated within 30 days of the index patient’s treatment.

Data sources for measure: CSO database, laboratory records, or other reports from clinical providers assisting with partner notification and/or treatment.

Measurement specifications: This performance indicator only applies to partners for which the patient has reported to the CSO and has requested the CSO do the contacting. This does not apply to any other reported partners for whom the patient has elected to contact themselves. Use the date of when the index patient was treated and the date when the partner was treated.
Numerator: the total number of reported partners requested to be contacted, and subsequently were contacted by the CSO, who were treated.

Denominator: the total number of reported partners that were requested by patients to be contacted by the CSO.

Outcome Performance Indicators - Clinical

**CO1 – Total number and percentage of positive index patients (opportunistic screens outside GUM only) who received treatment.**

This measure is from Items B & C of the annual patient management proforma.

Target: At least 95%.

Data sources for measure: CSO database, patient management proforma returned to the HPA at the end of the financial year.

Measurement specifications: This measure only applies to persons who were positive from an opportunistic screen performed as a part of the local screening programme; this does not apply to those tested for diagnostic reasons, who were contacts (regardless of the test result for the contact), or who were screened outside of the rubric of the local screening programme.

Numerator: the total number of positive screens who received treatment.

Denominator: the total number of positive screens.

**CO2 – Total number and percentage of reported partners (of chlamydia positives who were opportunistically screened outside GUM in the local screening programme) who received treatment.**

This measure is from Item I of the annual partner notification proforma.

Target: At least 50%.

Data sources for measure: CSO database, partner notification proforma returned to the HPA at the end of the financial year.

Measurement specifications: This measure applies only to the total number of partners reported by the persons who tested positive from an opportunistic screen done as a part of the local screening programme. This does not apply to all contacts traced by the GU medicine department or other contacts treated where the source case cannot be attributed to a screen positive.

Numerator: the total number of reported partners who received treatment.
Denominator: the total number of reported partners (of chlamydia positives who were opportunistically screened in the local screening programme).

**CO3 – Total number and percentage of contacted partners (of chlamydia positives who were opportunistically screened outside GUM in the local screening programme) who received treatment.**

This measure is from Item J of the annual partner notification proforma.

Target: At least 75%.

Data sources for measure: CSO database, partner notification proforma returned to the HPA at the end of the financial year.

Measurement specifications: This measure applies only to the total number of partners contacted as partners of the persons who tested positive from an opportunistic screen done as a part of the local screening programme. This does not apply to all contacts traced by the GU medicine department or other contacts treated where the source case cannot be attributed to a screen positive.

Numerator: the total number of contacted partners who received treatment.

Denominator: the total number of contacted partners (of chlamydia positives who were opportunistically screened in the local screening programme).
LABORATORY

Structural Performance Indicators - Laboratory

**LS1 – Laboratory has documentation of participation in a quality assurance scheme.**

Target: all laboratories that provide NAA testing on specimens submitted from local screening programmes should have on file record of participation in a recognised quality assurance scheme.

**LS2 – Laboratory has full capacity to perform high volume (at least 20,000 tests per year) nucleic acid amplification testing on non-invasive specimens.**

Target: The NAAT platform used by the lab should run at at least 90% efficiency, i.e., 90% of the maximum number of samples that can be processed in a year should be processed by laboratories receiving samples from programme areas participating in the NCSP.

Data sources for measure: Product specification for NAAT platforms provided by the Purchasing and Supplies Agency (PaSA) of the NHS or by participating laboratories.

Measurement specifications: It is important to note this target is dependent upon the platform and front-end processing equipment available at participating laboratories. To minimise delays in notification of test results to clinical providers, it is recommended that laboratories network for NAAT specimen processing to ensure costs are reduced to run this more expensive technology.

**LS3 – Laboratory has a dedicated contact person for queries about samples submitted as a part of the NCSP.**

Target: All laboratories should have available staff who can liaise with the local screening office or screening venues regarding specimen submission, processing or notification of test results.

Process Performance Indicators - Laboratory

**LP1 – Number and percentage of samples from the local programme area received by the laboratory which are processed (test result known) within 2 working days of receipt in the laboratory (3 working days if the sample is initially reactive).**

Target: At least 90%.
Data sources for measure: Laboratory database.

