



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 963
SESSION 2008–2009
12 NOVEMBER 2009**

Department of Health

Young people's sexual health: the National Chlamydia Screening Programme

Summary

1 In 2003 the Department of Health (the Department) launched the National Chlamydia Screening Programme in England; to date £150 million has been included in NHS allocations for the Programme. We estimate on the basis of survey data, that around £100 million has been spent on delivering the Programme. Funding is not 'ring-fenced' and local Primary Care Trusts (PCTs) decide local budgets. Chlamydia is the most commonly-diagnosed bacterial sexually transmitted infection and is increasing, especially in young people under the age of 25. The Programme aims to identify, treat and control this infection, which is often symptomless and can cause serious health problems including infertility.

2 The Programme has been coordinated nationally since November 2005 by the Health Protection Agency (the Agency), which facilitates and supports the implementation of the Programme and its monitoring and evaluation. The Agency does not allocate local budgets for the Programme, nor engage directly in performance management. The Programme is delivered locally by the 152 PCTs in England, who commission Chlamydia Screening Offices to coordinate the testing of young people under the age of 25.

3 Most testing under the Programme takes place in community health services such as doctors' surgeries and community sexual health services (family planning clinics). A significant amount of testing also occurs in other settings including schools, colleges and youth centres. Many PCTs also offer self-testing services in which young people order test kits from a website, produce a urine sample or swab and return the samples by post for laboratory analysis. This is because the Programme has an 'opportunistic screening' approach – in contrast to the systematic approach adopted by screening programmes for other conditions – aiming to reach young people without requiring them to visit a genito-urinary medicine clinic. This approach was adopted for chlamydia screening for a number of reasons, including the difficulty of maintaining an accurate register of young people, who tend to change their addresses frequently. The approach also reflects current government thinking which aims to increase access to sexual health services for young people by developing primary care and other community services.

4 Our examination of the Programme has explored two main concerns: whether the Programme will be able to achieve its stated aims of reducing the levels of chlamydia infection in the population and the related consequences of untreated infection; and whether the delivery model, in which individual PCTs are free to devise and deliver testing and treatment services locally, is providing value for money. These issues are examined in detail in Parts Two and Three of this report.

Our findings

The Programme's effect on chlamydia infection and associated disease

5 The scientific evidence upon which the Programme is based is subject to debate: both the level of infection in the general population and the probability of chlamydia leading to related and potentially severe health complications are not well understood. A screening programme was recommended by an expert group appointed by the Chief Medical Officer; the Programme was launched without generally agreed, robust data on the levels of chlamydia infection in the general population of young people in England, to provide a baseline against which the impact of the Programme could be measured. There was, however, evidence that infection rates in young people attending healthcare services were high.

6 Modelling by the Agency, published in 2006, indicated that testing between 26-43 per cent of 16-24 year-olds, along with robust arrangements to trace and treat the sexual partners of infected people, would secure a significant impact on the prevalence of chlamydia. In 2008-09, the Agency estimates that 50 per cent of PCTs reached 26 per cent, through a combination of testing under the Programme, other tests in community settings which were not reported to the Programme, and tests in genito-urinary medicine clinics. For infectious conditions such as chlamydia, testing and treatment rates need to be high enough to control the spread of the infection as well as treating those infected. Lower impacts would be seen at lower testing rates, the model predicted. The Agency has developed plans to monitor changes in the prevalence of chlamydia which it expects will contribute to evaluating the Programme and is seeking funding to implement these.

The Programme's local delivery by Primary Care Trusts

7 Following its launch in 2003, the Programme was rolled out in three successive phases. By March 2008, one year later than the Department's target date of March 2007, all PCTs were commissioning chlamydia testing under the Programme. During the financial year 2007-08, 4.9 per cent of 15 to 24 year-olds were reported to the Programme as having been tested, against a target of 15 per cent.

8 For 2008-09 onwards, the Department set PCTs a new national priority for local delivery, in the form of a 'Tier 2 Vital Signs indicator', including progressively increasing annual testing rates of 17, 25 and 35 per cent of under-25s, for the three years 2008-09 to 2010-11. This led to a step-change in activity by many PCTs in 2008-09 in an effort to deliver these rates. In fact, PCTs across England achieved an average testing level of 15.9 per cent by the end of 2008-09, a large increase from the 4.9 per cent achieved in the previous year, although around half of this increase was due to the inclusion of chlamydia tests in community settings not registered with the Programme and tests which, although they took place in registered settings, were not reported to the Programme. In the first quarter of 2009-10 PCTs screened 4.1 per cent of the target population, compared to 2.9 per cent in the first quarter of 2008-09.

