



Health & Social Care
Information Centre

Busting Bureaucracy

Collaborative audit findings
and recommendations



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Published by the Health and Social Care Information Centre

Version 1.1

May 2014

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With thanks...

The following Trusts participated in the collaborative audit. We thank them for their participation, willingness and frankness during the audit period, and their support and suggestions made, all of which have contributed to the richness of this report, the conclusions drawn and the recommendations made:

Barnsley Hospital NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Burton Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Chelsea and Westminster Hospital NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
Liverpool Women's NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northumbria Healthcare NHS Foundation Trust
Portsmouth Hospitals NHS Trust
The Royal Liverpool and Broadgreen University Hospitals NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Tameside Hospital NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust

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Executive Summary

In November 2013, the Government published “Hard Truths”, its response to the Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust¹. This establishes beyond any lingering doubt the importance of the fundamental principles of quality and safety of care.

At the same time, the NHS is having to manage the significant pressures on precious but reducing resources – staff time as well as funding. Anything that diverts resources from direct patient care must be justified.

It is in this context that we have seen renewed interest in the need to reduce unnecessary burden and bureaucracy which gets in the way of direct patient care, starting initially on the burden generated by national data collections. Coinciding with the publications of “Hard Truths”, NHS Confederation published its study into burden and bureaucracy “Challenging Bureaucracy”², which had been commissioned by the Secretary of State. That study concluded that:

- 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.
- 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.

This study complements that of the NHS Confederation by looking more closely at how burden and bureaucracy manifests itself for clinical and administrative staff. This study also makes recommendations which emphasise some of the NHS Confederation’s findings and which focus on reducing the experience of burden and bureaucracy within Trusts.

We also saw the launch of a new concordat agreed across several of the national organisations which agreed to work together to reduce burden and bureaucracy on the front line.

1 www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

2 www.nhsconfed.org/Publications/reports/Pages/challenging-bureaucracy.aspx

The Health and Social Care Information Centre was established in April 2013 and has a clear responsibility in the new health and care system to manage and reduce the collective burden associated with national data collections. During 2013, we ran a “Busting Bureaucracy” campaign with several Trusts, to gain a better understanding of the ways in which burden and bureaucracy affect staff on the front line.

The campaign was built around local audits which we carried out in 16 Trusts. It comprised a mixture of observation, interviews, and a structured survey that we completed with staff. We spent a week in each Trust, shadowing clinical and administrative staff, to see at first hand how they carry out their jobs, and how they handle the multiplicity of factors that they have to deal with. We are grateful to the staff in all the Trusts for their time, and their willingness to share their experiences with us.

Before we started, we knew that there were many different perceptions about burden and bureaucracy – people had particular views informed by specific local circumstances. We used five hypotheses to test those perceptions.

	Hypothesis:	What we found:
1	“Nurses and doctors spend a significant amount of time per week on bureaucracy”	An average of 66 per cent of a junior clinician’s time is spent accessing or updating patient notes (See Table 1 , page 16).
2	“The use of technology and smarter processes reduces burden and bureaucracy”	77 per cent of Trusts type up paper notes retrospectively into an electronic system (See 2e , page 19)
3	“The use of technology releases clinical staff time (which could positively contribute to the time to care)”	The use of Computers on Wheels has reduced ward round times by 45 minutes (See 3e , page 24).
4	“The better the local systems are, the better the acute provider is able to meet reporting needs”	It has taken some audited Trusts two years to fully implement a solution to delivering a new return; involving interim ad-hoc solutions, requirements definition, supplier quotation, delivery, testing and implementation. Until developed, manual bureaucratic processes pervaded.
5	“A national concordat would have a positive impact on reducing burden”	In the preceding 12 months, an average of 10 external datasets were introduced or changed (See 1f , page 12).

Burden and Bureaucracy: working definitions

For the purposes of this report the following definitions are used in the context of data collection:

Burden is defined in the Oxford English Dictionary as “a duty or misfortune that causes worry, hardship, or distress”.

For the purposes of the collaborative audit this is interpreted as “requests for information that result in additional workload for staff with no perceived benefits accruing”.

Bureaucracy is defined in the Oxford English Dictionary as “excessively complicated administrative procedure”.

For the purposes of the collaborative audit this is interpreted as “processes which have perceived benefits but are resource intensive, inefficient and time consuming”.

We have distilled the evidence gathered from our busting bureaucracy audits into 13 recommendations

This report sets out the evidence we obtained about each of the five hypotheses. We have learned a lot from this work. We believe that there is enough evidence for each of these hypotheses to inform more robust plans for the reduction of burden that take account of the different interests and perspectives.

To be effective, our work must be a collective effort, involving national and local organisations, commissioners and providers of services. It must be relevant to all care settings. We must recognise that the way national collections are introduced will affect the way they are implemented locally, and so each national data collection must involve an element of co-production with those who will be required to submit the data.

The appetite for nationally available information about health, public health and social care is still growing. So that is another reason why we need to have systems and processes in place to manage burden and bureaucracy. As national organisations, we have an important role to play in supporting local organisations to implement processes which can gather and submit data efficiently and effectively. Increasingly, these will use extraction techniques in the future, but that is some way off. In the meantime, we must do more to ensure local organisations use efficient and effective processes to do this. Technology has a big contribution to make, but alone it is not the answer. We have seen evidence of good technology being implemented poorly and not-so-good technology being used wisely in local settings. To achieve the bigger gains, technology must be part of a bigger change programme that addresses informatics skills and capabilities, as well as operational practices. Proper local ownership is vital.

The evidence gathered provides rich, broad and deep information on the actual and perceived burden and bureaucracy associated with data collection in the Acute Trust care setting. We have distilled this into 13 recommendations across the three themes of controlling burden and bureaucracy, implementing processes, and technology adoption to minimise bureaucracy. These recommendations are detailed on page 25.

This report outlines our proposals for discharging our duty to manage and reduce the burden and bureaucracy that impacts on the delivery of care. It is the start of a sustained effort.

Audit findings

The following sections provide detailed findings and supporting context together with statistical and observed illustrative examples drawn from the collaborative audits leading to the associated recommendations.

Testing of hypotheses

Each of the five hypotheses were tested as follows:

Hypothesis	Supported by audit evidence	Summary finding
That nurses and doctors spend a significant amount of time per week on bureaucracy	Yes	The audit confirmed that nurses and doctors and in fact all clinical staff spend a significant amount of time per day and week on bureaucracy. An average of 66 per cent of a junior clinician's time is spent accessing or updating patient notes (See Table 1 , page 16)
That the use of technology and smarter processes reduces burden and bureaucracy	Yes	The use of technology and smarter processes together, i.e. when implemented as part of a business change programme, can reduce burden and bureaucracy. However, the audit findings confirmed that in all organisations there are examples of technology being implemented without process change, resulting in similar or increased levels of burden and bureaucracy due to a mixed economy of digital and paper. The use of Computers on Wheels has reduced ward round times by 45 minutes (See 3e, page 24).
That the use of technology releases clinical staff time (which could positively contribute to the time to care)	No	Without paper and electronic systems within the Trust being integrated with each other, and smarter application of processes, staff spend more time managing multiple systems inputting to and transcribing from paper. 77 per cent of Trusts type up paper notes retrospectively into an electronic system (See 2e, page 19).

