Young people's sexual health : the National Chlamydia Screening Programme : seventh report of session 2009-10 : report, together with formal minutes, oral and written evidence / Committee of Public Accounts.

House of Commons

Committee of Public Accounts

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

Seventh Report of Session 2009–10

HC 283

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Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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The current staff of the Committee is Sîan Woodward (Clerk), Emily Gregory (Senior Committee Assistant), Pam Morris and Jane Lauder (Committee Assistants) and Alex Paterson (Media Officer).

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Contents

Report

Summary

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and the prevalence of this infection is increasing, especially in young people under the age of 25. The infection is often symptomless but if left untreated can lead to serious health problems including infertility in women. In 2003 the Department of Health (the Department) launched the National Chlamydia Screening Programme (the Programme) which is overseen by the Health Protection Agency (the Agency) and delivered locally by the 152 Primary Care Trusts (PCTs) in England. The Programme aims to identify, treat and control the infection in young people aged under 25.

Since the Programme's launch an estimated £100 million has been spent but the Department does not yet know what effect, if any, this has had on reducing the prevalence of the infection. During the financial year 2007–08, five years after the Programme was launched, only 5% of 15 to 24 year-olds were tested, against a target of 15%. When it became clear that very little was happening the Department introduced a new requirement for PCTs to test 17% of their 15–24 year-old population, which drove the testing rate up to around 16% in 2008–09.

The Department's lack of urgency in pressing PCTs to reach a high volume of testing means that the Programme has not yet reached the level of activity where models predict that the prevalence of chlamydia will be significantly reduced. As a result, more young people than necessary are still being infected and potential savings to the NHS in treating the consequences of chlamydia infection have been lost.

The Department missed an opportunity to refine the Programme and to improve its cost-effectiveness, during the lengthy rollout. When PCTs increased their activity to meet the 17% target, a fragmented and inefficient programme became even more wasteful of taxpayers' money.

The Department needs to make this Programme a national response to a national problem. The Department should identify the most cost-effective local delivery strategies, establish regional or national commissioning arrangements, increase testing numbers and measure the Programme's impact on the prevalence of chlamydia. By improving efficiency, economies estimated at £40 million per year could be made by 2010–11.

On the basis of a Report by the Comptroller and Auditor General,[1] we took evidence from witnesses from the Department of Health and the Health Protection Agency about the delivery of the Programme, improving the efficiency of services and the Department's approach to managing a national initiative in a devolved National Health Service.

1 C&AG's Report, *Young people's sexual health: the National Chlamydia Screening Programme*, HC (2008–09) 963

Conclusions and recommendations

1. **The costs of testing vary significantly between PCTs.** The Health Protection Agency should, by April 2010, complete its costing review and publish its results. The Department should require PCTs to review their costs against the findings of the review and report the results to Strategic Health Authorities by July 2010. Where costs are significantly higher than the Agency's estimate of an appropriate achievable cost per test, Strategic Health Authorities should seek explanation from the individual PCT and require a cost improvement plan to be implemented within twelve months.

2. **PCTs' localised procurement and commissioning of the equipment and services needed to run chlamydia testing programmes is inefficient.** As a matter of priority the Department should:

    a) establish, as soon as practical, national or regional arrangements for the procurement of testing kits, patient record forms, laboratory processing of samples and other standardised, high volume goods and services;

    b) evaluate the case for a national website from which young people can request testing services, with a national brand identity;

    c) review the number of separate Chlamydia Screening Offices currently in place (91 for 152 PCTs), with the aim of cutting the administrative costs of the Programme, and

    d) require the Agency to complete its plans for a model contract for chlamydia screening in GP practices and pharmacies, and provide PCTs with guidance, including indicative payment rates, by April 2010.

3. **The Department does not have a mechanism in place to measure the Programme's impact on the level of infection.** The Department should develop a business plan with a clear timeframe for measuring the Programme's impact on chlamydia and related health complications. This should specify a trajectory for the reduction in chlamydia prevalence which the Department expects the Programme to deliver.

4. **Although the Programme instructs health professionals to advise young people on safer sex when they are tested for chlamydia, not all of those tested say they are receiving such advice.** The Agency should provide renewed guidance to all those delivering testing to remind them of the importance of providing advice alongside testing.

5. **During the five years that the Programme was rolled out, the Department did not exploit opportunities to learn lessons, particularly around how costs might be reduced.** The introduction of the Vital Signs target in 2008 required a step-change in PCTs' activities, which magnified existing inefficiencies. For key forthcoming strategies, such as that for autism, the Department should demonstrate that it has learned lessons from the chlamydia programme by:

   a) establishing regional and national structures where appropriate, to support the most efficient commissioning arrangements, and

   b) setting out how it intends to evaluate the cost effectiveness of these new strategies, with defined milestones and success criteria.

1 Achieving cost effective delivery in a devolved healthcare system

1. The National Chlamydia Screening Programme is a major Department of Health initiative, launched in 2003, which aims to identify the sexually transmitted infection (STI) *Chlamydia trachomatis* ('chlamydia'), treat those infected and reduce transmission to others.[2] Chlamydia is the most common bacterial STI and is increasing in young people under 25. Between 2004 and 2008 the number of young people diagnosed with chlamydia in genito-urinary medicine clinics rose by 14%, to more than 71,000. The infection can be easily identified and treated, but if left untreated may cause severe health complications including pelvic inflammatory disease, ectopic pregnancy and infertility in women.[3] The probability of chlamydia infection leading to complications is not well understood.[4] In November 2005 the Department appointed the Health Protection Agency to oversee the Programme which is delivered locally by the 152 Primary Care Trusts (PCTs) in England.[5]

2. The Department does not know how much money PCTs have spent on delivering testing and therefore cannot tell whether the Programme represents value for money.[6] The Department allocated £150 million for the Programme to PCTs between 2003 and 2009, but only £100 million is estimated to have actually been spent on delivering the Programme.[7] The Department explained that many PCTs were facing financial deficits between 2005–06 and 2007–08 and that the money had been spent on other priorities, but accepted that it had no way of tracing what these had been.[8] An estimated £42 million was spent on the Programme in 2008–09, however, PCTs engaged more energetically with the Programme after chlamydia testing was made a national priority.[9]

3. 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. There has been duplication of effort and cost in several aspects of the Programme and the Department accepted that lessons should be learnt from the Programme, in particular the need to be very clear about what should be done at national, regional and local level.[10] Recent reports by the Committee, including end-of-life care, tackling alcohol harm, and autism, have provided evidence that PCTs often do not have a good sense of what local need actually is, are not yet good at

2 C&AG's Report, para 1

3 C&AG's Report, para 1.1

4 C&AG's Report, para 2.8

5 C&AG's Report, paras 1.10 and 2

6 Qq 40 and 41

7 C&AG's Report, para 3.7

8 Qq 60–64

9 C&AG's Report, paras 1.2 and 2.9

10 Qq 30 and 53; C&AG's Report, para 10

commissioning and do not have the information to recognise the costs and benefits of different services.[11]

4. The costs of delivering a chlamydia test under the Programme are highly variable between PCTs, indicating that there is scope for efficiency savings. Savings of £40 million per year could be made from 2010–11 if every PCT delivered tests for £33, which the Agency estimates is achievable.[12] The Department accepted that the variations in cost were unacceptable and committed to provide PCTs with a costing model, based on work conducted by the National Audit Office and the Agency, to break down their costs more easily and to benchmark themselves against the kind of price shown in the model.[13] The Department had produced guidelines on costs when the Programme started to be rolled out nationally in 2005, but it accepted that there was now evidence of large cost variations which needed to be tackled.[14]

5. Following its launch in 2003, the Programme was rolled out in three successive phases. All PCTs were commissioning chlamydia testing under the Programme by March 2008.[15] The phased delivery of the Programme could have been beneficial if lessons had been learnt along the way, however this only started to happen some ten years after a screening programme had been recommended by the Chief Medical Officer's report.[16] This meant that when PCTs increased their activity in response to the Department's introduction of a target in April 2008, inefficiencies in the Programme were multiplied, making it even more wasteful of taxpayers' money.[17]

6. Fragmented local purchasing led to a broad range of prices being paid for equipment and services. Local areas paid between 50 pence and £44 per test kit purchased in 2008–09, and each local area developed its own IT system for the Programme with prices varying from £1,000 to £100,000.[18] There was an opportunity to secure economies of scale by bulk purchasing standard items for the Programme, but the Department failed to put in place any national or regional procurement arrangements and as a result money was wasted.[19] The Department is now setting up regional procurement hubs for the NHS and committed to make dramatic improvements in procurement and IT for the Programme.[20]

7. PCTs acting individually also procure services which support the Programme, such as marketing activities to encourage young people to get tested, and websites which allow them to order testing kits through the post. This has contributed to 45 different local 'brand identities' being developed for the Programme.[21] The Committee heard evidence of

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11 Qq 9 and 54

12 C&AG's Report, para 3.8

13 Qq 39–41

14 Q 11

15 C&AG's Report, para 1.8

16 Qq 10 and 11

17 Q 87

18 Q 24; C&AG's Report, para 3.10

19 Qq 20–31

20 Qq 19–31

21 Q 45; C&AG's Report, para 3.11

a company which had approached the Department and the Agency two years previously, offering to provide a national website to allow young people to order tests through the post, but was told to approach the 152 PCTs individually. The Department acknowledged that a report on the Programme conducted on its behalf by Dr Ruth Hussey and issued in November 2009 had recommended that a national website should be established. The Department said it would look at this very seriously.[22]

8. The Department has not defined by how much or by when the Programme should reduce the prevalence of chlamydia.[23] A model developed by the Agency in 2006 indicated that testing 26–43% of the 16–24 year old population could be expected to produce a substantial reduction in the prevalence of chlamydia infection. Taking into account all chlamydia testing under the Programme and in genito-urinary clinics, an estimated 24% of young people were tested in 2008–09, approaching the level where the Programme's impact could be measurable.[24] However, the Department currently has no means to measure the Programme's impact[25] and needs to do so in order to gain an understanding of the cost-effectiveness of the Programme.[26] The Agency has developed a proposal for a population-based survey to monitor changes in chlamydia prevalence and is seeking funding to implement this.[27]

9. Unless young people are provided with advice on safer sex and how to prevent infection when they are tested, any reductions in the level of chlamydia infection will only be sustained through continued high levels of testing and treatment, which may not be cost-effective.[28] The Department acknowledged that it is vital that the Programme is used to deliver advice to young people, pointing out that this was a difficult client group to deliver such messages to.[29]

10. In 2008–09, 88% of people who tested positive for chlamydia were recorded as having received treatment, against the Programme's standard of 95%. 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.[30] The Agency acknowledged that it should aim to treat all people who test positive, but said that over the life of the Programme an average of 90% of people identified as positive had been treated and that considering the difficulties in reaching young people with this type of Programme, this was not a bad outcome. The Agency had looked at the PCTs with the lowest treatment

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22 Qq 27 and 34–37

23 C&AG's Report, Recommendation a(i)

24 C&AG's Report, para 2.5

25 C&AG's Report, para 2.5

26 Q 82

27 C&AG's Report, para 2.5

28 C&AG's Report, para 2.19, Recommendation b(ii)

29 Qq 14 and 15

30 C&AG's Report, para 2.12

rates and considered that the predominant reason was one of reporting treatment data to the Programme rather than problems in getting people treated.[31]

11. 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%) failed to meet the Programme's recommended standards for partner treatment.[32] Partners are very likely to be infected and failure to trace and treat them means that the infection will continue to spread.[33] However, genito-urinary medicine clinics, which are outside the Programme, also do not meet recommended standards for tracing and treating partners. The Department acknowledged that some areas needed to improve but said that contacting and treating partners of infected people was a challenging area and that levels of partner treatment were higher than those initially predicted by the Agency.[34]

31 Qq 48, 49 and 68–72

32 A programme area may include more than one Primary Care Trust. There are 91 programme areas and 152 Primary Care Trusts in England.

