

ICB Public Board of Directors

Clinical correspondence failures between point of care : Information Technology implications

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Reminder of the problem

- Recent highly publicised discovery of large backlog of clinical letters that failed to transfer from local (and national) hospitals to General Practice recipients.
- Similar 'smaller-scale' issues in other provider organisations. Sometimes clinical documents but also radiology and pathology test results.



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Newcastle Hospitals reviewing
documents for unsent patient letters



Newcastle upon Tyne Hospitals is to implement an integrated digital imaging system from Carestream.

Newcastle Hospitals said on Tuesday that they are reviewing 24,000 documents from their electronic records after a Care Quality Commission (CQC) inspection in the summer identified a number

Nottingham Hospitals failed to send more than 400,000 letters – BBC

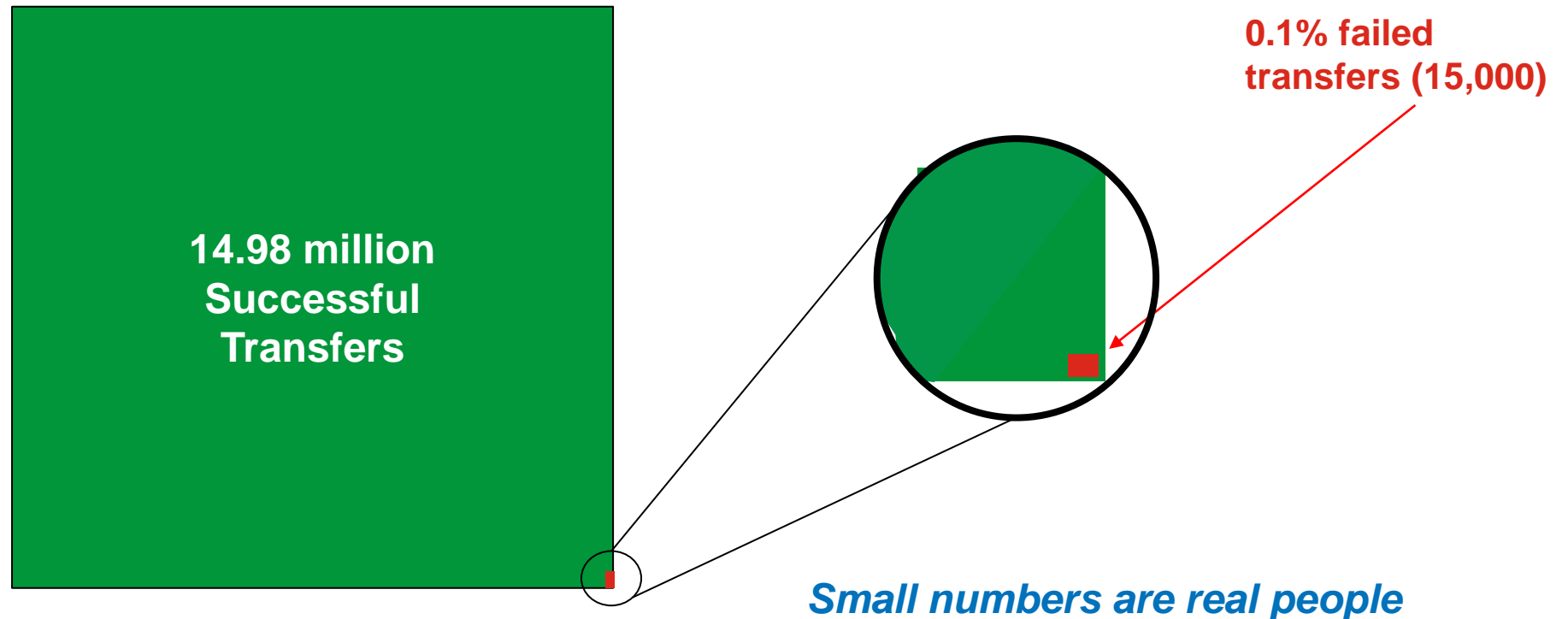


Nottingham University Hospitals NHS Trust (NUH) failed to send out 400,000 digital letters and documents to GPs and patients, some dating back as far as 2000, BBC News reported Saturday.