Hypothesis	Supported by audit evidence	Summary finding
The better the local systems are, the better the acute provider is able to meet reporting needs	Yes	"Better" in this context is defined as being flexible enough to allow the Trust to respond quickly to new reporting requirements. Current systems are not able to respond in a timely and cost effective manner to meet changing local or national reporting needs. The evidence shows that there is significant cost both in resources and to third party suppliers for new and changing reporting requirements. It has taken some audited Trusts two years to fully implement a solution to delivering a new return; involving interim ad-hoc solutions, requirements definition, supplier quotation, delivery, testing and implementation. Until developed, manual bureaucratic processes pervaded.
A national concordat would have a positive impact on reducing burden	Yes	A national concordat will alleviate burden imposed through the introduction of new datasets and changes to existing datasets as well as the current significant ad hoc reporting requirements placed upon Trusts, particularly by commissioners. In the preceding 12 months, an average of ten external datasets were introduced or changed (See 1f, page 12)

The findings for each hypothesis together with the detailed outputs of the audits have provided rich, broad and in-depth information on the actual and perceived burden and bureaucracy associated with data collection in the Acute Trust setting.

Out of these findings, three themes have crystallised with a number of recommendations associated with each:

- 1. Controlling burden and bureaucracy**
- 2. Implementing processes**
- 3. Technology adoption to minimise bureaucracy.**

All three of these themes contribute individually and collectively to reducing burden and bureaucracy. In the short term, however, Trusts can receive significant benefit and improvement quickly by focusing immediately on two areas, namely 'controlling burden and bureaucracy' and 'technology adoption to minimise bureaucracy'.

Supporting evidence and illustrative examples for each of the themes are given in the following sections.

Trusts can receive significant benefit and improvement quickly by focusing on two areas: controlling burden and bureaucracy and technology adoption to minimise bureaucracy

1. Controlling burden and bureaucracy

a) No organisational policy on use of data collection forms

All data collections have a cost to the Trust yet, although there were isolated examples of best practice in some Trusts, there was no evidence of any one Trust having an organisational policy covering the process for implementing new data collections or the use of data collection forms. This is evidenced by the lack of corporate branding, indication of owner or support, review or expiry date. Requests for new data collections can be implemented in clinical departments without any corporate governance having taken place.

Illustrative example

A typical medical admissions ward manually filled in a pack of over 30 pages of varying forms for every admission and were not aware of the source, owner or review process for any of those forms.

Issues

- Duplication.
- Data value.
- Burden and bureaucracy.

b) The purpose and value of data collections is not always apparent

Staff involved in data collection, recording and entry consistently confirmed that the purpose and value of data collections is not always apparent. From 11 stroke units that responded, 8 reported collecting information that they would not need to collect for the direct care of the patient, including:

- venous thromboembolism (VTE)
- diabetes
- Safety Thermometer
- Sentinel Stroke National Audit Programme (SSNAP) – a data collection as part of a programme of work by the Royal College of Physicians that aims to improve the quality of stroke care.

Illustrative example

An acute medical unit matron has to complete over 20 reports a month which includes locating data not collected on the ward, adding them into a report, and then sending it off. This matron felt that clinical professionals are not consulted when data collections are designed, or on the purpose of the submitted data.



Issues

- Disconnect between collections data and care data standards.
- Disconnect between care data for direct care and indirect care.
- Burden and bureaucracy.

The methods of data collection are considered burdensome rather than the collections themselves

c) Uncertainty on how/where to access feedback from data collections

There is little awareness of feedback or outputs available from data collections. Feedback information is often published on websites which means the user must seek the information rather than it being presented.

Illustrative example

Stroke units collect Sentinel Stroke National Audit Programme (SSNAP) data which they do not receive any feedback on for up to 12 months. Of those asked, they are not sure what the feedback will be or how that feedback will be used.



Issues

- Poor customer care.
- Little opportunity for innovation and learning in a timely manner.

d) The methods of data collection are considered burdensome rather than the collections themselves

The audits identified that the majority (71 per cent) thought that data collection is not considered to be burdensome or bureaucratic where it is clinically based and supports good professional practice. The 29 per cent of responses that did not support this view cited as the causes of bureaucracy the methods of collection or who had to complete the returns rather than the data collection itself.

39 per cent of respondents highlighted demographics and patient past medical history as the most common duplication

Illustrative example

In one Trust, the Safety Thermometer is completed by senior nurses and is considered to be a waste of their time because the processes involved in collecting and recording the data takes them away from direct patient care.

Issues

- Measure of burden and bureaucracy and its professional ownership.
- Data for direct care more highly valued.

e) Duplication is one of the biggest burdens

One of the biggest burdens reported through the audit is the duplication of information needed at various points throughout the patient journey. 39 per cent of respondents highlighted demographics and patient past medical history as the most common duplication.

Illustrative example

Demographics will be collected in A&E and then again on admission to a ward. A copy of the A&E Casualty (CAS) card will go to the admitting ward and yet the admitting ward will have their own forms that often duplicate information on the CAS card. Whilst it is often necessary and beneficial to repeat this type of information verbally to ensure that the right treatment is being given to the right patient, the repeated documented capture of information is burdensome.

Issues

- Control by forms: Burden and bureaucracy via internal organisational processes.
- Perhaps a disconnect between data standards in different systems.
- Duplication, waste and inefficiency.

f) Amount of new and changing data collections are a significant burden

There is a significant burden placed on Trusts in responding to new, changed and ad-hoc submissions to external organisations. An average of five national and five local targets/datasets were either newly introduced or changed within the 12 months preceding the audit.

Illustrative example

When asked about specific national returns 25 per cent of Trusts reported the Friends and Family Test as the biggest burden in a newly introduced dataset followed very closely by Maternity and Commissioning for Quality and Innovation (CQUIN).

Trusts report that the burden involved in responding to a new target/dataset is:

- Resources to implement new systems and data collection procedures (12 out of 16 Trusts reported a significant impact on resourcing).
- Costs for updates to 3rd-party systems (10 out of 16 Trusts).

The time for Trusts to implement systems to respond to a new target/dataset is reported between 6 months and 2 years.



Issues

- Burden and bureaucracy related to overly hasty timescales.
- Cost implications of those timescales via IT vendor.

g) Requests for information and the on-going management of data requests from commissioners have risen sharply this year.

