BASHH Statement on Partner Notification for Sexually Transmissible Infections

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1. Summary of key principles

- Healthcare workers (HCWs) providing PN should have documented competencies appropriate to the care given. These competencies should correspond to the content and methods described in the Society of Sexual Health Advisers (SSHA) *National Sexual Health Advisers Competencies – Competency Record Book*
- All services involved in managing STIs should follow the NICE Guidance on one-to-one interventions to reduce transmission of STIs
- Services providing PN should have written care pathways linking all providers of STI care and PN to local Level 3 services included in service operational policies that are easily accessible to HCWs services
- If the offer of discussion of PN is declined, the reason for this should be documented in the patient record
- The appropriate look-back interval and use of epidemiological treatment should be used in PN
- Performance in PN provision should be included in service quality monitoring, and audited at least annually against the process outcome standards set in this Statement (see below)
- Services providing PN should have written guidance in service operational policies, that are easily accessible to HCWs, on when to collaborate with local HPUs, including the management of outbreaks of STIs
- Services providing PN should have written guidance in service operational policies that are easily accessible to HCWs on the use of data for safeguarding children and vulnerable adults. This guidance should be in accordance with the most recent BASHH Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People, and local guidance on safeguarding adults and the Mental Capacity Act 2005
- Services should keep up-to-date with developments in data collection for PN, including data collection methods that facilitate quality improvement activity

2. Partner notification

Partner notification (PN, also known as contact tracing) is the process of providing access to specific forms of healthcare to sexual contacts who may have been at risk of infection from an index case. This includes supportively providing advice to contacts about possible infection, and providing treatments for infection. The PN process includes identifying a look-back interval in which infection of contacts may have occurred, agreeing and recording contact actions with the index case, and following up and recording the outcomes of PN. Re-infection with chlamydial and gonorrhoeal infection is common,[1,2] stressing the importance of PN for the care of both individuals and their sexual partners. This applies to infection detection, reducing onward infection and re-infection, and the complications of infection. PN is important for the Public Health because it is a core component in the prevention of sexually transmitted infection. PN also involves providing other sexual health needs, including managing risk behaviour and ethical issues.

3. Aim

The aim of this Statement is to outline general principles on PN and to provide a resource for quality improvement activity. It is not intended to provide operational detail to support the provision of PN, which is described in the Society of Sexual Health Advisers Manual.[3]

4. Audience

The intended audience for this Statement are all those HCWs, managers, commissioners and other workers involved in the provision, initiation, contracting or support of PN. Recommendation 4 in the National Institute of Clinical Excellence evidence-based guidance on one-to-one interventions to reduce the transmission of sexually transmitted infections (STIs) specifies a wide range of HCWs taking action to 'Help patients with an STI to get their partners tested and treated (partner notification) …'. [4] This includes referral to specialist centres if necessary. The BASHH and Medical Foundation for AIDS and Sexual Health STI management Standards set a standard of clear clinical care pathways linking STI care networks to local Level 3 STI management services and leadership.[5]

5. Competency in PN provision

HCWs providing PN should have documented competencies appropriate to the care given. These competencies should correspond to the content and methods described in the Society of Sexual Health Advisers (SSHA) *National Sexual Health Advisers Competencies – Competency Record Book*.[6] Appropriately trained medical staff may contribute to the PN process.

6. Offering PN

At least one discussion (which may be a face-to-face or telephone discussion) should be offered to people found to have the infections listed below to begin the PN process. This discussion should be provided by a HCW with the appropriate documented competency. If the offer of discussion of PN is declined, the reason for this should be documented.

7. Infections for which PN should be offered and look-back intervals

The appropriate look-back interval for PN should be used. The look-back interval is the time during which the index case may have been infectious and transmitted infection, and should be applied to all contacts whether or not condoms were used. The table below lists the infections for which PN should be offered contact actions agreed with the index case, and followed up by a HCW with the appropriate documented competency. The corresponding look-back intervals, and whether or not epidemiological treatment of contacts is recommended, is also given. However, these look-back intervals are for guidance. Every case should be assessed on the basis of the sexual history, risk assessment and particular circumstances. There may be benefit in offering PN for some contacts outside these look-back intervals, and justification for not offering PN within the specified intervals.

