The NHS Confederation has for many years emphasised the need to tackle the bureaucratic burden in the NHS. But our members are still often asked for unnecessary information, to give the same information multiple times, or to gather data in poorly designed and cumbersome formats.

This paper assesses progress since our 2009 report, What’s it all for?, sets out where the risks of new burdens may lie, identifies what should be done now and suggests issues for discussion.

Key points

• It is more important than ever to tackle the bureaucratic burden in the NHS.

• Our members are often asked for unnecessary information, to give the same information multiple times, or asked to gather data in poorly designed and cumbersome formats.

• Insufficient progress has been made since our 2009 report, What’s it all for?.

• NHS reforms, by making the system more complicated, will increase still further the burden.

• This paper sets out actions which should be taken now, and questions for discussion.

• We will continue to highlight the actions our members need to see.

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Background

Information about our health services is incredibly valuable. It enables commissioners and providers to keep a close eye on the quality and efficiency of care and patients to understand which may be the best services for them. The NHS Confederation supports strong, effective regulation which ensures patient care is safe and of high quality, secures public trust, avoids overlap and duplication and offers value for money.

We have for many years emphasised the need to tackle the bureaucratic burden of gathering and sharing information to support various types of monitoring, regulation, inspection and accreditation. The problem is only partly about identifying any unnecessary regulations. It also concerns poorly designed data collection and inefficient monitoring, data gathering and regulation by a wide range of organisations, often with overlapping remits.

This issue is now even more pressing, given that the NHS faces an unprecedented financial squeeze.
Executive summary

We are concerned that insufficient progress has been made since we set out the actions needed to tackle the burden of bureaucracy in our 2009 report, What’s it all for?. In particular:

• there has been insufficient cooperation between the various agencies that request information, particularly at local level
• the Review of Central Returns (ROCR) process, run by the NHS Information Centre (NHSIC) to ensure information demands are not duplicated, has been strengthened and promoted to some extent. However, the Department of Health and its arms length bodies will no longer be required to use it after April 2013
• providers still lack the right to formally challenge agencies which ask for the same or similar information that has been requested by others
• the Government has yet to implement recommendations from the NHSIC identifying data collections which could be scrapped
• it is far from clear that the areas being considered by the Cabinet Office’s ‘red tape challenge’ will result in a significant reduction in burden.

We are worried that the current NHS reforms, by making the system more complicated, will increase still further the administrative burden. In particular:

• a more complex system architecture, and more commissioners, will inevitably increase the number of interfaces and transactions, and thus the administrative burden
• providers may ultimately have a greater number of smaller contracts, each of which may contain minor variations and different reporting requirements
• there will be more layers of organisations that will need to be involved in and consulted on local decisions
• with a large number of new or significantly reformed bodies, there is inevitably a risk of ‘mission creep’, leading to overlap and duplication and potentially a lack of clarity about whose responsibility it is to take action when failings are identified
• Monitor’s new regulatory role is inevitably complex and will add to the bureaucratic burden
• the NHS Trust Development Authority’s performance management will almost certainly add to the burden, particularly if its regime is not aligned with that of Monitor
• the transition to the new system seems to have created duplication of requests for information
• it is not yet clear whether outcomes measures will be developed in ways which gather and use information efficiently.

Quality regulation has evolved in recent years. Our members have found the Care Quality Commission (CQC) registration processes very bureaucratic, although we are pleased that the CQC has made some improvements, acting on feedback from the health service. The CQC told us they have renewed their commitment to eliminating unnecessary burdens; local leadership on this will be vital, alongside national leadership.

This paper sets out our ambitions for tackling the burden of bureaucracy. We urge strong leadership from ministers to drive reductions in the bureaucratic burden. We also recommend a number of actions which the Department of Health and national bodies should take now. Many of these relate to how agencies in the reformed NHS should work together.

Finally, we put forward questions for feedback from our members, to identify any further recommendations that would be helpful. We want to start a discussion with members, national bodies and the Government about how best to tackle this.