Illustrative example

Of the Trusts audited one Trust has seen the average number of commissioners that it deals with increase from 6 to 18. Additionally each commissioner has introduced unique reporting requirements and as a result more intensive data management processes.

Illustrative example

Audited Trusts reported a vast burden as a result of queries originating from commissioners regarding the quality of activity data used in managing the provider contract.



Issues

- Disconnect between national standards and local demands which creates an unnecessary significant burden and bureaucracy which have been magnified by the number of commissioners.

h) Mismatches between captured and reported data

There appears to be a significant burden around managing mismatches between captured and reported data.

Illustrative example

A number of audited Trusts kept manual logs of the handover process between A&E and the ambulance service, in addition to data electronically captured at handover, as the electronic data used for discussing target breaches had proved unreliable. This local decision of duplicating imperfect electronic systems with a manual system was identified to be avoidable bureaucracy.

Issues

- Mixed paper and electronic systems which do not interoperate create burden and bureaucracy.
- Data transcription creates errors that affect data quality, organisational performance and/or patient safety.

i) Imposed targets result in additional perceived burden

Whilst the 4 hour wait target has had a positive impact on the patient experience in A&E departments, imposed targets result in additional perceived burden.

Illustrative example

100 per cent of admission units surveyed indicated that A&E breach times figure significantly in their daily operations. For example in one Trust the Medical Assessment Unit (MAU) ward is often put under huge pressure from A&E to accept patients but cannot transfer patients to the receiving wards as those wards do not discharge their patients until later in the day. To compound this the staff in the receiving wards are often too busy to organise necessary patient transfers from MAU to specialist wards.

Another Trust publishes escalations four times per day and holds daily operations meetings where the breach profile is discussed.

In yet another Trust, a dedicated coordinator attends escalation meetings with A&E, bed managers, the on-call medical manager and sometimes clinicians on a daily basis at 9.30am, 1pm and 4pm to manage the 4 hour wait target.

An end to end process and the availability of integrated systems covering at least admissions, bed management and discharge would remove the need for these burdensome and bureaucratic processes.



Issues

- Lack of system and process integration and support for the care pathway.

**Duplicating
imperfect
electronic systems
with a manual
one was identified
to be avoidable
bureaucracy**

2. Implementing processes

Technology alone does not reduce burden and can increase bureaucracy

a) No end-to-end data management processes in place to avoid duplication

Whilst there are data management processes in place, there is no evidence within the audited Trusts of systematic data management processes and practices that take account of data collection, availability and flow, particularly end-to-end across the patient journey to avoid duplication. Operational management of data typically focuses on individual wards or services.

Illustrative example

In one Medical Admissions Unit (MAU) staff copy the admittance pack details for a patient to their own admittance pack, by hand as the MAU doctors do not like the way information is recorded or the clerking methods that are used in A&E.

Issues

- Electronic handover under-developed.
- Professional record keeping standards.

b) Capturing and accessing data takes up a lot of time

Capturing and accessing data forms a significant part of a front-line clinician's activity.

Illustrative example

From observed ward rounds, **Table 1** (below) shows that an average of 66 per cent of a junior clinician's time is spent either accessing or updating patient notes. Whilst this, as an activity, is essential in the provision of high quality care for the patient, the amount of time may be reduced by improving the means of access.

Table 1
Average durations of activities observed through ward rounds.

Activity	Duration (approx mins)	Proportion of time
Discussion	16	11%
Patient notes (finding, reading, updating)	98	66%
Patient contact	35	24%

Illustrative example

A junior doctor was observed for approximately 90 minutes during and following the ward round and in that time spent approximately 10 minutes on direct patient care. The rest of the time was spent on finding notes, updating paper notes, telephoning for results and preparing discharge summaries. When questioned if this was a true representation of her working day, the junior doctor confirmed that out of eight working hours only about two hours are spent with the patient.

It is clear that finding and updating paper notes, together with the subsequent transcription of data from paper to electronic records and discharge letters, has a considerable resource impact. The evidence gathered from the audits would indicate that a significant amount of clinicians' time could be released if processes were streamlined through the implementation of integrated systems and technology.

Issues

- Electronic Patient Record (EPR) systems that are smart and can use existing data to create discharge summaries, enterprise wide access to all patient records within a Trust without multiple sign-ins, stopping dual systems of paper and electronic records.
- Burden and bureaucracy created by poor systems and poor implementation of them.

A significant amount of clinicians' time could be released if processes were streamlined through the implementation of integrated systems and technology

c) Methods and associated processes of data collection are considered burdensome

The methods and associated processes of data collection are considered burdensome:

- where they are not integrated into the flow of patient care
- where they involve mixed approaches, i.e. paper, electronic system or whiteboard, and
- where they do not appear to contribute to the direct care of the patient.

Many of these collections centre on collecting information to feed back into patient care such as national audits.

Figure 1

Perception of data collection burden and benefit

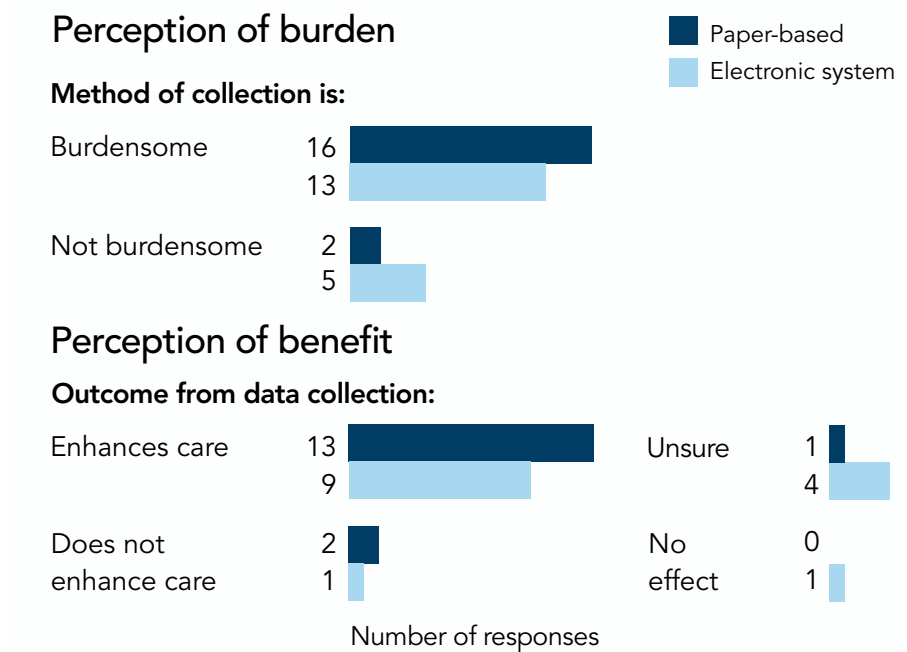


Figure 1 (above) shows that in both EPR enabled and paper based organisations collecting data is considered burdensome as well as enhancing patient care. This apparent tension supports the hypothesis that “the use of technology **and** smarter processes reduces burden and bureaucracy” but technology alone does not reduce burden and can increase bureaucracy.

d) Assessments are completed for all patients regardless of whether there is a clinical risk

Standard assessments are completed for all patients regardless of whether there is considered to be a clinical risk.