33 C&AG's Report, para 2.13

34 Qq 65–67

2 Understanding levers and setting priorities to deliver improved services quickly

12. The Department lacked urgency in trying to reach the high volume of testing necessary to reduce the prevalence of chlamydia. Despite regarding chlamydia as a big enough problem to warrant a national screening programme the Department addressed this risk through a lengthy and drawn out roll out over five years.[35] During the financial year 2007–08, five years after the Programme was launched and ten years after the Chief Medical Officers report had recommended a national screening programme, only 5% of 15 to 24 year-olds were tested, against a target of 15%.[36]

13. Against a climate of financial deficits and the reorganisation of Primary Care Trusts (PCTs), the Programme lost momentum at a crucial point when the Department attempted to roll it out nationally.[37] There was no compulsion for PCTs to take up chlamydia testing under the Programme until 2008–09, and the Department recognised that they could and should have given clearer national prioritisation to the Programme earlier.[38]

14. When the Department made chlamydia testing a priority under its 'Vital Signs' framework in 2008–09 the numbers of tests completed under the programme dramatically increased (**Figure 1**). Nevertheless, six years after the Programme's launch only half of PCTs were testing over 26% of young people, the minimum required to make significant progress in reducing infection (**Figure 2**).[39]

15. The original vision for the Programme saw GPs and community sexual health services as central. Most stakeholders consulted in the Comptroller and Auditor General's report also felt that GP involvement was vital to the success of the Programme, but 61% of local screening coordinators said that difficulty engaging with GPs was one of the greatest obstacles to achieving higher testing rates.[40] To encourage GPs to engage with the Programme, 59% of PCTs set up Local Enhanced Services contracts which pay GPs for providing chlamydia testing, on top of their normal remuneration. The structure and payments under such contracts varied considerably, from £1 to £15 for testing activity and from £8 to over £100 for treatment and partner notification services.[41] When the Programme started there was resistance and uncertainty amongst some GPs about whether they should or could conduct testing. The Department accepted that it should have worked

35 Qq 2–8 and 87

36 Qq 3–8

37 Qq 2 and 32

38 Qq 32, 33 and 57–59

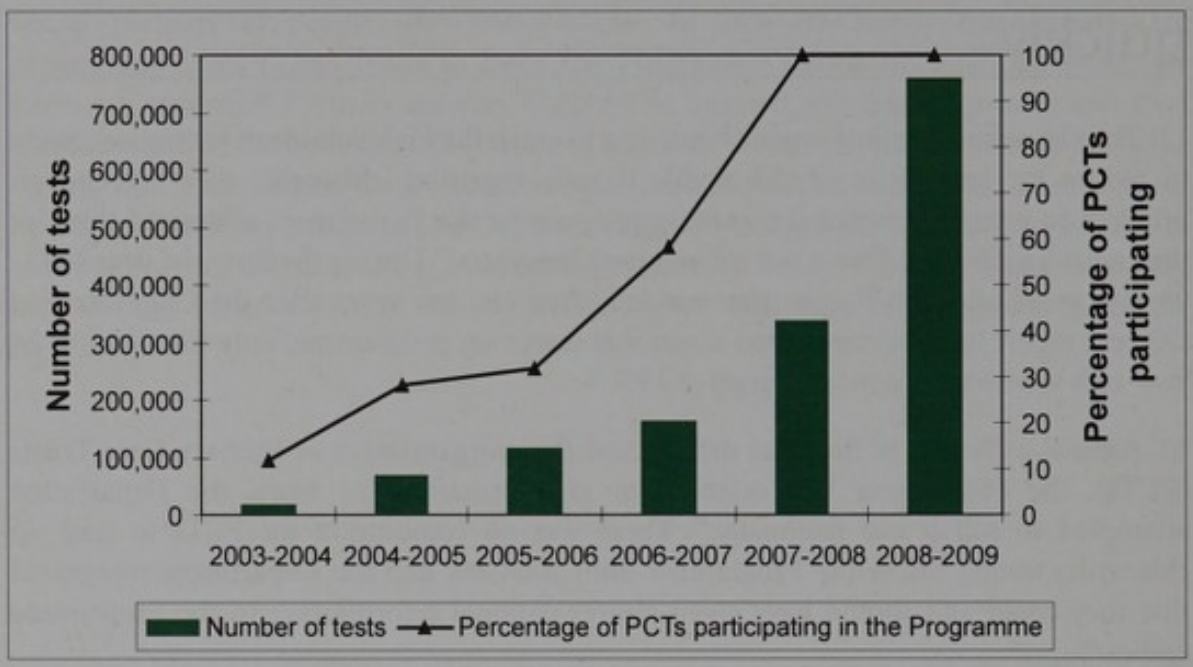
39 Q 10; C&AG's Report, paras 8 and 15

40 Q 17; C&AG's Report, para 3.5

41 C&AG's Report, para 3.3

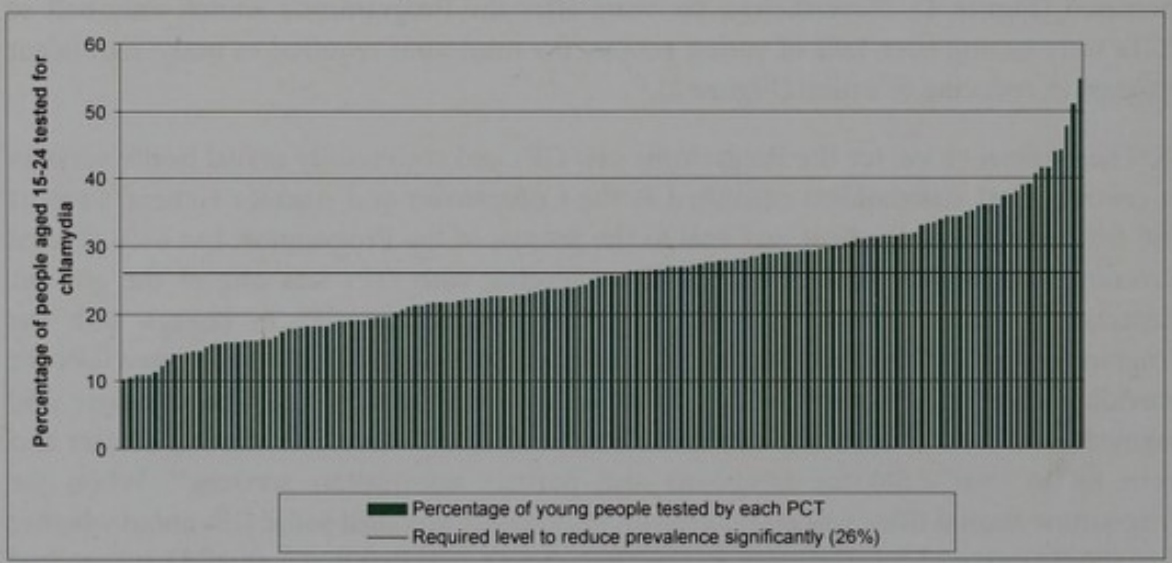
harder from the outset at getting more engagement for the initiative from a wider group of clinical and senior managers in the NHS.[42]

Figure 1: Annual testing numbers for the National Chlamydia Screening Programme



Source: C&AG's report, Figure 6 page 22

Figure 2: Estimated rates of testing in 2008–09 by PCTs



Source: Health Protection Agency data on PCT performance against Vital Signs target, plus testing in genitor-urinary medicine clinics

Formal Minutes

Monday 18 January 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Austin Mitchell
Angela Browning	Rt Hon Don Touhig
Nigel Griffiths	Rt Hon Alan Williams
Rt Hon Keith Hill	

Draft Report (*Young people's sexual health: the National Chlamydia Screening Programme*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 15 read and agreed to.

Conclusions and recommendations 1 to 5 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 20 January at 3.30 pm

Witnesses

Wednesday 25 November 2009

List of written evidence

List of Reports from the Committee of Public Accounts 2009–10

First Report	A second progress update on the administration of the Single Payments Scheme by the Rural Payments Agency	HC 98
Second Report	HM Revenue and Customs: Improving the Processing and Collection of Tax: Income Tax, Corporation Tax, Stamp Duty Land Tax and Tax Credits	HC 97
Third Report	Financial Management in the Foreign and Commonwealth Office	HC 164
Fourth Report	Highways Agency: Contracting for Highways Maintenance	HC 188
Fifth Report	Promoting Participation with the Historic Environment	HC 189
Sixth Report	Train to Gain: Developing the skills of the workforce	HC 248
Seventh Report	Young people's sexual health: the National Chlamydia Screening Programme	HC 283
Eighth Report	Department for International Development: Aid to Malawi	HC 282

Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 25 November 2009

Members present:

Mr Edward Leigh, in the Chair

Angela Browning	Mr Austin Mitchell
Mr Douglas Carswell	Dr John Pugh
Mr Ian Davidson	Mr Don Touhig
Nigel Griffiths	Mr Alan Williams

Mr Amyas Morse, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General and **Mr Mark Davies**, Director, National Audit Office, gave evidence.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL YOUNG PEOPLE'S SEXUAL HEALTH: THE NATIONAL CHLAMYDIA SCREENING PROGRAMME (HC 963)

Witnesses: **Sir Hugh Taylor CB,** Permanent Secretary, **Professor David Harper CBE**, Director-General, Health Improvement and Protection and Chief Scientist, **Dr Ruth Hussey OBE,** Regional Director of Public Health/Senior Medical Director for NHS North West and DH North West, Department of Health and **Mr Justin McCracken**, Chief Executive, Health Protection Agency, gave evidence.

