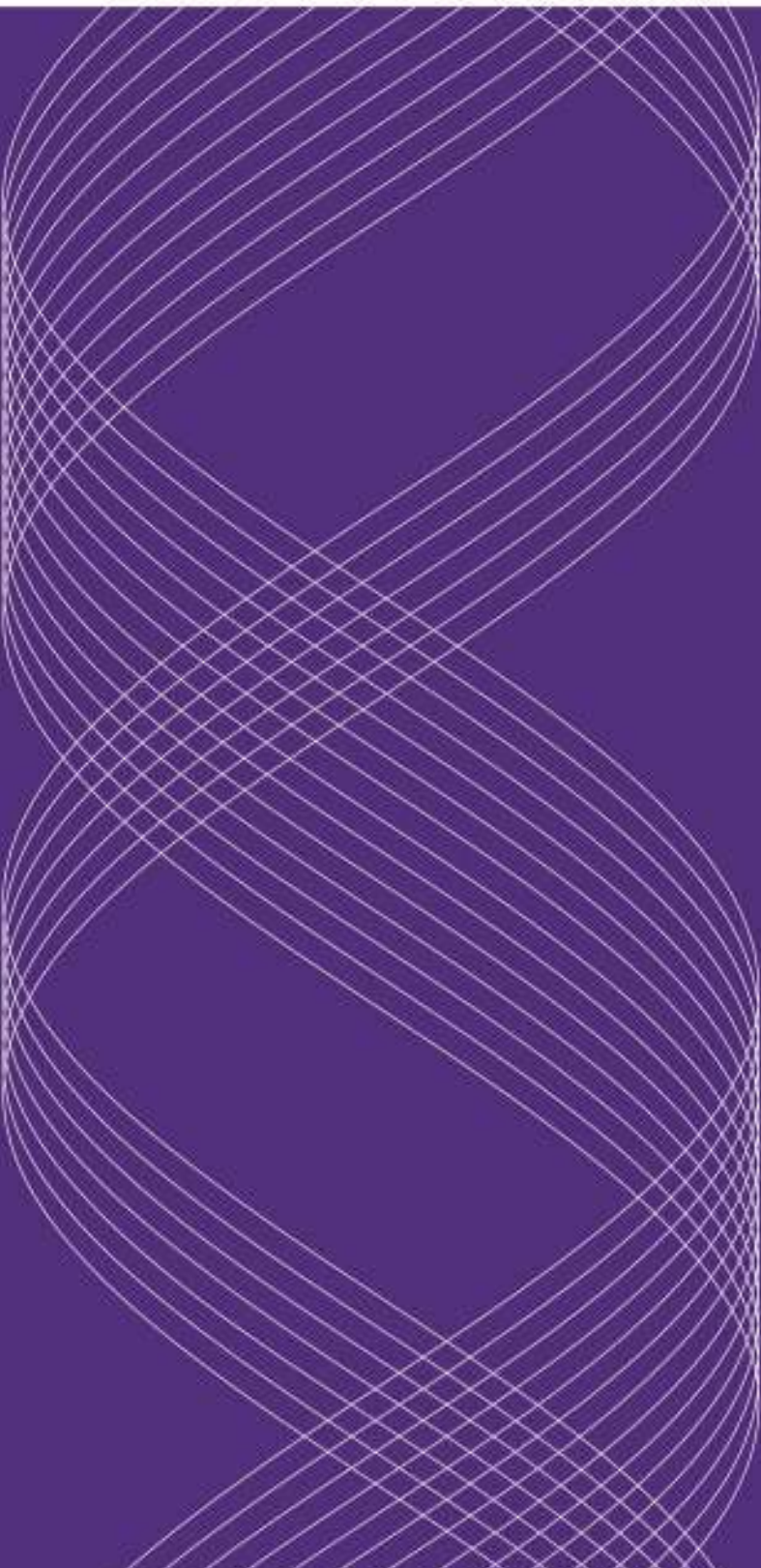


Making a Difference: Safe and Secure Data Sharing Between Health and Adult Social Care Staff





Making a Difference:
Safe and Secure Data Sharing
Between Health and Adult
Social Care Staff

FOREWORD BY:

RT. Hon. Jane Kennedy MP, Minister of State for Delivery, Quality and Patient Safety

Jim Murphy MP, Parliamentary Secretary at the Cabinet Office

The government is committed to providing the best quality public services.

