

# Challenging bureaucracy



# The voice of NHS leadership

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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.

Cover image taken from the NHS Confederation's animation 'Reducing bureaucracy in the NHS'.

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Registered Charity no: 1090329

BOK60069

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# Letter to the Secretary of State

Dear Secretary of State for Health,

Earlier this year you requested I lead a review of bureaucracy in the NHS, with a focus on the burden coming from national bodies. This request came in the wake of Robert Francis QC's report into the tragic events at Mid Staffordshire. One of the important lessons borne of that harrowing episode was the need to ensure information helps rather than hinders good quality patient care. By making data in the NHS work harder to improve patient outcomes, staff are enabled to get on with caring for patients.

You asked the NHS Confederation to carry out this work because we are uniquely placed to speak on behalf of the whole healthcare system. Our membership includes NHS acute, community, mental health and ambulance trusts, as well as commissioners and independent sector providers of NHS services. The Confederation's independence and standing among those responsible for delivering care also makes us well-placed to work with organisations such as the Health & Social Care Information Centre (HSCIC).

We have worked with the HSCIC and other national bodies throughout this review to investigate how to reduce the burden of information collection and reporting on a range of providers. We have also been mindful of the other reviews you commissioned into complaints, patient safety and care quality. This review acknowledges the work of Professor Don Berwick, Ann Clwyd MP, Professor Tricia Hart, Professor Sir Bruce Keogh and others, and complements their conclusions by advocating

an approach to reducing bureaucracy that places patients front and centre of every improvement.

It is clear that providers, national bodies, commissioners, patients and staff are still adjusting to a reformed healthcare system. There have been a number of system changes since April this year, and some confusion over areas of responsibility and accountability. It is now more crucial than ever before to provide clarity on how we can reduce bureaucracy that is unnecessary, who is responsible for making that happen and how we can squeeze the most value out of the data already in use.

I want the NHS to be in line with the best performing industries across the world when it comes to using data effectively, and I believe the recommendations in this report provide a blueprint to do just that. If we want a 21st century NHS, we need to make sure the way we use data and information is brought into the 21st century. To do this, we must be ambitious about how information is used. The way data is collected and reported should not be punitive or burdensome, but contribute to improving care and increasing transparency about the care people receive.

This review has discovered that the national burden of bureaucracy is much bigger than originally thought – it's now crystal clear that we need to manage the burden better. While vast amounts of NHS data and information are relevant to patient care, the processes used to collect and record them are often outdated and

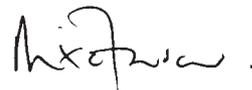
time-consuming for staff. That is why this review has not only looked at tackling the *volume* of data, but reducing the *effort* it takes to gather it, and increasing the *value* that can be extracted from every bit.

We can address this volume, effort and value challenge by supporting trusts to use data better so that staff can get on with their jobs and deliver better patient care. And we need to incentivise the use of smarter technology to streamline data collection.

Data is precious. It can be incredibly valuable when it's used to help deliver better, safer patient care, and to understand what's really happening in the health service. This review

concludes that those requesting data in the NHS must always be able to prove how that data will be used to support improvements in quality, safety and outcomes. It is only by sticking to these principles that we can truly lift the 'burden' of bureaucracy in the NHS.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Mike Farrar'.

**Mike Farrar**

Former Chief Executive  
of the NHS Confederation

# Key findings and recommendations

## What we found

- Bureaucracy, including the recording, collection and reporting of information, is an essential part of any effective healthcare system. Much of the data the NHS collects and reports on is of value and essential to assuring and improving patient care. It enables clinicians to better understand the care they provide. Where bureaucracy becomes burdensome is when it becomes excessive or undue.
- We estimate that national bodies<sup>1</sup> account for a quarter of the total reporting burden on NHS providers. The cost of nationally required data collection and processing is approximately £300–£500 million a year. This is a significantly higher cost than previously estimated.
- National bodies and providers differ in their understanding of the impact and cost of data requests. Trusts told us that the cost of configuring systems to collect new data requests, or make small changes to existing ones, could be significant.
- Clinicians, managers and national bodies agreed that reporting requirements are increasing. While some of this can be minimised through more efficient working, this increase is not necessarily a bad thing in itself. An increasing focus on understanding the quality of care, and how we measure it, is a positive development. We potentially need more and better data to improve care for patients, not less.
- National bodies overlap in holding responsibility for providers' performance, resulting in duplication. This is further complicated by the lack of a clear definition of 'quality' and core dataset to measure it.
- NHS providers vary in how they respond to reporting requirements. Supporting providers to adopt new information technology and improve business processes could reduce the effort involved in responding to requests.
- It is important that the right datasets are collected, and that the information is processed and made available in a timely way to enable improvements in clinical care. Clinical staff largely understand the value of the data they collect and its relevance to patient care, but feel more could be done to increase its value.
- There has been progress to reduce the volume and increase the efficiency of requests from national bodies, but more still needs to be done.

## What we recommend

- The Health & Social Care Information Centre should direct all bodies, including ministerial units, to disclose the full cost of data collected (using an updated Review of Central Returns methodology) and provide a clear business justification for each request.
- The Health & Social Care Information Centre should work with the Academy of Medical Royal Colleges, professional bodies, clinical

1. As we have not looked at the burden from commissioners during this review, this excludes NHS England.

specialist societies, the Care Quality Commission's chief inspector of hospitals and patient representatives to ensure clinical and patient engagement in agreeing the definition of 'quality' and a core dataset.

- The Department of Health should introduce a tight governing concordat for national bodies, based on an agreed set of data collections.
- It is important the Secretary of State for Health is able to hold the national bodies to account in terms of reducing the overall burden. We therefore believe that requiring each of the national bodies to reduce their burden by 10 per cent over each of the next two years would be a reasonable mechanism by which the Secretary of State could do this.
- The Health & Social Care Information Centre should consider the options for piloting a trust recharge scheme for national bodies for data requests that fall outside a core dataset. If a national body requests data outside of the core dataset they would incur a charge for the cost incurred by the trust to collect, validate and report the data.
- To enable a better understanding of the variation of effort across providers, NHS England should lead the development of an index that enables providers to self-assess and benchmark their information capabilities and business processes to manage information requests. The index should be used to identify and facilitate the sharing of best practice.
- Providers and the national bodies need to work together to build capabilities and skills throughout healthcare staff, to support them to better understand the information already available and how they can use it.
- The Health & Social Care Information Centre should commit to making submitted data available to trusts within 30 days of submission (with fully validated data to follow).

# Introduction

In February 2013, the Secretary of State for Health commissioned the NHS Confederation to complete a review of the bureaucratic burdens on providers of NHS care from national bodies. The request followed the publication of Robert Francis QC's report into failings in care at Mid Staffordshire NHS Foundation Trust.

This report sets out what we found and what actions should be taken to free the NHS from *unnecessary* bureaucracy. We believe our recommendations will help ensure that healthcare staff spend as much time as possible delivering patient care.

Our review has focused on the effects and impact of unnecessary bureaucracy from national bodies. It is vital that further work is done – as a matter of priority – to understand the burden from local bodies, including commissioners, local authorities and local Healthwatch. This should address instances of unnecessary bureaucracy throughout the commissioning system, including the burden experienced by local commissioners themselves.

## The problem we want to solve

We want to ensure data in the NHS works harder to improve patient outcomes and enable staff to focus on delivering high-quality patient care, without being distracted by unnecessary bureaucracy.

## Bureaucracy: help or hindrance?

Within public services, the term 'bureaucracy' has become synonymous with processes and systems that are *unnecessarily* burdensome. We challenge this assumption; regulation and oversight are essential to good governance and accountability, and the availability of information about service quality and outcomes

is vital to enabling choice and engaging and empowering service users. It is also essential for effective planning, research and scientific development. A 21st century healthcare system requires sophisticated information derived from robust data. A degree of 'bureaucracy', if taken to include the recording, collation, verification and reporting of information, is fundamental to understanding and improving both patient care and population outcomes.

But the NHS should neither generate nor tolerate 'burdensome' – that is, excessive or undue – bureaucracy. In a new system with competing demands from several new organisations, it is more important than ever for the health service to make the most of available information, and achieve the right balance of regulation and oversight so that providers are not overwhelmed or distracted from patient care by requests for information and inspection.