Q1 Chairman: Good afternoon and welcome to the Committee of Public Accounts where today we are considering the Comptroller and Auditor General's Report on the National Chlamydia Screening Programme (NCSP). We welcome back Sir Hugh Taylor, who is the Department of Health's Accounting Officer. We also welcome Justin McCracken, who is the Chief Executive of the Health Protection Agency (HPA). Would you like to introduce your two colleagues?
Sir Hugh Taylor: Dr Ruth Hussey, who is the Regional Director of Public Health in the North West Region and Professor David Harper who is a Director-General in the Department of Health with responsibility for a wide range of public health issues.

Q2 Chairman: In your 2001 sexual health strategy you described this as a national programme. In fact was it not just a national suggestion and not a national programme because there was no compulsion on PCTs to do anything until 2008 in April?
Sir Hugh Taylor: It was always the intention to have a national programme. It was decided from the outset to implement it on a phased basis because it is a long-term public health programme. It is a highly ambitious programme; the first of its kind, certainly in Europe. We felt it right first to pilot and then to introduce it on a phased basis. It is making very good progress now. There is no doubt that we lost momentum at a crucial point when we started to go for national rollout, for reasons which we can explore, but certainly since we established it clearly as a national priority in 2008–09 we have made very significant progress.

Q3 Chairman: A lot of ground was lost. Am I right in saying that in April 2008, five years after this was described as a national programme, 10 years after the Chief Medical Officer (CMO) had made his alarming report in 1998, only 5% of young people had been tested?
Sir Hugh Taylor: It is correct that over the period 2007–08 that is the proportion of people who were tested.

Q4 Chairman: Did your own modelling not suggest to you that you needed to be at a level of 26% to make any real impact?
Sir Hugh Taylor: That is modelling which has been produced more recently by the Health Protection Agency.

Q5 Chairman: When was that modelling given to you?
Sir Hugh Taylor: I think it was produced in the course of—

Q6 Chairman: I have been briefed that it was given to you before April 2008.
Sir Hugh Taylor: Yes, it was probably before April 2008; yes, 2007.

Q7 Chairman: So you described this as a national programme in 2001. By 2008 only 5% had been tested, you had already been told that to make any impact 26% needed to be tested. Is the reason why we have had such an initial failure that you relied on Primary Care Trusts?
Sir Hugh Taylor: No, we had always planned on a five-year lead-up to national rollout. A decision was taken in 2004 to accelerate that by a year.

Q8 Chairman: A phased rollout suggests to me that you phase out the rollout. You do not announce a national programme and five years later it has only reached 5% of people. That is not a phased rollout, it is an inefficient failure.

Sir Hugh Taylor: I would not describe it in those terms because it was made clear from the outset that we intended to introduce this on a phased basis. That was an explicit part of the plan. The aim was to have a national rollout; originally we had planned by 2008. The 2004 Choosing Health White Paper accelerated that to 2007. The fact is that we launched this out as a national programme into a very unpromising environment because we did so effectively over the 2005–06/2006–07 period when deficits were beginning to emerge in the NHS and when we put PCTs through a major reorganisation. I fully accept that at the moment when we hoped to gain real national impetus on the programme it stalled and it really needed a fresh approach to the delivery model and to the commitment to the programme which we delivered through the establishment of this as a clear national priority in the operating framework for 2008–09.

Q9 Chairman: I want to bring in the Comptroller and Auditor General here. You look at a number of health problems and it seems to me that we often have problems with local delivery of national programmes. Do you have any comment on this?

Mr Morse: We do find this. There is a genuinely difficult balance to be struck and I think Sir Hugh would probably accept that. There is a difficult balance. There are obviously advantages in having a local delivery programme; it is clear that those advantages exist. On the other hand it is quite clear also that achieving that and at the same time achieving degrees of uniform progress across the population is actually proving to be a difficult thing to manage. If I turn to Mark Davies who is the Director responsible he might amplify that.

Mr Davies: In our recent Reports on non-acute activities and end-of-life care, tackling alcohol harm, autism, we found three things with local delivery. The first thing is that PCTs often do not have a good sense of what local need actually is. Second, they are not yet good at commissioning and, in particular, it is fair to say, that they do not have the information to recognise costs and benefits between different service providers and different services. The third area we find regularly is that PCTs do not always have a good grip on the costs, what they are actually spending on different services out there in the community. The problem with something like chlamydia is that it is a national programme, a national priority, but locally delivered. In a sense that puts more pressure on PCTs and the risk there is that PCTs continue in their existing patterns of activity to deliver the national targets and that exacerbates the inefficiencies around the three points that I make.

Q10 Chairman: Sir Hugh, I am not just trying to have a go at you for the sake of it. I am trying to help you do things better in the future. If we are honest, is there not a clash between localism, to which we all pay lip service, and getting things done. When things do not get done, as clearly happened here, then the political liability still rests with central government and you have to step in. Maybe it would have been better, would it not, for this to have been a centrally driven programme from the beginning?

Sir Hugh Taylor: There is a piece of history here which is relevant. We had a period of expansion in the capacity and funding available to the NHS, a period during the mid part of this decade with very heavy top-down management of a number of national priorities. I have to say that was also accompanied by quite a lot of other priorities sent out to PCTs which were not always as carefully graduated as they might have been. It was because of that that we took a step back during 2007—it was not just this programme which drove us to this sort of conclusion—and deliberately created what we call the vital signs framework, which is a much more studied framework for delivery. Since then we have indicated that chlamydia testing is a tier two priority, which is described in the operating framework as a national priority for local delivery, where we know that concerted effort and action is required across the board but where we recognise that local organisations will benefit from a greater degree of flexibility on how they deliver as opposed to the national requirements. We think chlamydia screening fits that definition of delivery well and the facts speak for themselves. Since we did that, we have significantly increased the rate of chlamydia screening.

Q11 Chairman: That is a very interesting answer but unfortunately it is not an answer to the question I asked you. Would it not have been better if you had had a national programme from the beginning because you say this was going to be a phased programme but clearly it was a very inefficient programme, it was very expensive and if you have a phased programme, do you not learn lessons as you go along? However, we find out that only now, in December 2009, will you provide guidance on costing to PCTs. This is a fairly crucial part of their work because there is obviously great disparity between the costs across the country. Far from this being a carefully phased out programme which you were on top of from the beginning, in fact it was just passed over to the primary care trusts, they did not do a great deal, a lot of it was by trial and error and you are actually only learning lessons now. It is now over 10 years since the Chief Medical Officer's first report saying this was a major national problem.

Sir Hugh Taylor: I do not accept that we rolled this out to the NHS without any guidance on costs; in fact when we effectively commissioned the national rollout in 2005 quite detailed advice was given on how to do it, which included some quite detailed guidelines on costs. What has happened since then and I am recognising this, is that because of the circumstances which I described, there was low take-up of the programme initially. We then saw a surge of activity in the 2008–09 period following the establishment of this as a clear national priority. It was over that period that evidence began to emerge

of differential costs arising in PCTs to which the HPA and the NAO have drawn attention. It is not the first time we have addressed the issue of costing, but certainly the evidence from the programme suggests that this does need to be tackled and we are doing that now.

Q12 Angela Browning: When you said to the Chairman that the programme was rolled out in a phased manner I wonder whether we could just complete that sentence. On page 7 at section 15 we see it says "The Department introduced the Programme in a phased manner, in line with the availability of funding".
Sir Hugh Taylor: That is true.

Q13 Angela Browning: So it is not the case that this was something which the CMO, through his initial report, had identified as important. I think you said it came through a Health White Paper, being flagged up as important and it was deemed to be a very worthy and important thing to do but actually the will to do it, the will to will the funds to do it properly was not there at the time. This whole Report is really an indictment right the way through from start to finish of a programme which had very worthy intentions but which has actually wasted a lot of public money.
Sir Hugh Taylor: I cannot accept that. Substantively the reason for putting this out on a phased basis was, as I have said, that it was an ambitious programme. Prior to this, testing for chlamydia had really only been run in specialist centres, in GUM clinics effectively. This involved shifted care, a new form of treatment, a simple test but a difficult logistical exercise, into the community where it had not been done before, into GP surgeries, into community health settings, into a wide range of other settings. We felt that it was right to learn as we went along and that is what we have been attempting to do. It was a conscious decision to introduce it on a phased basis. I am not aware that we were subject to criticism for doing that. I fully accept that at the moment where we planned—and on reflection it is possible to see that turned out to be a difficult moment in the programme—to go for national rollout we ran up against what were real problems in the NHS at that time, problems relating to PCT reorganisation and funding; funding clearly was diverted from this programme. I am not trying to say that the programme has not encountered problems on the way. I certainly would not accept that it has been a waste of time.

Q14 Angela Browning: Let us take a step back then from this question of not as many people being tested and the test made available to as many people as you would have liked in order to meet those targets and take a look at what it says on page 9, paragraph ii. Even if you only tested a fraction of the people you had intended to test, how do you account for the fact that it says here "Many of those who take a chlamydia test are not receiving any advice about safer sex or the prevention of infection". Surely, in terms of value for money and this being a service which is going to do some long-term good, to miss out on that opportunity cannot be excused, even if you are only seeing a small percentage of people?
Sir Hugh Taylor: Clearly one of the absolutely vital elements of this programme is to use opportunistic testing in the community precisely to do this thing.

Q15 Angela Browning: So why was it not done?
Sir Hugh Taylor: It has been done. What the NAO Report is referring to there is a survey which they carried out which says that 40% of young people that they surveyed who had received the programme said they could not recall that they had received such advice. I am not saying that is not an important finding; it is an important finding. It is one of concern to us. However, in some instances they will have been doing this following contact through letter, through the internet, a various number of ways. There is a compulsory leaflet which gives such advice, which should be available every time a test is carried out. That does not necessarily mean that young people in this age group mark, learn and inwardly digest the material they are given or even sometimes the messages they are given when they get this information face to face. I am not trying to diminish the finding. It is a finding based on a survey of what is a pretty tricky customer group.

Q16 Angela Browning: You do not think the cause for that might actually be that this was a poorly resourced programme in terms of its ambitions and that the main priority was to tick boxes to get numbers and that adjunct of giving the advice on sexual health and making sure that was proper advice on contraception and people not reoccurring in terms of the infection was regarded as secondary. In other words were the people who were carrying out the tests actually resourced enough to be properly trained to do that second part of their contact with the patient?
Sir Hugh Taylor: I think that would be a gross slur on the many GPs, community health nurses and practitioners who are doing this on a day-by-day basis and using the opportunity of the routine work they do. Nearly 50% of the chlamydia tests which have been done on this programme are being done as part of core services delivered by GPs in what used to be called family planning clinics and now community health services, in pharmacies. In those areas I am confident that people are getting this advice. I am also confident that leaflets giving people advice on safer sex and the prevention of infection are being given. I cannot say in every single instance that that happens; how could I from where I sit? I readily accept that this does not always impact on the young people to whom we are administering the programme. It is clearly an area we want to follow up following the Report. I do not think that finding in itself is a pointer to lack of value for money in the programme.