Our ambitions for tackling the burden of bureaucracy

• All organisations that require information from the health service must take responsibility for minimising the burden imposed by their work.
• Information should only be collected nationally when it will genuinely be useful at a national level.
• Information requests must always have a clear purpose, and the benefits for quality, safety and efficiency should outweigh the costs.
• Duplicated requests for information must be eliminated.
• Information requirements should be well designed, building on existing good practice.
What has happened so far?
Over the last couple of years NHS organisations have significantly reduced their administrative staff. Between May 2010 and September 2012 the number of managers was reduced by 18 per cent and the number of clerical and administrative staff declined by 10 per cent. However, if the administrative burden does not also fall there is a risk that frontline staff will be diverted to form filling.

Despite an apparent commitment on the part of government to improve matters, we are concerned that not enough progress has been made since our 2009 report identified an urgent need to act. For further information about progress against our 2009 recommendations, see the table on page 7. Most national bodies are taking seriously the need to find ways to streamline regulation and information gathering. However, there is a mixed picture, with some potentially valuable measures initiated but not always followed through to full implementation. Given the current Secretary of State’s commitment to reduce bureaucratic burdens on providers by a third, there appears to be a renewed focus on this issue.

Three hundred and five data collections from the Department of Health and its arms length bodies alone were identified by the NHSIC’s review in 2011. Following the Government’s review of arms length bodies, some bodies have been abolished, but this has not necessarily reduced the burden because often their information collection requirements have simply transferred to other bodies.

At the time of writing (January 2013), it is far from clear that the areas currently being considered by the Cabinet Office’s healthy living and social care ‘red tape challenge’ will result in a significant reduction in the bureaucracy affecting our members. Many of the regulations on which feedback was requested are either already due to be abolished as a consequence of the Health and Social Care Act 2012 or are obsolete and thus impose little or no practical burden. Other regulations included in the exercise provide the basic underpinning of major policies such as CQC registration; asking whether to revise or remove such regulations is not meaningful in isolation from any wider proposals for policy change in this area.

The Health and Social Care Act 2012 requires the NHSIC to report to the Health Secretary every three years on the burden of data collection in the NHS. We welcome the explicit inclusion of bureaucracy within a ministerial portfolio at the Department of Health, and hope for sustained ministerial leadership on tackling bureaucracy. These measures need to be more than merely symbolic. Where avoidable bureaucracy is identified, commissioners and providers will want to see that ministers take action.

For example, in 2011 the NHSIC identified a number of data collections administered by the Department of Health and its arms length bodies which could be scrapped. It estimated this would deliver savings of £66 million and reduce the data burden from these bodies by approximately 15 per cent. However, despite consulting on these recommendations in autumn 2011, the Department of Health has yet to implement them. It must do so as soon as possible.

Impact of the Health and Social Care Act 2012
The current reforms in the Health and Social Care Act 2012 include the introduction of sector regulation and a more fragmented commissioning architecture. This will inevitably increase the number of interfaces and transactions (and thus administrative burden) within the health service.

Commissioning is becoming more complex, for example, child health services are now commissioned by eight different parts of the system, including local authorities. Providers and commissioners will need to coordinate and build working relationships with more organisations than previously, which inevitably takes time.

The number of commissioning organisations is also increasing, for example, 211 clinical commissioning groups (CCGs) are proposed to replace 152 primary care trusts. Inevitably, this will mean there are more transactions and thus more reporting, accountability and feedback mechanisms, each of which could potentially vary. Providers may ultimately have a greater number of smaller contracts, each of which may well contain minor variations, increasing the administrative burden. In this context, it is worth noting that National Audit Office reported in 2011 that fragmented purchasing contributed to poor value for money for NHS providers. Work
will be needed to develop and spread best practice, both in collaboration by commissioners and in commissioning in the least bureaucratic way.

A significant increase in the complexity of system architecture, post-reform, will potentially make it far more burdensome for commissioners and providers to consult on local decisions. There will be more layers of organisations that may need to be involved in a decision, for example, on major service changes – health and wellbeing boards, overview and scrutiny committees, the NHS Commissioning Board (NHSCB), NHSCB local area teams, specialist clinical networks, clinical senates, academic health science networks, as well as the Department of Health and Secretary of State. There will also be a greater number of local bodies to involve, with health and wellbeing boards, local Healthwatch and more CCGs than there were primary care trusts. The reduction in co-terminosity between CCGs and local authority boundaries adds further to this. With a large number of new or significantly reformed bodies there will inevitably be a temptation for organisations to develop their roles and try to carve out their own territory, increasing the risk of overlap and duplication and potentially generating a lack of clarity about whose responsibility it is to act when there is a major risk of failure. The ministers responsible for bureaucracy and regulation should pay close attention to this and hold these bodies to account, to prevent ‘mission creep’.