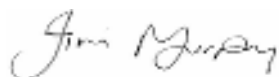
A key challenge is to create a world class health service for the people of this country. In particular, a health service where patients are at the centre of safe and high quality care and enjoy fast access to the best modern treatment available. Where the people who deliver care are able to make the best use of their potential and have the time and resources to respond to local needs.

We recognise that delivering this world class service depends both on effective data sharing across health and adult social care staff and the confidence of the public that data sharing is appropriate, controlled and visible. As such, there is work currently underway to develop a cross-government strategic approach to data sharing. It is envisaged that this work will provide a much needed clear approach to sharing data across health and adult social care services.

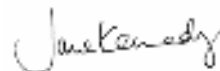
In the short term, this report suggests some practical ways to address the perceived lack of clarity regarding data sharing between health and adult social care staff and identifies work that is already underway.

From a patient perspective, this work will not relax existing controls over the security, confidentiality and sharing of patient identifiable information but will add clarity to ensure that all staff are clear about their responsibilities and patients have peace of mind over data sharing.

By clarifying the policies and guidance around data sharing and reducing some of the burden of unnecessary information requests, health and adult social care staff will be able to focus on what they do best – delivering world class health and adult social care.



Jim Murphy



Jane Kennedy

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SUMMARY OF OUTCOMES	
Outcomes	Implementation Date
Patient Record Requests	
1. There is a rebuttable presumption, agreed by the Law Society, Association of British Insurers and the Association of Personal Injury Lawyers that subject to the expert witnesses view, no patient records will be requested for claims below £10,000 ¹ .	June 2006
Legislation on data sharing	
2. The Department of Health in incorporating the outcomes of the review of Information Governance and in conjunction with the Care Record Development Board will review and streamline, where necessary, existing policies and guidance around sharing information between health and adult social care organisations. This will include identifying when data needs to be shared and what data this is and clarifying the requirements for patient/service user consent. The Department of Health in conjunction with the Care Record Development Board and groups representing patient and service users will develop a single information sharing protocol for health and adult social care staff.	December 2006
Medical Research	
3. The Department of Health will develop and issue a single set of guidance on the secondary uses of personal information for medical research, population health and management. This will take account of the recommendations of the Academy of Medical Sciences and of the Council for Science and Technology, the views of frontline staff and of appropriate patient and service user groups. This guidance will promote consistent interpretation of the legislation on the use of patient information for research purposes, and will provide clarity for frontline staff, patients and service users. It will also explore solutions based on anonymisation of personal data.	September 2006

¹ Practitioners should think about how necessary the patient records are to the particular case and whether they need to see them, since the purpose of this outcome measure is to try to reduce burdens on GPs and other health professionals. Practitioners should note it is not an absolute bar to seeking patient records and they can always be sought if the solicitor deems it necessary to do so. This outcome does not amend the personal injury pre-action protocol or patient's rights to see their own records.

EXECUTIVE SUMMARY

It has been increasingly recognised that effective and intelligent sharing of information within the public sector is crucial for the delivery of modern, high-quality services. Nevertheless, there needs to be a balance between personal privacy and the need for public authorities to share personal data in the delivery of public services. The NHS has taken steps to clarify how it will deal with patient identifiable information by publishing the NHS Care Record Guarantee for England.²

Within the context of the report, 'data' is defined as all factual information that can be used to support the delivery of patient care.

A great deal of data can and should be shared within the existing procedural, professional and legal frameworks. However, persistent confusion exists amongst practitioners and professionals over the interpretation of data sharing legislation. This confusion stems from the perception that the Data Protection Act is vague and lacks sufficient detail required at grass-roots.

This *Making a Difference: Safe and secure data sharing between health and adult social care staff* report, suggests practical changes for delivery that will reduce unnecessary bureaucracy associated with dealing with requests for information and clarify information sharing requirements within the **health and adult social care sectors** whilst respecting the need to maintain patient confidentiality and information security.

Key issues identified during fieldwork and included in this report are:

- Increased numbers of patient record requests as a result of personal injury claims;
- Confusion about the legal position on data sharing and existing guidance from central government departments and professional bodies, particularly around the common law duty of confidentiality and Data Protection Act; and
- A lack of clarity around gaining patient consent to share information for medical research.