Measurement specifications: Use date of when sample arrived in the laboratory and date when the test result was known.

Numerator: the number of samples from the local programme area submitted to the laboratory for which the result was known (in the laboratory) within 2 days of the date received in the laboratory (3 working days if the sample is initially reactive).

Denominator: the total number of samples from the local screening programme received in the laboratory.

**LP2 – Number and percentage of samples (from the local screening programme) where the result was reported by the laboratory to the CSO within 7 working days of receipt of the sample in the laboratory.**

Target: At least 90%.

Data sources for measure: Laboratory database.

Measurement specifications: Use data of when the specimen arrived in the laboratory and date of when the test result was sent to the CSO.

Numerator: the number of samples (from the local screening programme) where the result was reported by the laboratory to the CSO within 7 working days of receipt in the laboratory.

Denominator: the total number of samples from the local screening programme received in the laboratory.

**LP3 – Number and percentage of samples submitted from the local screening programme where the sample was inhibitory.**

Target: Less than 5%.

Data sources for measure: Laboratory database, CSO database, and/or the HPA NCSP database.

Measurement specifications: This performance indicator only applies to samples submitted as a part of the local screening programme.

Numerator: the number of samples submitted from the local screening programme where the sample was inhibitory.

Denominator: the total number of samples submitted from the local screening programme received in the laboratory.
**LP4 – Number and percentage of samples submitted from the local screening programme where the patient’s test result was equivocal after the second test.**

Target: Less than 5%.

Data sources for measure: Laboratory database, CSO database, and/or the HPA NCSP database.

Measurement specifications: This performance indicator only applies to samples submitted as a part of the local screening programme.

Numerator: the number of samples submitted from the local screening programme where the patient’s test result was equivocal after the second test.

Denominator: the total number of samples submitted from the local screening programme received in the laboratory.
DATA

Structural Performance Indicators - Data

**DS1 – Programme area has electronic capacity to collect and report the NCSP core data in one of the three file format specified in the Core Requirements using encryption guidelines provided by the HPA.**

Target: All programme areas should be able to report the core data for screening programme chlamydia tests electronically in one amalgamated file (across the entire programme area) to the HPA every quarter of the financial year.

**DS2 – Programme area can document capacity to collect the NCSP core data from each person tested within the programme on either the national NCSP test request form or an HPA-approved test request form.**

Target: All programme areas must submit their test request form to the HPA for approval to use. All test request forms must comply with the data collection standards set out in the Core Requirements.

Process Performance Indicators - Data

**DP1 – Number and proportion of data that are complete for each core data item.**

Target: At least 90% of each core item will be complete for every test record submitted to the HPA NCSP database.

Data sources for measure: HPA NCSP database.

Measurement specifications: The completeness of data collection will be assessed item by item for each of the core data by the HPA on a quarterly basis and reported back to local programme areas if the target is not met.

Numerator: for each data item, the total number of test records reported where there is a valid value.

Denominator: for each data item, the total number of test records reported.
PERFORMANCE CHECKLIST

To be completed at the end of each financial year.

