National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health

Investigation: clinical correspondence handling at NHS Shared Business Services

HC 41 SESSION 2017–2019 27 JUNE 2017

What this investigation is about

1 The NHS commissions administrative services to support primary care providers such as general practitioners (GPs). These are known as primary care support services. They include updating patient registration lists and processing contractual payments to GPs. During the period to which this report relates, redirecting correspondence such as test results was also included in these commissioned services. The correspondence may have been misdirected where patients had changed practice or correspondence was sent to the wrong practice. In all such cases the redirection sought to direct mail to the correct address.

2 Between 2008 and 2012, NHS Shared Business Services (NHS SBS) entered into contracts with 26 Primary Care Trusts (PCTs). These contracts were to provide primary care support services, including redirecting clinical correspondence. NHS SBS is a limited company set up as a joint venture between the Department of Health (the Department) and a private company, Sopra Steria. The Department has a 49.99% share in NHS SBS. In 2015, NHS SBS had revenues of around £87 million from its services to the NHS, of which the primary care support services accounted for approximately £12 million (Appendix Two). NHS SBS calculate that the mail redirection service accounted for £193,000 a year of this.

3 When the Health and Social Care Act 2012 abolished PCTs in April 2013, the National Health Service Commissioning Board (known as NHS England) was established, and became the commissioner of primary care support services. NHS SBS continued to provide these services in the East Midlands, North East London and South West England.

4 In March 2016, NHS SBS informed NHS England and the Department that it had discovered approximately 435,000 items of unprocessed clinical correspondence.[1] This later rose to 709,000 items after NHS SBS found more boxes of unprocessed clinical correspondence in its archives. This investigation will set out:

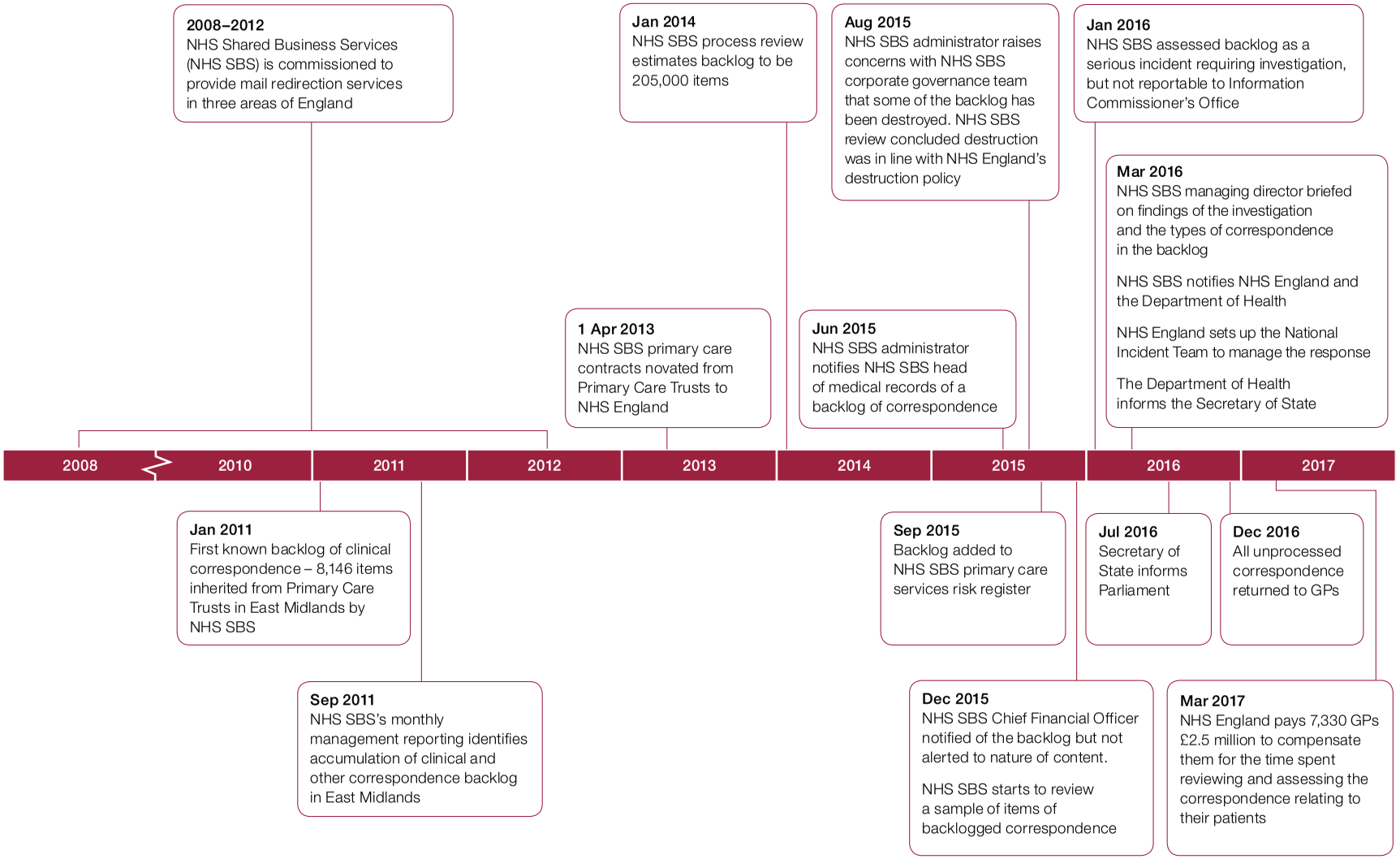
- the commissioning and contracting responsibilities for misdirected clinical correspondence;
- the build-up of the backlog of clinical correspondence within NHS SBS; and
- the action taken by NHS SBS and NHS England to investigate, understand and rectify the problem.