Measurement of chlamydia testing

Performance of PCTs against the Vital Signs indicator includes all testing reported through the Programme, as well as other testing in community settings. The Vital Signs figures exclude, however, all testing activity in genito-urinary medicine (GUM) clinics. Assessment of the impact of testing on chlamydia prevalence in under-25s needs to include all testing activity regardless of setting. Hence, paragraph 6 discusses this overall testing rate (26 per cent, achieved by 50 per cent of PCTs), while the figure of 15.9 per cent in paragraph 8 focuses on the testing activity relevant to the Vital Signs indicator alone.

9 The costs of delivering the Programme are highly variable from place to place, indicating that there is scope for efficiency savings. In 2008-09 we estimate that the average cost per test delivered under the Programme was £56, including follow-up activities such as treatment of positive patients and partner notification, and local overheads. PCTs who have achieved higher testing rates tend to have lower costs per test; the Agency estimates, based on a detailed review of seven PCTs who achieved the Vital Signs indicator of 17 per cent testing in 2008-09, that they paid around £45 per test, including follow-up activities and local overheads. However, some PCTs managed to pay much less and still reach the indicator. The Agency estimates that a cost of £33 per test is achievable, as screening volume increases, chlamydia screening gets better integrated in all community sexual health pathways, and collaborative procurement develops. This is in alignment with the evidence from our survey data. The Agency expects to have produced guidance for commissioners on costs at around the time of publication of this report.

10 There has been duplication of effort and cost in several aspects of the Programme which have been purchased in a fragmented way by multiple local commissioners: the marketing and advertising of chlamydia testing services (with at least 45 different brands across England); IT support including website development; and the procurement of testing kits, laboratory processing and treatment. It is likely that it would have been more cost-effective to deliver these elements of the Programme regionally or nationally, which would have produced economies of scale.

11 In 2008-09, 88 per cent of people who tested positive for chlamydia were recorded as having received treatment, against the Programme's standard of 95 per cent and three attempts to contact infected people. This means that an estimated 6,480 people who tested positive for chlamydia were not recorded as having received treatment. Without treatment, testing is wasted for the individuals concerned, since these people remain infected and may go on to infect others. The Agency intends to further prioritise collection of treatment data and promote local treatment structures and processes, with the aim of meeting the Programme standard of 95 per cent of patients being recorded as treated, by the end of 2010-11.

12 Most areas are not achieving the Programme's standards for tracing and treating the sexual partners of people who test positive. In 2008-09, nearly three-quarters of programme areas (72 per cent) failed to meet the Programme's recommended standards for partner treatment. Partners are very likely to be infected and failure to trace and treat them means that the infection will continue to spread. Partner notification rates in genito-urinary medicine clinics, which are outside the Programme, are also lower than recommended standards.

13 There is evidence that young people's awareness of chlamydia as a serious health issue is high. Those who have had a chlamydia test report positive feelings about the experience, but in our survey 40 per cent of young people who were tested for chlamydia said that they had not received advice on issues such as contraception and safer sex when tested. Programme guidance, including a mandatory information leaflet for patients, promotes condom use which can prevent sexually transmitted infections including chlamydia, but at the local level, our survey indicates that some of those delivering the Programme have focused on the ease of testing and treatment for chlamydia to the detriment of guidance on prevention. The test should be used as an opportunity to provide wider guidance and promote safer sex, so helping to reduce infection rates in the long-term.

Wider lessons for other NHS programmes

14 The Programme is an example of the difficulties which can arise when a national initiative is introduced into a locally-managed NHS, when influences and incentives for PCTs are not adequately addressed from the beginning and all aspects are locally commissioned, regardless of economies of scale. The Programme's implementation was limited until a Tier 2 Vital Signs indicator was introduced in 2008-09. The bias towards local commissioning of support services such as marketing and IT has led to inefficiencies.

Overall conclusion on value for money

15 The delivery of the Programme to date has not demonstrated value for money. Annual testing of between 26 and 43 per cent of young people is needed in order to significantly reduce the prevalence of chlamydia; only half of PCTs reached 26 per cent or more in 2008-2009, six years after the Programme's launch. While aspects of the Programme such as making contact with and treating infected young people and their sexual partners can be challenging, the core of the Programme involves delivering a straightforward test to a well-defined group of people. The Department introduced the Programme in a phased manner, in line with the availability of funding, reflecting the need to increase local capacity for testing, and the intention to develop new ways of engaging with young people about their sexual health. A more rapid roll-out, however, would have allowed PCTs to reach the necessary level of testing earlier, which is the key objective of the Programme.