While we understand the need for bureaucracy in the NHS, we believe it can be done in a more efficient way, and national bodies have an important part to play in ensuring their demands do not become unnecessarily burdensome. We view bureaucracy as a key part of ensuring and improving patient care; *unnecessary* bureaucracy, however, can detract from these goals.

## Reducing volume, minimising effort, increasing value

This report examines how national bodies can work together to reduce and better control the volume of information requests and reports; how providers can be supported to reduce the effort needed to respond to them; and how to ensure clinical staff get the most value from existing data.

We have identified three main ways to reduce unnecessary bureaucracy:

- understanding and actively policing the **volume** of requests from national bodies
- minimising the amount of **effort** involved in responding to information requests with accurate data
- increasing the **value** from collected information, for staff, the wider system and the public.

## What we did, and how

We wanted our recommendations to be led and informed by real experiences and evidence, and so worked with seven providers of NHS care from across England to develop a bottom-up perspective of the burden associated with data requests from national bodies. The providers (see page 34) included a combination of acute and mental health services, of which four were integrated with community services.

Each trust conducted a review of the bureaucratic burdens they experience from national bodies, using a standardised methodology that detailed which questions to cover and the approach to take.

We completed fieldwork with these trusts over a three-week period in the summer of 2013. We recognise that this is a limited sample of trusts over a snapshot of time, and have exercised caution when drawing generalisations from our findings. However, we believe the trusts we worked with represent a fairly typical spread of NHS organisations, and provided us with sufficient information on which to base our generalisations.

To oversee and guide the review, we were supported by a Programme Advisory Group (PAG). The PAG included representation from a large number of national bodies, as well as providers and commissioners of NHS care (see page 34). The group was invaluable in advising and informing this review, and we recommend that it continues in its advisory capacity to support the implementation of our recommendations, if accepted by the Secretary of State, and any future associated work.

We also conducted a small number of interviews with patient representatives, to understand their perspective and experiences of bureaucracy in the NHS. Their guidance and insight were extremely useful.

## Previous work

This report follows our interim report, *Bureaucracy and regulatory review: a report of early findings and recommendations*, published in March 2013, and builds on previous work by a range of organisations:

- NHS Confederation and Independent Healthcare Advisory Services, *What's it all for? Removing unnecessary bureaucracy in regulation* (2009)
- The Royal College of Physicians' response to the *Equity & Excellence* white paper (2011)
- The Royal College of Nursing's *Paperwork and administration* (2012)
- The Department of Health, *Fundamental review of data returns* (2009)
- The NHS Confederation, *Information overload* (2013)
- nhsManagers.net survey of NHS staff.

# What is bureaucracy? When is it a burden?

In undertaking this review, we have been conscious that the term 'bureaucracy' is not neutral, and is often used to imply a set of activities that are obligatory and unnecessarily burdensome.

In the NHS, it is usually associated with form-filling and box-ticking, and is viewed as burdensome because of the effort required to respond to numerous national, regional and local requirements.

But the NHS lacks a commonly agreed definition of 'bureaucracy'. In this report, we define it as the combination of requests made by national bodies to NHS providers as part of national reporting and assurance. It comes in a number of different forms, including routine and ad hoc reports, inspections and assessments (see Figure 1). We see bureaucracy as both *what* is done (whether it is valuable or not) and *how* it is done (whether it is efficient or not).

## Inherently burdensome?

We challenge the assumption that bureaucracy is *inherently* burdensome. While we believe there is unnecessary bureaucracy in the system, a degree of oversight and regulation is essential to any effective healthcare system, and much of the information the NHS collects and reports on is of value and crucial to assuring and improving patient care.

In fact, doctors and nurses told us that evidence-based practice requires collecting and processing significant amounts of data. And the patient representatives we interviewed understood why the NHS needs bureaucracy, so long as it does not distract from delivering

high-quality patient care. But *unnecessary* bureaucracy is distracting staff from patient care.

Bureaucracy can be perceived as burdensome based on the volume of requests and the effort required to respond to them. However, the volume and effort involved might be proportionate to the value of the information collected, to both patients and professionals. It is also possible that the excessive time and effort expended in some organisations is due to inefficient systems and technology, rather than the nature of the data request.

As such a bureaucratic burden is not just an assessment of the volume of data collected and the time and cost to do so, but whether the data is valuable or not – whether that value is proportionate to the cost – and if it is being processed efficiently, or not.

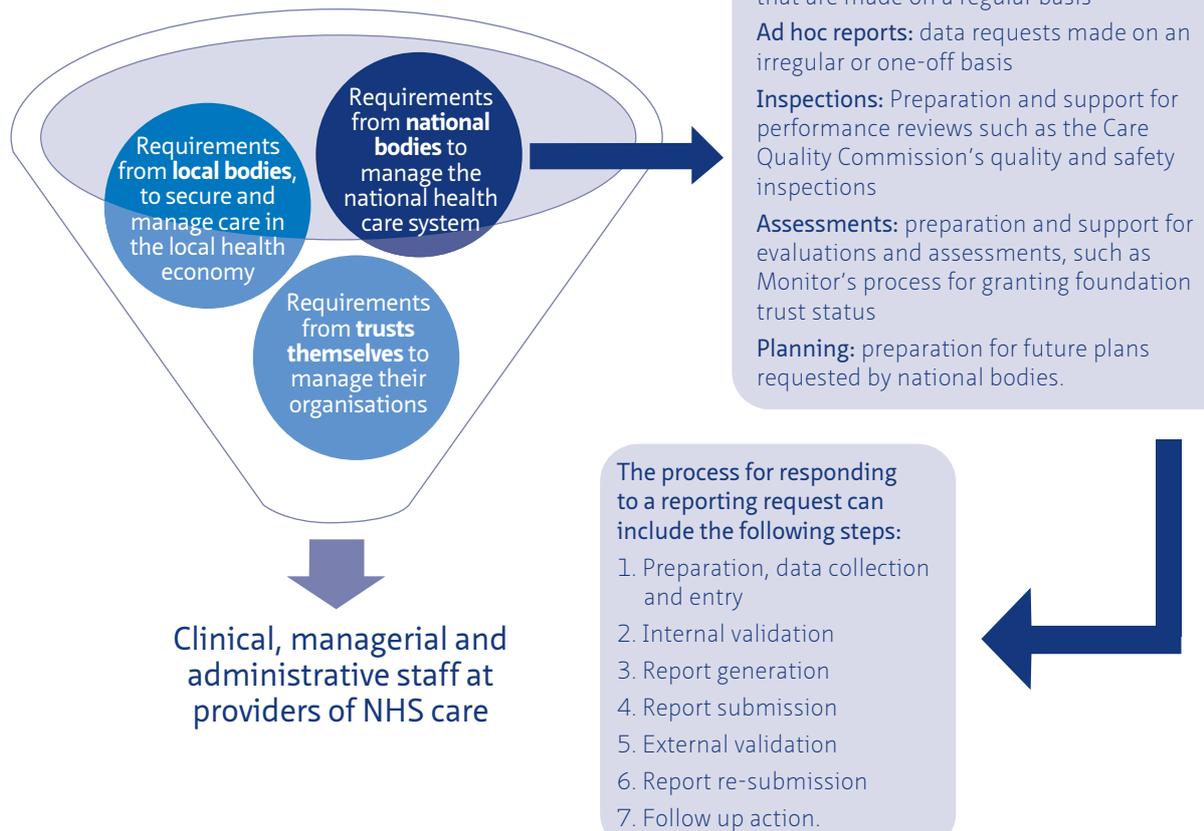
Our review has centred on finding the answers to three main questions: When is bureaucracy unnecessarily burdensome? What are the causes? What can we do about it?

## When is bureaucracy unnecessarily burdensome?

Bureaucracy is unnecessarily burdensome, for example, when:

- national bodies request that providers collect and record information that does not add value
- there is excessive validation and follow up on data requests, either within trusts, by commissioners or regulators
- information is requested by multiple bodies and in different formats
- information requirements change regularly.

