### NAO Podcast on Investigation into clinical correspondence handling at NHS Shared Business Services transcript

**The NAO has conducted an investigation into how NHS Shared Business Services (NHS SBS) handled unprocessed clinical correspondence after a backlog of approximately 435,000 unprocessed clinical correspondence was discovered. The investigation sets out details of the incident and the action taken by NHS SBS and NHS England to investigate, understand and rectify the problem, including the work of the National Incident Team set up by NHS England.**

 **I’m joined by Ashley McDougall, a director who worked on the report. Thank you for joining me Ashley.**

**What is Clinical correspondence?**

We are talking about letters which have been sent from hospitals to local GP’s and they have somehow gone astray. So the types of correspondence could be: test results, child protection notes, patient medical records and perhaps somethings round where a patient has been a temporary resident – if you are treated on holiday in the UK - that would be a record that would be sent back to your GP. Those records sometimes go astray, so NHS SBS were dealing with about 700,000 items of misdirected correspondence every year.

**What does the NHS Shared Business Service do?**

NHS SBS provides a lot of the back office services to NHS trusts. This means it helps with payment schemes, paying bills, doing their accounting and helping with their procurement, so it covers about a third of trusts and almost all clinical commissioning groups.

**What prompted this investigation?**

Well we were prompted by the disclosure by NHS SBS to NHS England, who were paying for the service and they were the commissioners. So, when they disclosed the problem to NHS England, we became aware of that through their audit papers and we said we would look and see what was happening and report to Parliament when it was appropriate.

**When did NHS Shared Business Services find out about the problem?**

Well, they knew about the problem of a backlog since they took over the services from Primary Care Trusts in about 2011: they inherited a small backlog of about 8,000 items; and their reporting through a couple of internal reviews through about 2012/13. By 2014 they knew there were about 200,000 items in the backlog, by 2015 they knew there were 350,000 items in the backlog. So they’ve known about the problem at some level in the organization for years. I think the question was it wasn’t really escalated in an effective way. So the top of the organization, for example their board, didn’t get any reporting statistics, didn’t have any visibility of what had happened, what had been found and the fact that the backlog was growing.

**Why did it all go so wrong?**

We think it largely went wrong because people didn’t appreciate the sensitivity of handling clinical correspondence. There’s a line in the report that talks about some of the people dealing with it saw it as “just filing” – so it was just papers being moved around. I think there were no payment mechanisms attached to it, so it was quite a low priority task in contractual terms. There were no payment indicators, there were no performance standards, so it was just something people did not take as seriously as perhaps they should have.

**So why was there such a delay in alerting NHS England and Parliament to the problems?**

We talked about the extent to which the senior management weren’t really aware of it. Once they became aware of it around the end of 2015, they asked for more work to be done. They wanted to know, as everyone wants to, how much of it is there? What’s the scale? What’s the problem? What sorts of documents are we talking about? Once they got that they actually commissioned another review to say whether it’s clinically sensitive, and what they were dealing with. When they got that in March 2016, they then notified the commissioners in NHS England and Department of Health who are the part owners of NHS SBS.

**Has any harm been caused to patients as a result of the backlog?**

We don’t know yet. NHS England have set up quite the process to review each of the items of correspondence and see where there is potential clinical harm. So far they’ve finished about two-thirds of that work and they’ve identified 1,788 people, which their clinical advisors have said there is potential harm to the patient here. Now they’ll keep on reviewing that. So far they have found no incidence of actual harm, but they’ve still got 175,000 items of correspondence that GP’s have been asked to get back to them. So they’ve sent them to the GP’s and said “Can you look at this. Do you think there’s potential harm here?”, and that’s the process they’re still going through. If someone identifies potential harm, they then come back and say “Let’s go through it in more detail. Let’s talk to the patient perhaps. Let’s get in expert clinical advice. Let’s go through the whole medical record to get a fuller picture”. Harm is something quite wide ranging, it doesn’t have to just be someone who has died, and perhaps they might have just had distress? It’s really the linking of whatever the harm was to the delay.

**How much is all this going to cost to put right?**

NHS England estimate that they and NHS SBS will spend about £6.6 million. That’s in reviewing the cases, scanning and sending it back to clinicians, engaging expert clinicians – there are quite a lot of people involved. They think they should have finished that work by the end of December 2017.

**And what is the situation now?**

They currently still working through, they’ve got 175,000 items of correspondence, they’re still chasing with GP’s to see if there was any harm. They’re working through with clinical advisors the 1,788 people as at the end of May where they have identified potential harm, and they’ll keep on working through that. So they’re notifying patients, having discussions, its just a long process with a lot of documentation to go through.

**Thank you Ashley**

**If you would like to find out more about this investigation, it is available on our website,** [**www.nao.org.uk**](http://www.nao.org.uk)**. Or you can follow us on twitter @NAOorguk or on Facebook www.facebook.com/NAOorguk/**

**Thank you for listening**