**The pre-reform structure of the NHS in England**

- Department of Health
  - 10 strategic health authorities (SHAs)
  - 152 primary care trusts (PCTs)

**The post-reform structure of the NHS in England**

- National Trust Development Agency (NTDA)
- NHS Commissioning Board (NHSCB)
- Department of Health
  - 4 regional offices
  - 212 clinical commissioning groups (CCGs)
- Health and Social Care Information Centre (HSCIC)
  - 27 local area teams
- Health Education England (HEE)
  - 16 local education training boards (LETBs)
- Public Health England (PHE)
  - 4 regional offices
  - 15 local offices
  - 152 local authorities

Source: Unison
From April 2013, a new licensing system for most providers of NHS-funded services is expected to be established. Through this licence, Monitor will protect the interests of patients by promoting services that are economic, efficient and effective. The NHS Confederation supports the introduction of a sector regulator in the NHS and agrees that Monitor is best placed to fulfil this role. However, the proposals for Monitor’s new role, including licensing of providers and regulation of prices, are complex and will almost inevitably add to the bureaucratic burden in the NHS. This will be in addition to the information required to support the extension of tariff to more types of service. We have so far been very encouraged by Monitor’s willingness to listen to concerns about the bureaucratic burden and amend its proposals accordingly. However, with the health system currently undergoing significant change it is impossible to identify the full implications of the currently proposed design of Monitor’s regulation. Monitor must respond if regulation is becoming too cumbersome and complicated, or if it fails to achieve anticipated objectives.

Similarly, the NHS Trust Development Authority’s (NTDA) performance management regime will almost certainly add to the burden of information collection. Our members have already expressed concern that the regimes of the NTDA and Monitor may not align well, and if this turns out to be the case its information gathering may also be unnecessarily burdensome. We would encourage the NTDA to design its information gathering to be as efficient as possible, avoiding duplication with other agencies and accepting, where possible, information already submitted to other bodies.

The current period of transition to the new NHS architecture seems to have created a duplication of requests for information. For example, for NHS trusts aspiring to become foundation trusts, there is some overlap between integrated performance reports required by strategic health authorities (SHAs) and the self-certification required by Monitor, and primary care trusts are able to demand different performance information again. One of our members commented: “When you weave in CCGs, commissioning support units, SHAs, clustered SHAs, the Department of Health and the NHS Commissioning Board, etc, we are all running around sending returns to each other and not actually doing any work.” It will be important to minimise this duplication, which should only happen when it is genuinely unavoidable and for as short a period as possible. Instead of duplicating information requests, organisations should examine whether they can accept evidence from other reliable sources.

We previously recommended that the performance management of the NHS should shift away from process measures and towards outcomes measures. The Government has been clear about its desire to move away from centrally driven service targets. Although welcome, the impact of this policy on the costs of information gathering will depend on whether outcomes measures are developed in a way that uses information efficiently. For example, the B19 national response time target for ambulance services has been replaced by an outcome requiring data on a ‘basket’ of 11 separate indicators, many of which were not already collected by ambulance trusts. Similarly, the Mental Health Network’s report on developing outcomes measures found there was concern in the sector about the likely future burden of data collection for outcomes measures and identified the need to consider how separate reporting mechanisms across health, social care and public health could be better aligned to reduce any duplication and ensure databases can be adequately connected, if not nationally then locally. This could build on best practice at local level.

Our CCG members have some concern that elements of Everyone counts, the 2013–14 planning guidance published by the NHSCB, sound like a return to a regime of targets and performance management. While there is clearly a need for appropriate levels of monitoring, this must not be so overwhelming that fulfilling the requirements overly curtails the ability of CCGs to focus on delivering for their populations. Where possible, information requirements should make use of existing data sources and overlap and duplication should be avoided.
Evolution of quality regulation

The use of information and regulation to assure and improve quality is also still evolving, with the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry likely to focus on the use of information to identify quality issues and propose reforms to current regulation.

The main change since 2009 has been the introduction of CQC registration. Our members have told us that preparing for registration and on-going compliance are immensely bureaucratic processes that demand significant resources. Our members have previously expressed concern that the registration processes are too generic, cumbersome, bureaucratic, poorly administered, and subject to significant delays.