LOCAL PROGRAMME MEASURES

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Assessment</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>PS1</td>
<td>All programme areas should have a screening plan on file in the local screening office, which should be reviewed against progress at the beginning of each financial year.</td>
<td>Screening plan is in screening office. Yes ☐ No ☐</td>
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<tr>
<td>PS2</td>
<td>All programme areas should have accommodation for the central screening office/coordinating body and ensure this location is widely known throughout the local area.</td>
<td>There is a central screening office and the location is widely known. Yes ☐ No ☐</td>
<td></td>
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<tr>
<td>PS3</td>
<td>All programme areas should have a LCSSG membership list on file in their local screening office, which should be reviewed annually.</td>
<td>Membership list for LCSSG is in screening office. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>PS4</td>
<td>All programmes should have a description of the functions of their LCSSG on file in the local screening office.</td>
<td>Description of LCSSG functions is in screening office. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>PS5</td>
<td>At the discretion of local programmes. What additional uptake of opportunistic screening is required to achieve 50% coverage targets outlined in the LDP line.</td>
<td>Uptake targets for screening are documented in the screening plan and in the screening office. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>PP1</td>
<td>At least twice yearly.</td>
<td>LCSSG met at least twice in the past financial year. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>PP2</td>
<td>At least 90%.</td>
<td>Numerator: total number of chlamydia positive results notified to the patient by the CSO within 2 working days of receiving the result from the laboratory. = ____________ Denominator: total number of chlamydia positive results received by the CSO from the laboratory. = ____________ Percentage = ______________</td>
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<tr>
<td>PP3</td>
<td>At least 90%.</td>
<td>Numerator: total number of chlamydia negative results notified to the patient by the CSO within 5 working days of receiving the result from the laboratory. = ____________</td>
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<tr>
<td>Measure</td>
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<tr>
<td>Denominator: total number of chlamydia negatives received by the CSO from the laboratory.</td>
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<td>Percentage = _______________</td>
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<tr>
<td>PO1</td>
<td>at least 75%.</td>
<td>Numerator: total number of unique clinic ID numbers within the programme area with at least one reported opportunistic screen during the past financial year.</td>
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<td>Percentage = _______________</td>
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<tr>
<td>PO2</td>
<td>at least 50%.</td>
<td>Numerator: the number of GP practices within the programme area that have at least one opportunistic screen on record in the HPA NCSP database.</td>
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<td>Percentage = _______________</td>
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<td>PO3</td>
<td>at least 50% of the original goal set for year 1, rising to &gt;90% of the goal set for year 3.</td>
<td>Numerator: the total number of screens among women (a) and men (b) aged &lt;25 reported to the HPA.</td>
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<td>Percentage = _______________</td>
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<tr>
<td>PO4</td>
<td>the level required to achieve the LDP target of 50% coverage of the sexually active 15-24 year old female and male population.</td>
<td>Numerator: the total number of NCSP screens among women (a) and men (b) aged 15-24 reported to the HPA.</td>
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<td>Percentage = _______________</td>
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</table>
| PO5     | 50% of the total sexually active 15-24 year old male and female population. | Numerator: the total number of sexually active 15-24 year old women (a) and men (b) who received a chlamydia test during the financial year.  

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Denominator: the total number of sexually active 15-24 year old women (a) and men (b) in the programme area.  

\[= \ \]  