**Figure 1. Where does bureaucracy come from?**



## What causes unnecessary bureaucracy?

Unnecessary bureaucracy can occur, for example, when:

- local or national processes are inefficient and do not make the most of information technology
- there is a lack of clarity of roles and responsibilities across different organisations
- there is a lack of consistent definitions used, especially in relation to quality.

## What can we do about it?

Our review has uncovered a number of ways to reduce unnecessary bureaucracy from national bodies on NHS providers. We believe our recommendations will help manage the volume of requests, reduce the effort involved in responding and, crucially, maximise the value of information for staff, patients and the public.

# Managing the size of the burden

## The cost of reporting

We estimate that national bodies account for a quarter of the total reporting burden on NHS providers. The cost of nationally required data collection and processing is approximately £300–£500 million a year.

### Key statistics

- According to those we interviewed, national bodies account for approximately 25 per cent of the bureaucratic burden
- Nationally required data collection and reporting costs approximately £1.4 million a year per trust

## What we found

A significant amount of the information requested by national bodies is entirely appropriate and reflects the need for scrutiny and assurance in a public health system – this is recognised by many working in the NHS. But the cost of nationally required data collection and processing is significantly higher than previously estimated.

### Reporting costs more than previously estimated

Our interviews suggested that national bodies account for approximately 25 per cent of trusts' costs associated with data collection, processing and reporting; the rest comes from the commissioning system and trusts' internal processes<sup>2</sup> (see Figure 2). We recognise

that more work is needed to confirm this breakdown, but our research suggests this is a good indication.

National requests can, on average, cost a trust approximately £1.4 million a year.<sup>3</sup> This is made up of:

1. the cost of routine reports, which can range from £700,000 to £1.3 million, with an average of approximately £1 million
2. the cost of ad hoc reports, assessments, inspections, planning and fees, which add between £200,000 and £600,000, with an average of approximately £400,000.<sup>4</sup>

Multiplying £1.4 million across the (approximately) 220 acute and mental health trusts in England, the total cost to this type of provider could be in the region of £300 million. This excludes other types of NHS providers not included in this review.

We also used a second method to calculate the cost of national reporting. The Review of Central Returns (RoCR) methodology, operated by the Health & Social Care Information Centre (HSCIC), estimated that its 154 centrally mandated reports cost approximately £50 million in total across England. But the trusts we worked with recorded a per-report cost ten times greater than that listed in RoCR.<sup>5</sup> The reason for this is partly because not all of the reporting steps are included, including the validation and submission steps. Applying this multiple to the £50 million total burden of the RoCR list implies

2. Interviews were conducted with 79 clinical members of staff and 89 managerial and administrative staff.

3. This is based on feedback from the seven trusts and includes a combination of RoCR reports and others. It does not reflect all RoCR reports.

4. This is likely to be conservative as there appeared to be additional costs that trusts were unable to quantify.

**Figure 2. Breakdown of where data collection, processing and reporting requests come from**



Source: NHS Confederation interviews with managerial and administrative staff

a total national cost of £500 million. As such, the estimated cost of national reporting could be between £300–£500 million – this is a significantly higher cost than previously estimated.

If the cost of nationally required data collection and processing is between approximately £300–£500 million – which represents a quarter of the reporting cost on providers – the implied total could be between £1–2 billion a year. However, much more work is needed to provide an accurate figure.

## What should be done

### Develop a consistent approach to calculating bureaucracy

The NHS is facing unprecedented financial challenges. It is now more important than ever to understand the true cost of bureaucracy to the NHS, based on a consistent and agreed methodology for calculating the burden. An agreed methodology should be developed in consultation with different parts of the system and applied in a consistent way.

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
1	Revise the RoCR burden calculation methodology to include trust costs for all steps in the data return process.	HSCIC	Late 2013

5. Reasons for this discrepancy include: partial coverage of burden type-burdens of assessments, inspections and planning are not currently included; partial coverage of cost chain, the validation and submission (and, frequently, re-validation and re-submission) steps are not included; conservative assumption of clinical staff burden, does not reflect the steps needed for trusts to collect the required data and put it into the report format; conservative estimation of staff costs – analysis of the NHS staff survey indicates that RoCR may underestimate staff per diem rates by approximately 20-30 per cent.

## The impact of data requests

National bodies and providers differ in their understanding of the impact and cost of data requests. NHS providers told us that the cost of configuring systems to collect new data requests, or make small changes to existing ones, could be significant.

### Key statistics

- New reports can cost a trust as much as £300,000 to set up
- The majority of managerial and administrative staff we interviewed reported that they spend between five and 20 hours a week on nationally required data collection, reporting and validation

## What we found

National bodies told us they want to minimise the amount of time providers spend on collecting data, and the associated costs. However, many believed the resources necessary to compile their reports was reasonable. They told us:

- reports are generated or aggregated from everyday operational data that trusts should be collecting
- as data is already collected, extracting it from IT systems should be straightforward, with little effort required by trusts.

The trusts we spoke to told us a different story. They reported that the cost of configuring their systems to collect new data requests, or make small changes to existing ones, could be significant. National bodies underestimated these costs by around a factor of 10. While this may be one extreme, we heard that a new report can cost as much as £300,000 for a trust.

Front-line staff perceived that national bodies impose a small burden on them<sup>6</sup> directly. However, the burden on managerial and administrative staff appeared to be substantial; on average they reported that they spend between five and 20 hours a week on nationally required data collection, reporting and validation.<sup>7</sup>

Managerial and administrative staff told us that duplication, ad hoc requests, changes and updates to routine reports and multiple reporting timelines were the main sources of unnecessary burden.

**“Demands for reports change frequently in terms of what they hold and how they are to be presented. Changing analysis tools and report templates also take large amounts of time.”**

**Service manager**

6. Most of the data they collected was not specifically required by national bodies and would have been collected anyway, as part of delivering high-quality patient care.

7. Our evidence suggests that internal and external validation accounts for 41 per cent of total burden from national bodies, although this was proportionally less in the mental health trusts we worked with.

## What should be done

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### Understand the impact of data requests

It is important that there is an open and transparent understanding of the cost and resource impact on providers from national bodies' information requests. More clarity on the rationale for requests would also be beneficial.

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
2	Direct all bodies, including ministerial units, to disclose the full cost of data collected (using the updated RoCR methodology when it is available) and provide a rationale for the request; a similar process should be used for changes to clinical data collections.	HSCIC	Immediately

## The trend

Clinicians and managers told us that data collection and reporting have increased over the last five years. National bodies reported that changes to the health system – especially the increased focus on assuring the quality of care – were highly likely to further increase the volume and type of data collected in future. While some of this can be minimised through more efficient working, the health service will potentially need more and better data to improve care, not less.

### Key statistics

- 70 per cent of clinical staff felt the increase in data collection and reporting over the last five years has been significant

## What we found

Clinicians, managers and national bodies agreed that reporting requirements are set to increase. This increase could be due to:

- the health service operating in a new system with several new organisations and a lack of clarity of roles and responsibilities, resulting in duplicated requests
- an increased focus on quality and safety, but it is not always clear how they should be measured
- external pressures on the NHS driving the volume of requests – just as trusts are under pressure from national bodies, the latter are under pressure from Parliament and the public
- a lack of incentive or requirement for national bodies to check existing national datasets before making new requests
- little incentive to cut back on requests, as the benefit of terminating a reporting requirement is minimal

- many of the institutional barriers to unreasonable or duplicative data requests have been removed in recent years, such as Monitor's gateway evaluation of new reports.

## What should be done

### Collect, manage and coordinate the right data

Practical steps can be taken to better manage the increase in demand for information (addressed in later chapters of this report).

The increased focus on understanding the quality and safety of care, and how it is measured, is a positive development. To transform patient care and improve quality for patients, the health service potentially needs more and better data, not less. For example, reorganising data collections to maximise clinical outcomes may mean collecting more data to fill gaps in the landscape. NHS England's consultation on hospital data is likely to expand the data collected from hospitals.

Collecting and using data are essential to patient care. The health service will need to focus on collecting the *right* data and ensuring it is managed in the most coordinated and efficient way.