Q17 Angela Browning: May I ask you to turn to Part Three, page 29, paragraph 3.5 which talks about GPs and their involvement in this programme? It says "... but in our survey of local screening

coordinators, a majority (50 of 82, or 61%) said difficulty engaging with GPs was one of the greatest obstacles to achieving higher testing rates". You have just told the Committee that it is thanks to GPs that this is such a successful programme. That paragraph does not seem to endorse what you have just told us, does it?
Sir Hugh Taylor: I think it is a partial picture. What we know is that 15% of the tests delivered in 2008–09 were delivered by GPs. The number of GPs registered to support the programme is increasing all the time. Undoubtedly, when the programme started out there was some resistance and uncertainty amongst some GPs about whether they should or could do this. There is a wonderful example of one of the areas in Leicester where initially there was strong resistance from the local GPs to getting involved in this service. Now 80% of the tests in that part of Leicester are being delivered by GPs; they have changed their practice, they have embraced the screening programme with enthusiasm. So part of the task that the local offices had in taking this forward was to involve GPs and it has not always been easy, as this NAO Report fairly says, but we are making progress in that area. We have GP champions in certain areas who are going out and talking to their colleagues, encouraging them to take part in the programme and we are seeing a gradually increasing number of tests being carried out as part of routine GP work which is precisely what we are looking for.

Q18 Angela Browning: I have to say that I thank you for your answers but on the one hand I am led to believe that amnesia on the part of the client group is probably part of the problem and on the other hand we are told how important GPs are to this but from what you have just told us we see that there have been significant problems with GPs. It cannot be both. They either bought into it at the beginning and were seen as an important deliverer of what you intended to achieve or they did not, but that does not seem to have been the case. Was it because they were not paid to do this test?
Sir Hugh Taylor: In practice just over half the PCTs have agreed local enhanced service agreements with GPs which effectively give them payment to carry out the tests. If we go back and look at this programme in retrospect, I would accept that, were we pushing this programme out now, we would work harder from the outset at getting real buy-in in a co-production sense from a wider group of clinical and senior managers in the NHS. I am not saying that there are not lessons to be learned from the way we rolled this out. I am merely saying that as things have gone on, as we have worked more closely with GPs at local level, so we have made more progress.
Angela Browning: My time is up. I do apologise to the whole Committee that I am not able to stay for the rest of the session, but thank you.

Q19 Mr Touhig: The Comptroller and Auditor General's Report certainly casts doubt on whether this programme has delivered value for money. My colleague Mrs Browning said you had been wasting public money and you said you could not accept that. I think she has a point; perhaps you need to re-read the Report. Do you think you have delivered value for money in this programme?
Sir Hugh Taylor: There are two elements to this. First of all, it is too early to form a conclusion on the value for money of the whole programme, partly because this is a long-term public health programme. Second, the evidence produced by the NAO and indeed by our colleagues in the HPA has demonstrated that there are elements of the delivery of this programme where we have fallen short in terms of value for money.

Q20 Mr Touhig: You have fallen very considerably short, have you not? If we look at page 6, paragraph 10, here we see there has been duplication of effort and cost because you have a fragmented purchasing policy for the kit. Why is there no national or even local purchasing consortium for acquiring the kit?
Sir Hugh Taylor: There are some now.

Q21 Mr Touhig: Nothing to do with your initiative; that was done by the PCTs themselves.
Sir Hugh Taylor: We encouraged them to do that. I am glad to say that is bearing fruit.

Q22 Mr Touhig: Can you answer the question? Why is there no national or regional procurement policy?
Sir Hugh Taylor: Because at the time this was rolled out the emphasis was, to go back to Mr Leigh's original form of words, on encouraging PCTs to do this locally and to collaborate locally. We would accept—and it is a fair recommendation of the NAO—that there is more scope than has occurred in this case for consideration of national and regional procurement. We are now getting regional procurement, for example in Yorkshire and Humberside, in London, where they are looking at coming together to look at collective procurement for the kits. I acknowledge that in retrospect it is clear that is an area to which we should have given greater attention in the early days of the programme.

Q23 Mr Touhig: If you look at page 31, paragraph 3.9 "Local procurement of equipment and support services", it says "Another important factor which contributes to local cost variations is the local procurement of equipment such as testing kits, laboratory analytical services and data collection systems". There are three areas there where you are being told that if you had perhaps had some regional or national procurement policy then we could have saved a lot of money on this. I take it getting value for money is part of your job.
Sir Hugh Taylor: It clearly is. We did signal to PCTs when we rolled this out the importance of doing that. Frankly when we began to see evidence of these sorts of facts emerging, we got the HPA involved to do a survey of costing and we just had a major conference yesterday for the NCSP which we presented with the emerging facts in relation to some of these issues around collaborative procurement. I do not want in any way to belittle the point you are making, but if we look at paragraph 3.10 of the Report, these are

telling facts but they are—I hesitate to use this—in NHS terms relatively small amounts of money and the amount of saving therefore would be relatively small as well. That does not mean that we should not have been paying more attention to the scope for regional and national procurement; we should have been.

Q24 Mr Touhig: Let us look at that paragraph. It tells us that local procurement policies for testing kits have varied between 50 pence and £44 per piece of kit. Surely alarm bells ought to be ringing in your Department. You say it might be relatively small but you can get far more items of kit at 50 pence than you will at £44.
Sir Hugh Taylor: Unquestionably, which is why the case is well made for collective procurement in this sort of area. These numbers are based on an NAO survey. We have not had access to all the details of all that survey.

Q25 Mr Touhig: You could have asked for it. I take it you have agreed the Report.
Sir Hugh Taylor: Yes; absolutely.

Q26 Mr Touhig: So you could have asked for this information.
Sir Hugh Taylor: Indeed. We have been working with the NAO on the information and indeed we have information to this effect from the HPA. I do not know exactly how the PCTs have calculated some of those costs in what they have given to the HPA, nevertheless I am not going to argue that there is not a case for collaborative procurement of kit and so on; there clearly is.

Q27 Mr Touhig: There clearly is. Right. So have you now directed someone to set up one purchasing operation for the whole of this project?
Sir Hugh Taylor: No, I do not think that would be appropriate. Dr Hussey, in her report, recommended that we look effectively at the creation of a single national website for elements of this and we will certainly look at that. More promising is regional procurement. We are setting up regional procurement hubs as part of a newly developed approach to procurement in the NHS and we will certainly make it a priority for them to address this issue.

Q28 Mr Touhig: I am pressing this point because it just seems to me that it is not rocket science when you have a project you are launching, a programme you are launching like this, with large numbers of items of kit to be procured, that somewhere along the line someone would have understood that a bulk purchase of these items would have benefited the whole system rather than the fragmented approach you now have. Did anybody think about that?
Sir Hugh Taylor: What you have said is undeniable.

Q29 Mr Touhig: Can we have a look at IT? We have seen many IT projects come before us as a committee and some of them have been so large and ambitious that they were almost bound to fail. You are at the other extreme; everybody has their own IT system, varying from £1,000 to £100,000. Surely this is a fairly common programme, the needs are common right across the country and the systems could be common. Why is there no common IT programme?
Sir Hugh Taylor: A conscious decision was taken at the outset not to go for national IT procurement in this. That was partly associated, in the case of the big National Programme for IT, with wanting to keep that focused on the programme on which it was already working and we wanted to get this up and running. We did set out an IT specification, in other words we made it clear what should be in an IT specification. We gave some guidelines on what IT systems were required but it is true that we did leave them to local procurement. In retrospect I think that is a questionable judgment.

Q30 Mr Touhig: The Department have been quite neglectful over this programme. You announced the scheme, let everybody get on with it in their own way and it has varied dramatically right across the country. This has been a classic case, has it not, of a department failing to get to grips with an issue, making sure there was a common approach right across the country, saving the taxpayer a lot of money and delivering a more effective system?
Sir Hugh Taylor: It is important to learn lessons from the way we do things. When this programme was rolled out nationally, there was a very, very heavy emphasis on giving space for PCTs and local people to take their own initiatives in these areas, which I understood. I agree with you that, when rolling out a national programme of this kind, we should be applying what we call four principles of change which we developed in the Department. One of those is subsidiarity and we need to be very clear what should be done at what level. That would include thinking about what should be done nationally, what should be done regionally and what should be done locally. Were we doing this all over again and learning the lessons, I think we would take a different judgment in respect of procurement of certain items for this programme.

Q31 Mr Touhig: I accept that in all our lives the most perfect view is the one looking back "What if?" and "If only". However, lessons have been learned out of this and the C&AG's Report has pointed you in certain directions. Can we expect some dramatic improvements on procurement and a unified IT system in future?
Sir Hugh Taylor: Yes, you certainly can expect dramatic improvements in these areas.

Q32 Mr Mitchell: An interesting point is that five years after the programme was introduced the Primary Care Trusts were testing less than 5% of young people but as soon as you made a priority target, they trebled their activity levels. Could making it a priority target not have been done much earlier?
Sir Hugh Taylor: The point I want to try to get across here—and I appreciate that it may not be easy to do so—is that making this a priority in 2008–09

was part of a wider approach to systematising the way we prioritise things for the NHS anyway. It was not a question just of singling out the chlamydia programme at that stage for a clearer prioritisation approach. It happened in other areas. I would accept that, particularly in the period 2005–06/2006–07 and 2007–08 when this programme was struggling, the service did not have a clear enough steer from the Department on its priorities which we subsequently gave in 2008–09.

Q33 Mr Mitchell: What made you think phased delivery was better? This is a national campaign, it is a national issue and a major problem, why a phased delivery?
Sir Hugh Taylor: Because it was a first, we ran a pilot and we had enough confidence from the pilot to feel that we could move it out further. We were pressed to go further and faster by the Health Select Committee, indeed they encouraged us to widen the programme from what had been originally envisaged and asked us to start on it. Mrs Browning was right to say that we had to do that initially within funding that we had available. We thought we could make a virtue of that by introducing it on a phased basis. The early pilots and the early starters did do well until in 2005–06 the NHS ran into financial problems and then it is clear—and it is reasonably well documented in the Report—that this programme fell back. Some of the funding which had in a sense been earmarked by the Department for this programme went on to other NHS priorities. That is a matter of record.

Q34 Mr Mitchell: You were not lacking in advice. We have a memorandum from an organisation called Freetest.me. You have probably seen it. This is following the point Mr Touhig made about IT services. It says "Nearly two years ago our company (Preventx) presented to DoH/HPA/NCSP our vision for a national website, whereby 15–25 year olds could access a postal test. Importantly, the delivery of the test would also be provided at national level". Clearly it offers economies of scale if you are going to do it on that basis, marketing economies, delivery economies. They argued that in excess of 180,000 tests per annum would be completed and this would make a meaningful contribution to overall numbers. They were then told by the Department that Department of Health policy did not allow national delivery, as has been described, and that they should approach 152 Primary Care Trusts; in other words "Bugger off". That seems daft, does it not? There are obvious economies of scale in a national service. Here you have a provider wanting to run it and they are referred to 152 Primary Care Trusts.
Sir Hugh Taylor: First of all, we would not use a programme of that kind to deliver the whole ambition of this programme.