Percentage = \[\] |
## CLINICAL MEASURES

<table>
<thead>
<tr>
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<tr>
<td>CS1</td>
<td>Programme area has documented care pathways for chlamydia screening that are on file at the local screening office and distributed to each venue participating in screening.</td>
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<tr>
<td></td>
<td>Care pathways for screening are in screening office and distributed to screening venues.</td>
<td>Yes □</td>
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<tr>
<td>CS2</td>
<td>Programme area has documented care pathways for notification of screening results to participants in the screening programme which are on file at the local screening office and distributed to each venue participating in the programme.</td>
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<tr>
<td></td>
<td>Care pathways for notification of results are in screening office and distributed to screening venues.</td>
<td>Yes □</td>
<td></td>
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<tr>
<td>CS3</td>
<td>Programme area has documented care pathways for patient treatment that are on file at the local screening office and distributed to each venue participating in the programme.</td>
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<tr>
<td></td>
<td>Care pathways for patient treatment are in screening office and distributed to screening venues.</td>
<td>Yes □</td>
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<td>CS4</td>
<td>All local programme areas have documented care pathways for all partner notification activities that are on file at the local screening office and distributed to each venue participating in the programme.</td>
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<td></td>
<td>Care pathways for partner follow-up are in screening office and distributed to screening venues.</td>
<td>Yes □</td>
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<td>CS5</td>
<td>A documented plan for “failure to treat” is kept at the local screening office and distributed to each venue participating in the programme.</td>
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<td>Plan for ‘failure to treat’ is in screening office and distributed to screening venues.</td>
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<td>CP1</td>
<td>At least 50% of positives are treated within 14 days, and at least 90% are treated within 30 days from when the patient provided the sample for testing.</td>
<td>Numerator: the number of positives who were treated within 14 or 30 days from the date of the specimen.</td>
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<td>= ____________</td>
<td>Denominator: the total number of positives.</td>
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<td></td>
<td>= ____________</td>
<td>Percentage = _______________</td>
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<td>CP2</td>
<td>At least 50% of reported partners that are requested to be contacted by the CSO are treated within 14 days of the index patient’s treatment, and at least 75% of reported partners that are requested to be contacted by the CSO are treated within 30 days of the index patient’s treatment.</td>
<td>Numerator: the total number of reported partners requested to be contacted, and subsequently were contacted by the CSO, who were treated.</td>
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<td>Denominator: the total number of reported partners that were requested by patients to be contacted by the CSO.</td>
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| CO1     | At least 95%. | Numerator: the total number of positive screens who received treatment.  
|         |        | = __________ |      |
|         |        | Denominator: the total number of positive screens.  
|         |        | = __________ |      |
|         |        | Percentage = _______________ |      |
| CO2     | At least 50%. | Numerator: the total number of reported partners who received treatment.  
|         |        | = __________ |      |
|         |        | Denominator: the total number of reported partners (of chlamydia positives who were opportunistically screened in the local screening programme).  
|         |        | = __________ |      |
|         |        | Percentage = _______________ |      |
| CO3     | At least 75%. | Numerator: the total number of contacted partners who received treatment.  
|         |        | = __________ |      |
|         |        | Denominator: the total number of contacted partners (of chlamydia positives who were opportunistically screened in the local screening programme).  
<p>|         |        | = __________ |      |
|         |        | Percentage = _______________ |      |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Assessment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>LS1</td>
<td>All laboratories should have on file record of participation in a recognised quality assurance scheme.</td>
<td>Record of participation in a recognised QA scheme is in the laboratory. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>LS2</td>
<td>The NAAT platform used by the lab should run at least 90% efficiency.</td>
<td>The NAAT platform runs at least 90% efficiency. Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>LS3</td>
<td>All laboratories should have available staff who can liaise with the local screening office or screening venues regarding specimen submission, processing or notification of test results.</td>
<td>Laboratory has staff who are available to answer questions from screening offices and venues. Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>
| LP1     | At least 90%.                                                          | Numerator: the number of samples from the local programme area submitted to the laboratory for which the result was known (in the laboratory) within 2 days of the date received in the laboratory (3 working days if the sample is initially reactive).  
= ____________  
Denominator: the total number of samples from the local screening programme received in the laboratory.  
= ____________  
Percentage = _______________ |      |
| LP2     | At least 90%.                                                          | Numerator: the number of samples (from the local screening programme) where the result was reported by the laboratory to the CSO within 7 working days of receipt in the laboratory.  
= ____________  
Denominator: the total number of samples from the local screening programme received in the laboratory.  
= ____________  
Percentage = _______________ |      |
| LP3     | Less than 5%.                                                           | Numerator: the number of samples submitted from the local screening programme where the sample was inhibitory.  
= ____________  
Denominator: the total number of samples submitted from the local screening programme received in the laboratory.  
= ____________ |      |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| LP4     | Less than 5%. | Numerator: the number of samples submitted from the local screening programme where the patient’s test result was equivocal after the second test.  
|         |        | = _______________                                                           |      |
|         |        | Denominator: the total number of samples submitted from the local screening programme received in the laboratory.  
|         |        | = _______________                                                           |      |
|         |        | Percentage = _______________                                               |      |
## DATA MEASURES

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| DS1     | All programme areas should be able to report the core data for screening programme chlamydia tests electronically in one amalgamated file (across the entire programme area) to the HPA every quarter of the financial year. | Programme area can correctly report core data electronically to the HPA each quarter.  
Yes □  
No □                                                                                                                                                                                                  |      |
| DS2     | All programme areas must submit their test request form to the HPA for approval to use. All test request forms must comply with the data collection standards set out in the Core Requirements. | Programme area has submitted test request form to the HPA for approval and form complies with data collection standards.  
Yes □  
No □                                                                                                                                                                                                  |      |
| DP1     | At least 90% of each core item will be complete for every test record submitted to the HPA NCSP database.                                                                                                                                                                                                                           | Numerator: for each data item, the total number of test records reported where there is a valid value.  
= ____________  
Denominator: for each data item, the total number of test records reported.  
= ____________  
Percentage = _______________                                                                                                                                                                        |      |