**"We are seeing a growing appetite for data which is generating much enthusiasm and exciting opportunities for new ideas, new products and new analyses. While this is of course an entirely positive development, it cannot happen at the expense of the time that care professionals spend at the front line with people who need their services."**

**Kingsley Manning, Chair,  
Health & Social Care Information Centre**

## Clarifying responsibilities and definitions

National bodies overlap in holding responsibility for providers' performance, resulting in duplication. This is further complicated by the lack of a clear definition of 'quality' and core dataset to measure it.

## What we found

### Overlapping jurisdictions

Central oversight, scrutiny and control are a necessary and appropriate part of the NHS, but with more clarity on accountabilities and boundaries in the system, the cost of oversight could be reduced. A degree of overlap between organisations is inevitable and may even be healthy, as not every eventuality can be predicted. But all seven trusts in our review considered overlapping jurisdictions between national bodies a major cause of bureaucratic burden.

This is particularly problematic in the approach to quality of care. While 'access' and 'finance' are relatively clear, both in definition and responsible national organisations, interviewees consistently stated there was no clear definition of 'quality', and warned of the significant risk of overlap between bodies claiming responsibility for quality assurance.

Individual quality measures reflect this vagueness; terms are not always standardised nationally, and the results of these measures not readily comparable. Separate, overlapping outcomes frameworks with slightly different measures can also add to the data collection burden.<sup>8</sup>

Many national bodies view quality as part of their oversight responsibilities, leading them to demand different information and reports on quality. Organisations such as the NHS Trust Development Authority (TDA) and the Care Quality Commission (CQC) can claim a mandate to investigate and evaluate, with professional bodies such as the General Medical Council (GMC) becoming involved if medical practice is implicated.

The issue is substantially exacerbated when organisations seek to understand and correct deviations in provider performance. In such instances, the reporting burden is multiplied as providers try to work with and respond to sometimes contradictory requests. Trusts face the challenge of assuring external bodies that a situation is under control, while ever-growing demands from these organisations take time away from establishing control.

**"The current NHS regulatory system is bewildering in its complexity and prone to both overlaps of remit and gaps between different agencies. It should be simplified."**

**Berwick Review**

### Regulatory creep

There can be a tendency for regulators to expand the boundaries of their responsibilities. With some regulators now having expanded roles and responsibilities, it is important there is ongoing clarity for providers around who is responsible for what.

8. NHS Confederation (2013) *Information overload*.

Ministerial units are also taking a growing interest in quality; the Department of Health makes a number of requests, and the Cabinet Office's Implementation Unit has requested data on referral to treatment times.

**"Action plans are required for everything, often the same actions are in numerous plans, therefore duplicating work. So much time is spent writing the action plans, detracting from time to actually complete the actions."**

**Team manager**

## What should be done

### Establish a coordinated approach on key topics

More needs to be done to ensure a coordinated approach from national bodies on key areas – operations, access, finance and quality – and the process for collecting core data. This would encourage and facilitate the sharing of existing data as the first response to data needs, with demands to trusts as the last resort.

### Set consistent definitions

The trusts we interviewed were concerned about inconsistent definitions. Establishing a standard, core set of definitions – including, for example, what good quality care is – and what

metrics are used to measure it, is crucial. The definitions must have clinical credibility, developed in consultation with clinicians and patients. It is important that consistent definitions and templates for reports are developed and aligned to clinical audits.

### Establish a core dataset

Developing a core dataset agreed by all national bodies will provide clarity on what needs to be collected to deliver and improve patient care. This is an important first step to enable the Health & Social Care Information Centre (HSCIC) to coordinate and manage duplicative requests for information from different national bodies. We recognise there may be exceptional circumstances where it might be necessary to request additional information, and further consideration would be required to understand how this would work in practice.

We are supportive of HSCIC's and NHS England's review of what data hospitals should be collecting; the development of a core dataset would need to align with this. In addition, it is important that a core dataset complements the Royal College of Physicians' work to standardise the clinical structure and content of electronic patient records.<sup>9</sup> If these record standards are implemented in electronic patient records, they will enable datasets to be automatically extracted for secondary purposes, which will avoid separate, duplicate data collections.

9. The Royal College of Physicians (RCP) has led development of standards for the clinical structure and content of patient records in conjunction with healthcare professionals from multi-disciplinary backgrounds, patients, carers and health information technology specialists.

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
3	Develop a data definition service to set relevant definitions and content for a national quality dataset, in consultation with the other relevant national bodies.	HSCIC	Late 2013
4	Work with patient representatives, the Academy of Medical Royal Colleges, professional bodies, clinical specialist societies, the CQC's chief inspector of hospitals and the Professional Record Standards Body to ensure clinical and patient engagement in agreeing the definition of quality and the core dataset.	HSCIC	Late 2013

## Managing the volume better

There has been progress to reduce the volume and increase the efficiency of requests from national bodies, but more still needs to be done.

### Top five suggestions from non-clinical staff to reduce unnecessary burden

- eliminate duplication and report only what is necessary
- standardise data report structures
- make requests clear and minimise changes
- streamline reporting timelines
- create a centralised system where national bodies can share the information they receive.

## What we found

### Incentives needed to discourage proliferation of reports

National bodies have all contributed to reducing the volume of reports requested from providers and to improving the way remaining reports are processed. Since 2011, the number of reports listed in the Fundamental Review of Data Returns has dropped by nearly half.

The Care Quality Commission (CQC) has also recently dramatically cut its collection requests by 90 per cent without compromising its core purpose. Following a recent consultation on its regulatory framework, the regulator reduced the number of indicators from more than 1,000 to fewer than 200.

There is a lack of incentives in the health service for streamlining data requests and reports. Every national body we interviewed expects the volume of data requested from providers to increase in the near future. It is therefore important the existing principles of *Better regulation* are adhered to.

### Information sharing and coordination of data requests

There is still a need for better information sharing and coordination of data requests to reduce duplication; this confirms what we heard earlier this year through the nhsManagers.net survey. As national bodies demand data, particularly in response to concerns about performance, trusts feel unable to challenge or even streamline the process for supplying information. In one example we heard, a trust held 11 different meetings in a month with national and local bodies to discuss A&E waiting time breaches. While recognising this was an inefficient use of their senior managers' time, the pressure to respond to each separate body kept the trust's leadership from having the breathing space to better coordinate the various meetings.

### Use of the Review of Central Returns (RoCR) process for ad hoc requests

Although the Health & Social Care Information Centre (HSCIC) has its RoCR process for reports, it is not consistently used for ad hoc requests. This is important as ad hoc requests can have a significant impact on providers.

### Reviewing new data requests and rejecting duplicative or excessively burdensome requests

National bodies highlighted their concern about the lack of a process for reviewing new data

requests and dealing with duplicative or excessively burdensome requests. Several also raised the need for a more aggressive review of existing data requests to ensure obsolete reports are quickly cancelled. Many interviewees recalled the processes in place a decade ago, including the 2004 Inspection Concordat<sup>10</sup> and Monitor's power to review all RoCR requests made of foundation trusts.

### Changes and updates to routine reports

Continued changes and updates to routine report formats are time-consuming, as trusts need to reset systems and procedures to account for changes to data gathering.

### Data collection processes and reporting times

National bodies have different data collection processes and reporting times. These differences undermine attempts to aggregate national data, make inter-body data comparisons extremely difficult, and feed confusion at trust level that can result in multiple trips around the 'submission-external validation' cycle.

### HSCIC processes

While there was support for HSCIC's central role, some interviewees felt the centre could improve several of its processes. For example, some told us HSCIC's website interface is not user-friendly; substantial amounts of non-sensitive information are restricted (such as commissioning codes) and users complained of severe delays when attempting to connect to HSCIC systems and services.