Q35 Mr Mitchell: You could use it as a basis of information provided nationally.
Sir Hugh Taylor: Dr Hussey herself made a case in a recent report to us—and we need to look at this very seriously—for a national website which provides clear access, guidance on where young people can access screening tests, addresses and so on. I am not trying to dodge the central point you are making.

Q36 Mr Mitchell: Why did this approach from a private organisation not start bells ringing that this is the way to do it?
Sir Hugh Taylor: I do not think there was any question at the time that the Department's approach to this was to say they wanted PCTs to focus on local delivery of this. I am not apologetic about that in this sense: it is based on an opportunistic screening approach and PCTs do know their local areas, they know what services they have, we expect them to commission according to local need and that makes the sort of approach that we have set out in the national operating framework correct. That does not necessarily mean that we were right or wrong. I do not know the details of that approach to be certain.

Q37 Mr Mitchell: PCTs are likely to mix it in with the provision of other services in respect of sexual health, as indeed some have done. That creates a new ballgame in the sense that many people find difficulty in approaching sexual health services or presenting themselves for the advice from the service provided. We have a UNICEF report here about young people and one of their findings indicates that some young people find it hard to access sexual health services and highlights the fact that provision varies enormously. There are some quotations from young people "I went to the clinic for some birth control and I was scared shitless, it was full of loads of dodgy people, well horrible" "I would be embarrassed about going to a clinic. I'd imagine a load of prostitutes would be there, and everyone would think I was a slag". This is a recognisable phenomenon. Some people are as bold as brass, some people are shy and inhibited. If you are going to provide it in common with other services, you are going to exclude that section.
Sir Hugh Taylor: I do not know that the facts bear that out. I think it is right that people need to think that this is not a one club business. For example, I was in Lewisham and I visited the Lewisham PCT to see how they were delivering these services. They were already running at a 35% screening rate and 86% of that is delivered out of four community health service clinics which young people go to for a variety of reasons. In fact they are open from 11am until 8pm five days a week and have a footfall of 60,000 visits a year. This is a model really of how to do this sort of thing. You can get screening up and what they have learned how to do is to do this well, sensitively and take account of just those sorts of things. Similarly we need to remember GPs. I am surprised at this number but young people in this age group visit their GPs on average between two and four times a year. Something like 70% of young people visit their GP every year. That provides an opportunity for quite sensitively delivered advice on this area. The key to this is normalising the use of chlamydia screening as part of the general run of community health services.

Q38 Mr Mitchell: If you are going to offer it in the way this organisation proposed—not UNICEF—and have a national postal service, it is surely going to be cheaper. They estimate a quoted price of £21.40; not complete costing, but it compares well with the National Audit Office estimate that it costs £56. That £56 includes cost of treatment and partner notification. What is the cost of those? You have refused to supply them to the company.
Sir Hugh Taylor: The evidence is reasonably clear about this. For the initial screening we would like to see the average cost per test at around £20; more than that for full treatment.

Q39 Mr Mitchell: Theirs is £21.40 and you are trying to get it down to that level from a higher level.
Sir Hugh Taylor: My only point on that, and I am not trying to belittle their proposition because I do not know facts about it, is that we can see evidence of screening being delivered in the community for those sorts of rates. Clearly there is variation in costs across the NHS; some variations on the basis of the NAO Report are at a completely unacceptable level. HPA have done some modelling for us which suggests that we should be able to get the costs down to an average of around £33 per test, taking into account the cost of treatment and that is the sort of benchmark we are going to be setting for the system from now on.

Q40 Mr Mitchell: You cannot know that this is value for money unless you know actual costs, can you?
Sir Hugh Taylor: Do you mean the national one?

Q41 Mr Mitchell: Paragraph 3.7 "There are no exact figures available on the costs of the Programme to date, since there is no standard approach which PCTs use to record what they have spent on implementing the Programme. In some cases . . . may be included in block contracts for other sexual health and public health services" which is the point we were talking about earlier. So you do not actually know the costs.
Sir Hugh Taylor: We have done quite a lot of work on this now. It is true that it is quite complex, which is one of the reasons I suspect why PCTs have struggled to get unit costs out because the costing falls in a number of different places, including block contracts and others. With the support of the NAO and the HPA we have now developed quite a good model for benchmarking costs across the system. It is quite a sophisticated model and that is what we are going to share with PCTs and expect them in effect to benchmark themselves against that kind of price. They will be able to break down their costs more easily.

Q42 Mr Mitchell: Why do you have so many individual purchasing programmes? Why not combine them all and get cheaper purchasing?
Sir Hugh Taylor: That is the point that Mr Touhig was making that clearly there is a case for collaborative procurement here which would have certainly brought some marginal gain.

Q43 Mr Mitchell: The Terence Higgins Trust makes the case for combining services in different PCTs but there is a point in an overall purchasing policy.
Sir Hugh Taylor: First of all, we did encourage the systematic grouping of PCTs, which is why there are fewer programme offices than there are PCTs. We accept the recommendation of the NAO Report that we should re-look at the balance of the procurement practice in the programme and get the right balance between national and regional and local.

Q44 Chairman: We still have two more colleagues who want to come in but I am conscious that there are three witnesses here who have not said anything so far so I would like to try to encourage the three of you to say something. You are the experts while the poor Permanent Secretary has to do a lot of other things with his time. Let us take up this Terence Higgins memorandum. "THT's own experience in delivering chlamydia screening has been that unit costs fall as screening volumes increase. You may be interested to know that in two of the PCT programmes which THT coordinates, we reached 30% and 29% population coverage in 2008/09" and obviously this reduced the unit cost. What are you doing Professor Harper, as a director of commissioning and system management, to talk to people like the Terence Higgins Trust to try to get better coordination of this programme?
Professor Harper: We are talking to as many of the stakeholders, the partner organisations as we can and have been for some considerable time but it is in the context that Sir Hugh has given, so clearly the higher the throughput the more we would expect the unit cost to decrease. However, there are different ways of achieving that and we are driving this as hard as we can to increase that screening throughput.

Q45 Chairman: It seems you have not been very successful in that in the past. The Terence Higgins Trust memorandum also says ". . . there are currently over 40 different campaigns in operation". What are you doing to coordinate all this?
Professor Harper: Campaigns in social marketing terms?

Q46 Chairman: Yes. "As the NAO report makes clear there are currently over 40 different campaigns in operation and there are multiple web based postal testing services. Significant economies of scale and increases in impact would be achieved by undertaking these functions once and nationally.
Professor Harper: There is a very good point there and that is the approach we are taking now. We are looking systematically at the social marketing campaigns, not least in the context of increasing value for money.

Q47 Chairman: Dr Hussey, may I bring you in and try to encourage you to speak up during this hearing. Why are you here? You are Regional Director of Public Health and Senior Medical Director for NHS North West. You are not part of the Department so you can tell the truth. What has been going on?

Dr Hussey: Just to clarify that, I both work for NHS North West but I also lead the Department of Health presence in the region in the Government Office. I have two roles here. First of all, I do work at regional level and, second, I was asked specifically to look at the programme and pull together some ideas and suggestions on the way the programme could be further developed. I can assure you, certainly at regional level and in my region, we have built up our sexual health networks now for some years and have looked collaboratively at a whole range of ways in which they can improve delivery of the programme and are very mindful of the opportunities to collaborate. The report I did sets out some ideas from the conversations I had with people about other areas which could be developed.

Q48 Chairman: Now Mr McCracken, let us give you a chance to say something. You are in charge of this really. Some 88% of people who are positively tested in fact do get treatment but obviously that means significant numbers are not going on to get treated properly. What are you doing about it?
Mr McCracken: First of all we would agree that our aim should be that everybody who tests positive should be treated. The 88% is the figure for the year 2008–09; in each of the previous years the figures have been higher and broadly speaking in line with the 95% target. What we have been doing about it is going back to look at the PCTs which performed least well to analyse the reasons for that. Actually the predominant reason is one of data recording, so what we found in a number of the PCTs which performed poorly is that they have had issues with data recording. Almost certainly the actual number of people treated is higher than that recorded, so we are obviously giving them some help with the data recording aspect. One PCT for instance had a problem that their data provider went bankrupt and therefore did not give them the information. That is the type of issue that has cropped up. There is a secondary issue which is that, because there is encouragement to make as many pathways of care open as possible to these young people, they may actually go to get treated, say they might go to a GUM clinic to get treated, and because of the confidentiality arrangements that information might not actually get back to the PCT which initiated the test and which actually informed the individual. We are providing help and support to those PCTs where we see there is low performance and although clearly 88% is far from ideal, if one considers the client group that the programme is dealing with, actually to have averaged over 90% through the life of the programme is not a bad outcome.

Q49 Chairman: That is a very good answer. Sir Hugh, if you get a question you may pass it to your colleagues, you do not have to take everything on your own shoulders.
Sir Hugh Taylor: When I visited Lewisham and asked about this very point, they reminded me that they are required effectively to try to contact somebody who has received a positive treatment three times. Just very occasionally—and this will not be a large percentage of people—they are dealing with people who will give them a mobile number and it is really jolly difficult to get hold of them; it is just not practical.

Q50 Mr Carswell: I want to ask you questions looking at the localist versus the centralist theme. Is it not the case that localist delivery failed because it is not really actually localist delivery at all? Primary Care Trusts remain satellites of Whitehall, they are delivering Whitehall priorities. In what meaningful sense were the Primary Care Trusts locally accountable for delivering this?
Dr Hussey: Perhaps I might comment. Certainly in terms of the commitment to deliver, the chlamydia screening programme has grown over the years and people realised how it worked and what was required of them. As a Strategic Health Authority in our region we hold PCTs to account for the delivery of this particular programme.

Q51 Mr Carswell: So they are upwardly accountable to you as an official rather than locally accountable. In what sense are they locally accountable?
Sir Hugh Taylor: PCTs are required to publish locally their performance against all the indicators in the vital signs framework and they are answerable through local authority scrutiny committees and others for their activities in this and in every other area. Clearly their formal line of accountability is to the Secretary of State and that is why I am sitting in front of the PAC today to answer questions about this programme.

Q52 Mr Carswell: So it is upward.
Sir Hugh Taylor: As far as their accountability to me is concerned. We would certainly say they should be looking out to their local populations and that includes working in partnership with their local authorities, which they certainly do on sexual health and on other areas.

Q53 Mr Carswell: Leaving it to Primary Care Trusts means that by definition you are going to get different approaches, possibly 152 different approaches. Difference can be good if the local solution matches local priorities and local circumstances. Because Primary Care Trusts are not effectively locally accountable, do you not think that the differences in delivery within the different Primary Care Trusts are entirely arbitrary rather than by design?
Sir Hugh Taylor: I do not think they will be arbitrary. The differences will often reflect dimensions of current service provision there, so there is no doubt that in areas which have well established community sexual health services at the outset of this programme, for example south east London, Lambeth, Lewisham and Southwark all had well developed services at the outset, they in a sense have had a strong platform on which to build. They have built the programme around that essentially. In other areas, for example in Dorset, they have really built up their relationships with

local pharmacists and have got up to 20% with local pharmacists. That is an entirely proper local variation. I am not sure that relates to local accountability.