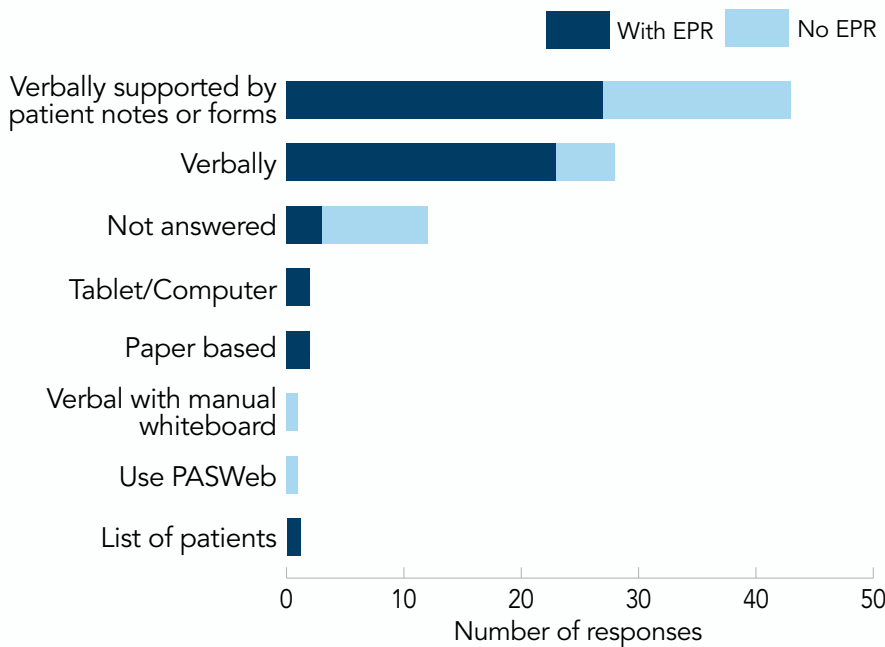
Illustrative example

In many medical admissions wards of the audited Trusts a Waterlow assessment form, which assesses the risk of bedsores, is completed for every patient irrespective of age, physical condition and expected length of stay. This highlights issues with the process in that it is either easier to complete the assessments for all patients or that the process is not sophisticated enough to make the judgement as to whether assessment is required or not.

i Issues

- Removal of clinical judgement by managerial policy creating burden and bureaucracy.
- Professional standards of record keeping.
- Measure of burden and professional support.

Figure 2
Methods of patient handover



e) Still a significant reliance on paper in most Trusts

Even in the more technologically mature Trusts there is still a significant reliance on paper. Across all participating Trusts, 77 per cent of respondents confirmed a requirement to record data on paper and subsequently transcribe it into the electronic system. This burden tends to fall on clerical and nursing staff.

Illustrative example

Figure 2 (above) shows that patient handover is still largely supported by verbal and paper based processes even in Trusts with an EPR.

77 per cent of all Trusts audited had a requirement to record data on paper and subsequently transcribe it into the electronic system

3. Technology adoption to minimise bureaucracy

85 per cent of audited maternity units used a local or bespoke electronic system, none of which are integrated with other Trust systems

a) An accessible, integrated Electronic Patient Record (EPR) would reduce perceived information burden

Staff in the audited Trusts felt that an accessible integrated EPR would reduce their perceived information burden by reducing duplication in entering information and by making information readily available from other departments and services. Whilst many electronic systems are in use within the audited Trusts, a large percentage are local or bespoke systems specific to a particular ward offering no integration with wider information systems.

Illustrative example

- 85 per cent of the audited maternity units use a local or bespoke electronic system, none of which are integrated with other Trust systems.
- 95 per cent of the audited stroke units use a local or bespoke electronic system, only 16 per cent of which are integrated with other Trust systems.
- 62 per cent of the audited A&E departments use local or bespoke electronic systems which are predominantly used to track 4 hour wait and ambulance check in/out, none of which are integrated with any other systems.
- 50 per cent of the audited MAU wards use some type of local system, none of which are integrated with other Trust systems.

Table 2

2i. Most important enhancement to improve patient care – percentage of responses

	A&E/ MAU	Maternity	Stroke	Average
Ease of access to information through better IT, integrated systems and mobile devices	75%	67%	57%	66%
Reduce duplication	14%	24%	27%	22%

2ii. Most important enhancement to improve clinicians’ patient-facing time

	A&E/ MAU	Maternity	Stroke	Total average
Ease of access to information through better IT, integrated systems and mobile devices	47%	62%	60%	56%
Reduce duplication	28%	29%	20%	26%

i Issues

- Duplication of data entry.
- Data transcription errors.
- Data silos.

b) Issues with systems accessibility and integration

The lack of systems integration, sharing of devices and security requirements result in the need to log in up to 100 times per day identified at some Trusts.

Accessibility of systems is fundamental to their adoption and routine use. Consideration must be given to deploying sufficient computers, tablets and smartphones together with biometrics, proximity sensors, smart logins, single view and persistent session technology to facilitate efficient and responsive system access.

Multiple partner systems, e.g. GP and ambulance systems result in multiple processes in the Trusts.

Illustrative example

One of the audited Trusts has two ambulance service providers. One service has an electronic system which provides advance notice of arrival and patient details and which is integrated with the Trust EPR. The other service has paper forms, requires manual handover and subsequent update to the Trust EPR.

i Issues

- Mixed systems.
- Mixed processes.
- Inconsistency.

The lack of systems integration, sharing of devices and security requirements result in the need to log in up to 100 times per day identified at some Trusts

Finding medical notes, entering data into the paper record and finding information in the record were viewed as the three most wasteful non-productive activities

c) Perceived most wasteful non-productive activities

Finding medical notes, entering data into the paper record and finding the required information in the paper record were identified by staff as the top three most wasteful non-productive activities across all care settings.

Illustrative example

Figure 3 (below) details the staff perception of most wasteful activities

It was noted, however, at the same time that staff in the audited Trusts who have an EPR, identified entering data into the EPR as a burdensome activity. The clear inference is that the available benefits of technology have not been realised in these organisations.

Illustrative example

In an audited Trust an A&E nurse manager has introduced a new manual form to replace the previous EPR process in order to save staff time.