## What should be done

### Introduce a concordat for national bodies

The Secretary of State should introduce and take responsibility for a tight governing concordat to govern the collection of data from national bodies and hold them to account, with the HSCIC as the coordinator of all collected or extracted data. The concordat should aim to ensure that:

- **requests for information are coordinated** – to improve coordination and reduce duplication, an integrated system under HSCIC oversight should be introduced to control and coordinate demands from various national bodies (in a similar way to previous systems, such as the Review of Central Returns, Inspection Concordat, and gateway systems such as those formerly run by Monitor for foundation trusts). Providers would benefit if they had more confidence that each request for information is handled and processed in a consistent way.
- **requests for information are clear and changes minimised** – national bodies should be clear about why a request is being made and what is to be included, ensuring any changes to requests are kept to an absolute minimum, recognising the effort needed to respond to any essential changes.
- **there is regular governance and review** – a system of governance and regular review would ensure each report's continued value and remove those failing to justify their burden, a requirement set out in the Health and Social Care Act. This could include using

10. At the time of *What's it all for?* in 2009, the Healthcare Commission had established the Concordat to improve coordination and collaboration among regulators and inspection bodies. Responsibility for the Concordat passed to the Care Quality Commission when the Healthcare Commission's functions became part of the regulator.

the equivalent of 'sunset' clauses so that when a requirement is no longer needed it can be removed or updated, to help prevent a continued rise in requests.

- **information shared and available** – the sharing of existing national body data should be the first response to data needs, with demands to trusts seen as the last resort. A list of all national collections and extractions should be published, detailing why the requests are of value.

### Implement system-wide incentives

It is vital that a balanced set of incentives and controls are set in place across the system. A provider recharge scheme for data requests that fall outside a core dataset should be piloted.

### Continue to remove unnecessary reports

Where possible the recommendations of the Department of Health's Fundamental Review of Data Returns, managed by the HSCIC, should be implemented.

A small number of additional reports were identified as worth considering for discontinuation:

- **reference cost reporting:** trusts cited many problems with reference costs. Monitor is planning to replace them with patient-level information costs (PLICS) by 2016/17.
- **estates information:** reports such as the Estates Return Information Collection (ERIC) were cited as examples of reporting without a clear objective; it did not facilitate useful benchmarking or performance improvement, or give assurance to regulators about wise use of resources.

### Streamline collection processes and reporting times

Standardising collection processes and reporting times would considerably reduce the burden across the system. A business support officer that we interviewed explained that: "Timeliness of reporting cycles are a big problem. The trust reporting cycle is clear and concise. Locally there are several reports required at different times of the month. Report requests only at the beginning/month end would reduce the burden."

### Progress toward automatic data extraction

Moving to automatic data extraction from electronic patient records, rather than separate data collections, would have a large impact on reducing the burden.

"The responsibility that the new reforms have placed on the Health & Social Care Information Centre regarding oversight of the system-wide burden and bureaucracy is clear. I expect that the HSCIC will act as the 'conscience' for the front line on this. We will of course work collaboratively with all of our partners. But there will be occasions where we need to speak out and act in the interests of the service – and therefore the public – at large."

**Kingsley Manning, Chair,  
Health & Social Care Information Centre**

### Case study: Australia's Department of Health reduces volume of requests

Australia's Department for Health and Ageing decreased the volume of requests for smaller providers despite an increase in overall data collection volume. This was done by aligning data requirements to the provider's level of funding, creating streamlined versions of

current reports and modifying reporting standards for providers receiving less than A\$100,000 in departmental funding. As a result, smaller providers had more time to concentrate on delivering clinical care.

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
5	Introduce a tight governing concordat for national bodies based on an agreed set of data collections.	DH	Immediately
6	Designate the HSCIC as the official coordinator and controller of national bodies' data requests to trusts.	DH	Immediately
7	Establish an integrated system of oversight to control and coordinate demands from the national bodies in a similar way to previous systems, for example the Review of Central Returns, Inspection Concordat, gateway systems such as those formerly run by Monitor for foundation trusts.	HSCIC	April 2014
8	Encourage and facilitate the sharing of existing national body data as the first response to data needs, with demands to trusts as the last resort.	HSCIC	April 2014
9	Communicate, including by annual publication, the list of all data collections by the HSCIC, and other national organisations, why they are needed and their cost.	HSCIC	April 2014
10	Put in place a system of governance and regular review to confirm each report's continuing value and remove those failing to justify their burden.	HSCIC	Summer 2014
11	It is important the Secretary of State for Health is able to hold the national bodies to account in terms of reducing the overall burden. We therefore believe that requiring each of the national bodies to reduce their burden by 10 per cent over each of the next two years would be a reasonable mechanism by which the Secretary of State could do this.	DH	Immediately

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
12	Pilot a trust recharge scheme for national bodies for data requests that fall outside the core dataset. If a national body requests data outside of the core dataset they will incur a charge for the cost incurred by the trust to collect, validate and report the data.	HSCIC	Late 2013
13	Where possible continue to implement the recommendations of the Department of Health's Fundamental Review of Data Returns.	HSCIC	Immediately
14	Explore opportunities for stopping high-burden, low-value reports, taking account of any possible unintended consequences. Examples of such opportunities include: <ul style="list-style-type: none"> <li>· the system-wide collection of reference costs; instead use existing sampled data until patient-level information costs are adopted (Monitor)</li> <li>· the Estates Return Information Collection (ERIC), cited as a high-burden and low-value (DH)</li> <li>· any reports made redundant or duplicated by the introduction of new services such as care data.</li> </ul>	Monitor and DH	Immediately
15	Explore opportunities for stopping any reports made redundant or duplicated by the introduction of new services such as care.data.	HSCIC	Immediately
16	The Department of Health should note its role as the biggest national contributor to trust burden and manage its demands on trusts from departments (including the Department of Health's ministerial briefing unit and the Cabinet Office).	DH, ministerial offices	Immediately

# Reducing the effort needed to manage information requests

## Variation between providers

NHS providers vary in how they respond to reporting requirements. This is why supporting providers to adopt new information technology and improve business processes could reduce the effort involved in responding to requests.

### Clinical staff suggested the following would reduce the burden on staff

1. Better communication between departments and clinical divisions
2. Better IT interoperability
3. More administrative support for clinicians<sup>11</sup>
4. Greater automation of data collection and presentation, potentially through an electronic patient record

## What we found

Providers vary significantly in how they respond to requests for information, and have different processes and digital capabilities for doing so. This was seen in the mix of reports cited as the most burdensome, whereby six trusts compiled a list of the top ten most burdensome nationally mandated reports. The lists covered a total of 40 reports, of which only 11 appeared on more than one trust's list. The reporting burden also varied significantly by trust type, with mental health trusts identifying different reports from acute trusts. Only the NHS Safety Thermometer and reference costs collection spanned both types.

### Information technology can have a big impact

We support the drive for electronic capturing of data and the digitalisation of processes. Trusts in our sample without sophisticated information technology systems, and in particular electronic patient records (EPRs), reported more steps involved to collect and submit data (and therefore more time and cost).

One of the providers had an established EPR and found that the burden of data collection and internal validation was lower than their less automated counterparts. This makes intuitive sense as the process of gathering and confirming data would be significantly shortened if supported by a good information technology system. It would also enable greater extraction of data from systems, rather than focussing on data collection.

For example, Salford Royal NHS Foundation Trust was the most technically advanced provider in our sample. With one exception, its self-assessed top ten burdens were significantly lower than those of the other acute trusts. For example, the trusts estimated the cost associated with the NHS Safety Thermometer; Salford's indicative cost was significantly lower at £26,000, compared to other trusts that cited £95,000 and £70,000.

Information technology can also play an important role in improving patient safety. Moving from paper-based records to an EPR, for example, would allow important information to be shared more quickly and reduce the risk of paper records being lost or misplaced.

11. Clinicians we interviewed expressed a strong view that many of the data entry and administrative tasks could and should be performed by non-clinically trained staff, a position echoed by professional bodies such as the Royal College of Nursing. This would, clinicians argue, free up more time for front-line staff to deliver direct care.

While we recognise the importance of maximising the use of technology to improve safety and reduce the effort involved within the system, it is vital to develop a culture in which staff are supported, through clinical business changes. Systems must be designed to meet the needs of patients and those who care for them. After all, information technology and tools are only as good as the way they are used. We should also acknowledge that this is not necessarily always concerned with investing in new technology, but also how providers can maximise the value of the technology they already have.

#### **Support for providers to improve is limited**

Providers told us they can and want to improve their information management processes, make better use of information technology and maximise the information available to them. But there is limited support in the system to build their capability and skills to achieve this. For example, it can be difficult for providers to know what 'good' looks like, how to achieve it and how other providers have succeeded in developing their capabilities.