Q54 Mr Carswell: Dr Hussey, wearing your regional hat and your regional perspective, do you think PCTs are actually good at gauging local priorities? Surely the evidence of this Report shows that quite often they are not.
Dr Hussey: We work with all our Primary Care Trusts very systematically to help develop their understanding of the needs of the local population and, as you know, they are required to produce joint strategic needs assessments with local partners. On that understanding and through the competencies of world class commissioning, we assess how they are doing in terms of understanding the needs of local populations. It is evident that some are better developed in some areas than others and that is part of the assessment process that the PCTs are going through.

Q55 Mr Carswell: Mr McCracken, you run a big quango so I want to direct this question to you. Officials quite often like to talk about spreading best practice; we get this cliché about spreading best practice. We have 152 different PCTs, some doing it well, some clearly not doing it well. At present there is no real means of ensuring that what works in one area is replicated other than by the fiat of Whitehall, other than by the intervention from the centre. Surely this Report shows that is inadequate and that if you are to have different approaches and different solutions, you actually do not need the centre to decide what works but you need some mechanism of organic replication of what works.
Mr McCracken: The approach which the programme has taken has actually very much sought to drive benefit from that type of replication that you suggest. The Health Protection Agency has set up a network of regional facilitators who work both regionally and locally with trusts, actually sharing information that we generate because we are monitoring what is going on, sharing that locally. So if we see a particular trust perhaps not making much use of core services, then we will give that information to them and discuss with them what might be done better. Because these regional facilitators also operate as a network and actually come together and share experience, they are able, when they go back to the regions and to their local PCTs, to take good practice from one part of the country to another. We back that up with guidance. For instance, in 2007 we found that there was not enough; too few men were actually being targeted for treatment. We actually produced a guidance document which was made available to all the PCTs about actually encouraging people to target men more.
Mr Carswell: My final question is to Sir Hugh. You mentioned the phrase "learning lessons". Tell me if I am projecting too much onto this Report, onto the broader picture of how we deliver health in this country. Is there not a danger of running our NHS on a big scale along the lines used in this programme on a small scale? Some politicians talk about an NHS Board, in effect turning it into a monster quango, probably like the Health Protection Agency, forking out the money with no clear lines of accountability. Does this not show the danger of turning the NHS into a super quango?
Chairman: You can plead the Fifth Amendment on this. You do not have to answer this.
Mr Carswell: With respect, it is a serious question.
Chairman: I know it is a serious question but it is touching on a policy issue. You can answer it but you do not have to answer.

Q56 Mr Carswell: With respect, I would like you to answer it in a serious and earnest manner.
Sir Hugh Taylor: I will certainly answer in a serious and earnest manner, just being careful. What I think about this is that if, as is the case here, the success of a programme depends to some extent on effective national rollout, after all what we are trying to do here is reduce the prevalence of chlamydia in the community in order to produce health gains, primarily for women, to stop them getting really quite damaging related health problems, in those sorts of cases you do need a national dimension to the task. You can question, and we should keep open all the time the scientific basis for that, the evidence that is emerging, but while that remains the ambition, you have to have a national dimension to it. In this case we think that is best delivered at the moment by making it clear that this is a national priority, but with clear flexibility for how it is delivered at local level. We need concerted action across the country. That fits well a programme of this kind. Then it is a matter of choice, and partly political prioritisation at the time, what things you choose to run nationally through a system like the NHS and what you give more emphasis to locally. This is just poised between those two things.

Q57 Mr Williams: What we have here is a system which has failed the public, is failing the public and will continue to fail the public. It has put devolution above the health of the public. Do you think that is acceptable?
Sir Hugh Taylor: I do not think I accept the premise of that question.

Q58 Mr Williams: You do not? Have you not read the Report?
Sir Hugh Taylor: I have read the Report.

Q59 Mr Williams: How can you read the Report and draw any other conclusion but that the devolution has been disastrously ineffective?
Sir Hugh Taylor: We could not have established it or run it or got the gain we need from it without a very strong element of devolution in the way that we do it. I have recognised that we should have given and could have given clearer national prioritisation to the programme, that it had a rough time during a period of instability in the NHS and the evidence that we now have, built on foundations of the phased introduction of the programme, of a

significantly increased rollout, demonstrates that the emphasis on localisation within a national priority was the right one and I would not accept that it is failing the public. Over 82,000 people have been treated for chlamydia as a result of this programme in the community who would not otherwise have been treated.

Q60 Mr Williams: That is a minute proportion of the people who are probably affected. We are told here that one third of the programme funding has been diverted to other uses. Is that very much to the credit of devolution? Is it or is it not? One third has been diverted and you do not know where it has been diverted. Is that true?
Sir Hugh Taylor: What happened in 2005–06/2007–08, as I said, was that deficits emerged in the NHS.

Q61 Mr Williams: How much of that one third can you account for?
Sir Hugh Taylor: I cannot because it was in PCT allocations.

Q62 Mr Williams: So one third of it is written off already.
Sir Hugh Taylor: It is not written off; it would have been used on other dimensions of the NHS.

Q63 Mr Williams: You do not know that. You do not know that it is not written off because you do not know.
Sir Hugh Taylor: With respect, we do know, since this Committee and others know very well what money was spent on what in broad terms in the NHS in 2005–06/2007–08. I have frankly acknowledged that during that period deficits emerged and it is clear that for some programmes, including this one, where the Department earmarked money but put it into general PCT allocations, not all the money we had hoped would be spent was spent on it. That does not mean to say it was misspent. It was spent on other priorities.

Q64 Mr Williams: Exactly; that is where we go next. We are told the money has been put to other uses and you do not know what those uses are. You have no way of tracing it.
Sir Hugh Taylor: In respect of the funding during those two years, that is true. What I would say is that the Report confirms, based on the NAO's own assessment, that £42 million were spent on this programme in the NHS in 2008–09. That is more than the indicative allocation which was in PCT budgets in 2007–08 and confirms that when we established this as a clear national priority, the programme recovered ground and the PCTs are now spending money on it. Indeed the evidence from the first six months of this year is that the programme is continuing to grow and we set a target for this year of 25% for the proportion of people tested and we remain optimistic that we will hit that target or very close to it.

Q65 Mr Williams: Nearly three quarters of local areas fail to meet standards of testing partners of infected people. Is that not neglect?
Sir Hugh Taylor: No. It is not a straightforward element of the programme.

Q66 Mr Williams: It is not neglect?
Sir Hugh Taylor: No, I do not think it is neglect.

Q67 Mr Williams: How on earth can you justify it as not being neglect when you are leaving people who may end up infertile as a result of this failure?
Sir Hugh Taylor: Because I think it is generally recognised that this is quite a difficult thing to do. The standards to which you refer are an expectation, which is an expectation, an aspiration, that in urban areas 40% of partners would be traced and in less difficult areas 60%. The achievement overall in 2008–09 was that 29% of partners were contacted. This depends very heavily on the individual who is being tested giving accurate information and on the capacity of the system to follow it up. If you look at the NAO's own Report, figure 4 on page 19, which reflects the modelling the HPA did to demonstrate the levels of screening we would need to do in order to get significant health impacts according to the NAO's model, that assumes a partner notification rate of 20%, which we are already exceeding. While clearly we are challenged by the level of partner notification and some areas are not doing as well as we would want—

Q68 Mr Williams: You are talking, talking, talking, but you are not giving us any meaningful answers. The fact of the matter is that the system is exposed to probable litigation by some people. Let us look at the case of people who test positive. We are told by the NAO that the programme is failing to treat some people who test positive. Is that not only neglect of the people concerned, but a clear possible danger of possible litigation as far as the NHS is concerned?
Sir Hugh Taylor: Mr McCracken has already dealt with this point.

Q69 Mr Williams: I do not remember litigation being dealt with at all.
Sir Hugh Taylor: I cannot believe that the NHS is subject to litigation as a result. First of all, the 88% figure which is quoted—

Q70 Mr Williams: Are you saying that quite seriously?
Sir Hugh Taylor: Yes, I do. What would the basis be for litigation?

Q71 Mr Williams: You have failed to treat people who have tested positive.
Sir Hugh Taylor: First of all, that statistic is a statistic of recorded people treated. As Mr McCracken has explained, there are problems in the recording of the data here.

Q72 Mr Williams: Does the person who has not received treatment, who could have received treatment and should have received the treatment,

not have a case against those who should have supplied the treatment and knowingly failed to do so?

Sir Hugh Taylor: If the individual has presented for treatment or requested treatment, they will get treatment. The circumstances in which they would not are where the people who receive the positive assessment attempt to contact the individual concerned with the information that they have been given for how to contact them, bearing in mind a number of these people are young people who will give a mobile number, and if they cannot get hold of them, then we have a clear requirement for how many times they are expected to try to get hold of them but in the end, if they cannot get hold of them, there is nothing much more that the tester can do.

Q73 Mr Williams: It will be interesting to see what arises. One other thing I am interested in is that this is essentially an English initiative. Why is it, since people travel around the country inevitably, we are a small country, that there is not more attempt to integrate whatever is able to be integrated with Scotland, Wales and Northern Ireland?

Sir Hugh Taylor: I am not an expert on the position in Scotland, Wales and Northern Ireland. I think the Northern Irish are moving in the direction of implementing a screening programme along these lines. For Wales and Scotland it is a devolved matter and they make their own decisions in these matters and they have not decided, so far anyway, to implement a screening programme of this kind and that is clearly a matter for the devolved countries.

Q74 Dr Pugh: May I just go back to basics for a second? What is the total cost of treating chlamydia in the NHS irrespective of screening programmes? If you take screening programmes out for the moment, what does it actually cost us as a country to treat people with chlamydia?

Sir Hugh Taylor: I am afraid I do not have that number directly in my head. Do you mean—

Q75 Dr Pugh: My point is that we are spending £150 million on doing something and presumably one thing we are trying to do is defray the cost to the NHS of this disease and also do something about the disease as well. Without the screening programme, how much would we spend ordinarily on dealing with chlamydia?

Sir Hugh Taylor: The answer is that I would need to get back to you with a detailed number. Before the programme was created virtually all chlamydia treatment was done in specialist GUM clinics and I could give you the cost.[1]

Q76 Dr Pugh: The only problem with doing that possibly is what you have mentioned all the way through and that is the additional cost to the NHS because of complications with untreated chlamydia. If you could include that in as well, then we could look at a figure the screening programme is trying to do something about. In terms of screening and the practice of screening, could you help me with this as well? When screening is generally done—and you have obviously done a lot of screening—does it pick up the disease in most cases in the early stages or is it normally people who have had the disease for some time and it is in quite a developed phase?