5 Our work is based on a review of available documents from NHS SBS, NHS England and the Department.

1 Clinical correspondence is a record of a patient interaction with a healthcare professional. NHS England's review found only approximately 1,000 items of the 709,000 in the backlog were not clinical correspondence.

Figure 1

Timeline of key events in the handling of clinical and other correspondence



Source: National Audit Office

Summary

Key findings

The contracts

1 Between 2008 and 2012, NHS Shared Business Services (NHS SBS) entered into contracts with 26 Primary Care Trusts (PCTs) to provide primary care support services. The contracts were with PCTs in North East London, East Midlands and the South West. Most included a service to redirect clinical correspondence which had been sent to the wrong GP or other clinical providers. NHS SBS estimates that it redirected around 700,000 items of mail each year, although it did not record the nature or volume of misdirected correspondence received (paragraphs 1.1 to 1.3 and Figure 1).

2 PCTs were abolished in 2013 and NHS England took over the contracts with NHS SBS. NHS England told us it considered that there was no opportunity to review, amend or renegotiate the terms of those contracts before the contracts were transferred to it. NHS England continued to manage the contracts as PCTs had, via local teams. It did not review the contracts later (paragraphs 1.4, 1.6 and Figure 2).

3 Under most of the PCT contracts, NHS SBS had a contractual responsibility to process and redirect clinical correspondence. Only 21 of the 26 contracts explicitly required redirection services. However, none of the contracts contained key performance indicators (KPIs) to measure how well NHS SBS was delivering the redirection service although there were KPIs for other services provided by NHS SBS. There were no direct financial incentives or penalties attached to NHS SBS's performance in redirecting mail, although the work remained a contractual responsibility (paragraph 1.5).

The incident

4 When NHS SBS took over the work from the East Midlands PCTs in 2011, it inherited a backlog of unprocessed clinical correspondence. NHS SBS's initial checks found 8,146 items of unprocessed correspondence including clinical notes, temporary resident forms and child protection conference notes. NHS SBS does not know where or for how long these items had been held before it received them from the PCTs. NHS SBS told us that it used the same people and methods to redirect mail as the PCTs had used (paragraph 2.1).