#### **Other factors have an impact**

Time and motion studies previously undertaken at trusts broadly confirm wide variations in business processes and the amount of clinical time spent on administration, paperwork, writing notes, data entry or data collection. In addition to administrative duties, a significant amount of time is spent away from patients as a result of ward layout, handover protocols, and other issues that could be dealt with by trusts' management teams.

## **What should be done**

### **Improving information management at trust level**

Providers of NHS care should take a leading role in improving how they manage information in their own organisations. They should ensure a systematic approach to using data to better understand the business, and set a culture in which this approach is the norm. They should also avoid assurance procedures that dominate the delivery of care in practice, focusing on data that stems from clinical practice, not what sits on top of it. This will require a large communication and engagement exercise with NHS staff, and ideally their trade unions.

### **Sharing what 'good' looks like**

More work needs to be done to understand and share good practice across the system, as part of a sustainable and sector-led approach to improving how providers manage information and adopt information technology. For example, the Health & Social Care Information Centre (HSCIC) has recently conducted fieldwork with several trusts and could play a valuable role in sharing good practice.

### **Supporting providers to improve their capabilities**

There are a number of ways providers can improve how they manage information and how they use information technology. It can, however, be unclear how to achieve improvements and what the different options are as there isn't a 'blueprint to success'. A number of different solutions and experiences exist. This intelligence, experience and learning should be shared and made accessible across providers.

NHS England has created an index to benchmark the digital capabilities of providers to help drive improvement, called the Clinical Digital Maturity Index (CDMI). This will help providers understand

their digital capabilities in relation to their peers, and how others have approached the challenge. We support the approach of using an index to support providers, and think this should be applied to how providers manage information more broadly. We believe the use of an index should have four core aims:

- Enabling comparative assessment, baselining and benchmarking the capabilities of providers to help them better understand the variation of effort in the system and make this information transparent.
- Documenting and sharing best practice, by making different approaches, insights and expertise easy to identify.
- Becoming a rolling self and peer-assessment tool that providers can choose to use as part of driving their own improvement.
- Facilitating discussions between providers, and engagement between providers and suppliers, to create a more sustainable and supportive approach to improvement in information technology.

As part of this focus on building support within the system to improve capabilities, it is

imperative that when NHS England develops hospital data, it ensures that providers of NHS care are able to absorb it.<sup>12</sup> We support this move and recognise it as a first step in an ambitious strategy to move the NHS onto a digitally enabled path.

### Developing skills among NHS staff

More needs to be done to increase the skills and capabilities of staff within the system to empower them to understand the information already available and how they can use it to improve care. This should include staff across the NHS, not just those at board level. Raising awareness of the range of information already available to the system will form an important part of this.

**“Most healthcare organisations at present have very little capacity to analyse, monitor, or learn from safety and quality information. This gap is costly, and should be closed.”**

**Berwick Review**

## Case study: Information sharing in Singapore

Singapore’s health system encouraged information sharing and reduced duplication in electronic medical records (EMRs). The Ministry of Health created and provided start up funds for an Electronic Medical Record Exchange (EMRX) for clinicians in public hospitals and polyclinics to share patient records online. They adopted a pull-on-demand policy with appropriate safeguards rather than a pre-delivery model. The system prevents duplication and, due to its success, has been extended to include operating theatre reports, discharge summaries, immunisation reports, school medical reports and key safety alerts.<sup>13</sup>

12. NHS England’s development of hospital data will expand the data collected from hospitals as part of the transformation of hospital episode statistics (HES) into care episode statistics (CES), starting in early 2014.

13. SingHealth, *Commonwealth Health Ministers’ Book 2008*.

	Recommendation	Who	By when
17	Improve the processes for trusts supplying information to the HSCIC, for example by creating a single upload platform for all its data requests.	HSCIC	Process to begin in 2014
18	Rationalise collection tools and ensure details about each are widely available so national bodies can consider the practicalities when scoping new collections.	HSCIC	Summer 2014
19	In implementing care.data it will be important for NHS England and HSCIC to work with clinicians and the provider sector to understand the barriers to implementation and what the cost of overcoming those barriers will be. We would counsel the HSCIC and NHS England to work closely with trusts to understand the implications of the changes proposed.	NHS England	
20	Develop an index for providers to enable them to self-assess and benchmark their information technology capabilities and their business processes in place to manage information requests. We anticipate this could become part of the overall approach to governance.	NHS England	April 2014
21	Use the index to identify and incentivise provider-level best practice by sharing lessons learnt and facilitating sharing of experiences, including how to improve technology capability, business processes and how to use information.	NHS England	April 2014
22	Work together to build capabilities and skills throughout healthcare staff, to support them to understand the information already available to them and how they can use it. We recommend this is an area that the ongoing Programme Advisory Group (PAG) should look at in more detail.	National bodies and providers	April 2014

# Increasing the value of information

## Using data to improve care

It is important that the right datasets are collected, and for information to be processed and made available in a timely way to enable improvements in clinical care. The clinical staff we interviewed largely understood the value of the data they collect and its relevance to patient care, but felt more could be done to increase its value.

### Key statistics

- Clinical staff spend between two and ten hours a week collecting, recording or validating data (from all sources)
- The clinical staff we interviewed reported, on average, that 65 per cent of the data they collect is useful and relevant to patient care; this breaks down to 69 per cent for acute providers and 59 per cent for mental health providers

## What we found

It is important that the right datasets are collected, and that clinicians have access to any benchmarked, comparative or outcomes data resulting from that collection. The clinical staff we interviewed largely understood the value of the data they collect and its relevance to patient care, but many still felt the clinical relevance of reports was often weak. One sector manager told us that smaller but more meaningful amounts of data/reports, with clear links to patients' outcomes, would reduce cost and increase value.

**“Ensure the data is clinically relevant – not just counting activity.”**

**Consultant psychiatrist**

Developing a shared understanding of quality and a core dataset to measure it – agreed by providers, healthcare professionals, national bodies and patients – will help ensure the right data is collected.

### More can be done to increase the value of existing information

While the burden on clinicians from national bodies appears to be small, clinicians collect a significant amount of data and more could be done to increase its value. The Health & Social Care Information Centre (HSCIC) needs to do more to improve the value of national data already collected and extracted. We also recognise that the care professions, patients, carers and providers will need to co-own this agenda and help design the way information is made available to them.

There is great value in data; correctly collected, validated and shared, it has enormous power to improve the quality of clinical care in the NHS. Those we interviewed identified a number of programmes where collecting data and comparing performance had enabled trusts to improve clinical performance. This extended to inspections. A number of clinicians expressed enthusiasm for Care Quality Commission (CQC) visits, which enabled them to show the quality of care they delivered and learn how their practice could be improved.

However, there was a clear message that more could be done to increase the value of what is already collected. For example, there was frustration at the lack of a national dataset to enable performance to be compared at trust, specialty and clinician level. There was a strong sense that increasing the comparability of data would bring substantial benefits to the system.

### Time lag between data submission and return

The time lag between submissions and return can be long enough to reduce the usefulness of the information received. One trust explained that hospital episode statistics (HES) data was not useful for planning purposes by the time it was returned.

Even once reports were returned, they were often not made available to staff, or were difficult to understand and relate to patient care. This supports what we heard through the nhsManagers.net survey, where 41 per cent said they did not receive any feedback. While many interviewees felt that the HSCIC was the natural repository for data, they said it needs to make substantial improvements to its information technology and customer service.

Clinicians were keen for more transparency in the rationale for requests and the way the information is used to make decisions. A clinical director told us: "We want to understand the rationale for the request and what is done with it – many clinicians believe there is a black hole filled with the stuff."

**"As a clinician trying to deliver stuff based on data, it is really hard when all my spare time goes into generating data. Less experienced clinicians, such as junior doctors and nurses, never get past data collection."**

**Acute medicine consultant**

### Valued reports

Reports that enabled real improvements in clinical care were consistently cited as the most valued reports by clinical front-line staff, such as the Systemic Anti-Cancer Therapy dataset. This

**"The communication between who wants the data and who produces it is often unclear and therefore takes a lot more effort."**

**Clinical nurse specialist manager**

dataset is overseen by cancer specialists and has a deliberately small number of data fields (42) as unsubstantiated additions were aggressively challenged and a premium placed on rapid turnaround (three months, despite limited resources and a complex subject area covering multiple organs and treatment schedules). Users felt that the dataset's objective – demonstrating effectiveness and value for money for an expensive and opaque treatment – is supported by the insights it provides.