We are pleased that the CQC has listened to and acted on feedback from the health service. We broadly support the recent changes to the regulations for CQC registration, particularly those that have sought to simplify and reduce the burden of regulation on providers. For example, the regulations alter the level at which mental health providers must notify the CQC of unauthorised absences for people who are liable to be detained under the Mental Health Act 1983. This change removes the duplication of reporting to both the CQC and the mental health minimum data set.

To support the CQC to continue to improve its processes, there needs to be clarity about whether the CQC’s role should be about improving quality or assuring essential standards, and the distractions of major structural reorganisation should be avoided.

The CQC’s challenge in getting all services into registration has been enormous. The scale of the task seems to have prevented the CQC from making as much progress as we would have wished for in improving the efficiency and reducing the burden of its regulation. However, the CQC told us they have renewed their commitment to eliminating unnecessary burdens. It will be important that this commitment is sustained by the CQC’s leadership.

At a national level, the CQC is now making progress in working with other agencies to minimise overlap and duplication, and some national agreements are in place with bodies such as the Health and Safety Executive. It is vital that work continues at this level, particularly given the scope and extent of information that various bodies in the new NHS architecture will require. In particular, we would like to see the CQC and the NHSCB (as well as the NTDA) aligning their approaches to looking at various indicators and collecting information, and using existing sources wherever possible. The CQC and Monitor should also agree how they will work together where their regulatory regimes overlap, particularly in assessing governance, leadership and culture in organisations. This should reflect the learning (which still needs to be captured) from the operation of the Concordat – particularly in terms of how regulators can help providers and commissioners manage risk.

However, many CQC information requests are driven locally rather than centrally. At the time of What’s it all for? we found that individual local inspectors did not always abide by national agreements. Since then, collaborative risk summits, in which various agencies discuss concerns about local healthcare organisations and agree action collectively, appear to have become weaker. Anecdotally, those attending can be too junior to effect change in their organisations’ practice. Local leadership – for example, by CQC compliance managers – will be crucial in strengthening local collaboration so that risks are identified and acted on quickly and overlap and duplication between organisations is prevented. It will also be important to clarify how quality surveillance groups, run by NHSCB local area teams to monitor the risk of failures in quality, will relate to collaborative risk summits run by the CQC and processes in place in local authorities.

Quality accounts represent another significant change and a source of local variation. Since their introduction by the Department of Health in 2010, a range of different approaches have emerged to the reporting by individual organisations of their data on quality. It is worth considering whether greater consistency in what is reported and how it is presented would significantly enhance the value of these accounts to new clinical commissioners, as well as to patients and the public seeking assurance of quality.
### Progress on key recommendations from *What’s it all for?*