The report outlines agreed actions that will yield the following benefits:

- a reduction of patient record requests;
- a single protocol which details when information can be shared between health and adult social care staff; and
- the clarification of the use of patient information for medical research.

These actions will in the short to medium term, make the most difference to the working lives of front line staff and in turn, further support improved patient care. In addition, the report indicates areas where the NHS has already taken action – establishing the Care Record Development Board, publishing the

² http://www.connectingforhealth.nhs.uk/news/crdb_guarantee

Care Record Guarantee and undertaking a review of information governance arrangements and a review of medical research committees.

Methodology

Building on the changes presented in five previous joint Department of Health (DH) and the Better Regulation Executive Public Services Regulation Team (PSRT) projects, the DH invited PSRT to identify existing concerns associated with information sharing between health and adult social care staff.

Workshops were held in North Tyneside and London, with 60 front line stakeholders from a range of Trusts and Local Authorities across England. These workshops aimed to identify key problem areas to sharing information. A summary of one of the workshops was circulated to front line staff to ensure that the right issues and solutions had been captured. Stakeholders were also kept informed of progress and invited to contribute throughout the project.

Findings from these workshops were also supplemented by the data gathered from a survey commissioned by the Health Records and Data Protection Review Group (HRDG)³.

The project team worked with DH and other stakeholders to negotiate and agree practical changes to be implemented over the next two years.

By reducing the number of unnecessary requests for patient records and by streamlining the processes and guidance around data sharing, staff will be freed up to concentrate on what they do best – caring for patients and service users.

³ Health Records and Data Protection Review Group – Patient Access to Health Records; Research report, Research Works Limited, February 2004.

INTRODUCTION

We have chosen to illustrate the concerns identified by front line staff in the words of front line staff. They identified areas where they considered unnecessary paperwork and processes were confusing and time-consuming and prevented them from focussing on improved care for patients and service users.

Consequently, the report is structured as follows:

- An overview of the issue/s raised by front line staff;
- A description of the outcome that has been agreed and the timetable for implementation; and
- An outline of the benefits expected.

KEY ISSUES IDENTIFIED

Key Issue 1: Patient records requested as a result of personal injury claims.

Front line staff spend a number of hours per week screening and photocopying patient record requests for personal injury claims.

The case study below illustrates the impact of the “no win no fee” compensation culture on public services.

Case study: The British Medical Association.

Context

The British Medical Association represents doctors from all branches of medicine all over the UK.

It is a voluntary association with about 75 per cent of practising doctors in membership. It has a total membership of over 135,000, rising steadily, including more than 3,000 members overseas and over 15,000 medical student members.

Requests for patient information causes significant burdens

Solicitors' claims and requests for patient information cause significant burdens. More so, Subject Access Data Requests (SADRs) have a particularly significant impact on small organisations such as General Practitioner (GP) practices.

SADRs is when an individual or organisation requests a copy of the health information that is held on them or a person. When an SADR is received, health staff are required to screen for third party information prior to sending it to the organisation or individual that has requested it.

Personal Injury claims

Dr Peter Holden, a member of the BMA and a General Practitioner explained that the last few years have seen an almost ten fold increase in the number of requests prompted by the “no-win, no-fee” industry.

He believes requests for access to patient records in relation to personal injury claims generate a significant amount of work as often requests are non-specific and are for entire patient records. The impact is that all of the patient records need to be screened by a doctor for third-party information and photocopied.

Dr Holden told us that many records are being requested by solicitors in an effort to determine whether it is worth a client pursuing a personal injury claim. “Of the 88 patient record requests I received in one six month period, all but one were as a result of personal injury claims”.

“I had one member of staff spend half a day a week photocopying medical records and that didn’t include the time it took me to screen the records for third party and harmful information”. This process consumes an inordinate amount of NHS resource.

Solution

Dr Holden felt that an agreement between stakeholders involved in the process of personal injury claims that patient records would not be routinely requested would significantly reduce the burdens on GPs.

Dr Peter Holden – British Medical Association General Practitioners Committee

In 2004/5 there were 755,875 accident claims⁴ recorded with the Compensation Recovery Unit (CRU), 402,924 of these were motor accident claims. For the majority of cases, patient records are requested despite 75 % of claims being below £10,000⁵. For the purpose of this report, patient records are defined as records consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual.

“Oh, we get about 10 or 15 a day of those solicitors letters coming in. It runs into the hundreds. Our post from solicitors is staggering really.”