Mr McCracken: It normally picks it up, and indeed this is the purpose of this screening programme, when people still do not have symptoms; so it has not progressed to the later stages and the complications.

Q77 Dr Pugh: So the bulk of people going through the screening programme are people without symptoms not people who are referring themselves to the programme because they have symptoms.

Mr McCracken: Yes, that is exactly the purpose of the programme and that is why it has been focused on primary and community care to catch people who might be going to their GP for an entirely unrelated matter and to encourage them to have a test for chlamydia because we know it may be asymptomatic so that they can be treated before they suffer the consequences and indeed before the Health Service then has more expenses.

Q78 Dr Pugh: In terms of what the screening is designed to do, clearly one very laudable objective is to reduce the incidence of the disease in the first place. Another objective might reduce the cost of treatment because you pick up the ailment earlier and the other might be the incidental benefit that you pick up other sexually transmitted diseases or do you pick up other sexually transmitted diseases in the process?

Sir Hugh Taylor: It will depend on the setting and where the test is carried out. A number of people will be tested just for chlamydia. Where this is done in a community sexual health service, they may well be testing for gonorrhoea at the same time.

Q79 Dr Pugh: On an individual case basis, if somebody goes, having developed symptoms, to their doctor there is a cost involved in treating them, in dealing with them, in diagnosing that. If they are picked up in the screening programme there is obviously earlier diagnosis and presumably a more rapid intervention. What is the cost differential between those two situations?[2]

Sir Hugh Taylor: I will have to come back to you with the precise number, but it is very considerable. If somebody who is asymptomatic, and most of the people with chlamydia are, which is that they have no symptoms, then the treatment is a simple antibiotic, which is not very expensive. If you begin to get the onset of the consequentials of chlamydia, my understanding is that then the expense becomes very much greater because you are potentially dealing with pelvic inflammatory disease, which may in itself lead to complications like ectopic pregnancy and infertility and so on. Indeed I have been given very moving accounts by GPs of people who have come into their surgeries for one purpose, which was to consult in relation to infertility, only to discover

[1] Ev 13

[2] Ev 13

that they are infertile because they have had unknown chlamydia over some time. The whole purpose of this programme, as you say, is to try to address just that sort of issue.

Q80 Dr Pugh: Presumably one test as to whether you are actually achieving one of your objectives, which is to reduce the incidence in the first place by making people more alert to the complaint in the first place, would be that in an area which has good screening practice you would get fewer people with serial chlamydia, because you can catch it many times, can you not? Is that the case?
Sir Hugh Taylor: I do not think the evidence is yet clear on that. That is clearly one of the things we need to evaluate. It is very important that we combine testing and treatment with advice on sexual health issues more generally and that is one of the reasons why we are very keen to press for this screening to be done as part of core services and not just in a more opportunistic way.

Q81 Dr Pugh: I was thinking of it from the point of view of the chair of a PCT. They have a problem and there are various ways of addressing the incidence of chlamydia and reducing the incidence of chlamydia but presumably the ultimate objective is not treating it, not having it at all. You can spend your money either on screening people or you can spend the same amount of money on other things like propaganda on sexual health of one kind or another or different sorts of messaging to young people. If you are making that judgment you are going to need some pretty hard data to work on, are you not?
Sir Hugh Taylor: You are probably going to need both actually.

Q82 Dr Pugh: If you do not have the data, you do not know which is the best way of spending the money for the best effect, do you?
Sir Hugh Taylor: That goes to the heart in many ways of what is the dilemma of the programme because until we get up to what the HPA modelling shows us, until we get up to a certain level of screening, we cannot expect to have a real impact on the prevalence of chlamydia on the community. At that point we need to start measuring both overall prevalence in the community and comparing that against the impact of the testing. At that stage you begin to have a better sense of the overall cost effectiveness of this kind of measure. It is true that remains to some extent an open question at the moment and it was why we embarked on this essentially long-term public health programme in the first place.

Q83 Dr Pugh: Getting back to the theme of localism, in terms of your debate with local commissioners of health care, the PCTs in a sense, there must be a fairly educated discussion about where best to put their money really. I understand there is a big problem in the North West and a severe problem on Merseyside. Am I right?
Dr Hussey: In what regard?

Q84 Dr Pugh: To do with chlamydia.
Dr Hussey: Yes, there is a prevalence of chlamydia in the region.

Q85 Dr Pugh: In terms of that high degree of prevalence and in terms of addressing it, different PCTs within the area will perform differently, will they not? They will spend the money differently and we bemoan the fact that it is all rather fragmentary but presumably you have an educated discussion with all of them about how they are doing this?
Dr Hussey: Yes. The approach we have taken is first of all to make very clear the priority we attach to sexual health services overall, an encouragement to integrate where possible, get multiple benefit from the way programmes are offered, whether it is chlamydia screening or other sexual health services, looking for opportunities to reinforce messages. Going back to your previous question, I do not think it is as clear cut as messaging or a chlamydia programme because actually the very awareness of the fact that there is a test is helping young people to talk about sexual health practice and services and to find out where they can get support. It is not a simple either/or; it is a case of needing a range of ways in which we raise the awareness of sexual health services in the region.

Q86 Dr Pugh: So they do not say things like "If I do more testing that just makes my stats look worse. I prefer to spend my money in other ways"?
Dr Hussey: Interestingly from my point of view, we are currently having a number of conversations with primary care trusts, looking at where they are at this point in the year and how the programme is going and encouraging them to take best practice advice from the Health Protection Agency, the national support teams and then looking at where they can strengthen the programme. That is the role the Strategic Health Authority plays in terms of improving performance and we are actively in those conversations with some primary care trusts at this time.

Q87 Chairman: That concludes our hearing. Six years this summer since it was launched. By our calculations only one half of Primary Care Trusts are testing just over one quarter of young people for chlamydia and that is the absolute minimum to make any kind of progress in reducing infection. As this infection apparently shows very few, if any, symptoms and can lead to infertility, I think it is a matter of great national concern that we have made so little progress. What went wrong? You ploughed ahead with local, fragmented implementation, the programme has been inefficient, it has wasted public funds and each programme has been buying its own kit, devising its own marketing and websites. We have a total of 45 different brands across the country. I believe you could have saved a lot of time, a lot of money and you could have treated many more young people if you had had a centrally driven programme. Then of course, as so often happens,

after about five years, when nothing was happening, you panicked and you introduced a compulsory target for testing levels, so once again PCTs had to scrabble to catch up. They made an inefficient programme even more wasteful of taxpayers' money. In conclusion, I think this is a classic example of where you have unthinkingly rolled out a national programme on a locally devolved NHS and, Sir Hugh, you have failed. Do you wish to comment before we break?

Sir Hugh Taylor: I do not accept all the premises in your analysis. I agree that there are lessons to be learned from the way we rolled this out. We intended to get to national rollout on a phased basis. Since we clearly established this as a national priority, which was not a one-off in relation to chlamydia, it was an overall response to a need to give the NHS more clarity about the priorities being set by the Department, we have made very substantial progress. In fact we delivered the level of screening in the first year of national rollout which we had always aimed for. We are now making substantial progress on the chlamydia screening programme. We still have some way to go. We certainly have lessons to learn and the NAO Report has been helpful in that respect. We will take those on board, together with the recommendations from Dr Hussey's report and I am sure that will see the programme develop further over the next 18 months.

Chairman: Thank you Sir Hugh.

Supplementary memorandum from the Department of Health

Questions 74–75, 79 (Dr Pugh): *cost of treating chlamydia in NHS irrespective of screening programs*

The National Audit Office estimated, using information from the survey of Primary Care Trusts that was undertaken, and which was quoted in their report at paragraph 1.2, that the cost of detecting and treating chlamydia in the NCSP was £42 million in 2008–09. For those who are symptomatic, or in the absence of a screening programme, most people seeking testing and treatment for chlamydia would attend a genito-urinary medicine service (GUM). GUM services are subject to a mandatory Payment by Results tariff of £139 for a first appointment and £86 for follow up appointment (for positives to receive treatment). In 2008, just over 71,000 young people under the age of 25 were diagnosed with chlamydia in GUM in England. In this age group, over the past five years, there has a been a 13.7% increase in the number of diagnoses in GUM.

However, those attending GUM receive a wider range of tests than under the National Chlamydia Screening Programme, and it is therefore not possible to separate out the costs of chlamydia from all the other activity included in this tariff. We are therefore unfortunately unable to provide an overall figure for the cost of chlamydia to the NHS in 2008.

The Programme aims to detect and treat chlamydia in those without symptoms, who would not otherwise seek care, so a cost comparison is hugely complex. Without the Programme, the large majority of infections it has found may have remained undetected or untreated. This means that any comparisons need to consider the costs of early intervention to detect chlamydia versus the costs of treating those who develop reproductive health complications if their chlamydia remained undiagnosed.

Untreated chlamydia is a leading cause of reproductive ill health in women but epidemiology is hard to study because of the difficulty in making a clinical diagnosis and because Pelvic Inflammatory Disease (PID) is often unrecognised if it presents atypically or is asymptomatic. The Centre for Disease Control and Prevention in the USA estimates that because of vague symptoms, PID goes unrecognised by women and their health providers about two-thirds of the time and because of this research to address the uncertainties in the natural history of chlamydia is complex to design and conduct.

However, it has been estimated that after one episode of PID around 10.8% of women may become infertile and 7.6% of subsequent pregnancies may be ectopic which can be life threatening. The financial costs of treating these conditions can be considerable. The Report to the Chief Medical Officer in 1998 estimated the annual cost of chlamydia to the NHS to be approximately £100 million per year. This is highlighted in paragraph 2.7 of the NAO report. However, more work is needed to determine the financial costs of Chlamydia currently. The costs to health and quality of life can also be considerable, and are important components of cost-effectiveness analyses. Prompt and appropriate treatment can help prevent complications of PID and is one of the key reasons why the programme has been established.

11 December 2009

Memorandum from Terrence Higgins Trust

I am writing ahead of Wednesday's Public Accounts Committee discussion of young people's sexual health. I hope this will help to further inform committee members ahead of the meeting.

Terrence Higgins Trust is the largest supplier of chlamydia screening services in England, and we welcome the recently published NAO report. We believe that the National Chlamydia Screening Programme already plays an important part in improving the nation's sexual health even though it is only 18 months since it became fully established across all PCTs. However we also believe that as currently organised, chlamydia screening is not delivered as efficiently as it could be.

There are at least four ways in which value for money can be improved. These are:

— Increasing the number of people screened by maintaining, as a minimum, the 35% population coverage target for PCTs beyond 2010–11. THT's own experience in delivering chlamydia screening has been that unit costs fall as screening volumes increase. You may be interested to know that in two of the PCT programmes which THT coordinates, we reached 30% and 29% population coverage in 2008–09, and this contributed to us being able to reduce the unit cost in these PCTs. This approach would also enable the Government to obtain ongoing benefit from the initial expenditure outlay necessary to get the national programme established.