8. Table showing look back intervals for partner notification and where epidemiological treatment recommended

Infection	Look-back intervals for partner notification*	Epidemiological treatment*
Chancroid	All contacts since and in the 10 days prior to onset of symptoms.	Yes
Chlamydial infection	• Male index cases with urethral symptoms: all contacts since, and in the four weeks prior to, the onset of symptoms[†] • All other index cases (*i.e.* all females, asymptomatic males and males with symptoms at other sites, including rectal, throat and eye): all contacts in the six months prior to presentation[†]	Yes
Epididymo-orchitis	Use the look-back intervals for chlamydial infection or gonorrhoea, if these are detected. If these infections are not detected, the look-back interval is for all contacts since, and in the six months prior to, the onset of symptoms[†].	Yes
Gonorrhoea	• Male index cases with urethral symptoms: all contacts since, and in the two weeks prior to, the onset of symptoms[†] • All other index cases (*i.e.* all females, asymptomatic males and males with symptoms at other sites, including rectal, throat and eye): all contacts in the three months prior to presentation[†]	Yes
Hepatitis A[‡]	Index cases with jaundice: all contacts in the two weeks prior to, and one week after, the onset of jaundice. Index cases without jaundice: if possible, estimate when infection is likely to have occurred based on a risk assessment. Notify the local CCDC[§], or equivalent, if an outbreak is suspected, there are household contacts, there are concerns about food or water borne infection, or the index case is a food handler.	No
Hepatitis B[‡,‖]	PN should include any sexual contact (vaginal or anal sex, or oro-anal sex) or injection equipment sharing partners during the period in which the index case is thought to have been infectious. The infectious period is from two weeks before the onset of jaundice until the index case is surface	No

	antigen negative. In cases without jaundice, if possible, estimate when infection is likely to have occurred based on a risk assessment. In cases of chronic infection, trace contacts as far back as any episode of jaundice, or to the time when the infection is thought to have been acquired, although this may not be possible for long look-back intervals. Appropriate repeat serological testing of contacts should be offered. Arrange hepatitis B screening of children who have been born to infectious women, if the child was not vaccinated at birth, according to national guidelines.[7] For screening of non-sexual contacts, including household contacts, who may be at risk, discuss with the CCDC[§] or equivalent.	
Hepatitis C[‡,‖]	The infectious period for acute hepatitis C is from two weeks before the onset of jaundice. However, usually there is no jaundice or history to suggest acute infection, and the look-back period for PN is to the likely time of infection (*e.g.* blood transfusion or first sharing of injection equipment), although this may not be possible for long look-back intervals. However, PN should be offered in two situations only, where: • There was vaginal or peno-anal sexual contact and either the index case and/or the sexual contact(s) have HIV infection • Sharing of injection equipment occurred during the period in which the index case is thought to have been infectious Appropriate repeat serological testing of these contacts should be offered. Sexual transmission of HCV through heterosexual sexual contact is uncommon if both the index case and sexual contacts do not have HIV infection, and PN is not recommended for this group. Check that children born to women with hepatitis C infection have been tested for hepatitis C infection in accordance with nationally accepted guidance.[8] For other non-sexual contacts thought to be at risk, discuss with the CCDC[§] or equivalent.	No
HIV infection	An estimate, based on a risk assessment, of when infection is likely to have occurred should be made and PN provided to include all contacts since, and in the three months prior to, this estimate. If this is not possible, all previous partners should be contacted and offered HIV testing. The risk assessment should take into account sexual history, HIV testing history (including antenatal and Blood Transfusion Service testing history), and history of possible seroconversion illness. Additionally, any results for recent infection testing algorithm (RITA) assays[10] for HIV infection, as well as CD4 cell counts and trend in CD4	Post exposure prophylaxis where indicated- see BASHH Guidelines[9]

