Public Health England

Protecting and improving the nation's health

National Chlamydia Screening Programme: Lessons learnt report

The incident/background

This report relates to the falsification of screening samples within an outreach service over the period 2008 to 2014.

The incident was identified via a complaint from a member of the public, known to a member of the outreach team, who had received a result for a screening test they had not provided.

The investigation showed outreach team staff had provided urine samples themselves and assigned falsified personal contact details in order to increase the sample numbers being achieved by the service.

In view of the seriousness of the allegations an external independent enquiry was initiated and the senior manager of the service was suspended whilst an internal HR investigation was commenced.

Immediate and root causes

The investigations established that:

From 2008-2012 the local PCT commissioned activity from the local sexual health service in line with achieving the NCSP coverage rate targets, and the local outreach team was tasked with delivering large numbers of screens to supplement the core delivery through the sexual health clinics/ other providers.

The focus on volume of screens resulted in a culture which was very target-focused, with a lack of clarity about what constituted acceptable and quality practices. As a result poor practices, including falsification of results became normalised in the service and were not challenged or reported. The senior manager of the service actively encouraged this inappropriate practice due to pressure to deliver the target activity.

Training of frontline staff did not include change in focus to increasing diagnosis rate in 2012 and they continued to focus on delivering volume of screens rather than targeting their activity.

The data management system did not facilitate detection of the fraudulent activity.

What was done well

- a thorough and extensive executive-led investigation process was established as soon as the issue was identified, including suspension of the service until remedial measures had been implemented
- the data management system enabled the counter fraud service to identify potentially falsified samples and the scale and duration of the problem
- the investigation approach enabled full and frank disclosure of untoward practices by the outreach staff, and enabled a productive revision of their role and function to support young peoples' sexual health

Lessons to be learnt

Enhanced staff training must ensure workers are aware of:

- the quality requirements of the chlamydia screening programme and standard operating procedures
- how to target outreach testing
- how to escalate concerns, and the support available to staff
- the financial costs and wider implications of the falsification of tests/ what constitutes fraud

Data anomalies must be examined in terms of their potential to highlight poor practices rather than assuming data inputting errors

Final outcome

- following intensive re-training regarding standards of good practice, the outreach team was reinstated, and new management was put in place
- an HR investigation was conducted and concluded in accordance with the Trust policy
- data management systems have been reviewed to ensure early identification and investigation of anomalies and improved data quality

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