Dear Ms Hillier

Clinical correspondence handling in the NHS

I am writing to update you on a number of recommendations in the Forty-Third Treasury Minute on clinical correspondence handling in the NHS (session 2017-19), published in September 2018. Please accept my apologies for the delay in the update. The delay was to ensure we were fully able to update you on all areas of the clinical correspondence incident.

Recommendation 1: NHS England should write to the Committee in November 2018 and again in May 2019 with an update on the total number of items of misdirected correspondence identified to date; the size of the current backlog of unprocessed correspondence; any new backlogs of misdirected correspondence that have been identified since our March 2018 evidence session; and an update of its assessment of whether there has been harm to patients.

All 708,259 items identified in the SBS Incident have now been fully investigated. Of the 423,784 items identified in the PCS Incident there are 8 outstanding cases where we are awaiting the required information to complete the review. In March 2018 NHS England declared two cases where harm cannot be excluded. The affected patients have been informed. No further cases of harm have been identified.

During the decant of the SBS historic archive 11 boxes of clinical notes were identified in November 2018. The 7,451 items were reviewed by a clinician and 26 items were deemed to require GP action. These items were repatriated to GP practices on 19th December 2018. The patients’ GPs have confirmed no harm for 11 of these cases. A further 9 cases require a central clinical review, and we are awaiting responses from GPs for 6 cases. No further backlogs have been identified.
Recommendation 2: NHS England should set out in its November 2018 update what it has done differently to ensure that its planned communication campaign is more effective than the last, as well as the impact the campaign is having on reducing the volume of correspondence that GPs are sending to Capita in error.

NHS England has undertaken comprehensive communications to remind GP practices of the correct procedures for handling clinical correspondence. Messaging was added to the Primary Care Support England (PCSE) website in early summer 2018 meaning searchable guidance is readily available to practices who have queries. This was supplemented by messaging issued directly to GP practices via the monthly PCSE bulletin in August and October 2018. Further, the importance of following the correct procedures for clinical correspondence was covered in a number of trade publications over the summer. This approach was discussed in advance with the BMA to help improve the effectiveness of the communications.

Between May and October 2018, 46,767 items have been received and handled through the new PCSE process. Of this total, 17,312 items were correctly sent by practices to PCSE for processing and 29,455 items of clinical correspondence were incorrectly sent to PCSE. We have undertaken a review to compare the current volumes with the numbers received in the first 30 months of the contract which shows the monthly average has reduced from around 14,100 items to around 7,800. We will continue to work with PCSE to further reduce the number of items sent in error.

Recommendation 3: NHS England should report back to the Committee by November 2018 on what it is doing to identify consistently non-compliant GP practices and how it is going to work with GP representative bodies to ensure GP practices are following the correct correspondence handling procedures.

Around 600 individual practices per month have been identified as responsible for sending items incorrectly. This is out of a total of around 7,500 practices in England, confirming that the majority of practices are following the correct procedures. Further communications were undertaken during November with Clinical Commissioning Groups and stakeholder bodies to reinforce the practice-wide messaging re-issued last month, and more targeted communications are being undertaken with local teams and CCGs regarding the non-compliant practices to supplement the wider messaging.

We are working with PCSE to establish regular analysis and reporting mechanisms to embed the process of highlighting errors back to practices. NHS England worked with the BMA to help ensure the recent communications campaign was effective in reaching GP practices, to ensure GP practices follow the correct procedures.

Recommendation 4: In its November 2018 update, NHS England should set out what it has done to ensure that issues and risks get escalated promptly in the future.

We have agreed a closer risk and issue management process with PCSE to ensure prompt escalation to NHS England’s board. This includes a joint risk log to identify
and take action on emerging risks, and a reinforced incident reporting regime to ensure that incidents are reported and escalated in a more timely manner.

I will write again in May 2019 to give a final update on recommendation one.

Yours sincerely

[Signature]

Emily Lawson
National Director: Transformation and Corporate Operations