<table>
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<tr>
<th>Key recommendation</th>
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<tr>
<td>The Government should consider rationalising regulators, auditors, inspectorates and accreditation agencies</td>
<td>The number of national bodies that collect data from the health service is being reduced following the review of arms length bodies. This should help, although only if existing processes are not simply lifted and shifted into successor organisations.</td>
<td>Sector regulation delivered by Monitor will inevitably add to the burden. Royal Colleges, charities and local organisations can also require information. We would therefore welcome the NHSIC broadening the scope of its work looking at the burden of data collection to these types of organisation, for example, in its three-yearly reports to the Health Secretary on the burden of data collection in the NHS.</td>
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<td>The Government should streamline the work of regulators, auditors, inspectorates and accreditation agencies</td>
<td>There are now examples of individual agencies actively looking to streamline their work. For example, the NHS Litigation Authority will from April 2013 put a moratorium on virtually all its assessments, and develop a more streamlined and outcomes-focused approach.</td>
<td>Some regulators, auditors, inspectorates and accreditation agencies have lacked a sense of urgency about this work. Sustained leadership will be required to drive real improvements.</td>
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<td>The NHSIC should strengthen the ROCR process® and promote its wider use</td>
<td>The ROCR has been strengthened to some extent. The NHSIC has powers to refuse any data collection request where it believes the information is already collected – although we understand it has not yet refused any request in practice. The NHSIC had made progress in promoting ROCR to SHAs and encouraging them to use it, although this has been less of a priority since the abolition of SHAs was announced. We note that some organisations which are not formally required to use ROCR have started to do so, such as the National Audit Office, indicating that they find it helpful.</td>
<td>From April 2013 there will no longer be a requirement for new data collections from the Department of Health and its arms length bodies to seek approval through the ROCR process. The NHSIC will be required to offer advice and guidance on new data collections, but it is not yet clear what this will cover and how effective it will be if there is no formal mechanism to stop any new data collections that are clearly unnecessarily burdensome.</td>
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<td>The NHSIC should establish a web portal by 2013 to facilitate improved information sharing</td>
<td>The RHSIC told us they have made good progress in cataloguing all data returns, and hope to launch their web portal during 2013.</td>
<td>It is important that the challenges of bringing the NHSIC and NHS Connecting for Health together do not delay delivery of the web portal, given it will underpin other organisations’ efforts to gather data efficiently. There is no firm date for when the ROCR catalogue of all data returns will be part of this.</td>
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<td>The CQC should work with other parts of the system, including securing cooperation between the various agencies</td>
<td>The CQC has begun to make progress in formally agreeing cooperation between various agencies at a national level.</td>
<td>Since 2009 there has been little apparent sustained work to embed the Concordat between regulators and inspection agencies or capture the lessons learned. Progress in local teams from various agencies working together has been more patchy. This has not been helped by disruption to organisations from NHS reform.</td>
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<td>The CQC should maintain and develop collaborative risk summits at local level</td>
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<td>Collaborative risk summits have become weaker.</td>
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<td>The CQC should maximise the use of existing data collections and information from other agencies</td>
<td>Quality risk profiles are primarily constructed using data from other agencies.</td>
<td>Many duplicative requests remain. These tend to be locally driven, which is more challenging for the CQC to address.</td>
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Key recommendation

| ✓ | The CQC should maintain an advisory group to support its work | The CQC has a stakeholder committee made up of around 20 invited bodies representing the user voice, care providers, campaign groups and care professionals. |
| × | Additional feedback from people ‘on the ground’ in health organisations would be valuable in helping the CQC understand what more it can do to minimise burden. The same applies to other regulators. |
| ✓ | Organisations should be assessed on outcomes, rather than (mainly) process measures | Government policy is to replace most process measures with outcomes measures. |
| × | The impact of this policy on the costs of information gathering will depend on how outcomes measures are developed, including what use is made of data which is already collected. |
| ✓ | Providers should take active responsibility for the quality and safety of services they provide, and rationalise their internal processes for collecting and submitting information | Boards take seriously their responsibility to present clear and transparent information to the public. Data gathered has increasingly been made available to the public, including through published quality accounts. |
| × | It is likely that more can be done to rationalise internal processes. It is important to share best practice. This paper asks for views on what more can be done. With more commissioners and a more complex commissioning environment, it is now even more important that commissioners have efficient processes for collecting information from providers. |
| ✓ | Providers should have the right to challenge agencies which ask for the same or similar information that has been requested by others | Providers have never been given this right. |

Our ambitions for tackling the burden of bureaucracy

Some bureaucracy – regulation, inspection, monitoring and information gathering – is important to provide assurance that care is of a high quality, supports work to improve quality and enables patients to make choices.

NHS organisations have a responsibility to ensure they collect good quality information, and that their internal systems for doing so are as efficient as possible. Boards have a responsibility to present clear and transparent information to the public.

But with NHS efficiency now more important than ever, it is essential the industry, as a whole, finds ways for the new system to share information that adds value, as efficiently as possible. With this in mind, we have set out below our five ambitions for how this should work in future.

1. All organisations that require information from the health service must take responsibility for minimising the burden imposed by their work

The starting point for looking at bureaucracy affecting the NHS tends to be the Department of Health and its arms length bodies. However, many bodies that require information from organisations in the health service are not arms length bodies of the Department of Health – for example, the Health and Safety Executive and fire authorities. So efforts to address NHS bureaucracy need to be prioritised across government.

