National **Chlamydia**
Screening Programme

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Public Health Outcomes Framework: **Annual Chlamydia Diagnosis Rate (15-24 year olds)** **Frequently Asked Questions (FAQ)**	
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Annual Chlamydia Diagnosis Rate Indicator:
Frequently Asked Questions

Q1. **Why monitor diagnosis rate rather than coverage?**

The diagnosis rate measures how many chlamydia infections are found in a population. (The previous coverage target measured only how many tests were accepted by that population.) The diagnosis rate reflects both the coverage of tests and the percentage infected amongst those tested (positivity). The control of chlamydia is improved by diagnosing more infections, provided treatment and partner notification standards are met (NCSP core requirements).

Q2. What does the level of at least 2,300/100,000 population aged 15-24 years mean?

Population health measures often use rates per 100,000 population. Another way of saying this would be that we must find at least 23 people with chlamydia infections in every 1000 young people aged 15-24 each year.

Q3. Why does Public Health England (PHE) recommend that a diagnosis rate of at least 2,300/100,000 is achieved?

Based on achievements to date, a diagnosis rate of 2,300/100,000 is a challenging but achievable level. Finding and treating chlamydia infections is important to reduce the risk of pelvic inflammatory disease, ectopic pregnancy and tubal infertility, as well as further transmission of infection.

Modelling demonstrates how increasing the diagnostic rate can affect the prevalence of infection. Work is in progress to estimate how achievement of a diagnosis rate of 2,300/100,000 people aged 15-24 will reduce the prevalence of chlamydia infection, assuming that recommended standards of treatment and partner notification are met.

Although the indicator includes symptomatic cases detected through testing, most of the diagnoses made will be asymptomatic cases ascertained through screening. Therefore, at this stage of disease control, the indicator should not be seen as a measure of disease where low rates would indicate success.

Q4. Why was the recommended diagnoses rate reduced from 2400 to 2300 in June 2013?

The Department of Health, in consultation with PHE, has reduced the recommended chlamydia diagnosis rate within the Public Health Outcomes Framework, from ≥ 2,400 to ≥ 2,300 chlamydia diagnoses per 100,000 resident 15 – 24 year olds per annum.

Following changes to the chlamydia reporting system, it is now possible to remove previously double-counted tests from national and local totals. The >2,400 diagnosis rate was set based on data from the previous reporting system, which included double-counted diagnoses. As these will now be removed from chlamydia datasets, the recommended diagnosis rate has been reduced accordingly.

Local areas should work towards the recommended ≥ 2,300 level. This change does not represent an opportunity to reduce chlamydia screening activity, as local data will now be reported with these diagnoses removed. The Public Health Outcome Framework online tool will be updated in August 2013

Q5. If a local area is not currently achieving the >2300 diagnosis rate, is it worth continuing with chlamydia screening?

Yes. Finding and treating chlamydia infections remains important for averting potential cases of pelvic inflammatory disease, ectopic pregnancy and tubal infertility, as well as further transmission of infection. Furthermore, chlamydia screening provides an opportunity for sexual health promotion at every contact. Every infection diagnosed will be contributing to the indicator.

We recommend that all areas aim for at least 2,300 chlamydia diagnoses per 100,000 people aged 15-24 years. Areas that are achieving at or above this level should aim to sustain or increase diagnosis rates, with areas achieving below it aiming to increase their diagnosis rate incrementally, for example by 10% from the previous year.

Q6. If the focus is now on finding infections, why not just target high-risk individuals?

A focus only on individuals who are perceived to be at high-risk of chlamydia infections is not recommended as this approach has a number of problems. Firstly, the recommended diagnosis rate will only be achievable by widespread community testing as well as testing in GUM services.

Secondly, modelled reductions in population prevalence are based on the assumption of population-wide testing. Thirdly, chlamydia infection occurs quite commonly in individuals without well-characterised risk-factors who should not be excluded from screening opportunities, and approaching groups on the basis of their perceived sexual risk behaviours can increase stigma and discrimination. Fourthly, a selective screening approach risks undoing the advances the programme has made in normalising discussions about sexual health with young people and making opportunities for sexual health promotion. The most effective and sustainable way to achieve this is to embed chlamydia screening in primary care and sexual health services.

Q7. How does the diagnosis rate correspond to rates of coverage and percentage infected?

The coverage needed to achieve the recommended diagnosis rate varies according to the percentage infected amongst those tested. As a guide, a diagnosis rate around 2,300/100,000 is achieved by a total test coverage of 28.8% if the percentage infected amongst all tests is close to 8% (including GUM).

Q8. How should local authorities commission to achieve the recommended diagnosis rate?

Commissioning for a specific diagnosis rate must consider the proportion of the population tested and the proportion that will be found to have chlamydia amongst those tested. By using existing data on percentage infected from different services, an estimate of the number of tests needed to achieve the recommended diagnosis rate can be calculated. One approach is as follows:

1. Use data from previous years to estimate the annual diagnosis rate likely to be achieved from GUM in the coming year.

2. Work out how many diagnoses you need to achieve outside of GUM to reach the required diagnosis rate.

3. Look at previous data on percentage infected, testing volumes and annual service footfall of 15-24 year olds (i.e. potential testing volumes), to decide how to invest appropriately to reach the required diagnosis rate.

4. This will most often mean investing in primary care and sexual health services and restricting outreach to groups that are hard to reach. Remember that over 60% of young people visit their General Practitioner each year, and that research indicates that young people wish to receive the offer of a test in this setting.

The NCSP has developed a simple calculator that local areas may use to assist them in calculating the necessary coverage that must be achieved to reach the recommended diagnosis rate (Annual Diagnosis Rate Calculator).

Q9. What approaches can we use to maximise our diagnosis rate?