	cell counts should be taken into account, although careful interpretation of these data is needed. PN for HIV infection should be part of ongoing care. Joint Specialist Society Guidelines recommend sexual history taking at six monthly intervals after first presentation with HIV infection.[11] Offer PN at follow-up visits when there are new sexual contacts whose HIV status is negative or unknown, or when new STIs are detected. Ongoing PN should include discussion about testing and re-testing of current partners and testing of children, where appropriate. Identifying undiagnosed HIV-positive children is a priority area of unmet need and practical guidance on the approach to HIV testing of children with HIV-positive parents is available.[12] Although there is no evidence-based guidance currently available, in a recent multi-disciplinary meeting[13] the following were agreed: • HIV PN should be initiated as soon as possible, and, by four weeks after a positive HIV test, agreed actions and timelines to resolve PN should be documented. Any outcomes of PN should also be documented at this time. • Consensus that PN should be resolved by three months, but that if PN is still unresolved by this time it should be continued, with clear timelines, as successful PN outcomes have been reported up to 12 months after a positive HIV test.	
LGV infection	All contacts since and in the four weeks prior to the onset of symptoms.	Yes
Non-specific (non-chlamydial, non-gonococcal) urethritis in men	Male index cases with symptoms attributable to urethritis: all contacts since, and in the four weeks prior to, the onset of symptoms[†] (Screening of men, without clinical features suggesting urethritis, by microscopy is not recommended practice, and therefore PN is not recommended for this group).	Yes
Pelvic inflammatory disease	Use the look-back intervals for chlamydial infection or gonorrhoea, if these are detected. If these infections are not detected, the look-back interval is for all contacts since, and in the 6 months prior to, the onset of symptoms[†,¶].	Yes
Phthirus pubis infestation	All contacts since, and in the three months prior to, the onset of symptoms.	Yes– current sexual partner(s) only

Scabies infestation	All contacts (including non sexual contacts: those with prolonged skin-to-skin contact, bed and clothes sharing, and household contacts) since, and in the two months prior to, the onset of symptoms.	Yes– current sexual partner(s) and current non-sexual contacts
Syphilis	• Early syphilis: ○ Primary syphilis: all contacts since, and in the three months prior to, the onset of symptoms ○ Secondary and early latent syphilis: all contacts since, and in the two years prior to, the onset of symptoms Sexual contacts of index cases with early syphilis should have serological testing for syphilis at the first visit, and have this repeated six weeks and three months from the last sexual contact with the index case. • Late latent and late syphilis: PN (of sexual partners and children of female patients) should be done back to the date of the last negative syphilis serology, if available. Otherwise, it should extend back over the patient's sexual lifetime as far as is feasible. Because of the possibility of congenital syphilis, consideration should also be given to the testing of mothers of patients with late syphilis who were born outside the UK in countries where sub-optimal antenatal care was a possibility	Yes– in cases of early syphilis, particularly for high risk contacts and events and when contacts may not attend for repeat testing for syphilis Not for latent and late syphilis
Trichomoniasis	Any partner(s) within the four weeks prior to presentation should be treated[**].	Yes– current partner(s) and any other partners connected with recurrent trichomoniasis. Current contact(s) should take treatment at the same time as treatment is taken by the index case

*The look-back intervals and recommendations on epidemiological treatment stated are consistent with the BASHH Clinical Effectiveness Group (CEG) Guidelines,[14] except for chlamydial infection, where there is more qualification based on the presence or absence of symptoms (the BASHH CEG Chlamydia Guideline states four weeks for [all] symptomatic infection and six months for [all] asymptomatic infection). The recommendation in this Statement is also more consistent with the PN recommendation in the CEG BASHH guideline for gonorrhoea.

[†]If there have been no sexual contacts in these intervals: the most recent sexual contact beyond this interval.