- A Care Administrator-

Front line staff stated that patient records are often requested as a matter of course by patient representatives such as solicitors and insurers rather than on the basis of value added by the data held in patient records. They stated that requests for records should be proportionate to the value of a potential personal injury claim.

⁴ Compensation Recovery Unit 2004-05. www.dwp.gov.uk/cru/performance.asp

⁵ Judicial Statistics 2002; Department for Constitutional Affairs (figures are taken from Judicial Statistics 2002 based on sample data from selected county courts)

The rise in the number of access requests from solicitors and insurers was perceived to be influenced by the cases generated by the large claims management companies.

When a patient record is requested it must be screened by a health professional for harmful and third party information and then photocopied and sent on to the organisation or individual that has requested it. In some cases, this requires input from GP practices, NHS Trusts and PCT staff. The Health Records and Data Protection Review Group (HRDG)⁶, led by the Department of Health undertook research into patient access to health records. This group was set up in May 2002 to advise Government on helping people gain access to their health records.

Responses from the HRDG research report indicated that depending on the size of the record:

- Staff in GP practices spent up to 3 hours screening records and up to 4 1/4 hours administrating and copying records.
- Staff in NHS Trusts spent up to 3 1/2 hours screening records and up to 6 hours administrating and copying records.
- Staff in PCTs spent up to 1 hour screening records and up to 2 hours administrating and copying records.

One GP stated that he had one member of staff in his practice spending half a day a week photocopying medical records. This did not include the time it took the GP to screen for third party and harmful information.

There was general consensus amongst front line staff we met that an agreement on practice between relevant organisations involved in personal injury claims would minimise burdens on medical staff having to screen for third party and harmful information.

At the same time, there is recognition by the NHS that patients would continue to exercise their rights to either requesting to see their medical records or entering into litigation if they feel this appropriate.

Outcome

1. There is a rebuttable presumption, agreed by the Law Society, Association of British Insurers and the Association of Personal Injury Lawyers that subject to the expert witnesses view, no patient records will be requested for claims below £10,000⁷. **June 2006**

⁶ Health Records and Data Protection Review Group – Terms of Reference - http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicotGuardians/AccessHealthRecordsArticle/fs/en?CONTENT_ID=4100546&chk=3SCiP8

⁷ Practitioners should think about how necessary the patient records are to the particular case and whether they need to see them, since the purpose of this outcome measure is to try to reduce burdens on GPs and other health professionals. Practitioners should note it is not an absolute bar to seeking patient records and they can always be sought if the solicitor deems it necessary to do so. This outcome does not amend the personal injury pre-action protocol or patient's rights to see their own records.

Potential Benefits

This will result in approximately 300,000 less patient records requests annually and enable GPs and other areas of the NHS to focus on patient care rather than providing information for personal injury claims.

Key issue 2: Confusion created by existing legal guidance and numerous data sharing protocols.

The perception from the front line is that there is a lack of clarity in legislation about what and how information should be shared between agencies and departments.

The case study below illustrates some best practice and difficulties front line staff encounter where there is a need to share information between service providers.

Case study: Kent County Council - The Kent and Medway Information Governance Programme Board

Context

The Kent & Medway Information Governance Programme Board (IGPB) consists of representation from Kent County Council (Social Services & Education), Medway Council, Youth Offending Service, Kent Police, the Kent & Medway Health Informatics Service, the local NHS IG Forum (which represents NHS Acute and Primary Care Trusts), and the joint NHS & Social Care Mental Health Trusts.

The aims of the IGPB are to ensure the effective implementation of Information Governance into health, social care and community services in Kent and Medway; to oversee, direct and support the work of the Multi-Agency Protocols Sub-Group; to ensure that appropriate links are made to related strategic and operational groups; and to report regularly on progress to appropriate Programme Boards as required.

Lack of clarity about how and what information should be shared between service providers.

Penny Payne, Information Governance Policy Manager for Kent County Council stated that there is some lack of clarity around how and when information could and should be shared between service providers.

Penny explained that boundaries within and between public authorities are blurring more than ever and there is an increasing need to share information. Furthermore, the interface between service provider and user occurs at the front line which is becoming increasingly multi-disciplinary. The only constant in all of this - is the service user.