### What should be done

#### Clinical staff told us the following would increase the value of existing information

1. Clear link to patient outcomes
2. Communicate its role in decision making
3. Improve feedback mechanisms
4. Increase accessibility

#### Reduce turnaround time for submitted data

The providers we interviewed cited the timeliness of information as a significant issue, and therefore a shorter turnaround time for submitted data is essential. Making submitted data available to trusts in a significantly shorter timeframe, with fully validated data to follow, would greatly improve how data can be used to improve care for patients.

**Figure 3. Reports most valued by clinical staff**

<b>Clinical Audit</b>	"Show levels of service quality against standards"	<b>Nursing and Midwifery Dashboard</b>	"Gives assurance that good quality care is delivered"
<b>Pressure ulcer Audit</b>	"Provides quality and safety assurance"	<b>NHS Safety Thermometer</b>	"For improving high priority interventions"
<b>Falls Audit</b>	"Provides quality and safety assurance"	<b>Patient Safety Indicators</b>	"Overview of what is happening to identify areas of good practice and for improvement"
<b>Documentation Audit</b>	"Gives opportunity to review records and improve practice"	<b>Patient surveys and feedback</b>	"Highlights what we are doing well and shows us what we need to improve on"
<b>National heart failure Audit</b>	"Highlights specific areas to focus on"	<b>Outcome measures</b>	"PROM/PREM measurement as they are the closest we have to true measures of quality"
<b>Departmental Audits</b>	"Looks at specific clinical activities and outcomes"	<b>Serious incident reporting</b>	"Helps us to learn lessons and improve clinical care"
<b>TARN/Major Trauma</b>	"Helps to understand how to plan/improve care"	<b>Mortality &amp; Morbidity</b>	"Identify and minimise risk"
<b>Risk assessment</b>	"Clients' needs and risk can be monitored"	<b>Peer review</b>	"Identifies areas for action"

**Enable meaningful comparisons**

Increasing the comparability of data would bring substantial benefits. Using datasets to benchmark financial, operational and clinical performance would enable trusts to understand how they are performing against their peers. To ensure effective benchmarking, methods for calculating indicators will need to be robust and transparent.

**Improve feedback mechanisms and access**

Clinical staff requested improved feedback mechanisms and accessibility to data and reports. Enabling easier user access to HSCIC's online resources would make access to information considerably more

straightforward. We have previously recommended a web portal.<sup>14</sup>

**Increase the transparency of information**

While this report has focused on improving the use of information for healthcare staff, making information and data more transparent and accessible to patients and the public should be a priority. The patient representatives we interviewed expressed how difficult it can be for patients to navigate their way through data in a timely and accurate manner. It is essential that patients and the public are able to get the most value out of the information available about their health service.

14. NHS Confederation (2013), *Information overload*.

### Improve communication about why requests are made and how data is used

Improving communication with healthcare staff so that they understand how data is used and the full value of information when it is made available is a necessary task. This should be done in a way that ensures the value is understood across healthcare staff, and not just at board level. The HSCIC should publish a list of the data it collects, who requested it and why it is valuable.

### Build on the strengths of the Keogh Reviews

The CQC should build on the strengths of the process used for the Keogh Reviews when designing its new inspection regime. One of the strongest innovations in the process was the data packs containing the key statistics and

background information for each trust in one document. These packs allowed everyone involved to have a shared understanding of performance, and swift comparisons between departments could be made. The scope and thoroughness of the site visits were one of the strongest aspects of the reviews.

### Enable effective use of aggregate data

To ensure the health service derives the most value from the data healthcare staff collect, there is a real opportunity to use aggregate data at a national level to better understand service use. Analysis of provider data alongside other data, for example on nutritional and physical activity, would help increase the impact of strategies and policies for broader health and wellbeing promotion.

## Case study: Improving cancer data

The London office of the National Cancer Registration Service has focused on improving the availability, timeliness and quality of cancer clinical information collected, as reported by NHS trusts in London, to the National Cancer Registry Service (NCRS).

**Approach:** their approach focused on improving local processes, practices and systems so that cancer staging data could be collected as part of routine clinical workflow. Clinical teams were directly involved in the data collection and took ownership and responsibility for the data quality. The Cancer Registry Team and Data Improvement Team provided support and guidance.

Timely, regular feedback to multi-disciplinary teams (MDT) was given on the data they provided, specifically highlighting:

- successful achievements
- areas for improvement
- comparative performance across London.

In most cases, organisations did not need to buy new systems to collect this data, needing only to release the data from their current systems.

**Outcome:** There were significant improvements in the MDT's staging data returns, from initial lows of 10–20 per cent up to the 70 per cent target or above.

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
23	Build on the strengths of the Keogh process in designing its new inspection regime. By working with the trusts involved, it should also identify where there are opportunities to create more value for the NHS from process.	CQC	Immediately
24	Ensure a shorter turnaround time for submitted data and commit to making it available to trusts within 30 days of submission (with fully validated data to follow).	HSCIC	Early 2014
25	Explore ways of supporting trusts to benchmark financial, operational and clinical performance based on submitted datasets, within 60 days of submission.	HSCIC	Early 2014
26	Explore ways of supporting specialist services to benchmark financial, operational and clinical performance based on submitted datasets, within 60 days of submission.	HSCIC	Early 2014
27	Explore how to make information and data more transparent and accessible to patients and the public so they too get the most value from the information available about their health service.	All national bodies	Immediately
28	Improve communication with providers so they understand how data is used and the value of information when it is made available. This should include extensive engagement with NHS staff to ensure value is not just understood at board level.	HSCIC	Late 2013
29	Ensure healthcare staff have easy access to online resources.	HSCIC	Late 2013
30	Establish a piece of work to develop the opportunity to use aggregate data at national level alongside other datasets, to help understand resource use, lifestyles and consumer habits and subsequently develop health promotion strategies.	NHS England, HSCIC, Public Health England	

# Recommendations for further work

We hope the findings of this report have contributed to a better understanding of the bureaucratic burden placed on NHS providers by national bodies, and that implementation of its recommendations will go some way to reduce bureaucracy in the NHS. However, we have identified a number of other areas we think require more work if we are to fully succeed in our ambition to reduce the burden of bureaucracy. We recommend that:

1. Further work is done to understand national reporting in other types of providers, including community providers, ambulance providers and independent sector providers of NHS care. Although our sample included a number of integrated providers, we think it would be beneficial to look at the experience of community providers in more detail. This is especially important as care increasingly moves into community settings.
2. More work is completed to understand the impact of the commissioning system and locally driven bureaucracy, including overlaps and duplications across local and national bodies. This should not be limited to the impact on providers, but include the bureaucratic burden experienced by commissioners. This should also look at integration and information sharing across different organisations, including across health and social care.
3. The Programme Advisory Group for this review continues to meet and act in an advisory capacity for future pieces of work, and oversees progress against recommendations made. We also recommend it publishes a statement of progress against the recommendations in six months' time.

# Conclusion: a three-part task

Bureaucracy is an essential part of an effective healthcare system, enabling it to understand, assure and improve patient care and outcomes for local populations. The effectiveness of any system rests on its ability to identify, challenge and address practices and processes that compromise the quality of care it delivers.

After the publication of the Francis report, we were commissioned to investigate the burden of bureaucracy on providers of NHS care. Our review has identified several instances of **unnecessary** bureaucracy arising from national bodies, and uncovered their potential impact and costs. We have sought to challenge the mechanisms, drivers and incentives causing unnecessary bureaucracy, and made tangible recommendations to address the issues to help ensure NHS staff are free to focus on delivering high-quality care.

We found that reducing unnecessary bureaucracy will require a three-part task to tackle the **volume** of requests, reduce the **effort** involved in responding and maximise the **value** of collected information.

This sets a challenge not only to national bodies, but NHS providers themselves to take the lead, where they can, to make sure that information works harder for patients.

We will work with our provider members, the Health & Social Care Information Centre, Department of Health and all of the national bodies to review the extent to which the recommendations in this report have been taken up and implemented.

