



Department
of Health &
Social Care

From [REDACTED]
Minister of State for Care

39 Victoria Street
London
SW1H 0EU

Our ref: [REDACTED]

HM Coroner Mr Roland Wooderson
Gloucester Coroner's Court,
Corinium Avenue,
Gloucester
GL4 3DG
By email: [REDACTED]

3rd March 2025

Dear Mr Wooderson,

Thank you for the Regulation 28 report of 09/01/2025 sent to the Department of Health and Social Care about the death of Maria Simpson. I am replying as the Minister of State for Care, responsible for primary care and general practice.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms Simpson's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The report highlights the issues brought about by the lack of a uniform case management system for storing patient records and the lack of capability to store all historic documents relating to a patient.

In preparing this response, Departmental officials have made enquiries with NHS England to ensure we adequately address your concerns.

The first concern in the report centres on the lack of a uniform case management system for storing patient records electronically. The report highlights that when transferring patient records to practices that use a different system, the receiving practice must input all records afresh, leading to delays in the compilation of records.

The NHS General Medical Services (GMS) contract regulations stipulate that contractors must keep 'adequate' patient records either on forms provided by NHSE, in computerised records, or a combination of both. The contract also states that any computer system must meet the requirements set out in the GPIT Operating model and that the contractor must have regard for the guidance laid out in Digital Primary Care: Good Practice Guidelines for GP electronic patient records.

In England, General Practices most frequently use either the EMIS web, TPP SystmOne or Medicus electronic patient records systems. All of these systems can transfer or make available a patient's coded and structured electronic health record (including any associated

attachments) to a patient's new practice in the event they re-register with a different general practice.

The process for individual patient migrations (or deductions) to new practices is triggered by the patient registering at a new practice. GMS contract regulations state that for the transfer of any patient records, the records must be sent to the new practice within 28 days. NHS England guidance recommends patient record migration takes place on a weekly basis to ensure the new practice receives the complete record quickly.

As per GMS contract regulations, practices must use the facility of GP2GP for the transfer of any patient records. GP2GP is the standard implemented by clinical systems that describes how a patient's electronic record should be translated, packaged and transferred so that it can be understood and integrated by the clinical systems in use in the new practice. Where this happens successfully, a patient's record is immediately available to their new practice. This includes historic paper information which has been summarised onto the individual's record.

Where an electronic record transfer fails, practices are instructed to print the electronic health record and any attachments and make it available for collection and transportation to the patient's new practice. Once received the record is then reviewed and summarised by the patient's new GP into a new electronic health record.

NHS England works closely and in collaboration with clinical system suppliers to identify and resolve issues related to record transfers to improve the reliability of GP2GP. The failure rate for GP2GP record transfers has improved year on year, from 4.46% in 2021 to 1.64% in 2024, with a rate of 0.78% for the week ending 17th January 2025. NHS England also publishes guidelines to help ensure a smooth transfer of patient records.

The second concern in the report focusses on the inability of a case management system to store all historic documents, including referral letters from one clinician to another. This leads to patient information being stored in both electronic and paper form, making it difficult for the GP to note quickly all of the relevant information.

The EMIS web, TPP SystmOne and Medicus records systems all have the capability to store attachments as part of the coded and structured electronic health record.

Some elements of patient records continue to be stored in a paper format, called the 'Lloyd George record'. Currently there are approximately 50 million Lloyd George records held by practices across England and approximately 15 million held in archive by NHS England. When a patient registers at a new practice the paper records must be made available by the patient's previous practice, or archive, for transportation to the patient's new practice. There is a system in place to deliver bar coded movement labels to each practice for any records that need to be moved to either the new practice or the archive. These records are then moved through a dedicated courier network and tracked until delivery at the new practice/archive.

Some practices and local health systems have scanned their paper records. In the majority of cases these scanned records are then attached to a patient's electronic health record. The exception is for practices using TPP SystmOne, where the supplier doesn't let practices upload scanned records due to system constraints. To mitigate against this issue, and to provide a strategic central storage facility for unstructured data for the NHS in England, NHS England has built and initially trialled, with Birmingham and Solihull Integrated Care Board,

a [National Document Repository](#). The National Document Repository is supporting storage of and access to scanned Lloyd George records. The system is due to be rolled out nationally in financial year 2025/26, subject to securing funding.

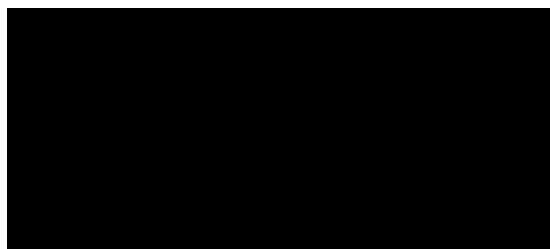
NHS England is currently designing the future requirements for the transfer of paper GP patient records. The intention is to build in a new service so that where a paper record still exists, it will be collected from a GP practice when a patient leaves a GP practice. It will be scanned and uploaded into the National Document Repository for access by the new GP practice. This will ensure that the number of patients having dual electronic and paper records steadily reduces. The intention is to introduce this as part of a new service contract which will take effect in 2028.

Actions undertaken by the ICB

The Gloucestershire ICB noted that in the case of Ms Simpson, a gap in the knowledge of the GP about a referral portal meant that a referral was made via 'Choose and Book' to the geographically nearest NHS trust (which was in another ICB area), rather than the NHS trust the patient was intending to have her baby in, within Gloucestershire. This was because the Gloucestershire trust did not use 'Choose and Book' for this service as it delayed the referral process. After the referral was rejected, the GP attempted to refer the patient via Gynaecology 'Advice and Guidance' services as Obstetrics did not have 'Advice and Guidance' at that time.

Local changes have now been made by Gloucestershire ICB, with an Obstetrics 'Advice and Guidance' service running since December 2023. Pathways have also been changed and there is now no need to confirm the pregnancy via scan before prescribing Low Molecular Weight Heparin. Communications have also been sent out to all GP practices via practice managers, news bulletins and via the Local Medical Committee.

Yours sincerely,

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