Magnitude of the challenge

High level (local) estimate suggests around 15 million data items transfer into primary care per year within NENC ICS**

- 5 X data items/patient/year



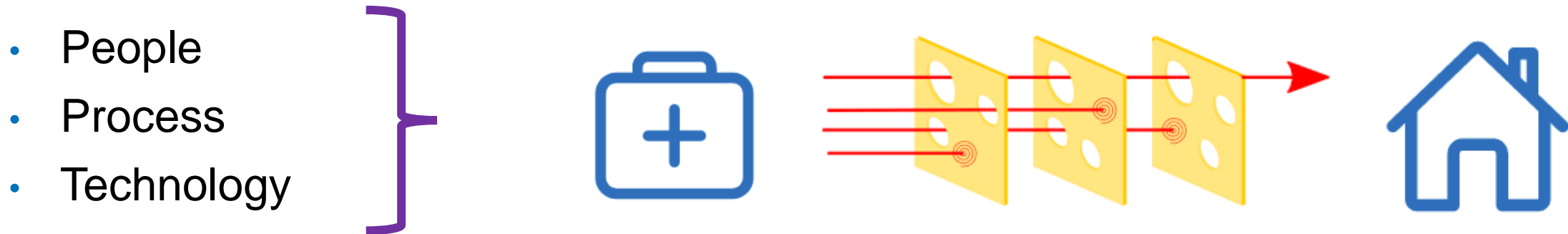
[**based on extrapolated sample from a single GP surgery]

Challenges to overcome

Current approach already effective;

- Estimated around 99.9% of data items successfully transfer.
- Multiple organisations, multiple systems, multiple transmission processes.
- Very hard to make significant improvements in such systems.

Causes of the problem are multifactorial

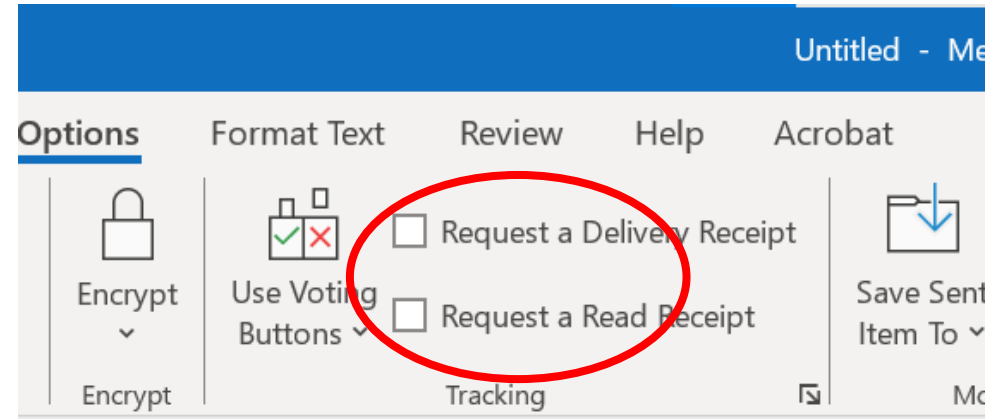


Receivers are not always expecting information to arrive in a given timeframe, no immediate concerns raised!

Handshake or closing the loop



Proof of delivery



Current priorities



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- Exploring options to confirm “data receipt” (i.e. WhatsApp 2 blue ticks, or email delivery/read receipt options) known as “closed loop”
- Technology providers should develop and build in ‘closed loop’ capability in new and updated systems/services.
- Data ‘senders’ become more responsible for safe systems to ensure data reaches recipients, implement error checking solutions (many exist).

Current priorities



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- Increasing NHS app adoption to allow patients to be their own “safety net” where possible.
- Ensure action points are clearly and consistently communicated.
- Reactive responses to newly discovered issues/expand system-wide learning from such events.
- Forming a digital clinical safety community, to learn and share best practice.

Finally....

A multifactorial challenge, requiring relentless focus on continuous improvement.

Systems will fail, timely recognition and action is critical.

Data transmission and receipt systems need to be closely coupled with “closed loop” feedback to identify failures in as near real time as possible and thereby reducing the risk of harm