NHS Improvement

**To:** The Board

**For meeting on:** 30 November 2017

**Agenda item:** 8

**Report by:** Bob Alexander, Executive Director of Resources and deputy Chief Executive

**Report on:** Deregulation and data duplication

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## Introduction

1. This report provides the Board with an update on NHS Improvement's efforts to address regulatory burden and data duplication. This is a follow on report from the paper on 'Reducing the Regulatory Burden' tabled at Board on 20 July 2017.

2. The Board is asked to note the progress made against the action plan set out in the last update to the Board in July 2017.

## Background

3. In 2016, the Department of Health established a burden reduction challenge panel to reduce the burden of red tape across the healthcare system. It described regulatory burden as the burden on trusts due to information requests and data collection, in line with the NHS Confederation's Challenge Bureaucracy 2013 report definition:

    a) *"Bureaucracy is unnecessarily burdensome, for example, when a) national bodies request that providers collect and record information that does not add value; b) there is excessive validation and follow up on data requests, either within trusts, by commissioners or regulators; c) information is requested by multiple bodies and in different formats; and d) information requirements change regularly."*

4. Identified as the first topic for exploration, the burden faced by providers in responding to requests for data is a longstanding area of interest and surveys of NHS Providers have suggested that this burden is felt to be high. Additionally, a recent NHS Improvement/Provider meeting to discuss data burden fed back that

one of the key areas where national organisations can support the sector is to reduce the burden of data collection, assurance and reporting.

5. We have committed to investigating what NHS Improvement can do to streamline our demands, and ultimately reduce the burden on providers. This report provides an update on progress on the action plan previously agreed.

**Progress on Action Plan**

| Agreed Outputs | Update |
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| a) Progress immediate actions to streamline **A&E** data collection processes: specifically:<br><br>i) Automate data collection as per ECIP in all trusts, prior to winter 2017;<br>ii) Produce a standard dashboard to play back data to providers; and<br>iii) Share data with NHS England and other Arm's Length Bodies (ALB's), to facilitate generation of one source of truth. | <u>Progress on what are collecting</u><br><br>The electronic Sitrep is not only reducing burden but also increasing the value of the information for improvement purposes as we are moving to site level collection. Burden will also be reduced as the collection is now national will be in place all year round. This has been considered too high a burden to implement in the past but is now possible as providers don't need to manually enter the data.<br><br>The solution enables secure submission of real time metric data to a cloud based hub. The solution also enables providers to retain control to validate and adjust their data. The solution is using technology designed for large scale real time data streaming. For the Sitrep reporting - Currently we have 11 trusts live that are only using the automated system; 41 in total are sending in reconciled data; 87 have sent in SitRep test data (ECIP + others); 92 in total have registered for portal access.<br><br>We are currently forecasting to complete 75% of providers by January 2018. Note: Those not able to move at this pace can still enter data manually using the existing webfom. We are working with the BI team to try and get 100 providers live by Christmas.<br><br>As part of the work on the national emergency care dashboard we are also exploring additional metrics from other parts of the system.<br><br>The dashboard is produced by NHS Improvement for use by the winter room but from week commencing 23 November 2017 will be opened up so that providers also have access to it. |

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| | We have worked with NHSD to setup a near real time stream of NHS111 metrics every 15 minutes from that providers insight on patients being referred to A&E. We are also exploring PHE sourced metrics for syndromic indicators for flu, COPD, norvirus.<br>We are also using the solution to receive the ECIP collection from providers. This collection will be reviewed once we complete the transition to the new Sitrep<br><br>Further automation<br><br>The solution has been designed to be extensible and could be easily extended to incorporate other metric based collections with a view to move to more real time KPI's' Once the platform is in place adding new collections is straight forward for providers. We could also extend the service to provide real time information for patients i.e. waiting times. We have agreement with NHSE to explore this in Q1 2018 but have prioritised reducing the burden first for the majority of providers |
| b) Progress immediate actions to streamline data collection processes relating to **Agency Cap Returns**: namely:<br><br>i) Review necessity and frequency of data collection, with a view to move away from weekly collection, and reduce volume of data<br>ii) Consider possibility of earned autonomy principle, to reduce burden on better performing trusts | i) In terms of agency data we are continually reviewing whether the datasets we collect are absolutely necessary for the dynamic programme that we are running. To this end we decided as from October to discontinue the weekly collection of the 'maximum wage rate', which our ongoing discussions with trusts identified was the most burdensome dataset that we collected. This is a useful metric, but one that can now be derived from other data that is collected, hence the decision to cease this collection. We have also as previously indicated introduced earned autonomy for trusts with a lower risk SOF score, which allows them to submit certain lines of data monthly rather than weekly.<br><br>ii) See above<br><br>iii) We have made significant progress in this area, and are close to agreeing a data sharing agreement with DH, and already have one in place with NHS Professionals. In addition we have worked with colleagues in Operational Productivity in order to develop a temporary staffing module of the Model |