5 Over the next four years, local teams and reviews within NHS SBS observed the backlog continuing to grow:

- NHS SBS's internal monthly reports in 2011 and 2012 noted the backlog in its East Midlands processing centre.
- In January 2014, a review by NHS SBS found a backlog of around 205,000 items across the three regions and highlighted the clinical risk to patients of notes not being with GPs.
- In June 2015, an administrator estimated the backlog in the East Midlands to be 351,500 items. (paragraphs 2.2 to 2.4, and Figure 4).

6 In June and July 2015, an NHS SBS administrator raised concerns with NHS SBS senior managers about the backlog in the East Midlands. The administrator sent three emails about the backlog to NHS SBS's Head of Medical Records Centre of Excellence and corporate governance team. NHS SBS replied on 31 July 2015, and confirmed that the administrator's concerns had been passed to a senior manager (paragraph 2.4).

7 In August 2015, the administrator raised further concerns that the backlog was being destroyed. The Head of Medical Records Centre of Excellence investigated and concluded that 35 sacks of records had been destroyed in line with NHS England's policy that medical records can be destroyed 10 years after the death of the patient. It is not clear from the evidence we have seen whether the mail destroyed was part of the backlog of unprocessed mail but the Medical Records Manager noted that the sacks may also have included completed outstanding medical record reports and urgent/clinically urgent requests (paragraph 2.5).

8 Senior managers within the NHS SBS primary care services business unit knew about the clinical risk to patients in January 2014 but it did not develop a plan to deal with the backlog. NHS SBS told us that despite an action plan to improve the wider medical records function, there was no improvement to the mail redirection service. The backlog was added to the primary care services risk register on 16 September 2015. The description of the risk included the costs to clear the backlog, but not the potential harm to patients. NHS SBS first considered the size of the backlog, its financial, reputational and clinical risks in November 2015, in a report by an operational NHS SBS manager (paragraphs 2.3 and 2.6).

9 The November 2015 report led to the eventual escalation of the incident to the NHS SBS chief executive. In December 2015, NHS SBS began to review the contents of a sample of boxes from the backlog and found that they contained some clinical correspondence. On 6 January 2016, the information governance manager rated the incident as a serious incident requiring investigation. An internal investigation found that staff had considered the misdirected clinical correspondence a lower priority than other work as there were no performance indicators attached to it. NHS SBS's managing director and chief executive heard the internal investigation's findings on 3 March 2016 (paragraphs 2.7 to 2.11).

The response

10 NHS SBS informed NHS England (its customer) about the problem on 16 March 2016 and told the Department of Health (its shareholder) the next day. NHS SBS put forward a proposal on how to clear the backlog in six weeks. NHS SBS's chief executive told the NHS SBS board about the backlog on 24 March 2016. The chief executive reported that staff considered this work to be 'just filing', although he stressed that this did not excuse the backlog (paragraphs 3.1, 3.2 and 3.4).

11 NHS England set up a National Incident Team (NIT) to deal with the backlog on 23 March 2016. The NIT included representatives from NHS England, NHS SBS, the Department of Health (the Department) and Public Health England. The NIT's responsibilities included reviewing the backlog to assess clinical and reputational risks, developing an action plan to deal with the backlog and monitoring its implementation (paragraph 3.7).

12 The Department of Health decided in April 2016 not to alert Parliament or the public to the incident. It considered that it did not have an accurate picture of the scale of the incident or of the potential harm to patients. It believed there was a risk of questions that the Department could not yet answer, potentially leading to unnecessary worry among patients and the public (paragraph 3.12).

13 The Department informed Parliament of the incident on 21 July 2016. The Department considered that, as the NIT needed to contact GPs and patients to access medical records to establish whether there had been any actual harm to patients, the incident was likely to become publicly known. NHS England believed patients should be told quickly that they may have been harmed. At this point the Department was still unable to provide clarity about the extent of any potential harm to patients or whether all relevant correspondence had been identified from NHS SBS's archives. The Secretary of State made a written statement to Parliament about 'an issue with a mail redirection service' at NHS SBS, advising that this was also disclosed in the Department's Annual Report, which made reference to 'a large backlog of unprocessed correspondence relating to patients (paragraph 3.14).