‡Acute infectious hepatitis (caused by hepatitis A, B and C) are diseases notifiable (to Local Authority Proper Officers) under the Health Protection (Notification) Regulations 2010 Health Protection Agency.[15]

§CCDC Consultants in Communicable Disease Control (or Consultants in Health Protection), are responsible for the surveillance, prevention and control of communicable disease (as well as the health aspects of non-communicable environmental hazards) for a defined population within (a) defined local authority area(s). They work, along with specialist nurses, in the Health Protection Agency network of Health Protection Units (HPUs) in England. HPUs work closely with other local services involved in disease detection, surveillance and control, including local microbiology laboratories. There are equivalent systems in Wales and Scotland.[16]

‖PN should be offered at follow-up visits when there are new sexual contacts, and to discuss re-testing of current partners and testing of children, where appropriate

¶The 6 month look-back interval for PID is given arbitrarily on the basis that *Mycoplasma genitalium* may cause disease in women and be asymptomatically carried in men and women for an unknown period.[17] Also, false negative chlamydial nucleic acid amplification tests, as well as discordant chlamydial test results, and different rates of spontaneous clearance of chlamydial infection, between sexual partners, are possible.[18]

**Trichomonal infection appears to resolve spontaneously in most men, usually within two weeks, with detection rates in men decreasing with increasing time from last sexual contact with female index cases. However, prolonged asymptomatic carriage has been demonstrated in some men.[19,20,21]

9. Agreed contact actions

When the first PN discussion takes place, a plan should be agreed with the index patient about which contacts to contact and, if so, how this should be done. All contacts in the appropriate look-back interval should be included. All contacts include those considered not traceable, as well as those who had attended a service for management of the relevant infection before the index patient was first seen. In deciding whether a contact is traceable, appropriate use of all information sources should be considered.

Possible contact actions are: patient, provider or contract methods of PN (see page 20 of the Manual for Sexual Health Advisers[3] for definitions of these methods), or no action. No action is appropriate when a contact is considered not traceable, or a contact has been verified as already seen. Not traceable may include contacts cannot be contacted by patient, provider or contract methods of PN because of lack of information, or because of patient preference or welfare needs not to involve a contact. However, there may be circumstances requiring a best interests obligation to break confidentiality (*e.g.* when the health of another person is at risk), when local policies should be followed.

These recommendations should be used together with those in the Society for Sexual Health Advisers (SSHA) Manual for Sexual Health Advisers[3] and the BASHH UK National guidelines on undertaking consultations requiring sexual history taking,[22] as well as the soon-to-be-published SSHA National Sexual Health Adviser Competencies.

10. PN resolution

PN resolution (the outcome of an agreed contact action) for each contact should be documented within four weeks of the date of the first PN discussion. Documentation about outcomes may include the attendance of a contact at a service for the management of the infection, testing for the relevant infection, the result of testing and appropriate treatment of a contact. A record should be made of whether this is based on index case report, or verified by a healthcare worker. Verified means confirming contact attendance by checking records in your own service, or by contacting other services where contacts may have attended.

Exceptions to meeting the four week documentation target include prioritising urgent health needs (*e.g.* in an ill patient or a patient with multiple health problems), as well as disclosure issues (*e.g.* with regard to the management of people with HIV infection). These exceptions, as well as an agreed time frame for resolution, should be clearly documented.

11. Legal issue regarding sharing of information between services

In England, The *NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000*[23] allow information to be shared about people with sexually transmitted infections for the purpose of control of infection, and support one service informing another service whether a contact has attended that service. In particular, the 2000 Directions maintain the principles in the *The National Health Service (Venereal Diseases) Regulations 1968*[24] and the instructions in the accompanying Memorandum[25] which describes good practice in contact tracing. The 2000 Directions will require review to account for the current organisational reform of healthcare services in England. In Wales the National Health Service Trusts (Venereal Diseases) Regulations 1974 and the 1968 Memorandum continue to apply[26]. Similar good practice of sharing information between services is well-established in Scotland and Northern Ireland without there being any equivalent legislation.

12. PN auditable outcome measures for BASHH Clinical Effectiveness Group Guidelines

The following four process outcome measures are intended for use in future relevant CEG Guidelines and National Audit Group audit questionnaires that deal with infections requiring PN:

1. The percentage of index cases documented as offered at least one discussion, which may be a telephone discussion, for the purpose of PN with a HCW with the appropriate documented competency. Performance standard 97%.

2. The percentage of index cases having the outcome of (an) agreed contact action(s), or the decision not to contact, documented for all contacts. Performance standard 97%.