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| iii) Address IG challenges regarding sharing data across ALB's and with providers | Hospital, which will allow trusts safe access to a range of agency and bank spend data including benchmarking between trusts. |
| c) Progress immediate actions to streamline data collection processes relating to Model Hospital Metrics Reporting: namely:<br><br>i) Provide greater visibility on which metrics are new vs. existing<br>ii) Introduce a gated process to control movement of metrics from voluntary to mandatory requests<br>iii) Share good practice on presentation with other analytical teams in NHS Improvement | i) Our data asset register indicates the new vs existing data collections. A summary of this is available internally and can be published on the NHS Improvement intranet, if required. In addition, our new Information Assurance Lead is now in post in Op Prod and will ensure direct visibility and co-ordination of data assets into corporate Data & Tech repositories, etc. Within the tool we indicate which are 'new' measures for end users and we are plugging into local indicator governance processes across NHS Improvement. We are engaging widely, looking to go out to all teams within NHS Improvement to demonstrate access and promote use. We have a plan to transition all data into the central Strategic Information Platform (SIP) by the end of 2017.<br><br>ii) Most of the Model Hospital indicators use existing data assets and we squeeze further value and utility out of existing collected data. There are already national processes (National Data Collection Board/ BAAS) on how to mandate a data request and convert it from voluntary to mandatory, which we will follow. We have been liaising with the Information and Analytics Team to ensure we follow the correct procedures for future datasets. We have a number of voluntary, exploratory datasets used in the Model Hospital.<br><br>These are tested with a small sample of trusts to reduce the burden and the results are fed back to organisations through the Model Hospital website. If the dataset is deemed useful by trusts and NHS Improvement we will go through the established process to mandate them following corporate indicator governance processes. If the data is useful and fed back to trusts, then it should not be seen as a burden. |

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| | iii) The Model Hospital is engaging with Regional Productivity Directors as well as SROs to ensure that we deliver a consistent and clear visualisation of metrics to them. The Model Hospital product uses clear visualisations of data and the presentation has been validated with trusts. We follow the principles of User-Centred-Design, focusing on user needs and agile product development. The data behind within the product has been fully tested and has clear meta data. In addition, it has been added to the overall NHS Improvement Data Asset registry to ensure that we are not duplicating information. We are also working with the CQC to ensure we are joined up on meta data for metrics. |
| d) Arrange a session with NHS England/Matthew Swindell, and organise a **provider session,** to illustrate what NHS Improvement have done / are doing to reduce data burden on providers; | NHS England and NHS Digital are both involved in and taking a close interest in the A&E automation project due to the potential benefits in burden reduction on providers and the transferable nature of this development to other data collections.<br><br>The project is still at an early stage and once it has "gone live" with the majority of acute trusts we will convene a meeting of the Arm's Length Bodies to review the benefits that have been realised, and agree a plan to see how the technology could be rolled out to support other national data collections. We will keep providers sighted on this important work area. |