Sharing information across disciplines

The problem with sharing information effectively across disciplines is a failure at national level to take advantage of opportunities that would make information sharing easier. For instance, the failure to take the lead on developing a single information sharing protocol for health and adult social care and the lack of clear guidance about how to apply the Data Protection Act's requirement for consent.

She stated that “currently in Kent & Medway, reorganisations are taking place within the Local Authorities, the Police, the Mental Health Trusts and the Primary Care Trusts. As such, the application of information governance standards provides support to our staff and partners to ensure legitimate, effective, auditable information exchange, and protection for service users' rights”.

“In addition, the delivery of our ‘3 Tier Model of Information Sharing’ provides us with the opportunity to clarify the administrative powers and statutory provisions that enable our staff and our partners to legitimately share information”.

Solution

Penny suggests that clarification at a national level from Government is still required on information sharing with other agencies, including the voluntary and private sectors, to keep pace with recent and expected changes in the way our services are to be delivered.

Penny Payne – Information Governance Policy Manager

A great deal of information can and should be shared within the existing professional guidelines and legal framework. However, persistent confusion exists amongst practitioners over the interpretation of the Data Protection Act and its relationship with the common law duty of confidentiality, and other legislation such as the Human Rights Act, Health and Social Care Act and other data sharing legislation. Such confusion often relates to what information can be shared and the level of detail permissible.

This confusion is further compounded where central government departments and professional bodies all issue guidance on sharing information, which is often inconsistent.

During this study, we received different views from stakeholders on data sharing issues but most agreed the perception that the interpretation of legislation can be a real constraint on cross-departmental data sharing. In particular, they perceive national guidance on the Data Protection Act as only offering generic advice. It lacks detail on how the law works in an operational context.

Individual departments, authorities and trusts have attempted to address the situation by producing their own interpretations and guidance in the form of

local information sharing protocols. These protocols vary across sectors and still lack the practical detail required by front line staff. They range from pre-defined protocols to ad hoc deliberations by professionals with responsibilities for data protection issues.

A key issue raised by many health and adult social care staff was the need for clarity around situations where consent can be overridden to share data across sectors. Misunderstanding about the common law duty of confidentiality is seen by many to inhibit appropriate and permissible sharing of information between health colleagues and other care agencies.

Front line health and adult social care staff consulted during this study stated that the area of confidentiality is important however, confusion arising from the various interpretations of legislation tended to create more obstacles. This in turn, makes front line staff more anxious about sharing information across care sectors and the patient has to provide personal information more than once.

Where information can be appropriately shared, health and adult social care staff spend more time than they perceive to be necessary creating information in a format that can be shared with colleagues so as not to jeopardise patient confidentiality.

Given the different ways organisations interpret and use data or decide when sensitive information can be shared, there is wide spread recognition by front line health and adult social care staff that a single approach to sharing information across services is needed.

Work to address some of these issues and assist front line staff is already underway. The NHS has completed a review of Information Governance which will report early in 2006. The improved local and national information governance arrangements which will result from implementing the recommendations of the review will tackle the problem of lack of clarity around when and what information can be shared amongst practitioners.

Work to support frontline staff is complemented by continued recognition of the Government's top priority to put the interests of the citizen first. To this end the Care Record Development Board (CRDB) was established in the NHS in 2004 to advise on aspects of the implementation of the NHS Care Record Service which is being delivered as part of the National Programme for IT in the NHS. The CRDB represents users of the Care Record (including patients, service users, the public and staff in health and adult social care) and reflects their views and interests. Its main roles are to ensure that ethical and policy issues, including data recording and sharing, are adequately addressed and to identify and promote the values and principles which should govern the development and implementation of the Care Record.

In conjunction with the direction of this work, this report includes a commitment to the development, on a national basis, of a single protocol for health and adult social care services as an effective tool for front line staff.

Clearly this protocol would need to reflect both the need to share data and the need to respect and uphold patient confidentiality.

Outcomes

2. The Department of Health in incorporating the outcomes of the review of Information Governance and in conjunction with the Care Record Development Board will review and streamline, where necessary existing policies and guidance around sharing information between health and adult social care organisations. This will include identifying when data needs to be shared and what data this is and clarifying the requirements for patient/service user consent.

The Department of Health in conjunction with the Care Record Development Board and groups representing patient and service users will develop a single information sharing protocol for health and adult social care staff.