Figure 3

Most wasteful activities carried out by clinicians (totals)

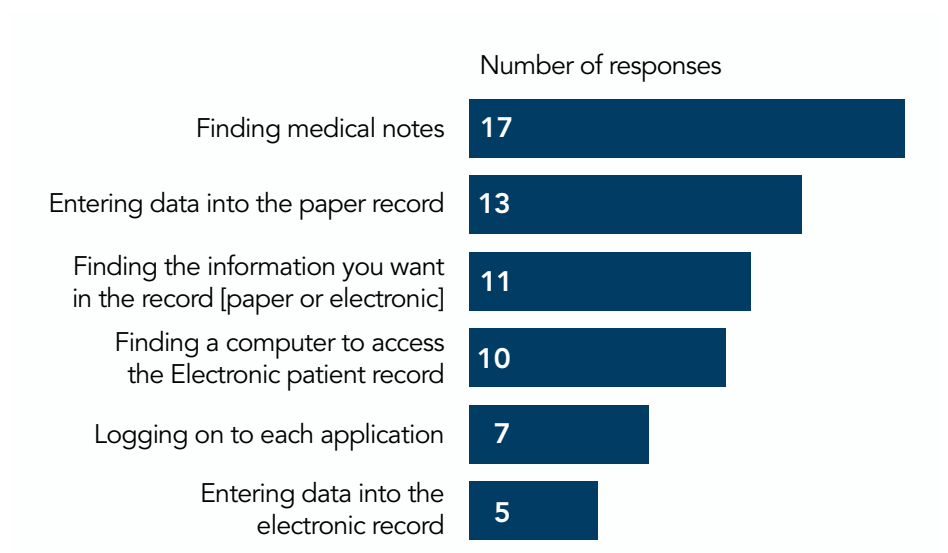


Table 3
Most wasteful non-productive activities; split by department type

	A&E/ MAU	Maternity	Stroke	Total
Finding medical notes	5	6	6	17
Entering data into the paper record	6	2	5	13
Finding the information you want in the record (paper or electronic)	3	5	3	11
Finding a computer to access the Electronic patient record	4	4	2	10
Logging on to each application	2	1	4	7
Entering data into the electronic record	1	3	1	5
	21	21	21	63

d) Most time-consuming manual process

The single most time-consuming manual process in the audited Trusts was identified as patient discharge.

Illustrative example

From the audited Trusts, this takes on average 30 minutes per patient for a junior doctor to perform. It involves collating information from a variety of paper, electronic and verbal sources including pathology results, radiology reports, clinical notes and medication reports.

Issues

- Technology not supporting efficient processes.
- Lack of business change.

e) Lack of computers or problems in accessing them

Lack of or inappropriately located devices contribute to the burden and bureaucracy experienced by staff by forcing processes to develop which involve paper recording and subsequent transcription to electronic systems.

The audit results show that there tend to be insufficient computers available to staff. It is interesting to note that administrative staff, who tend to have dedicated computers available in offices, are more likely to perceive sufficient access to computers. Some of the administrative 'no' responses came from the fact that although they saw sufficient numbers of computers for the administrative staff, they recognised there were insufficient numbers of computers on the wards. The split across care settings showed a tendency for maternity as a whole to have better access to computers, perhaps because they typically have an electronic record for clinical information.

Table 4
Do staff think there is sufficient access to computers?

All Care Settings

Role	Yes	No	Totals	% Yes
Admin	9	7	16	56%
Junior doctor/nurse	12	32	44	27%
Consultant	4	10	14	29%
Totals	21	27	48	43%

There is limited use of new and emerging technologies (34% of respondents) in the audited Trusts. In particular, tablets and smartphones were not in use in the majority of Trusts.

One Trust reported that the use of Computers on Wheels reduced the average duration of ward rounds by 45 minutes.

Recommendations

The following table summarises our recommendations itemised within the three themes of controlling burden and bureaucracy, implementing processes and technology adoption to minimise bureaucracy.






Recommendation priority

- ESSENTIAL**
 (do by) To increase the likelihood of a successful outcome the programme should take action in the near future
- RECOMMENDED** The programme should benefit from the uptake of this recommendation.



Controlling burden and bureaucracy

	Recommendation	Ownership	Priority	Status
1	There must be an open and transparent measure of the total cost of burden that is widely accepted as being valid particularly by NHS organisations and professions.	HSCIC, NHS England, DH		Work is in progress. Review July 2014.
2	New collections and extractions which are reliant on new data standards should have an appropriate implementation timescale for full conformance.	HSCIC, NHS England, DH		Work is in progress. Review July 2014.
3	All approved external data collections must include details of how the data will be used and what tools and feedback mechanisms are available to contributing organisations.	HSCIC (concordat)		With immediate effect
4	There must be a single set of comprehensive information standards for the patient record to support a range of requirements including transfer between systems and collections as extractions.	National Information Board (NIB), HSCIC, NHS England		Work is in progress. Review October 2014.
5	HSCIC to conduct further audits in Clinical Commissioning Groups (CCGs) to establish a rounded view as to the reasons for the reported increase in burden on Acute Trusts.	HSCIC, NHS England		Approved by the Programme Board. Review July 2014.
6	The concordat should be extended to cover CCGs and Local Area Teams (LATs).	HSCIC (concordat), NHS England		Review July 2014.

Implementing processes

	Recommendation	Ownership	Priority	Status
7	Review internal governance and consider developing and implementing an internal control system for managing and reducing the existing level of burden and bureaucracy	Trusts		Canvas Trust feedback at the workshop. Review via the self-assessment tool.
8	Develop a self-assessment tool and supporting toolkit to enable those Trusts not part of the audit to assess their position with respect to burden and bureaucracy.	HSCIC		Work is in progress. Review July 2014.
9	Consider the use of the self-assessment tool to develop a baseline view of the level of burden and bureaucracy that they currently experience. The baseline view should be reviewed at least annually to assess progress made and a refreshed baseline should be developed.	Trusts		Canvas Trust feedback at the workshop.
10	Consider offering an 'at cost' chargeable service to support Trusts in implementing the internal control system, complementing the self-assessment tool, implementing the toolkit, and performing local customised audits.	HSCIC		Canvas Trust feedback at the workshop.
11	When implementing targets, Trusts should assess the whole systems impact and processes to support the delivery of the target.	Trusts		With immediate effect. Review March 2015.

Technology adoption to minimise bureaucracy

	Recommendation	Ownership	Priority	Status
12	Ensure that investment decisions are assessed against criteria which drive clinical effectiveness, improve processes and reduce burden and bureaucracy.	Trusts		Work is in progress. Link to Technology Fund assessments. Review July 2014.
13	Review the implementation of existing technology and consider the implementation of new technology, in particular integrated systems to directly support care pathways and care settings.	Trusts		Canvas Trust feedback at the workshop. Review via the self-assessment tool.