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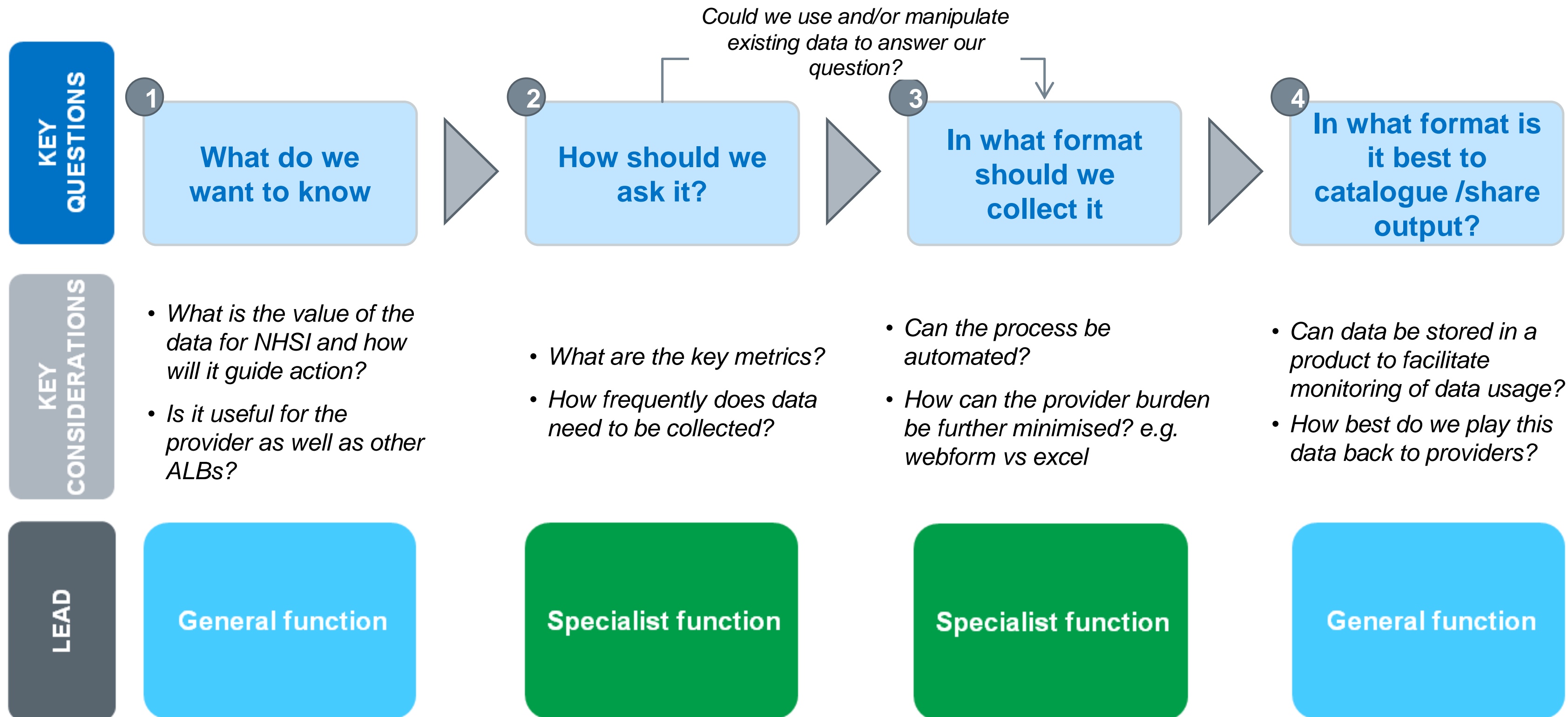
| e) Develop a set of guiding principles (to apply to all data collection requests to ensure they are as valuable, transparent and simple as possible) on which to base the development of an NHS Improvement burden reduction plan;<br><br>f) Develop, agree and roll out an internal mechanism to ensure future data requests adhere to the guiding principles (see Appendix 1 for draft process) | Appendix 1 sets out the internal mechanism to be followed to ensure future data collections adhere to the guiding principles.<br><br>The first stage in introducing the new process is to establish a baseline of existing NHS Improvement collections and data requests from providers We propose to undertake this baselining exercise for a 3 month period from January to March 2018. To minimise the impact this may have on people in NHS Improvement, and also not to delay any requests for data from going out, we will establish a simple electronic ticketing system which will just require the owner of the data request to log the detail of what is being asked for, who from and for what purpose. Each request will then be allocated a log number. This process is purely in the first instance to establish a baseline of requests and so no judgment or approval for the collection will be made.<br><br>Once the baseline is established, and we can introduce the new internal mechanism as set out in Appendix 1, there needs to be a discussion with the Executive Team to agree if we should introduce an internal gateway process to oversee all new data collections so that no request for data can be made by NHS Improvement without it having a gateway number. |
| g) Discuss NHS Improvement's burden reduction plan, guiding principles and internal data request process at the next **NHS Improvement and NHS Digital Joint Collaboration Quarterly Board**. | Burden reduction has now been added as a standing agenda item on the NHS Improvement and NHS Digital Joint Collaboration Quarterly Board meeting. |

## Appendix 1: Internal mechanism to ensure future data requests adhere to the guiding principles

j) Building from the guiding principles, we propose implementing a formal internal process design for new data collection requests, that comprises experts in content design, standard patterns of collection and a process for review and retirement:




***Should we include an internal gateway to oversee all new data requests?***