The 97% performance standards are to allow for one case in forty* audited not having the recommended documentation owing to a random performance lapse not accounted for in a list of exceptions or exclusions, or a single data entry error.

3. The number of all contacts whose attendance at a sexual health service offering services at Level 1, 2 or 3 was documented as reported by the index case, or by a HCW[†], within four weeks of the date of the first PN discussion[‡].

The performance standard for index-reported chlamydial PN is: at least 0.6 contacts per index case for all clinics, both outside London and in London, and documented within four weeks of the date of the first PN discussion.
(Please see the rationale in the annex below for the proposed updated chlamydial PN standards).

The performance standards for index-reported gonorrhoeal PN are: at least 0.4 contacts per index case in London clinics, or at least 0.6 contacts in clinics outside London, and documented within four weeks of the date of the first PN discussion.

More work is needed to determine standards for this measure for other infections.

*The number of cases suggested for audits by the Royal College of Physicians.[27]

[†] When counting the number of index-reported contact attendances, include:

- Contacts with attendance verified by a HCW, even if there is no record of attendance reported by an index case. Many contacts with verified attendance will also have reported attendance. However, it may be possible to record that a contact was verified as having attended the same clinic (or another clinic), without this being reported by an index case, provided that sufficient baseline contact information was obtained. Counting verified attendance in with reported attendance is intended to facilitate the counting of contacts for the purpose of audits and improve consistency between clinics. This means that the number of reported contacts should be greater than the number of verified contacts
- Contacts reported as attending by a HCW. A HCW may have received information, other than from the index case, that a contact has attended a service managing STIs, without verifying this by contacting that service

[‡]The first PN discussion is the first discussion (including a telephone discussion) for the purpose of PN between the index case and a HCW with the appropriate documented competency.

4. The number of all contacts whose attendance at a sexual health service offering services at Level 1, 2 or 3 was documented as verified by a HCW, within four weeks of the date of the first PN discussion.

The standard for verified chlamydial PN is: at least 0.4 contacts per index case for all clinics, both outside London and in London, and documented within four weeks of the date of the first PN discussion.
(Please see the rationale in the annex below for the proposed updated chlamydial PN standards).

It may not be possible to verify contact attendance, *e.g.* when there is no information about where a contact may have attended. However, as a minimum, a clinic's own records should be checked for contact attendance. Also, please see the comments below in the future developments section.

More work is needed to determine standards for this measure for other infections.

13. Interface between PN and outbreak/incident control

PN has a prime role in the control of outbreak of STIs, including blood borne infection, and these are occasions when HCWs providing PN should work closely with local HPUs. Guidance on dealing with infection outbreaks and collaborating with local HPUs for England is provided in the Health Protection Agency *Guidance for Managing STI outbreaks and incidents*.[28]

The HPA defines an STI outbreak/incident as one of the following:

- An observed number of cases that is greater than expected over a defined time period in a given community. This could amount to a small number of cases
- Linked cases that are of public health significance
- A situation that requires the re-organisation of services or development of additional resources to diagnose and manage cases

The Guidance also emphasises the need for local clinicians to review clinical data in order to detect, and act on outbreaks.

Where a potential outbreak or incident has been identified, the HPU can support the management of the outbreak/incident, including liaison with adjacent localities as appropriate. Typically there three phases of outbreak/incident control:

- **Phase 1 (Preliminary)**: an incident team is convened to determine whether a problem exists and, if so, what action to take next
- **Phase 2 (Control):** An outbreak control team (OCT) develops and implements strategies to limit onward transmission of infection, using a variety of investigation and control approaches
- **Phase 3 (Evaluation)**: a process evaluation, and assessment of success using primary outcome measures is undertaken, with audit as necessary

An example of an incident jointly managed in this way is described in a recent publication.[29]

14. Safeguarding children and vulnerable adults

HCWs should distinguish between obtaining information on sexual partners for the purpose of PN and when such information may be used for the purpose of protecting children or vulnerable adult. If there are concerns about a sexual partner and the risk of sexual abuse or exploitation, or if such concerns arise as a result of asking questions for PN, (further) questions should not be asked for PN purposes without firstly stating that any information obtained may be passed on to safeguarding services. Information obtained as a result of asking questions for PN purposes that raises concerns about abuse or exploitation in children or adults should be managed according to the BASHH Guideline on the management of STIs and related conditions in children and young people,[30] and local guidelines on safeguarding adults, respectively.

