

## Proposed BASHH statement on partner notification

### Offering partner notification

Partner notification (PN, contact tracing) is important both for the care of individuals and their sexual partners. PN is important for the Public Health because it is a core component in the prevention of sexually transmitted infection.

At least one discussion (which may be a telephone discussion) with a sexual health adviser, or other professional trained in Sexual Health Advising or in PN, should be offered to people found to have the infections listed below. Trained in PN means that the practitioner has attained documented competency in PN provision. If the offer of discussion of PN is declined, the reason for this should be documented.

### Look-back intervals

The appropriate look-back interval for PN should be used. The table below lists the infections for which PN should be offered, along with the corresponding look-back intervals:

Infection	Look back intervals for partner notification
Chancroid	10 days prior to onset of symptoms. Consider epidemiological treatment.
Chlamydial infection	<ul style="list-style-type: none"><li>• Symptomatic male index case: 4 weeks prior to the onset of symptoms</li><li>• Female and asymptomatic male index cases: 6 months, or the last sexual contact, whichever gives rise to the longer interval</li></ul>
Gonorrhoea	<ul style="list-style-type: none"><li>• Symptomatic male index case: 2 weeks prior to the onset of symptoms</li><li>• Female and asymptomatic male index cases: 12 weeks, or to the last sexual contact, whichever gives rise to the longer interval</li></ul>
Hepatitis A	2 weeks prior to and one week after the onset of jaundice. Based on risk assessment of cases without jaundice.
Hepatitis B	Contact tracing should include any sexual contact (vaginal or anal sex, or oro-anal sex) or needle-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 patient becomes surface antigen negative. 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 be impractical for periods of longer than two or three years. Arrange hepatitis B screening of children who have been born to infectious women, if the child was not vaccinated at birth. For screening of other non-sexual partners who may be at risk, discuss with the CCDC or equivalent.
Hepatitis C	Contact tracing should include any sexual contact (vaginal or anal sex, or oro-anal sex) or needle-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 in acute infection. If there was no acute infection trace back to the likely time of infection (e.g. blood transfusion, first needle sharing) although this may be impractical for periods longer than two or three years. Consider testing children born to infectious women. For other non-sexual contacts thought to be at risk, discuss with the CCDC or equivalent.
HIV infection	Based on a risk assessment, which should take into account sexual and HIV testing history, history of possible seroconversion illness, recent infection testing algorithm (RITA) for HIV infection result (where available) and CD4 cell count.
LGV infection	30 days prior to the onset of symptoms. Consider epidemiological treatment of sexual contacts.
Non-specific genital infection (including non-chlamydial, non-gonococcal urethritis)	<ul style="list-style-type: none"><li>• Symptomatic index case: 4 weeks prior to the onset of symptoms</li><li>• Asymptomatic cases: 6 months, or the last sexual contact, whichever gives rise to the longer interval</li></ul>

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and cervicitis in men and women respectively)	
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 6 months prior to the onset of symptoms or to the last sexual contact, whichever gives rise to the longer interval.
<i>Phthirus pubis</i> infestation	3 months prior to the onset of symptoms.
Scabies infestation	2 months prior to the onset of symptoms.
Syphilis	<ul style="list-style-type: none"> <li>• Early syphilis: <ul style="list-style-type: none"> <li>○ Primary syphilis: 3 months prior to the onset of symptoms</li> <li>○ Secondary syphilis: up to two years prior to the onset of symptoms</li> </ul> </li> </ul> <p>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.</p> <p>Consider epidemiological treatment of sexual contacts, particularly for high risk events.</p> <ul style="list-style-type: none"> <li>• Latent and late syphilis: contact tracing (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</li> </ul>
Trichomoniasis	Any partner(s) within the previous 4 weeks should be treated at the same time as the index case.

### **Agreed contact actions**

A contact action for all contacts should be agreed and documented at the first PN discussion with the index patient. All contacts include those contacts considered not traceable, as well as contacts who had attended a service for the management of the infection before the index patient was first seen for management. Not traceable means that a contact cannot be contacted by patient, provider or contract methods of PN because of lack of information or because of patient-preference not to contact.

Possible agreed contact actions are: patient, provider or contract methods of PN (see page 20 of the Manual for Sexual Health Advisers for definitions of these methods), or no action. No contact tracing action may be appropriate when a contact cannot be contacted by patient, provider or contract methods of PN because of lack of information, or because of patient-preference or welfare needs.

### **Partner notification resolution**

PN resolution (the outcome of an agreed contact action) for each sexual contact should be documented within four weeks of the date of the first PN discussion. Documentation about outcome 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 agencies where contacts are reported to have attended.

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Exceptions to meeting the four week documentation target include prioritising urgent health needs, 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.

