Review of NHS Data Collections

Report for the Department of Health and the NHS Health & Social Care Information Centre

2005

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Introduction

In 2004/05, the Department of Health (DH) undertook a major review of its information collections with the aim of reducing the burden on NHS staff. The review produced cuts of about one third in information collected by the centre, but anecdotal evidence showed that front line staff were not feeling the benefits. As part of this ongoing initiative to reduce the burden of bureaucracy and in response to frontline staff concerns, DH commissioned Dr Foster to study the wider impact of data collection on NHS staff from all sources, both internal and external. This focussed on the following questions:

1. What is the impact of data collection on all types of NHS organisation?
2. Which organisations are responsible for this workload?
3. Which groups of staff does the burden fall on?
4. Do NHS staff feel that the collection of data is overly burdensome?
5. Where is there most scope for reducing the impact of data collection on NHS staff?

A steering group made up of representatives from DH, the NHS Health and Social Care Information Centre (HSCIC) and representatives of other interested parties such as the Healthcare Commission, Foundation Trust Monitor and the NHS Confederation oversaw the project and final report.

Key messages

Overview
Though based on a small sample of organisations and staff and with a limited remit, the study has been the first attempt to provide a factual basis against which the anecdotal evidence from frontline staff about the burden of collection could be assessed. In this it has been successful, providing some broad conclusions and laying the groundwork for further detailed studies if felt necessary. However, the small numbers of some staff groups involved, particularly clinical staff in some Trusts and GP practices, should be borne in mind when using these figures.

The main conclusions are;

- Department of Health direct data requests are a minority of the overall burden, and are already controlled through the ROCR process.
- Requests from the local NHS and Strategic Health Authorities account for a large proportion of the overall burden on provider organisations (though some of this may be on behalf of others). There should be scope for rationalising these through ROCR type controls and the introduction of standard systems, in particular improved national IT (the Secondary Uses Service).
- The numbers of staff involved in data collection activity in organisations is not large in relation to the organisation's overall staffing, though Acute Trusts bear the heaviest workload.
- The burden in all organisations falls mainly on information staff, and levels of concern amongst this group are low. Clinical staff do not have a large involvement in data collection as defined by the study.
- Clinical staff in primary and secondary care feel that the burden of bureaucracy is increasing. However, they are generally not involved in data collection activity. Their concerns related largely to the impact of new policy initiatives, internal management issues and day to day paperwork.

Methods and definitions

Two Strategic Health Authorities (SHAs) – Surrey and Sussex and Shropshire and Staffordshire – participated, and identified a number of Trusts and GP Practices in their areas who would take part.

The HSCIC's Review of Central Returns (ROCR) process defines **burden** as **time spent on data collection activity**, and the report uses this definition. The impact of collections is estimated in person days per year; for example, if a collection is monthly and takes a day to complete the burden is 12 person days per year per organisation.

Data collection is defined as **activity in response to a request for data or information from an external organisation.** The study did not look at the flow of information internally within NHS organisations.

The study was a synthesis of several approaches:

1. **A survey of staff** in participating organisations**,** asking them to identify information requests from external organisations received in the past year. 220 people took part in this phase, and identified almost 600 requests.

2. **A list of data collections with consistent estimates of time taken (burden) to complete.** Bringing together information from the survey as well as ROCR and other sources (such as the Healthcare Concordat of Regulatory bodies) enabled burden for each collection to be estimated.

3. **A real time data collection exercise** - clinicians and informatics staff tracked requests for information over the course of a month. Clinical staff were asked to log **all** information requests they received, but informatics staff were asked to log only **ad hoc** requests as routine requests were covered in the list noted above. Participants were asked to record who the request came from and how long it took to complete.

4. **Interviews and workshops** – these gave a wider understanding of attitudes towards bureaucracy and data collection, and highlighted potential improvements.

What is the impact of data collection on all types of NHS organisation?

The total time NHS organisations spent on collecting data or information for external organisations was estimated by:

- Assessing the burden on individual organisations using the list of routine data collections
- Using the proportion of ROCR collections not identified via the survey as a proxy for the total unidentified burden, and applying to the total above
- Adding the estimated burden of ad hoc collections from the real time data collection exercise.

These data were used to derive an estimated number of full time staff engaged in data collection activity in each type of organisation (see tables 1 and 2 below). Given the low response rate from frontline primary care staff, feedback from the workshops was used to estimate the overall burden on a GP practice - these particular figures should be treated with caution due to the small numbers of staff involved.