14 NHS England wanted to scan the documents before they were sent to GPs so that there would be a record of all of the items being sent out. NHS England and the Department expected the repatriation of low-priority correspondence to GPs to start by July 2016. NHS England and NHS SBS encountered a number of problems reconciling what was to be sent to each GP with what was in the envelopes sent from NHS SBS to NHS England for scanning. Scanning began on 14 September 2016. NHS England waited to start scanning until it was satisfied that scanning and issuing the documents provided by NHS SBS would not generate any breaches of patient confidentiality (paragraph 3.8).

15 NHS England was dissatisfied with NHS SBS's cooperation in understanding the facts and causes of the incident. The main report by NHS SBS's internal auditors in May 2016 on the effectiveness of the internal investigation, root cause analysis and management response to the incident did not provide NHS England with the level of assurance it required that the incident had been appropriately investigated and the causes clearly established. NHS SBS disputed NHS England's right to commission further work and there were significant delays in NHS England's internal auditor securing access to relevant NHS SBS information. NHS England considered that NHS SBS was being obstructive and unhelpful in providing the access NHS England sought. NHS SBS has told us that it does not consider that it was obstructive or unhelpful. It planned a cooperative and collaborative approach with NHS England and was concerned to make sure that the audit process was properly managed and did not duplicate work carried out by others. It told us that it faced difficulties because of the requirements imposed by its contracted internal auditor and the need to obtain confirmations from relevant people involved before certain information was shared with NHS England. It was September 2016, four months after the report by NHS SBS's internal auditor was disclosed to NHS England and six months after the incident was first disclosed to NHS England, before agreement was reached for NHS England's internal auditor to access the material required for its review. Even then it was not able to complete the review to its satisfaction as it did not have full access to people or documentation (paragraphs 3.15 to 3.20).

16 The final audit report commissioned by NHS SBS into the incident found weaknesses in oversight at NHS SBS. It reported that NHS SBS had:

- weaknesses in the process for dealing with clinical correspondence;
- a lack of awareness of its importance; and
- a lack of urgency in dealing with the incident once it was escalated to senior management.

NHS England's internal auditor agreed with these findings (paragraphs 3.17 and 3.18).

17 NHS England's internal auditor concluded that there was no assurance that all unprocessed correspondence had been identified. NHS SBS's internal auditor reported that it could provide reasonable assurance that, as a result of the process followed by NHS SBS, all archived materials had been successfully identified. NHS England's internal auditor took a different view. Additionally, the Department's internal auditor reviewed the governance arrangements in place in the Department's investment into NHS SBS and found that:

- the Department had not taken up two of its three seats on the SBS Board; and
- there is a conflict of interest between the Secretary of State's responsibility for the health service as a whole and his position as an NHS SBS shareholder (paragraphs 3.21 and 3.22).

18 As at 31 May 2017, the review of the backlog of correspondence has found 1,788 cases of potential harm to patients. NHS England and NHS SBS have identified just under 709,000 items of unprocessed correspondence in total. NHS England classified 2,508 items as high priority. GPs have assessed 2,159 of those as having 'no patient harm' and are still examining the remaining items, with 229 classified as 'potential harm'. GPs have yet to respond on 175,000 items of correspondence assessed by NHS England to be lower priority, despite having received payment to review these additional items in February 2017. NHS England is still investigating the cases where potential harm has been identified. It expects to complete all review work by December 2017. No actual harm has been identified yet (paragraphs 3.23 to 3.25 and Figures 5 and 6).

19 NHS England estimates the cost of the incident will be at least £6.6 million for administration alone, and is still discussing with NHS SBS how the costs will be split. NHS SBS has borne £2.26 million of these costs so far but this does not include any contribution towards the costs incurred by NHS England. Without prejudice negotiations between the two parties are ongoing (paragraph 3.26).