These recommendations should be used together with those in the Society for Sexual Health Advisers [Manual for Sexual Health Advisers](#) and the BASHH [UK National guidelines on undertaking consultations requiring sexual history taking](#)

### **Proposed PN auditable outcome measures for BASHH Clinical Effectiveness Group Guidelines**

The following 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 partner notification (PN) with a sexual health adviser or healthcare worker trained in Sexual Health Advising or in PN. Standard 100%.
2. The percentage of index cases for whom the outcome of (an) agreed contact action(s), or the decision not to contact trace, was documented for all contacts. Standard 100%.
3. The proportion of all contacts whose attendance at a Level 1-3 sexual health service was documented as **reported** by the index case or by a healthcare worker (the healthcare worker may have received information, other than from the index case, that a sexual contact has attended a service managing STIs, without verifying this by contacting that service), within four weeks of the date of the first PN discussion. The first PN discussion is the first discussion (including a telephone discussion) for the purpose of PN between the index case and a sexual health adviser or healthcare worker trained in Sexual Health Advising or in PN.

*The standard for index-reported chlamydial PN is: at least 0.6 contacts per index case for all clinics, both outside London and in London, 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 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, 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.

4. The proportion of all contacts whose attendance at a Level 1-3 sexual health service was documented as **verified** by a healthcare worker, 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, 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).

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

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## Annex: Rationale for the proposed updated chlamydial PN standards

### **What is the proposed update for current standards based on?**

The proposed update of the current PN standards is based on PN performance data from the 2011 BASHH Audit against the KPIs in the BASHH MedFASH STI Management Standards (STIMS), summarised in the table below.

### **What has remained the same in the updated chlamydial PN standards?**

The 0.6 standard for index case-reported contact attendance for clinics other than large city clinics (London, Birmingham and Manchester) has remained the same.

### **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)
- Verified contact attendance is now being measured with the same standard proposed for outside London and London clinics (See below for the reason for measuring verified contact attendance and the reasons for the standard for verification, which are based on performance and acceptability factors)

### **Why are clinics now grouped as outside London or London clinics**

This distinction was made in the review (Low et al Sex Transm Infect 2004) that led to the current PN standards for chlamydial contact tracing. In the 2011 STIMS Audit, in one of the other large cities, patient-reported contact attendance was at the 0.6 level in two clinics. In two clinics in the other large city, although patient-reported contact attendance was lower than 0.6, verified contact attendance in these clinics was close to 0.6. Therefore, since PN performance for the two large cities outside London is similar to that in other places outside London, it is proposed that these clinics are included in the outside London group of clinics.

### **Why is the London standard for index case-reported contact attendance now 0.6?**

The current standard for index case-reported contact attendance for London clinics is 0.4, but the median performance for London clinics for this measure is 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. In support of high PN performance in London is a recent publication on PN performance in a London clinic (Brook et al Sex Trans Dis 2011) which 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).

### **Why is verified contact attendance being measured?**

Verified contact attendance reflects best practice in PN with ascertainment of whether contacts were actually appropriately seen, and a reliable measure of the Public Health impact of PN work. Verified PN requires more support and resources. There may be secure, web-based solutions available in the future to assist with verification of contact attendance.

### **Why is the outside-London standard for verified contact attendance 0.4?**

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 be less easy to achieve than patient-reported contact attendance and the 0.4 standard may be more acceptable to clinics outside London.

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### 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.

### Why might performance based on verification of contact attendance be higher than that based on patient-reported contact attendance?

It is possible to record that a contact was verified as having attended the same clinic (or another clinic), provided that sufficient baseline contact information was obtained, without asking the index case about contact attendance. For contacts seen in the same clinic, this can also be done, for example, by searching electronic patient records for a name, approximate age, and perhaps some information about where the contact lives. Of course, this may be offset by other index cases from whom sufficient baseline information about contacts is not obtained (for example, index cases not knowing contact surnames to allow this operation), but, depending on the net outcome, it is possible that performance based on verification may be higher.

**Table. Median number of contacts seen per index case in the 2011 STIMS Audit**

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

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**To help with processing comments, please use the following headers if responding to the consultation on this proposed statement:**

- State your particular interest area: health adviser, nurse trained in PN, etc.
- Reference the particular statement(s) to which you are responding (page, paragraph number, line numbers)
- State clearly your agreement or disagreement with the statement(s)
- Provide reference(s) to any evidence used to support your agreement or disagreement
- Where possible, provide a solution on how the statement(s) could be improved, including an edition of the statement(s)
- Other comments

Please send responses to [hugo.mcclean@chcphull.nhs.uk](mailto:hugo.mcclean@chcphull.nhs.uk)