Partner notification and treatment is vital to the success of chlamydia screening. Evidence suggests that 65% of male partners of female index cases also have chlamydia. Focussing on partner notification and treatment will not only prevent re-infection and possible onward transmission, but will also help increase diagnosis rates. Emphasising the policy of chlamydia testing on sexual partner change will also assist as there is an increased risk of infection among those with a new partner and a high rate of partner change in this age-group .

In terms of commissioning services, we need to balance the need to identify and treat infections with the need to ensure that chlamydia testing is accessible to the entire population of 15-24 year olds. This is the reasoning behind setting a percentage infected standard (all venues combined) of between 5% and 12%. The best way to achieve this is to embed high volume chlamydia screening in all community and sexual health services that have contact with young people, with outreach chlamydia screening provided to hard to reach groups on the basis of a need identified in the regular Joint Strategic Needs Assessment performed by local Health and Well-being Boards.

We recommend that percentage infected amongst those tested is considered by venue type as a whole rather than comparing individual venues of the same type within an area. For example we would not recommend commissioning chlamydia screening from a Sexual and Reproductive Health (SRH) service in one locality with high positivity rates but not in another with lower rates. This is because it is important to maintain access to chlamydia screening for all young people in an area.

Q10. Where do we find data on our total diagnosis rate and percentage infected in GUM and community services?

The chlamydia diagnosis rate per 100,000 by LA is routinely published each quarter on the NCSP website .

Q11. Why will repeat diagnoses within 6 weeks on the same individual be counted only once?

This avoids double counting of the same infection. The NCSP recommends that repeat testing is not performed within 6 weeks of a positive test, as NAATs tests are so sensitive that they may detect dead organisms for 6 weeks after effective treatment with azithromycin. This decision therefore aligns the surveillance case definition with NCSP standards and also improves consistency with other STI datasets. Analysis has demonstrated that this change will have minimal impact on overall diagnosis rates.

Q12. What if overall percentage infected among those tested is below 5 or above 12%?

If overall percentage infected among those tested is below 5%, review the contribution to your total testing made by venue types with the lowest percentage infected. It is possible that resources could be more effectively allocated to venue types with a higher percentage infected amongst those tested, and venues types with higher partner notification rates. For example, it may be better to invest in sexual and reproductive health services in general which provide continuous access to testing and a higher percentage infected amongst those tested, rather than educational settings which rely on one off events and are associated with a much lower percentage infected.

If overall percentage infected is above 12%, consider if screening is widely accessible and review the contribution to screening of NCSP core services (GUM, GP, Sexual and Reproductive Health Services, Pharmacy and Termination of Pregnancy clinics). The NCSP recommends that at least 70% of tests are performed in these core services. (ref: Standards 6th edition)

Actions for local areas to improve chlamydia screening provision with regard to diagnosis rate

Diagnosis rate	Percentage infected	
	High (above 12%)	Low (below 5%)
Low (below 2,300/100,000)	Increase coverage. Review percentages infected by venue type, and consider expanding testing in core services.	Review percentage infected by venue type and consider moving resources from venue types with a lower percentage infected (e.g. outreach) to venue types with a higher percentage infected, particularly those with high potential throughput (e.g. core services). Ensure potential of diagnoses from partner notification is maximised.
High (above 2,300/100,000)	If most tests done in venue type with a higher percentage infected, consider whether access to testing is adequate for all young people. If testing is being accessed at range of community venues and percentage infected is high at all venues, continue.	Consider moving resources from venue types with a lower percentage infected (e.g. outreach) to those with higher percentage infected, to improve efficiency.

Q13. Will local areas be performance managed on achievement of the diagnosis rate indicator?

The government is clear that the public health system will not be used to performance manage local areas. Local Health and Wellbeing Boards will set local priorities for public health outcomes through the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing strategies, with due consideration of the outcomes in the NHS, Public Health and Adult Social Care Outcome Frameworks, one of which is the chlamydia diagnosis rate. Local commissioning will be aligned with priorities set out in these strategies.

Provision of comprehensive sexual health services, including screening for chlamydia, will be a mandated function of Local Authorities. The government has indicated that the proposed health premium will be linked with achievement of public health outcomes, but the detail is still to be announced.

Public Health England will publish diagnosis rate indicator data by upper-tier Local Authority so local areas may monitor their progress to improve outcomes and compare their achievement with other areas.

Q14. What impact will the new Chlamydia Activity Dataset (CTAD) have on the diagnosis rate?

Previous monitoring of chlamydia coverage, percentage infected and diagnosis rate in primary care and community services combined a number of different data sources. In 2012 a new surveillance system was introduced, the Chlamydia Testing Activity Dataset (CTAD). This unified comprehensive reporting system replaces the NCSP core data return and the non-NCSP, non-GUM aggregate data return.

The introduction of CTAD, and other changes in STI surveillance mean that diagnosis rates for 2012 will be different from previous years, and this is likely to be more evident at local authority levels due to variations in reporting. Therefore, chlamydia data for 2012 and onwards is not directly comparable with the data reported in earlier years. The changes in chlamydia surveillance are summarised in the document 'Understanding the changes in 2012 chlamydia data'.

Q15. What about monitoring of other aspects of chlamydia screening, does that need to continue?

Yes, to achieve the expected falls in chlamydia prevalence, partner notification rates and treatment rates should be maintained in line with NCSP standards. PHE expects to be able to provide some monitoring of treatment and partner notification rates through GUMCAD, but this relies on services using the appropriate codes to record treatment and whether a patient is a contact of a chlamydia case. Treatment and partner notification that is not recorded through these systems will not be included in the data available at national level. The NCSP is planning to develop a PN audit tool for local use as part of our QA programme for 2013/14.

Other quality assurance standards such as turnaround times and patient satisfaction surveys should continue.