Individual bodies also need to work with each other to eliminate overlap and duplication between their work, align their approaches as far as possible and ensure it is totally clear whose responsibility it is to take action when problems are identified. We are pleased that a number are already doing so. This is particularly important at present, given the number of new bodies and bodies with changed remits resulting from NHS reform. It will also be important that people at less senior levels of the bodies that regulate, inspect and monitor play their part in minimising burdens, which can often be driven by local practice.
2. Information should only be collected nationally when it will genuinely be useful at a national level
Individual organisations will always need to gather local, ‘granular’ information to monitor and improve their own services so they can deliver good quality care efficiently. For example, ward-level outcomes data supports NHS leaders to ensure safety and drive improvements in their organisations. Information will also always be required by national bodies to run the NHS as a whole and for accountability, performance management and regulation. However, some information is requested nationally when it adds little value aggregated at that level. For example, national comparison of complaints levels is not helpful when complaints data is not collected using consistent methodology and categorisation, especially if context such as activity levels is missing. At present, there is a risk of national and local approaches being conflated and information being requested inappropriately by national bodies. The way in which new local commissioners and local Healthwatch define the information they require at local level will be important. It is also worth considering whether there should be some standardisation of the information required for quality accounts. This could not only help streamline data collection but would also give patients and the public truly comparable information.

3. Information requests must always have a clear purpose, and the benefits for quality, safety and efficiency should outweigh the costs
While good processes make an important contribution to good outcomes, approaches to monitoring and regulation that focus mainly on process can provide doubtful assurance and contribute little to driving up standards. We need to ensure there is a strong understanding of the links between regulation, performance and contract management and the role that each has to play in the system. Regulation and inspection should have a clear focus on quality and outcomes and be proportionate to risk.

4. Duplicated requests for information must be eliminated
Information should be requested once and used often. Bodies that ask for information need to build close working relationships with other organisations that also require the same or similar information. Information submitted to one body should be accepted by other bodies, wherever possible. It would be particularly helpful if organisations were to align their approaches to assessment and monitoring where there is overlap, for example, both Monitor and the CQC look at governance.

Before asking for information, the body doing so should check whether suitable information is already gathered by another body. The NHSIC can advise on this. It has already catalogued all NHS data returns, and the online information portal it is due to launch in 2013 will be a useful source of information on existing data sources.

5. Information requirements should be well designed, building on existing good practice
When developing policy that will require information from the NHS, policy-makers should look first at how they can make use of information that well-run organisations are anyway gathering in the normal course of following good practice. New monitoring and measurement requirements should be integrated with existing measures, as far as possible, so that they are used well and valued by staff and patients.

Providers should design information gathering processes which maximise the time frontline staff spend on care and minimise form-filling. This means information should be collected once, and as far as possible this should be integral to the job of caring rather than a separate process. This information should be shared and used elsewhere, if needed, rather than asking staff to input data multiple times. Responsibility for this needs to be shared at all levels – bureaucracy can be created internally, anywhere within an organisation.

‘Regulation and inspection should have a clear focus on quality and outcomes and be proportionate to risk’
Action that can be taken now

We are pleased that the NHSIC will be required to report to the Health Secretary on the burden of data collection in the NHS every three years. Health ministers should demonstrate sustained leadership on this issue and be responsible for driving reductions in the bureaucratic burden on health service organisations. We have developed a number of practical recommendations which the Department of Health and national bodies can implement now, outlined below.

The Department of Health should:
• implement as soon as possible the recommendations of the NHSIC’s 2011 fundamental review of data returns, which specified data collections that can be stopped now
• keep under review whether the ROCR process is used appropriately, and consider reintroducing an element of compulsion if necessary
• take the lead in brokering a formal, cross-government agreement of a set of principles for measuring, monitoring and sharing information in the least bureaucratic and most cost effective way
• be alert to potential ‘mission creep’ among bodies in the new architecture, as this may result in overlap and duplication between bodies as well as a lack of clarity about whose job it is to act when there is a problem
• clarify whether the CQC’s role should be about improving quality or assuring essential standards, and avoid the distractions of major structural reorganisation.

The NHS Commissioning Board should:
• ensure the outcomes measures currently in development gather and use information efficiently, in line with the principles above, in ways that add real value for patients
• consider moving to a single outcomes framework – separate, overlapping frameworks with some slightly different measures adds to the data collection burden
• ensure its performance management of CCGs is streamlined and makes as much use of existing data sources as possible
• address overlapping or duplicative information requests arising from the transition process, as soon as possible
• clarify how quality surveillance groups, run by NHSCB local area teams to monitor the risk of failures in quality, will relate to collaborative risk summits run by the CQC and processes in place in local authorities.