 **ESSENTIAL**
(do by)

 **RECOMMENDED**

Recommendation 1

HSCIC, NHS England, DH

There must be an open and transparent measure of the total cost of burden that is widely accepted as being valid particularly by NHS organisations and professions.

- NHS Confederation made the following recommendation in their report Challenging Bureaucracy: “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”³.
- Organisations must understand the cost of data collections in order to construct their local business case.

Recommendation 2

HSCIC, NHS England, DH

New collections and extractions which are reliant on new data standards should have an appropriate implementation timescale for full conformance.

- The implementation timescale will have an impact on the cost of the data collection and will need to be part of the measure of the total cost of burden.
- The implementation timescale will also impact directly on the quality of the data collection.

Recommendation 3

HSCIC (concordat)

All approved external data collections must include details of how the data will be used and what tools and feedback mechanisms are available to contributing organisations.

- Contributing organisations must understand the justification and purpose of data collections in order to construct their business case.
- Data quality will improve as a function of feedback quality.
- A valid data collection will be of value to contributing organisations.

3 www.nhsconfed.org/Publications/reports/Pages/challenging-bureaucracy.aspx

Recommendation 4

NIB, HSCIC, NHS England

There must be a single set of comprehensive information standards for the patient record to support a range of requirements including transfer between systems and collections as extractions.

- Transfer between systems e.g. maternity and the EPR will be facilitated by data standards.
- In order to progress to data collections as extractions there must be a standard which Trust systems conform to.
- Data collections as extractions will reduce the perception and cost of burden.
- Data collections as extractions will reduce bureaucracy.
- Data quality will improve as a function of standards.

Recommendation 5

HSCIC, NHS England

HSCIC to conduct further audits in CCGs to establish a rounded view as to the reasons for the reported increase in burden on Acute Trusts. Additionally HSCIC will engage with NHS England to understand their requirements and the drivers for any actual increases in burden on Acute Trusts.

- Acute Trusts have consistently reported that the increase in the number of commissioners and the increase in the reporting requirements and associated query handling have significantly increased their burden. Further audits in CCGs will establish the reasons for this increase, highlight the level of burden within CCGs and assist in developing joint approaches to reducing the burden.
- NHS England is responsible for managing CCG development and will have an influence on the information and reporting requirements placed on CCGs.

Recommendation 6

HSCIC (concordat), NHS England

The concordat should be extended to cover CCGs and Local Area Teams (LATs).

- CCGs and LATs are introducing new burden on Trusts by not conforming to national standards.

Recommendation 7

Trusts

Review internal governance and consider developing and implementing an internal control system for managing and reducing the existing level of burden and bureaucracy.

- Organisational ownership is fundamental to the effective management of data collections, the subsequent burden and bureaucracy that the organisation experiences, the resulting costs and ultimately the value that is returned to the organisation or the greater NHS.
- EPRs are safety critical systems and so access to them and business continuity using them is crucial, and policies and procedures to support these should be in place.
- All data collections have a cost and resource requirement to the organisation and should be treated consistently with requests for staff, equipment or services i.e. they must be subject to standing organisational governance including the requirement for a business case.
- Data collection processes should be designed to fit within the care pathway and care setting. That is, data should be collected as part of the clinical processes and not as an exercise in its own right. Trusts should be encouraged and supported to implement Trust-wide business process reviews and redesign across the entire patient journey, whether that is electronically or manually. Ownership for documentation across a pathway should be clear.
- As with the roles of Caldicott Guardian and Infection Control Lead the management of burden and bureaucracy and the implementation of the internal control system will benefit from an identified Senior Responsible Owner.
- The implementation of the internal control system will have a range of benefits with varying timescales. Trusts must monitor the progress of implementation to ensure that the benefits are being realised and to quickly respond to lessons learned during the implementation process.

Recommendation 8

HSCIC

Develop a self-assessment tool and supporting toolkit to enable those Trusts not part of the audit to assess their position with respect to burden and bureaucracy.

- In order to own and effectively control burden and bureaucracy, particularly as a result of data collections, organisations must first understand the scope and scale of the issues which they need to address.
- A self-assessment tool will provide a consistent and supported means of assessing an organisation's position with respect to the control of burden and bureaucracy.
- The supporting toolkit will:
 - accelerate the process of reducing burden and bureaucracy
 - ensure consistency of approach
 - provide methods to reduce the amount of local resource required to manage and perform data collections.

Recommendation 9

Trusts

Consider the use of the self-assessment tool to develop a baseline view of the level of burden and bureaucracy that they currently experience. The baseline view should be reviewed at least annually to assess progress made and a refreshed baseline should be developed.

- Without a baseline view, organisations will not be able to track or quantify the benefits that they are realising.
- The baseline view will be established using a number of indicators, including scoring from the self-assessment tool and locally defined measures that can be quantified in a comparable way, e.g. as clinician time.
- The ultimate goal of any reduction in burden and bureaucracy is to increase clinicians' availability to deliver direct patient care.
- The audit has highlighted that inappropriate data collections and resultant ad-hoc processes develop in organisations over time.
- Annual or more frequent review using a consistent approach will allow the Trust and HSCIC to understand and demonstrate progress.
- The self-assessment tool will provide a consistent and supported means of assessing an organisations position with respect to the management of burden and bureaucracy.

Recommendation 10

HSCIC

Consider offering an 'at cost' chargeable service to support Trusts in implementing the internal control system, complementing the self-assessment tool, implementing the toolkit, and performing local customised audits.

- Expertise exists within HSCIC which can usefully support the Trusts in reducing burden and bureaucracy.
- Trusts will vary in their own capacity and capability to successfully deliver requirements of an effective burden and bureaucracy reduction strategy.

Recommendation 11

Trusts

When implementing targets, Trusts should assess the whole systems impact and processes to support the delivery of the target.

- Simply implementing a target such as A&E 4 hour wait in one department will have significant unanticipated ripple effects throughout an organisation.
- Trusts must consider targets within the end to end patient pathway and implement systems and processes holistically to support both the pathway and the achievement of the target.

Recommendation 12

Trusts

Ensure that investment decisions are assessed against criteria which drive clinical effectiveness, improve processes and reduce burden and bureaucracy.

- Systems and technology implementations alone will not guarantee improvements to clinical effectiveness, processes or reductions to burden and bureaucracy.
- Consideration must be given to how systems and technology together with ongoing business change and process improvement can be used to achieve these objectives.
- The Local Service Provider (LSP) contracts have delivered significant capability through the deployment of products and services and it will be important to continue to leverage the value of these investments.
- Achievement of progress against the Clinical Digital Maturity Index (CDMI) and access to the Technology Fund will facilitate investment decisions and potential sources of investment.

