INTRODUCTION

- Sexually transmitted infections, HIV and unplanned pregnancies continue to be a major public health problem in England, especially in young adults.
- Strengthening the provision of sexual health services within primary care is seen as an important contributing factor to reducing poor sexual and reproductive health outcomes.
- National guidelines currently recommend general practices provide chlamydia screening to all sexually active 15 to 24 year olds and HIV testing for patients presenting with clinical indicator conditions and, all new patient registrants in high prevalence areas.
- Public Health England has piloted an educational training programme based on the Theory of Planned Behaviour (Figure 1) to support general practice staff to routinely offer chlamydia testing, information about the provision of contraceptive services and free condoms (the 3Cs) to all 15 to 24 year olds regardless of the type of consultation, plus HIV testing in line with the guidelines specified. This intervention was based on an intervention that was tested in a randomised control trial.

METHODS

- The pilot was implemented using a stepped wedge design so all recruited practices would receive training but at different time points.
- General practices were randomised to one of three training phases: August 2013, November 2013 and January 2014 (Figure 2).
- The primary outcome measures following training were changes to chlamydia testing and diagnosis rates within each practice for patients aged 15 to 24 years.
- Chlamydia testing and diagnosis data from January 2013 to September 2014 were retrieved from the national chlamydia surveillance system, the Chlamydia Testing Activity Dataset (CTAD) and patient registration data was available from the Health and Social Care Information Centre.
- Rates pre- and post-training (control and intervention periods respectively) were compared using incident rate ratios (IRR) from a multivariable negative binomial regression model with general practice fitted as a random effect.
- Data were analysed using both an ‘intention-to-treat’ method which included data for all practices initially recruited to the programme, and a ‘per-protocol’ method including data for practices that received the full intervention (two training sessions: one on the 3Cs and one on HIV).
- Regression models were developed for men and women separately to assess differences in effectiveness.

RESULTS

- 460 general practices across 49 local authorities were recruited to the pilot.
- 26,021 chlamydia tests were conducted during the pre-intervention period (control) and 1,493 chlamydia diagnosis made. The median number of tests per practice per month in this control period was 2.68 (IQR: 0.9-13.1) and median diagnoses per practice per month was 0.14 (IQR: 0.0-9.0).
- 18,797 chlamydia tests were performed during the post-intervention period and 955 chlamydia infections were identified. The median number of tests per practice per month in the intervention period was 2.67 (IQR: 2.0-20.7) and median diagnoses per practice per month was 0.13 (IQR: 0.0-9.0).
- The ‘intention to treat’ multivariable mixed effect regression analysis using data from men and women combined did not find a significant change in testing or diagnoses rates within general practices after they received training (IRR: 1.01, 95% confidence interval (CI) 0.96-1.07, P=0.718 and IRR 0.98, 95% CI 0.84-1.15, P=0.837 respectively).
- There was a significant increase in testing in practices that received payment for screening before training began and a near significant increase in practices that had a lower than the average chlamydia screening rate before training began. There was also a significant increase in testing for practices that employed between 6 and 15 general practitioners (Table 1).

DISCUSSION

- This large national pilot found that educational support sessions to increase chlamydia screening in primary care were only effective in subsets of general practices.
- 3Cs & HIV training may be a useful tool to help practices initiate chlamydia screening or make better use of the resources already available to them, as demonstrated by the interactions found in the model. However, these findings suggest that this intervention is unlikely to increase national testing rates in any substantial way as, whilst increases found were statistically significant, they were still relatively small in magnitude.
- This highlights the importance of using local data to identify specific sub-groups of practices where such an intervention may be most effective, and using this to inform implementation of complex interventions aiming to improve sexual health services for patients.

REFERENCES


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