15. HIV-PN

The development of outcome measures and standards for HIV-PN, to drive improved HIV-PN performance, is urgently needed in the face of a growing epidemic of HIV infection. This should be supported by the same principles described above. Appropriate resources should be provided to those involved in HIV-PN. This should extend to outreach work, including working effectively with workers involved with high risk venues, the voluntary sector and web-based social network sites. Approaches may need to be tailored for specific at risk groups (*e.g.* men who have sex with men and Black and ethnic minority groups). The more intensive support

which is often needed in helping people with HIV infection to involve contacts should have the necessary management and funding.

Clinics should review their systems intended to support HIV partner notification, including record-keeping. Although there are currently no standards against which to measure HIV-PN outcomes, clinics should also regularly measure HIV-PN outcomes – these data will help inform the future development of performance standards.

16. Future developments in PN

Verification of PN process outcomes, with evidence of contact management, rather than index patient-reported process outcomes, may be of greater value in future national performance reporting system. This may be particularly important for future evidence-based commissioning of services. The development of secure, patient-centred, web-based solutions, such as electronic PN, that can verify contact management will be important in providing tools to support such reporting.[31]
Patient-centred process outcomes (*e.g.* contacts seen per index case) conceal the variability in transmission likelihoods associated with different types of contact (*e.g.* live-in, regular, and casual). The measurement of PN process outcomes in terms of contact centred outcomes (*e.g.* transmissions prevented according to contact type) may be a better estimation of the impact, and optimal use, of resources for PN.[32]

17. Contributors

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18. Document development and review plan

20.01.2011. A BASHH CSU Meeting took place when it was recognised that there are many different statements relating to the measurement PN outcomes in the CEG Guidelines. Therefore, it was decided to develop a set of uniform questions on PN process outcome measures that could be referred in both future CEG Guidelines, as well as by NAG audit questionnaires. In order to support the provision of these audit questions, it was agreed a well-developed statement on PN was need. Additionally, it was decided the results of the BASHH 2011 audit against the BASHH MedFASH Standards could be used to update the existing chlamydial PN process outcome measures.
January 2011 to September 2011. Drafts were produced involving the BASHH NAG, CSU and CEG, as well as authors of the BASHH CEG Guidelines, and expert opinion obtained. During this time, the BASHH 2011 Audit against the BASHH MedFASH STI Management Standards was conducted and the results analysed.
10.09.2011. Initial submission to BASHH CEG, followed by further drafting.
October to November 2011. A draft statement was posted on the BASHH CEG public web page for consultation.
December 2011 to February 2012. Further drafts were produced, incorporating consultation with the SSHA and experts.
07.02.2012. Resubmission to the BASHH CEG post-consultation followed by further drafting.
08.05.2012. Final resubmission to the BASHH CEG.
03.07.2012. Final version agreed by the BASHH CEG and the authors.

Review plan: this document will be reviewed by the BASHH CEG in 2015, or earlier if a reason for change is presented to the BASHH CEG.

19. Annex: Rationale for the updated chlamydial PN standards

What is the proposed update for current standards based on, and why change?
The proposed update of the current PN standards is based on new PN performance data from the 2011 BASHH Audit against the KPIs in the BASHH MedFASH STI Management Standards (STIMS).[33]

Performance data from the STIMS Audit is summarised in the table below:

Median number of contacts seen per index case in Level 3 clinics in the 2011 STIMS Audit

	Verified by a HCW	Reported by patients
Outside London clinics that provided data for 40 cases (n=62 clinics)		
Median	0.60 % cases ≥ this level = 52%	0.55 % cases ≥ this level = 52%
London clinics that provided data for 40 cases (n=37 clinics)		
Median	0.35 % cases ≥ this level = 51%	0.80 % cases ≥ this level = 51%