The NHS Information Centre should:
• broaden the scope of its work looking at the burden of data collection far beyond the Department of Health and its arms length bodies, for example, in its three-yearly reports to the Health Secretary on the burden of data collection in the NHS
• we understand that the NHSIC expects to launch its data portal during 2013; it is important that this is not delayed.

The Care Quality Commission should:
• ensure it has formal partnership agreements with bodies whose remits overlap with the CQC’s, which set out how they will work together, including where information will be shared between organisations and who leads on what. It should capture the learning from the operation of the Concordat, and use it to inform this work
• consider how it can work more efficiently with other bodies at a local level to help providers and commissioners manage risk – including looking at the effectiveness of collaborative risk summits and the best fit with quality surveillance groups.

Monitor should:
• respond if its regulatory regime is becoming too cumbersome and complicated, or if it fails to achieve anticipated objectives.

The NHS Trust Development Authority should:
• design its information gathering to be as efficient as possible, avoid duplication with other agencies and accept, where possible, information already submitted to other bodies.
Questions for discussion and feedback

The NHS Confederation will continue to consult our members on their experiences of the bureaucratic burden and the implementation of the reforms. We will continue to highlight emerging issues to government and other stakeholders. With the NHS still in transition and the potential extent of bureaucracy currently unclear, there will be an ongoing need to consider further practical recommendations.

We are keen to open up a discussion with providers and commissioners, people whose jobs have a strong focus on data gathering (for example, heads of audit or clinical directors), the Department of Health and regulators, auditors, inspectorates and accreditation agencies. We will be inviting feedback from a range of stakeholders over the next few months. In particular, we are keen to hear your views on the following questions.

1. Which specific duplicative requests from external organisations remain an issue, and what are your thoughts on how these should be minimised?

2. Is the balance right between local collection of information and national collections? Is the information collected nationally always of value at the national level?

3. How can the impact of inspections be made less onerous and more effective in helping to safeguard and promote better quality care?

4. What should be the priorities of national bodies in minimising bureaucratic burden? Is the greatest concern for NHS organisations inappropriate requests for information, overlap and duplication, lack of coordination, too much paperwork, or something else?

5. How can regulators, commissioners and other bodies who impose burdens on providers be supported to minimise this burden? Would it be helpful to develop and disseminate best practice? Should some of the content of quality accounts become mandatory? This would help provide truly comparable information to support patient choice and could also help reduce the burden of information requests from commissioners, by ensuring they could rely on a standard set of data being collected.

6. What mechanisms should exist to enable providers to raise concerns where they are being required to provide information that seems duplicative or of little value? We previously suggested providers could issue a ‘yellow card’ where they are asked for information that is the same or similar as that requested by others, with the NHSIC or CQC adjudicating on challenges.

7. What further action should be taken to free up professional time from paperwork, to enable more time to focus on care?

8. Information technology has been cited as being central to minimising the burden of form filling. Where could the use of information technology make the greatest contribution to minimising the burden of gathering and sharing information? For example, can more be done to simplify or automate the flow of information so that IT saves staff time? Where else might solutions lie? Innovative thinking is required – it is not necessarily inherently less time consuming for staff to select an option on an iPad than it is for them to tick a box on a piece of paper.

We would welcome your comments and feedback on your experiences of bureaucracy in the NHS, and the questions set out above. Please send your views on these questions to us at bureaucracy@nhsconfed.org.

For more information on the issues covered in this paper, contact kate.ravenscroft@nhsconfed.org.
References

8. At the time of *What’s it all for?*, the Healthcare Commission had established the Concordat to improve coordination and collaboration amongst regulators and inspection bodies. Responsibility for the Concordat passed to the CQC when the Healthcare Commission’s functions became part of the CQC.
9. The Review of Central Returns process is run by the NHSIC and makes sure that information demands on the NHS are minimised, fit with current national health policies and are carried out in the most efficient way without duplication. It covers the Department of Health and its arms length bodies.

Our work

This paper forms part of our work programme on **NHS reform and transition**. To read more about our work in this area, see [www.nhsconfed.org/NHSreform](http://www.nhsconfed.org/NHSreform)

The NHS Confederation

The NHS Confederation represents all organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS. We help the NHS to guarantee high standards of care for patients and best value for taxpayers by representing our members and working together with our health and social care partners. We make sense of the whole health system, influence health policy and deliver industry-wide support functions for the NHS.