Confidential briefing

To: Heads of Primary Care, Medical Directors

From: Steve Verdon, Director of Governance

Date: 16 November 2017

Dear Colleagues

This briefing follows on from my previous updates of May and August 2017 concerning the NHS Shared Business Services incident, whereby correspondence in the mail redirection service did not reach the intended recipients.

In this briefing I provide a further update on the progress being made by the NHS England Incident team on the clinical review work for cases of potential patient harm.

In addition I provide an update regarding a further quantity of unprocessed clinical notes that have been erroneously received by PCSE since September 2015, and how NHS England is progressing the matter.

I hope you find the briefing useful.

Public Accounts Committee

A PAC hearing into the SBS Incident took place on 16 October 2017. This followed a National Audit Office (NAO) investigation into the Incident earlier this year. The NAO published its report in June 2017.

The PAC questioned senior representatives from NHS England, the Department of Health and NHS Shared Business Services on the issues raised in the NAO report, including: the reasons for the backlog; the response by the respective organisations; NHS England's management of the Incident; and issues relating to the Department's management of NHS SBS.

The PAC was informed that NHS SBS has agreed to reimburse NHS England for the total costs associated with the management of the Incident.

Clinical review

The PAC heard that good progress is being made by the NHS England Incident team in respect of the clinical assessment of cases of potential patient harm. The latest figures as at 31 October 2017, summarised below, show that of the 5,562 cases of potential harm, 80% have been confirmed as no harm following further clinical assessment from NHS England National Clinical Directors.

1,085 cases have been identified as requiring a more detailed clinical review of the patients' full medical records. For these cases, practices are asked to gain consent from the patient to undertake the review and provide copies of medical records. 313 of these reviews have been completed and there are **no confirmed cases of patient harm as at 31 October 2017**. The remaining clinical reviews are due to be completed by the end of December 2017.

As at	Current potential harm cases identified[1]	Clinical assessment						
		GP level review				Consultant level review		
		No. of Clinical Triages complete	No. of confirmed no harm[2]	No. of cases requiring GP level Clinical Review	No. of GP level Clinical Reviews complete	No. sent for further Clinical Review[3]	No. of further Clinical Reviews completed	No. of cases of confirmed harm post review
31 October 2017	**5,562**	**5,437**	**4,352**	**1,085**	**313**	**8**	**2**	**0**

[1] The number of potential harm cases could increase if GP practices return late response forms.
[2] No harm confirmed and therefore no further action to be taken, including 2 untraceable items.
[3] Those where potential harm remains post GP level review are sent to consultant level (further) review.

Additional unprocessed clinical notes received by PCSE

The mail redirection service that was previously provided by NHS SBS and local PCS services was terminated in May 2015 due to the service not complying with NHS England information governance or relevant legislation. Instead, practices were instructed that upon receipt of confidential information about patients that are not registered to them, they are to mark the envelope 'return to sender' and the information sent back to the provider who sent it initially.

The vast majority of GP practices have followed this instruction, however a small proportion of practices have erroneously continued to forward this confidential information to PCSE who have no contractual responsibility to process it. As a result a backlog of unprocessed clinical notes has built up. Simon Stevens notified the PAC of this backlog at the 16 October 2017 hearing.

The backlog has been passed to the NHS England Incident team for processing in line with the SBS Incident. All items of patient correspondence have been initially reviewed by practising GPs within the Incident team to identify whether the correspondence required any action from the patients' GPs. The majority of items only require recording in the patient's records and these items are being returned to practices without the need for further assessment.

There are approximately 17,000 items which required GP action at the time the correspondence was sent, including 1,800 urgent items. These items are being repatriated to practices in line with SBS Incident processes i.e. the local GP is being

asked to assess whether the correspondence was already received (e.g. duplicate or electronic copy) and whether the required action has taken place. A response form is being sent to GPs to complete and return to NHS England for these cases.

These items are being repatriated to practices week commencing 20th November. Because of the much smaller volumes compared to the SBS Incident, practices will be asked to complete their assessments within 14 days. Following receipt of the completed response forms, practices will receive payment in line with the payment model agreed with the BMA for the SBS Incident (shown below). It is expected that payments will be made in February 2018.

No. of documents received	**Agreed payment**
20 or less	Fixed payment of £50
Between 21-50	Fixed payment of £100
Over 50	£50 per 10 items

PCSE are currently working with NHS England to develop and implement a new BAU process which will prevent a future backlog from occurring.

End of briefing