— Reducing the overhead and coordination costs by operating local Chlamydia Screening Programmes which cover multiple PCTs. This approach enables core functions such as programme management, partner notification, GP capacity building and performance reporting to be undertaken as a single exercise across a number of PCTs with resulting economies of scale. There are a number of examples of multi PCT programmes, including a four PCT programme managed by THT. This programme has enabled THT to employ a single programme coordinator and a single partner notification team covering all four PCTs with resulting savings to the public purse.

— Reducing the promotional and web service costs by operating a national chlamydia screening promotional campaign and website. As the NAO report makes clear there are currently over 40 different campaigns in operation and there are multiple web based postal testing services. Significant economies of scale and increases in impact would be achieved by undertaking these functions once and nationally.

— Expanding the potential role of chlamydia screening services to enable a transfer of chlamydia testing from more expensive hospital based services. The cost differential between the NAO's target cost per screen and the NHS tariff for hospital delivered specialist sexual health services is almost fivefold. With expanded access to, and better planning of chlamydia screening there is no reason why a proportion of hospital based chlamydia testing activity could not be transferred to community settings at a cost saving to the public purse.

23 November 2009

Memorandum from test.me

I would be grateful if the following information could be considered for the evidence session for your Meeting Wednesday 25 November:

I read with interest your recent quote that the above programme has been "inefficient and wasted public funds" and that "This is a classic example of what can go wrong when a national programme is rolled out unthinkingly in a locally-managed NHS."

I agree, particularly for "remote testing" as outlined below in chronological order:

BACKGROUND

Nearly two years ago our company (Preventx) presented to DoH/HPA/NCSP our vision for a national website, whereby 15–25 year olds could access a postal test. Importantly, the delivery of the test would also be provided at national level.

In our presentation, we explained that:

> The target age group routinely order goods and services online, and that their preferred method to access a chlamydia test was via an online service (effectiveness and efficiency).

There were numerous economies of scale in offering a postal doing this (including marketing and operational economies and efficiencies).

We presented that in excess of 180,000 tests per annum would be completed, and that this would make a meaningful contribution to the overall numbers. (*We now believe these projections were too prudent and that in excess of 350,000 tests per annum could be completed).*

However, we were informed that DoH policy did not allow the national delivery as we described, and that we should instead approach all 152 Primary Care Trusts. We tried to argue that other services (eg bowel cancer screening were national), and that there was already appalling wastage. (Basically, for all of the reasons now identified by the NAO report). We suggested that the DoH Policy should be changed, to no avail. This was June 2008.

In November 2008 we launched our website, www.freetest.me. Freetest.me is promoted nationally, with 15–24 year olds looking for a chlamydia test offered the "best" option. Our service was modified to allow participating PCTs to include their local "brand". If, for example you enter the demonstration age "911", and any valid post-code, then you will see Cornwall PCT branding on the website and this local "branding" has then also been replicated on the specimen collection form sent to patients.

As above, there are numerous economies of scale:

> Marketing example: if you google the search term "chlamydia test", freetest.me will appear first in google for natural (unpaid search)—incidentally, above the NCSP website. It should be apparent that a single PCT will not be able to achieve first position in google. There are numerous other examples of marketing economies of scale.
>
> Operational example: our company has invested more in IT and Business Operational Processes than a single PCT could sensibly economically afford in developing operational processes. As a trivial example, negative patients are automatically electronically notified in the way the patient has chosen to receive their results: in contrast, a significant number of PCTs are manually texting "negatives" with their results.

We now have very clear proof that our service works, in terms of economy, effectiveness and efficiency. Our service is world class, with every aspect of the process well thought-out and executed. Our company supplies all aspects of the service: marketing; kit design, assembly and supply; patients results handling and data collection and reporting, with the lab test supplied by the leading laboratory test company in this field. I've attached a copy of our service information to provide some indication into the quality and professionalism of our offer. In comparison, we have yet to see a single PCT offer which even matches a single aspect of our service—at best their offer is average.

Value for Money: Pricing

Our average price is £21.40 per completed test. This varies very marginally from PCT to PCT, but is pretty tightly defined as ranging from £19.80 to £21.75. These costs are inclusive of all wastage (eg marketing, and unreturned kits). This is significantly less than the £56 average reported by the NAO.

Note: we fully accept that our quoted price of £21.40 is not a complete apples: apples comparison with the £56. Our price does not include the cost of treatment and partner notification: we have asked the NAO for the cost of "treatment" and "partner notification" so that we may add these costs back to our service, but unfortunately, we have not been provided with this figures. On the other hand, there is clearly a very wide range of prices £33 to £256, and it is unclear to me what is—and what is not—included in these figures, and how these costs have been treated.

Value for Money-Efficiency and Effectiveness

We are currently processing over 200,000 test requests per annum, and we have yet to start marketing our service—we are waiting until we have a "critical mass" of PCTs to justify an economic return. However, more than 80,000 tests have been lost from PCTs which have not joined our service. As above, these lost tests would be at a price which is basically less than half of the average currently paid by PCTs. The NAO report that, if the average cost were reduced to be £33 in the next year, then this would save £40 million per annum. Per today, we already have a service which delivers an increased number of tests and at significantly less than £33.

Communication

We now have 30/152 PCTs who have joined our full service. Frankly, we fail to understand why all PCTs have not joined. At present, they are losing tests, which could be fulfilled at a price less than they are currently paying. Unfortunately, we have also been unable to readily communicate our message to PCTs. The DoH/HPA/NCSP are, for perhaps understandable reasons, unable to endorse our service—but, again this obviously leads to a fragmented service. Generally, there appears to be a lack of joined up thinking between DoH/HPA/NCSP/PCTs.

NAO Recommendations: A conundrum for Remote Testing:

> b-i) NAO recommended that "The HPA to...perform a cost-effectiveness ..of remote testing...through websites"; and b-iv) and b –vi) "The Department (of Health) should also undertake reviews of online screening, data gathering and testing-kit procurement, with a view to putting national or regional arrangements in place".

We welcome and agree all these recommendations.

However, there then appears to be a conundrum between the respective organisations:

DoH:

In our most recent correspondence with the DoH, we were again advised that:

> "The issue remains the same, that local health economies are responsible for how they deliver services, since budgets were devolved to local control towards the end of the 1990s. This was a major shift in NHS policy and so there is no longer central control of how aspects of ongoing service such as this should be delivered, as this would impact local spending".

NAO:

> The NAO recommend (b-iv)..."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".

Public Accounts Committee:

> I also note that "The Committee does not consider the formulation or merits of policy (which fall within the scope of departmental select committees); rather it focuses on value-for-money criteria which are based on economy, effectiveness and efficiency".

Conclusion

Hence, for what the NAO refer to as "Remote Testing" at least, there appears to be to be a conundrum: DoH Policy does not allow "National delivery"; and yet this is precisely where value-for-money based on the NAO Report and also on PAC criteria lives.

So, which of the above organisations has the overall authority for decision making?

National Audit Office: Report feedback

We are sympathetic to the challenge faced by the NAO, in that the information they were seeking was probably not readily accessible. Nevertheless, we felt some aspects could have been addressed: briefly, these are:

- More rigorous cost analysis, in particular a check list of what is—and what is not—included in the costs.
- How costs have been treated, eg depreciated over time?
- Analysis of cost by "location". The HPA report is very qualitative, but seems to imply that the primary source of "location" ie outreach is the most time consuming (and expensive);
- Analysis by process stage: for example, the cost of "patient treatment".

NAO: Case Study

We spent two to three hours meeting with the NAO, following which we were advised that the NAO was considering making a "case study" of our service (presumably, for the right reasons!). In the event, we were informed that the report length had to be reduced, so there was no mention of our service. We are disappointed to note that there is no mention of our contribution. We initially presumed this was for the usual fear of "endorsement", but then noted that Roche and Pharmacy are included in the methodology.

Preventx/freetest.me Conclusions and Recommendations

We understand the initial logic of treating chlamydia as a "special case" and stripping out of GUM Clinics etc. It is the execution which has been poorly thought through.

We strongly recommend that although a national postal service should be considered, care of patients should still be delivered at local level, either by the current NCSP offices or via the GUM service within a patient's PCT. The dispatch of postal tests however, and potentially laboratory services should be delivered nationally.

Assuming patient care is available in some form via services in the local PCT, we would recommend one of the following national kit service options:

(1) Kits are requested from a national website and are posted directly to the patient. Kits are returned to the nationally commissioned laboratory. Negative results are handled automatically, positive results are passed to the patient's local PCT's designated care point (eg in the current NCSP system, the screening office). Patient care is then handled locally.

(2) As above, kits are requested from a national website, however each kits return postal address is printed "live" and depends on the patients PCT. The kit is sent to the patient, and when returned is addressed to the PCTs locally commissioned laboratory. The results would automatically feed into local patient management systems as they do at present, and patient care is then handled as it is currently. This would require existing Chlamydia screening tenders for laboratory services to be in pace (as they are under the NCSP at present).

Both of the above would require a national website and brand to be developed (or use an existing commercial brand, such as freetest.me) and the development of nationalised test kits and request forms etc. As with the freetest.me service, the forms in the kits are simplified and pre-printed as the patients details are collected online.

Preventx Limited is the only organisation worldwide currently in a perfect position and with experience to deliver either of the above services.

To be able to tender for a national remote testing service, DoH Policy will need to be modified. However, prior to going to tender it is recommended that DoH should run a "beauty parade" so that they may be properly briefed on what specification to go to tender for. I'm afraid that, we feel that the DoH is still not grasping what's really needed, so there's a risk an inferior service may be commissioned. An irony here is that, although our company is unique in offering a national delivery service, we have probably upset so many people along the way trying to tell them how this should be done that, if common sense does prevail we may be unsuccessful!

In addition, "treatment" could also be offered online: there is already a mechanism in place through a patient group directive (PGD).

In addition, other STI tests could also be tested online using the same sample (for example, to test seven STI's).

The above offers a "patient centric" solution: offering a service in the way young people prefer.

20 November 2009

Memorandum from UNICEF UK

I am contacting you with regard to your work on the sexual health of young people.

Earlier this year UNICEF UK, in partnership with the Terrence Higgins Trust produced a report on the views and experiences of young people in relation to sex and sexual health. The UN Convention on the Rights of the Child last year made recommendations to the UK Government to intensify its efforts to improve the sexual health of young people. Our report aims to shed light on this issue and help us to understand more about why some young people take risks with their sexual health.

Our research shows that more needs to be done to ensure that all young people receive the information and services they need to protect their sexual health. In particular, our findings indicate that some young people find it hard to access sexual health services and highlights that the quality of Sex and Relationships Education varies considerably.

The report can be found at: www.unicef.org.uk/publications/pdf/sexhealth_web.pdf

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