Recommendation 13

Trusts

Review the implementation of existing technology and consider the implementation of new technology and in particular EPRs to directly support care pathways and care settings.

- There is currently a mixed economy of paper and electronic records that leads to duplication in data capture and processing.
- Rather than force processes as a result of technology implementations technology should be implemented to support care pathways, settings and processes.
- EPRs integrated into care pathways and care settings using data standards will support effective and efficient data collection, audit, and reuse including data collection as extraction.
- Any strategy to see the widespread implementation of integrated EPRs across Acute Trusts should take care to ensure that there are sufficient and accessible devices supported by ease of use at the point of care to ensure a true reduction in burden.
- New and emerging technologies can provide significant benefits not least in reducing actual and perceived burden, but only if they are implemented as part of a clearly defined process and are supported and maintained.

Conclusions

Much work has been completed or is underway to further improve the actual and perceived burden and bureaucracy experienced by NHS organisations including:

- **Burden Advice and Assessment Service (BAAS)**
(formerly *Review of Central Returns/ROCR*)
Reviews and assesses the burden of all data returns to ensure that information demands on the NHS are minimised, there is a clear business justification for collecting data, and collections are carried out in the most efficient way without duplication.
- **Establishment of the Information Standards and Collections (including Extractions) (ISCEG) process**
New structures, processes and outcomes to validate the development of new data collections and systems.
- **NHS Confederation “Challenging Bureaucracy” report and actions**
Focuses largely on central returns and proposes a set of actions for HSCIC and others.
- **Development of care.data**
An open data approach supporting a “pull” model of data availability rather than a “push” model of data collection.
- **National Tariff Service**
(SUS replacement).
- **Concordat**
Applying controls to data collections by national bodies.

By collectively and collaboratively implementing the recommendations, as detailed in the previous sections, actual burden and bureaucracy and the experience of that burden and bureaucracy will be reduced.

Should they choose to implement the recommendations, Trusts will be in a better position to understand the baseline for their organisation and what steps need to be taken next in order to reduce the level of burden and bureaucracy within their own organisation.

Additionally, by conducting further audits in CCGs, a rounded view will be gained of the factors contributing to the perceived increase in burden

By collectively and collaboratively implementing the recommendations, actual burden and bureaucracy and the experience of that burden and bureaucracy will be reduced

resulting from the recent changes to commissioning and the associated reporting requirements.

At a national level, important next steps will be:

- the drive for standards by NIB
- the effect of the concordat
- the implementation of the HSCIC strategy, and
- the exploration of how stronger links can be developed between the outputs of this programme, the Clinical Digital Maturity Index and access to the Technology Fund to provide Trusts with the necessary support tools to strengthen their own Information Management and Technology strategy.

It will also be important to continue to leverage the value of local investments and investments made under the LSP contracts.

In addition the next phase of the HSCIC Busting Bureaucracy programme will focus on overseeing and supporting the use of the self assessment tool and the toolkit.

It should be recognised that Community and Mental Health Trusts face some similar but also some very different challenges to Acute Trusts and HSCIC should consider conducting further audit exercises in community and mental health care settings to assess the level of burden and bureaucracy in those organisations.

Appendix A

Audit method

Five hypotheses were used as the basis for the development of the audit method. The five hypotheses were as follows:

Hypothesis 1: nurses and doctors spend a significant amount of time per week on bureaucracy.

Hypothesis 2: the use of technology and smarter processes reduces burden and bureaucracy.

Hypothesis 3: the use of technology releases clinical staff time (which could positively contribute to the time to care).

Hypothesis 4: the better the local systems are, the better the acute provider is able to meet reporting needs.

Hypothesis 5: a national concordat would have a positive impact on reducing burden.

The Busting Bureaucracy collaborative audit was conducted in 16 Acute Trusts (10 per cent of the total number of NHS Acute Trusts) over a period of three weeks starting 30 September 2013.

Each audit was carried out by an HSCIC auditor supported by a Trust corporate information lead and a Trust clinical champion, on-site at each Trust for one week, focusing on the following areas:

- corporate audit
 - corporate submissions, information/planning (1 day)
- front line audit
 - stroke service (1 day)
 - accident and emergency (A&E) (1/2 day) with follow on to medical admission ward (1/2 day)
 - maternity (1 day).

At a minimum, each audit was designed to cover the following in each care setting:

- completion of a 'one-time' questionnaire with:
 - consultant
 - junior doctor
 - ward manager
 - sister

- observation of the role of the receptionist/ward clerk, particularly for an admission and discharge
- shadowing a ward round, in care settings where these take place
- observation of an admission
- observation of a discharge
- observation of an outpatient clinic, in care settings where these take place.

Additionally the following were conducted in A&E:

- observation of minors triage
- observation of ambulance triage.

Auditors completed a questionnaire for each setting, and these were submitted to a pool of audit analysts for analysis. Additionally the auditors compiled an audit report a copy of which was delivered to the participating Trust. This summarised the key findings for that particular Trust, closing the initial loop with the Trusts and thanking them for their involvement.

Completed questionnaires for each Trust are maintained by the HSCIC team.

The questionnaires used for the audit were drafted internally within HSCIC with input from members of staff with clinical and managerial backgrounds. These were then kindly reviewed by staff from Bradford Teaching Hospitals NHS Foundation Trust and Professor Martin Severs - Chairman of Information Standards Board for Health and Social Care. The questionnaires and audit method were then piloted and refined in Bradford Teaching Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Calderdale and Huddersfield NHS Foundation Trust.

The audits should be considered 'management studies' rather than statistically significant 'academic studies'.

It was the policy of this audit write-up not to name Trusts that were not thought to be managing its bureaucracy as effectively as others.

Appendix B

Audit analysis

- The completed questionnaires from the audit were collated by a team of audit analysts. In order to achieve consistency in the analysis each analyst was assigned one of the four audit areas (Corporate, A&E, Maternity, Stroke) and produced a single consolidated analysis for that area. This analysis sheet focused on quantitative analysis and common themes.
- A further consolidated sheet was produced that brought all the responses from each Trust together in a single view.
- Finally a summary report was produced for each audit area.
- A quality assurance review ran in parallel to the analysis activity. The collated results were each traced back to the original returns to ensure that interpretation was applied consistently by the analysts.
- The final analysis of the consolidated results involved four analysts, each reviewing an audit area other than the one which they had originally compiled. Two further analysts produced and reviewed an overall view across all settings and Trusts. Peer review was then used to validate the findings.

Appendix C

Our role on managing burden and bureaucracy

The HSCIC has a statutory duty to ensure that the amount of time and effort involved in administration and bureaucracy is kept to a minimum to allow health and care professionals to devote as much time as possible to providing care to people who need it.

