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Department of Health

From Ben Gummer MP
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30 OCT 2015

Dear Mr Walsh

Thank you for your letter of 28th September 2015, following the inquest into the death of Harry Pryal. I was sorry to hear of Mr Pryal's death and wish to extend my condolences to his family.

There appear to be two main issues of concern that you raise in this case. One is that X-ray information was not available in a timely manner to all of the professionals caring for Mr Pryal.

You outline the circumstances which led to this situation and direct several concerns to the 5 Boroughs Partnership NHS Foundation Trust (5BP) and Wrightington Wigan and Leigh NHS Foundation Trust (WWL) which relate to their joint Service Agreement, the reporting times for X-rays, the electronic systems available to support web viewing of X-rays and the recording of appropriate patient notes. These concerns are about the local systems that are in place and rightly addressed to the local providers, who I am confident will consider and review.

The other main issue you raise is about the lack of recording of information in the patient's notes, by medical professionals, that would have ensured a consistency of care for the patient. Not only was this an issue in this case but evidence suggested that the lack of recording of appropriate notes in hospital patient records is a problem on a nationwide scale.

Whilst the actual recording of patient notes is something that is agreed and implemented at local level, the general move away from paper to integrated digital care records should improve the comprehensiveness of information held, including essential diagnostic tests and it's availability to all professionals engaged in the care of individual patients.

A further advantage of digital systems is that they can be programmed to alert all professionals involved in the organisation and delivery of care about any outstanding test results.

Currently, the Health and Social Care Information Centre (HSCIC) is developing the Transfer of Care Initiative. Further information about the Initiative can be found on the HSCIC website.

This Initiative recognises that, in order to support the delivery of high quality care, there is an increasing need to share information in a more efficient and consistent way across health and social care. This is especially important in care settings that cross organisational boundaries. The Initiative aims to enable consistent electronic exchange of information between different care professionals and organisations. This will be achieved by driving the establishment and uptake of consistent professional and technical Transfer of Care data standards across the health and care sector, in direct support of the National Information Board (NIB) objectives, to *"help clinicians ensure that patients are safely transferred between episodes of care".*

In terms of how information is captured and recorded in a consistent manner in clinical systems, the Academy of Medical Royal Colleges (AoMRC) has produced *"Standards for the clinical structure and content of patient records"* (2013). These Standards can be found on the Royal College of Physicians website.

This work is important in standardising approaches for clinicians and healthcare professionals regardless of the care setting and is equally relevant for those who develop and implement electronic or paper care records.

The AoMRC standards document states:

'To record clinical information in a way that can be shared and re-used safely in an electronic environment, the structure must be standardised. For this to be realistically achievable, the standards for structure must reflect the way that patients and clinicians work together to the common goal of best practice and high quality care. This necessity has been recognised by the establishment of an independent Professional Record Standards Body to oversee rigorous development and maintenance of health and social care records...'

The scope of the AoMRC standards includes the structure and content of patient records, covering hospital referral letters, inpatient clerking, handover communications, discharge summaries and outpatient letters.

The adoption of these standards was proposed by the National Information Board in their published *framework for action*, (November 2014) which states:

"We propose the adoption of the Academy of Royal Medical Colleges' publication Standards for the clinical structure and content of patient records, with a requirement that all organisations and clinical systems should implement the standards, following consultation and completion of an impact assessment."

In addition, the HSCIC strategy 2015-20, *Information and technology for better care*, drew particular attention to the AoMRC standards:

"We will lead the work to deliver one of the key commitments in the National Information Board Framework - for all health and care organisations to adopt the Academy of Royal Medical Colleges' publication Standards for the Clinical Structure and Content of Patient Records. This will improve the timely integration of information across care settings."

The AoMRC standards are being further developed and implemented as part of the Transfer of Care Initiative. The Initiative has already published specifications using AoMRC standards for the electronic transmission of discharge summaries between acute and mental health providers and GPs.

I am grateful to you for bringing the circumstances of Mr Pryal's death to my attention and hope that you find this reply helpful.

BEN GUMMER