December 2006

Potential Benefits

Front line staff will be more confident about what information they can share and with which organisations. This will provide assurance that when it is necessary to share their data this is done in an appropriate and controlled manner.

Key issue 3: Medical research slowed down by legislative confusion

"...it is clear that many practitioners are confused about the requirements of the Data Protection Act and those of the various regulatory and representative bodies within the sector including the GMC, MRC and BMA"

– Information Commissioner

Uses and Disclosure of Health Data: Guidance on the Application of the Data Protection Act 1998, May 2002 –

Although the following case study illustrates the issues around obtaining patient consent prior to sharing information, its impact is also felt in the medical research field.

Case study: Wrightington, Wigan and Leigh Acute NHS Trust

Context

Wrightington Wigan & Leigh NHS Trust is a major acute Trust delivering quality care services from four hospital sites and a state-of-the-art out patient facility in the centre of Wigan. The Trust has 950 inpatient beds and invests around £180 million each year in a broad range of general and specialist acute services, including a specialist orthopaedic service of international repute, based on the Wrightington Hospital site. The Trust is part of the Greater Manchester Strategic Health Authority (GMSHA), having boundary alliances with Strategic Health Authorities of Cumbria and Lancashire and

Cheshire and Mersey.

Current Data protection protocols are not clear about how information can be shared across disciplines. This often inhibits effective medical research.

Beryl Woodall, Health Informatics & Governance Manager stated “data protection and patient confidentiality are important and do require controls. However there is confusion around the interpretation of legislation in the use of patient data for medical research and the implication of research results for patients”.

Beryl said “as an organisation, we believe that regulations regarding the confidentiality of **patient identifiable information** must be maintained. Nevertheless, it is important that when information is required by agencies who are directly involved in the provision of patient care, following consent, relevant and appropriate information is made available in a timely manner and in a format appropriate to the particular agency requiring access”.

Use of patient identifiable and anonymised data

Beryl explained that in medical research Lead Investigators can be faced with developing systems to secure different types of consent within one project – consent to the research, consent for use of data, consent to share information between agencies/parties to the research, and consent to hold data on a database repository.

The guidelines for the above are all sourced from the same legislative framework but have their own discrete methodology of control and are often associated with equally unique bureaucratic administrative processes that continue to be viewed as significant disincentives to prospective researchers.

Solution

Beryl suggested that a whole systems approach to consent for release of patient identifiable information to multiple-agencies directly involved in patient care should be developed in a format that bridges the Governance/Informatics service remit. Ideally this would be supported by formal written procedures and backed up with training programmes to staff groups operating within the known framework of multi-agency services. This would ensure that patients do not suffer detriment as a consequence of organisational officialdom.

Having established a more generic and transparent system of data processing, clearer guidance could be provided on how to consistently evaluate and assure the appropriate use of patient information within research and development studies.

Beryl Woodall – Health Informatics & Governance Manager

Much UK research is carried out using anonymised data which does not directly identify the patient. Where patient identifiable data is used, this must comply with professional guidance, the common law duty of confidentiality

and a wide range of legislation including, Data Protection Act, Human Rights Act, and Section 60 of the Health and Social Care Act. The Department of Health established the Patient Information Advisory Group (PIAG) to assist researchers in ensuring that they comply with the legislation.

The Data Protection Act accommodates the use of patient information for medical research, with the explicit consent of patients or subject to specific conditions, one of which is the information being necessary for “medical purposes”⁸. “Medical Purposes” is defined as but not exhaustively, to include preventative medicine, medical diagnosis, medical research, provision of care and treatment and the management of healthcare services.

On the other hand, the Lord Chancellor has asserted that the common law duty of confidentiality requires informed consent for medical researchers to access named patient records, unless there is overriding public interest.

Front line staff mentioned that the ambiguity around what constitutes “medical research”, “informed consent”⁹ and “overriding public interest” has led to a variety of different interpretations of the legislation. Also that guidance from the General Medical Council (GMC), Medical Research Council (MRC), British Medical Association (BMA) and various Royal Colleges has resulted in further confusion within the research community. One example suggested this had led to a reduction in data flow to cancer registries causing a negative impact on associated research.

There was a mixed response from the front line staff we consulted around whether patient consent should be based on the principle of opting out or opting in.