We must ensure that the work associated with the collection and submission of national data collections does not detract from direct care and services. The Department of Health' information strategy, "The Power of Information"¹ set out the strategic intention that we act as the main hub for managing the national data collections from health, public health and social care. We do not manage all the collections ourselves, but we have an oversight role for the system as a whole.

We have a key role to play across the health and social care system to reduce or broker reductions in the burden of gathering and submitting data for national collections across the health and care system – not just those submitted to the HSCIC, but also those generated for other purposes, such as regulation or local commissioning.

There are many aspects to the way we contribute to the reduction of bureaucracy:

- The HSCIC acts as the single gateway for approving and managing the national data collections. As set out in the new concordat, all national organisations who require information from front line organisations must in future approach the HSCIC to:
 - discuss their requirements, to identify whether the information is already available
 - if it is not available, to discuss how best to obtain the information
 - agree the content and format of new national collections or extractions, including any requirement for new information standards, and to calculate the "burden" impact arising from the collection.
- The HSCIC does not manage all the national collections and extractions. Other national organisations manage some collections for themselves. The national organisations have agreed a set of criteria for deciding how new national collections and extractions should be handled. The new concordat anticipates that, over time the HSCIC will take greater responsibility for more of the national collections.

¹ www.gov.uk/government/publications/giving-people-control-of-the-health-and-care-information-they-need

- The HSCIC publishes a list of all national collections that have been approved in this way, and includes the cost of collecting the data, the business justification for the collection, and the review date for each collection. The list is subject to ongoing review, and every three years, the HSCIC must provide a report to the Secretary of State for Health on the management and reduction of “burden”.
- The HSCIC uses a standard methodology for calculating burden generated by national data collections. This is kept under review and is available for all organisations to use.
- The HSCIC works with the National Information Board (NIB) which has been established to bring some collective strategic direction to the commissioning of informatics services. All national organisations are active members of the NIB. A subgroup of the NIB has been established to ensure that national data collections and extractions are underpinned appropriately by information standards. This subgroup, the Standardisation Committee for Care Information (SCCI) will have an important role to play in ensuring the national organisations manage this agenda in a co-ordinated and consistent way.
- The national organisations have agreed to share information they collect, in the interests of reducing unnecessary and duplicate requests for information.
- The HSCIC has an important role to play in designing and implementing standards that are used to ensure that information is captured in consistent ways, which helps keep unnecessary “burden” to a minimum, and enables greater use of extraction tools, locally and nationally.
- The HSCIC’s website is an important resource. As well as publishing the list of national collections, we also publish a range of self-assessment and audit tools which local service providers can use to measure the impact of burden and bureaucracy. The tools enable service providers to publish the details of these self-assessments, so that they can benchmark with other organisations. The website also includes discussion boards, case studies and guidelines for good practice.
- National and local organisations can commission the HSCIC to run audit and assessment studies as part of their local improvement programmes, such as via recent collaborative bureaucracy audits.
- The HSCIC can provide advice and guidance on practical issues relating to informatics skills and capabilities. These issues may involve the use of information standards, the design of information systems and processes that maximise the potential for technology to reduce inefficiencies, or they may involve staff training needs.

- The national technology and services that the HSCIC delivers all help local organisations to provide efficient healthcare services and contribute towards the goal of achieving a paperless NHS by 2018. They include the N3 network which supports safe communication and data sharing, the Spine service for accessing reliable patient information, the e-referrals service, and others.
- Over the next three years, as HSCIC supports the Department of Health in managing the LSP contracts to their expiry, the systems already deployed continue to play a critical role in reducing bureaucracy. They are used by 490,000 NHS staff in 239 NHS Trusts and now form critical NHS infrastructure. The NHS relies on these systems to track patients, order tests and receive results, and prescribe medicines. A major focus is the use of the existing deployed technology ('sweating the assets') to deliver efficient, safe and responsive services that help care professionals reduce the amount of time they need to spend on unnecessary burden and bureaucracy that takes them away from direct care-giving activities. In readiness for the contract expiry in 2015/16, HSCIC will support a safe and secure exit from the contracts to locally procured replacement products.
- The HSCIC publishes data in raw formats, without patient identifiers, for anybody to use for analytical purposes. We are the main supplier of national indicators such as those used in the national Outcomes Frameworks. We also publish reports on Official, National and Experimental Statistics. These enable organisations to access a wide range of key national information relatively easily. It covers activity data, population-based information and reference data. These help make the local analyses and reporting more efficient as a result. They also help build trust and confidence in the information and indicators, as people can see the way the information has been acquired, or the way the indicators have been calculated.
- Mindful of the "collect once, use many times" principle, the HSCIC will increase the number of standard reports or analytical packages it makes available, as this helps local organisations in their own benchmarking work.

We have said in our Strategy that we will do the following by March 2015:

1. Work with our partners to implement a national concordat which demonstrates our collective commitment to collaborate to manage and reduce the burden and bureaucracy for service providers.
2. Implement common data services that can be used by our partners to accelerate the adoption of more efficient methods for data collections and extractions.
3. Agree memoranda of understanding and the core performance standards with our key customers.
4. Publish on our website a range of tools that can be used for self-assessment and benchmarking purposes.
5. Identify opportunities for consolidating reporting and publication of indicators and information into standard formats which can be made available to all.
6. Contribute to the strategic planning for achieving a paperless health and care system.
7. Increase the use of standard data formats for routine outputs and reports to improve our own efficiency and stimulate wider use of these outputs for local analytical or reporting purposes.
8. Extend the national campaign to other care settings and to consider the impacts on local health economies.

Appendix D

Implementing the concordat

In the future, all organisations requiring data to be collected from care providers must work through the HSCIC to ensure that the requirements: have a clear business purpose; are underpinned by the use of information standards; and that the administrative burden involved in the collection process is kept to a reasonable level. The new arrangements will also allow for service providers to charge for the provision of information to national organisations which have not been through this process.

The Secretary of State has asked all the national bodies to collaborate on the reduction of administrative burden, through a joint concordat. Accordingly, to support this protocol, the HSCIC will agree memoranda of understanding with each of the national bodies. These memoranda will establish service levels for meeting their data requirements and targets for reducing the impact on direct care organisations. As part of these memoranda, we will commit to a set of core standards that will underpin our performance.

As a minimum, the standards will address:

- Rapid and responsive turnaround of the information it receives so that it is available for use within an agreed timeframe.
- Reporting on the accuracy and completeness of the data it provides and the information it publishes.

Initially, in 2013/14, our efforts focus on the national information requirements mainly from AcuteTrusts. During 2014/15, it will be expanded to include all care settings, and to include information exchanges between local commissioners and providers of services, including services managed by Commissioning Support Units and our Data Services for Commissioners.

Notes

Busting Bureaucracy

Collaborative audit findings and recommendations

Published by the Health and Social Care Information Centre

Version 1.1

May 2014

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