The potential benefits which devolved delivery through PCTs and the phased roll-out could have offered, by refining the efficiency of local programmes before increasing activity, were not realised because the Department did not monitor PCT spending on the Programme, seek to evaluate the most cost-effective local programmes, or set up effective joint commissioning structures to secure economies of scale.

Furthermore, due to uncertainties in the scientific evidence on chlamydia, the Department does not know how often infection leads to serious health problems and hence whether it is cost-effective to invest so much public money in tackling this problem.

We estimate that savings of £17 million could have been made in 2008-09, if all PCTs had delivered tests for £33 (the Agency's calculation of an achievable cost per test in established local programmes). Economies of £40 million per year could be made from 2010-11, when the Vital Signs indicator will increase to 35 per cent.

Recommendations

- a** **The Programme is approaching the volume of testing where models suggest it will have a significant impact on the prevalence of chlamydia and the Agency is currently developing mechanisms to evaluate this. However, the Department needs to set out clearly what the Programme is trying to achieve.** The Department, working with the Health Protection Agency, should:
- i** define criteria for the success of the Programme, which should include the reductions in chlamydia prevalence which it aims to achieve, by when;
 - ii** complete current work to produce a clear picture of the total population coverage of chlamydia testing in each PCT by drawing together data which are used currently to report progress against the Vital Signs national indicator on chlamydia screening with that from genito-urinary medicine clinics;
 - iii** put in place the means to measure the agreed criteria for the success of the Programme including its impact on chlamydia prevalence and disease, in order to demonstrate whether the theoretical models which are a central factor in the justification for the Programme, are reflected in reality. The Department and the Agency should produce recommendations on this by summer 2010, when the results of the second year of the Programme's national operation will be available; and
 - iv** pursue research, in the longer term, to understand better the probability of chlamydia progressing to severe health complications and use this to inform the setting of further criteria for the Programme's success.
- b** **NHS resources are being poorly used because of limited guidance on the most efficient way to deliver testing and this may get worse now the programme is being rapidly expanded.** The Department should introduce a number of key changes to improve the cost-effectiveness of the Programme:
- i** **PCTs have had limited benchmarks to guide their spending. The costs incurred by PCTs are highly variable.** The Agency should make available results from its recent costing review. Further investigations should be conducted to investigate the reasons for cost variations at PCT level, to identify the most cost-effective testing strategies and provide guidance for commissioners on chlamydia screening, including a pricing guideline. The cost-effectiveness assessment should include an evaluation of outreach events and 'remote' testing services such as those provided through websites.

- ii Many of those who take a chlamydia test are not receiving any advice about safer sex or the prevention of infection.** The Department should ensure that the Programme supports and reinforces the key messages of its own advertising campaigns on sexual health, by making education and advice about sexual health an integral part of the testing process. Otherwise, any reductions in the level of chlamydia infection will only be sustained through the continuation of high levels of testing and treatment, which may not be cost-effective.
- iii If people who test positive for chlamydia are not treated, the money spent on testing is wasted for these individuals. Overall, an estimated 6,480 people, or 12 per cent of those who tested positive, were not recorded as having received treatment in 2008-09. Only 28 per cent of Programme areas met recommended levels for treating the partners of infected people.** The Agency needs to improve data collection on the treatment of infected people, to highlight for poorer-performing PCTs how other areas are achieving much higher treatment levels, and also help them to meet the Programme's standards for tracing and treating partners. This should include an investigation of the effectiveness of different testing venues in securing treatment of people who test positive and their partners.
- iv Some aspects of the Programme are inherently more suitable for delivery at the national or regional level, rather than locally by PCTs.** Alongside its plans for a national campaign on chlamydia testing, due in 2010, the Department should consider ways in which the message about chlamydia testing can be reinforced nationally while ensuring that consistent messages are delivered locally. The Department should also undertake reviews of online screening, data-gathering and testing kit procurement, with a view to putting national or regional arrangements in place.
- v The local strategic planning, commissioning and delivery models for chlamydia screening vary, both in approach and in degree of success. Most PCTs have assigned dedicated coordinating teams, but the scope of influence, seniority and management experience of those recruited also varies.** Local PCTs need to provide appropriate support and training on key aspects of programme delivery, based on guidance provided by the Agency, to ensure that local co-ordinators can meet the requirements of their role and deliver efficient and effective local programmes.
- vi Mechanisms for influencing PCTs' spending or plans for chlamydia testing have been of limited effectiveness.** The Department should establish arrangements which will better enable the Agency and Strategic Health Authorities to more effectively influence PCTs' strategies for chlamydia testing and to pursue more focused and cost-effective delivery arrangements for the Programme, including commissioning at a regional or national level.