The Council for Science and Technology has published recommendations on the use of personal data for research and statistical purposes. The report recommends

- personal data must be anonymised whenever this is possible, or pseudonymised in the case of linked datasets
- that there should be a general presumption that access to data should be facilitated where that access is for research purposes
- appropriate safeguards should be in place before personal data can be accessed and used¹⁰.

A recent report of the Ad Hoc Advisory Group on the Operation of NHS Research Ethics Committees also recommended substantial improvement to local Research and Development procedures and their interaction with ethical review was required to reduce bureaucracy and timescales. Included in this

⁸ Data legitimately processed for research or statistical purposes, as long as such processing neither causes substantial harm or distress to the data subject nor is used to support measures or decisions in relation to individuals, are exempt from certain provisions of the Act – Data Protection Act 1998

⁹ Informed consent means patients know *every* consequence and possibility.

¹⁰ *Better use of personal information: opportunities and risks*. Council for Science and Technology. November 2005 <http://www2.cst.gov.uk/cst/reports/#10>

recommendation was an emphasis on making multiple use of information supplied once.¹¹

The Department of Health published on 25 January a national health research strategy *Best Research for Best Health*. The strategy reflects the Government's commitment to making the UK the best place in the world for health research, development and innovation. One of the strategy's goals is that the National Programme for IT will transform the research community's capacity both to recruit patients to clinical trials and to gather data to support research on the health of the population and the effectiveness of health interventions.

The aim is to develop systems and procedures that guarantee patient confidentiality while making it quicker and easier to do research focused on the needs of patients and the public. Achieving this will involve reviewing the current guidelines, seeking the opinions of patients and the public, the Information Commissioner and those that represent key stakeholders and professionals such as the UK Clinical Research Collaboration (UKCRC), the BMA, the GMC and also consultation with front line staff.

Outcome

3. The Department of Health will develop and issue a single set of guidance on the secondary uses of personal information for medical research, population health and management. This will take account of the recommendations of the Academy of Medical Sciences and of the Council for Science and Technology, the views of frontline staff and of appropriate patient and service user groups.

This guidance will promote consistent interpretation of the legislation on the use of patient information for research purposes, and will provide clarity for frontline staff, patients and service users. It will also explore solutions based on anonymisation of personal data.

September 2006

Potential Benefits

Researchers will be clear about the legislative requirements for the use of patient information for medical research and the role of PIAG in this. Patients will also be clear about what information can be used, under what circumstances, when consent is needed and how this is obtained. The process of gaining consent will remain rigorous but quicker for researchers as they will have unambiguous clarity of requirements.

¹¹ Report of the Ad Hoc Advisory Group on the Operation of NHS Research Ethics Committees
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4112416&chk=kw5gAf

Conclusions and Next Steps

Some progress has been made by central government to address the difficulties encountered by public services staff around data sharing that maintains the security and confidentiality of personal data. One example is, a "toolkit"¹² published by the Department for Constitutional Affairs. This toolkit includes model protocols, codes of practice, and a revised analytical framework which, together with the legal guidance will provide a significant resource for any public body involved in the provision of services in sharing personal data.

Others in the NHS include establishing the Care Record Development Board, the publication of the Care Record Guarantee and the review of Information Governance in the NHS.

Nevertheless, more needs to be done in moving forward the data sharing agenda. The consensus from front line staff is that an overarching approach to data sharing across organisations will reduce uncertainty for staff, allay suspicion from the public and lessen the frustration felt by those attempting to deliver seamless services. The practical actions and timetable for implementation identified in this report is just the beginning. Ensuring that they are effectively implemented is a much longer and difficult task. This will be achieved through continued stakeholder support and involvement in the dissemination of these solutions back to the front line.

Responsibility for delivering the changes outlined in this report remains with the Department of Health and key stakeholders. However, over the next year, the BRE will continue to work in partnership with the Department of Health and key stakeholders to ensure that the solutions identified by front line staff, policy owners and the project team are delivered successfully and on time.

Post-implementation monitoring will be achieved through continued collaborative working with key stakeholders, so that evidence from the front line is collected and progress reported periodically to Ministers.

¹² The Data Sharing Toolkit is aimed at service providers, such as local authority and other public sector employees, who have to grapple with data sharing issues. It provides comprehensive, up to date, information and guidance on information management practice. It also provides information and links to current practice developed by a broad range of public service providers – Department for Constitutional Affairs.