# Acknowledgements

We would like to thank staff at the following trusts for their hard work and support to deliver this report: Brighton and Sussex University Hospital NHS Trust; Central Manchester University Hospital NHS Foundation Trust; Central and North West London NHS Foundation Trust; Nottingham University Hospital NHS Trust; Salford Royal NHS Foundation Trust; South Tees Hospital NHS Foundation Trust; and South West Yorkshire Partnership NHS Foundation Trust.

We would like to thank nhsManagers.net for their help in completing a survey of NHS staff earlier this year to support our interim report.

We would also like to thank the senior representatives we interviewed from the following 14 national bodies:

- British Orthopaedic Trainees Association
- Care Quality Commission
- Department of Health
- General Medical Council
- Health & Social Care Information Centre
- Healthcare Quality Improvement Partnership
- Monitor
- National Cancer Intelligence Network
- NHS Blood and Transplant
- NHS England
- NHS Trust Development Authority
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Radiologists

We would also like to acknowledge the Programme Advisory Group (PAG) that has provided oversight and advice to the review, with representation from the following organisations:

- Barchester Healthcare
- Better Regulation Executive
- British Medical Association

- Care Quality Commission
- Care UK
- CHKS
- Department of Health
- Environment Agency
- Foundation Trust Network
- General Medical Council
- General Pharmaceutical Council
- Health and Safety Executive
- Foundation Trust Network
- Health and Care Professions Council
- Health & Social Care Information Centre
- Health Education England
- Healthcare Quality Improvement Partnership
- Human Fertilisation and Embryology Authority
- Human Tissue Authority
- Independent Healthcare Advisory Services
- Leeds and York Partnership NHS Foundation Trust
- Monitor
- National Institute for Health & Care Excellence
- NHS Clinical Commissioners
- NHS England
- NHS Litigation Authority
- NHS North Yorkshire and Humber Commissioning Support Unit
- NHS Trust Development Authority
- Nursing and Midwifery Council
- Oxford University Hospitals NHS Trust
- Public Health England
- Royal College of Nursing
- Royal College of Physicians
- King's College Hospital NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust

# Further reading

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# Annex 1– Table of recommendations

	<b>Recommendation</b>	<b>Who</b>	<b>By when</b>
1	Revise the RoCR burden calculation methodology to include trust costs for all steps in the data return process.	HSCIC	Late 2013
2	Direct all bodies, including ministerial units, to disclose the full cost of data collected (using the updated RoCR methodology when it is available) and provide a rationale for the request; a similar process should be used for changes to clinical data collections.	HSCIC	Immediately
3	Develop a data definition service to set relevant definitions and content for a national quality dataset, in consultation with the other relevant national bodies.	HSCIC	Late 2013
4	Work with patient representatives, the Academy of Medical Royal Colleges, professional bodies, clinical specialist societies, the CQC's chief inspector of hospitals and the Professional Record Standards Body to ensure clinical and patient engagement in agreeing the definition of quality and the core dataset.	HSCIC	Late 2013
5	Introduce a tight governing concordat for national bodies based on an agreed set of data collections.	DH	Immediately
6	Designate the HSCIC as the official coordinator and controller of national bodies' data requests to trusts.	DH	Immediately
7	Establish an integrated system of oversight to control and coordinate demands from the national bodies in a similar way to previous systems, for example the Review of Central Returns, Inspection Concordat, gateway systems such as those formerly run by Monitor for foundation trusts.	HSCIC	April 2014
8	Encourage and facilitate the sharing of existing national body data as the first response to data needs, with demands to trusts as the last resort.	HSCIC	April 2014
9	Communicate, including by annual publication, the list of all data collections by the HSCIC, and other national organisations, why they are needed and their cost.	HSCIC	April 2014
10	Put in place a system of governance and regular review to confirm each report's continuing value and remove those failing to justify their burden.	HSCIC	Summer 2014
11	It is important the Secretary of State for Health is able to hold the national bodies to account in terms of reducing the overall burden. We therefore believe that requiring each of the national bodies to reduce their burden by 10 per cent over each of the next two years would be a reasonable mechanism by which the Secretary of State could do this.	DH	Immediately
12	Pilot a trust recharge scheme for national bodies for data requests that fall outside the core dataset. If a national body requests data outside of the core dataset they will incur a charge for the cost incurred by the trust to collect, validate and report the data.	HSCIC	Late 2013
13	Where possible continue to implement the recommendations of the DH's Fundamental Review of Data Returns.	HSCIC	Immediately
14	Explore opportunities for stopping high-burden, low-value reports taking account of any possible unintended consequences. Examples of such opportunities include: <ul style="list-style-type: none"> <li>· the system-wide collection of reference costs; instead use existing sampled data until patient-level information costs are adopted (Monitor)</li> <li>· the Estates Return Information Collection (ERIC), cited as a high-burden and low-value (DH)</li> <li>· any reports made redundant or duplicated by the introduction of new services such as care data.</li> </ul>	Monitor and DH	Immediately

Recommendation	Who	By when
15 Explore opportunities for stopping any reports made redundant or duplicated by the introduction of new services such as care.data.	HSCIC	Immediately
16 The Department of Health should note its role as the biggest national contributor to trust burden and manage its demands on trusts from departments (including the Department of Health's ministerial briefing unit and the Cabinet Office).	DH, ministerial offices	Immediately
17 Improve the processes for trusts supplying information to the HSCIC, for example by creating a single upload platform for all its data requests.	HSCIC	Process to begin in 2014
18 Rationalise collection tools and ensure details about each are widely available so national bodies can consider the practicalities when scoping new collections.	HSCIC	Summer 2014
19 In implementing care.data it will be important for NHS England and HSCIC to work with clinicians and the provider sector to understand the barriers to implementation and what the cost of overcoming those barriers will be. We would counsel the HSCIC and NHS England to work closely with trusts to understand the implications of the changes proposed.	NHS England	
20 Develop an index for providers to enable them to self-assess and benchmark their information technology capabilities and their business processes in place to manage information requests. We anticipate this could become part of the overall approach to governance.	NHS England	April 2014
21 Use the index to identify and incentivise provider-level best practice by sharing lessons learnt and facilitating sharing of experiences, including how to improve technology capability, business processes and how to use information.	NHS England	April 2014
22 Work together to build capabilities and skills throughout healthcare staff, to support them to understand the information already available to them and how they can use it. We recommend this is an area that the ongoing Programme Advisory Group (PAG) should look at in more detail.	National bodies and providers	April 2014
23 Build on the strengths of the Keogh process in designing its new inspection regime. By working with the trusts involved, it should also identify where there are opportunities to create more value for the NHS from process.	CQC	Immediately
24 Ensure a shorter turnaround time for submitted data and commit to making it available to trusts within 30 days of submission (with fully validated data to follow).	HSCIC	Early 2014
25 Explore ways of supporting trusts to benchmark financial, operational and clinical performance based on submitted datasets, within 60 days of submission.	HSCIC	Early 2014
26 Explore ways of supporting specialist services to benchmark financial, operational and clinical performance based on submitted datasets, within 60 days of submission.	HSCIC	Early 2014
27 Explore how to make information and data more transparent and accessible to patients and the public so they too get the most value from the information available about their health service.	All national bodies	Immediately
28 Improve communication with providers so they understand how data is used and the value of information when it is made available. This should include extensive engagement with NHS staff to ensure value is not just understood at board level.	HSCIC	Late 2013
29 Ensure healthcare staff have easy access to online resources.	HSCIC	Late 2013
30 Establish a piece of work to develop the opportunity to use aggregate data at national level alongside other datasets, to help understand resource use, lifestyles and consumer habits and subsequently develop health promotion strategies.	NHS England, HSCIC,Public Health England	

# Challenging bureaucracy

In February 2013, the Secretary of State for Health commissioned the NHS Confederation to complete a review of the bureaucratic burdens on providers of NHS care from national bodies. The request followed publication of Robert Francis QC's report into failings in care at Mid Staffordshire NHS Foundation Trust.

This report sets out what we found and what actions should be taken to free the NHS from *unnecessary* bureaucracy. We believe our recommendations will help ensure that healthcare staff spend as much time as possible delivering patient care.

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