The current standards[34] are based on a number of different surveys, which used various methodologies, and all of which are more than ten years old, and where process outcomes for index case-reported and HCW-verified contact events could not be differentiated. Performance has also changed: index case-reported contact attendance for Level 3 clinics in London is now higher than that for Level 3 clinics outside London. The STIMS Audit provides a large amount of current data on PN performance, using a uniform methodology, that allows updating of the current standards, including the proposal of new standards for HCW-verified contact attendance. Further details on PN performance in the STIMS Audit await publication.[35]

What has remained the same in the updated chlamydial PN standards?
The 0.6 standard for index case-reported contact attendance has remained the same for clinics other than large city clinics (London, Birmingham and Manchester).

What is different in the updated chlamydial PN standards?
There are three main changes:

- Clinics are grouped as outside London or London clinics, instead of other and London/large city

(See below for the reason for this)

- The standard for index case-reported contact attendance for large city clinics, including London clinics, is now 0.6

(See below for the reason for this change, which is based on performance and acceptability factors)

- The standard for verified contact attendance is the same for outside London and London clinics

(See below for the reason for measuring verified contact attendance, and the basis for the verification standard)

Why are clinics now grouped as outside London or London clinics?
The original grouping in the review that set the current PN standards for chlamydial contact tracing[34] was 'London/large city' (qualified as London, Birmingham and Manchester) and 'Other,' since referred to as 'large conurbation' and 'elsewhere' in the STIMS . The STIMS Audit reported on performance for clinics in London and clinics outside London. The reason for this was that there is lack of current PN performance data to support grouping particular large cities with London, and there are other large cities with similar or greater population densities compared to Birmingham and Manchester.[36] More recent chlamydial PN performance in three large genitourinary medicine clinics in the West Midlands is closer to the 0.6 standard.[37] Additionally, more recent

national audits have presented London chlamydial PN performance data separately.[38,39] In the STIMS Audit, the four participating clinics in Birmingham and Manchester had a median index case-reported contact attendance of 0.49 contacts per index case, lower than the median for the London clinics and closer to that of other clinics outside London.

Why is the London standard for index case-reported contact attendance now 0.6?
This is based on performance and acceptability factors. The current standard for index case-reported contact attendance for London clinics is 0.4, but the median performance for London clinics in the STIMS Audit for this measure was 0.8. Rather than propose a new standard which is double that of the current standard, 0.6 is proposed as a standard that would be more acceptable. A recent publication on PN performance from a London clinic supports the proposed 0.6 standard (with 64% of patients with chlamydia having at least one partner treated within 4 weeks, mainly based on patient report and a well-designed electronic data recording system).[40]

Why is verified contact attendance being measured?
Verified contact attendance reflects best practice in PN because it allows ascertainment of whether contacts were actually appropriately seen, and provides a reliable measure of the Public Health impact of PN work. However, verifying contact attendance requires more support and resources, including dedicated time in job plans and administrative support for HCWs to do this work, as well as support from managers and commissioners.

Why is the outside-London standard for verified contact attendance 0.4?
This is based on performance and acceptability factors**.** Even though median verification performance for clinics outside London is 0.6, a lower standard at 0.4 is proposed. This is because verification may be generally considered to less easy to achieve than patient-reported contact attendance, and the 0.4 standard may be more acceptable to clinics outside London.

Why is the London standard for verified contact attendance 0.4?
Slightly more than half of all London clinics submitting performance data on 40 cases had a median verification rate of 0.35. This value has been rounded up to 0.4.

20. References

1 Hillis S, Owens L, Marchbanks P, et al. Recurrent chlamydial infections increase the risks of hospitalization for ectopic pregnancy and pelvic inflammatory disease. *Am J Obstet Gynecol* 1997;**176**:103e7

2 Fowler T, Caley M, Johal R, Brown R, Ross JDC. Previous history of gonococcal infection as a risk factor in patients presenting with gonorrhoea. *Int J STD AIDS* 2010;**21**:277-8

3 Society of Sexual Health Advisers. SSHA Manual. See http://www.ssha.info/resources/manual-for-sexual-health-advisers/ (last accessed 5 February 2012)

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