<http://www.dca.gov.uk/foi/sharing/toolkit/index.htm>

ANNEX A - Acknowledgements

The Department of Health and Cabinet Office Public Services Regulation Team would like to thank all those who took the time and effort to contribute to the research and publication of this report. In particular, we would like to thank the Project Board, Project Advisory Panel members, Local Authorities, health bodies and voluntary sector organisations without whose support none of this would have been possible.

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Stakeholders consulted

Association of British Insurers	Hammersmith and Fulham Primary Care Trust
Association of Directors of Social Services	Hammersmith Hospitals Trust
Association of Personal Injury Lawyers	Hertfordshire Partnership NHS Trust
Brent Primary Care Trust	Information Commissioners Office
British Association of Social Workers	INVOLVE - <i>a national advisory Group promoting active public involvement in public health and social care research.</i>
British Medical Association	Kent and Medway County Council
Department for Constitutional Affairs	London Borough of Ealing
Department for Trade and Industry	London Borough of Lewisham
Dorset County Council	Royal Free and university College Medical School
Ealing Hospital	Surrey County Council
Ealing Primary Care Trust	The Law Society
General Medical Council	The NHS Confederation
General Practitioners	The Patient Association
Greenwich Primary Care Trust	UK Clinical Research Collaboration

ANNEX B – Background

Unnecessary burdens created by processes, paperwork and requirements erode the time front-line staff have to deliver good quality, responsive public services. The Cabinet Office's Better Regulation Executive (BRE) works with other government departments and their stakeholders to identify and remove unnecessary and bureaucratic burdens and to free up the time of staff in the public sector.

The Project team

The project team consists of civil servants (both permanent members of Cabinet Office and DH and staff on loan). As a result, the team was able to draw on a diverse range of skills, knowledge and experience.

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DH Contact Details

The Department of Health has set up a website with information on this work:

www.dh.gov.uk/reducingburdens

Previous Reports:

The BRE has completed 15 '*Making a Difference*' projects in the following areas:

- Reducing Burdens in Colleges of Further Education. Joint report with Department for Education and Skills and the Learning and Skills Council (December 2005)
- Making a Difference: Reducing Bureaucracy in Children, Young People and Family Services. Joint summary of outcomes with Department for Education and Skills. (July 2005)
- Making a Difference: Bereavement. Joint report with ODPM, DWP, Inland Revenue, Court Service

- Making a Difference: Reducing Burdens in Schools and Community Sport. Joint report with DCMS (March 2005)
- The Review of Controls Assurance. Joint report with the Department of Health (November 2004)
- Special Educational Needs. Joint report with Department for Education and Skills (September 2004)
- Making a Difference: Reducing Post Sentencing Burdens on front-line Staff – Prison and Probation Paperwork. Joint report with, Home Office, HM Prison Service and the National Probation Service (July 2004)
- Reducing Bureaucracy in Central Civil Government Procurement. Joint report with Treasury and the Office of Government Commerce (December 2003)
- Reducing Burdens in Healthcare Inspection and Monitoring. Joint report with Department of Health (July 2003)
- Reducing Bureaucracy and Red Tape in the Criminal Justice System. Joint report with Home Office, DCA and the Attorney General's Office (May 2003)
- Reducing Red Tape and Bureaucracy in Schools – Second Report. Joint report with Department for Education and Skills (March 2003)
- Reducing Burdens in Hospitals. Joint report with Department of Health (July 2002)
- Reducing Burdens on General Practitioners – Second Report. Joint report with Department of Health (June 2002)
- Reducing Red Tape and Bureaucracy in Local Government. Joint report with Department for Transport, Local Government and the Regions and the Local Government Association (February 2002)
- Reducing School Paperwork. Joint report with Department for Education and Employment (December 2000)

All of these reports can be downloaded free of charge from the BRE web-site, at the following web address:

<http://www.cabinetoffice.gov.uk/regulation/publications/archive.asp>

ANNEX C – GLOSSARY

BMA	British Medical Association
BRE	Better Regulation Executive
CRDB	Care Record Development Board
CO	Cabinet Office
DCA	Department for Constitutional Affairs
DH	Department of Health
GMC	General Medical Council
GP	General Practitioner
HRDRG	Health Records and Data Protection Review Group
MRC	Medical Research Council
NHS	National Health Service
PCT	Primary Care Trust
PSRT	Public Services regulation team

ANNEX D – BIBLIOGRAPHY

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