Table 1 – Estimated total burden and full time equivalent staff by organisation type

Type of organisation	Estimated burden of data collection (person days per year)	Average full time equivalent staff per organisation
Acute Trust	708	3.5
PCT	285.5	1.4
Mental Health Trust	228	1.1
Ambulance Trust	201	1.0
SHA	146	0.7
GP Practice	36	0.2

Table 2 – Average annual burden by requesters on providers in full time equivalent staff terms

Requesting Organisation	Average annual burden on organisations providing data (person years)					
	Acute Trust	Mental Health Trust	PCT	Ambulance Trust	SHA	GP Practice
SHA	0.4	0.0	0.2	0.0	0.0	0.1
Local NHS	0.5	0.0	0.1	0.1	0.0	0.1
DH	0.7	0.7	0.7	0.5	0.4	0.0
ALB	0.8	0.2	0.3	0.2	0.0	0.0
Others	1.1	0.1	0.2	0.2	0.3	0.0
TOTALS	**3.5**	**1.1**	**1.4**	**1.0**	**0.7**	**0.2**

NOTES:

1. **Estimates refer only to staff collecting data directly for external organisations and do not include collection and analysis of data internally**. SHAs and PCTs in particular have many staff involved in analysis of data received from other organisations, but spent relatively little time collating data for external bodies. Most of the time that is spent, is on collating data from others to pass on to DH.

2. These figures are averages by organisation type; actual staff numbers will be dependent on organisation size.
3. Columns in Table 2 may not sum to Totals as the latter include an overall element for each provider for adhoc collections.

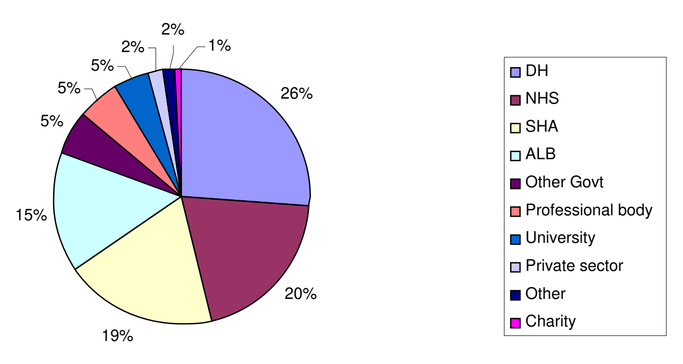
Which organisations are responsible for this workload?

Organisations requesting data were grouped as shown below;

- DH - Department of Health
- Local NHS - other NHS trusts, largely Primary Care Trusts
- SHA - Strategic Health Authorities
- ALB - Arm's Length or non departmental bodies including the Healthcare Commission and other DH sponsored organisations
- Other Government - other Government departments and organisations such as the Audit Commission, the National Audit Office and local government
- Professional bodies - Royal Colleges and other professional representative organisations
- University – academic institutions and units holding audit databases
- Private sector – miscellaneous private sector organisations such as insurance companies, private providers etc
- Other

The charts below show how they contribute to the load on the NHS in terms of numbers of collections and burden.

Chart 1 – Numbers of collections by organisation group, by percentage

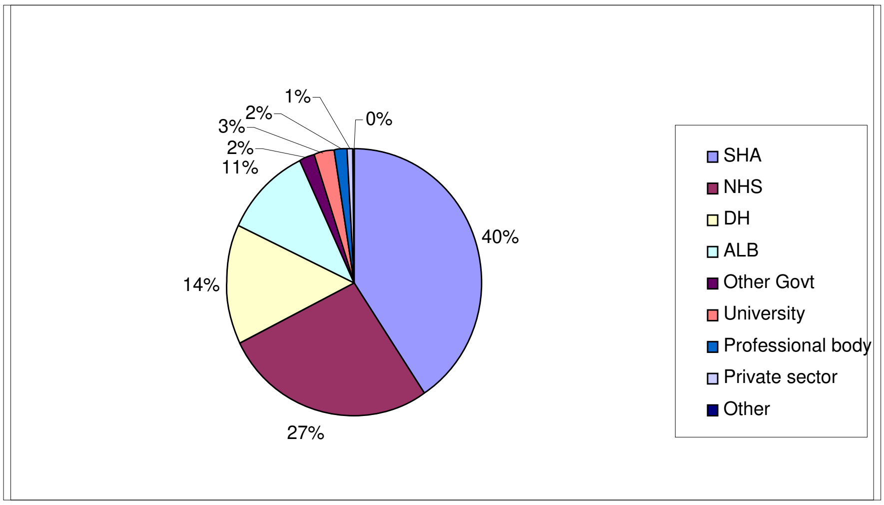


Of the almost 600 returns identified, DH, the local NHS and SHAs together accounted for about approximately two thirds; DH alone was just over a quarter.

The overall burden of data collection for external bodies was just over 2,700 person years.

Chart 2 below shows that SHAs and the local NHS accounted for approximately two thirds of that; burden directly from DH was less significant. However, the study could not identify how many collections were completed on behalf of other organisations, e.g. SHAs collecting on behalf of DH.

Chart 2 - Burden of collection by organisation group, by percentage



Which groups of staff does the burden fall on?

Table 3 below details the survey results by organisation type and staff group, supplemented by information from the interviews and workshops. These show that information staff (average 4.8) and management (average 2.6) were most involved in collections; clinicians were the least burdened, being involved in on average 1.5 collections each.

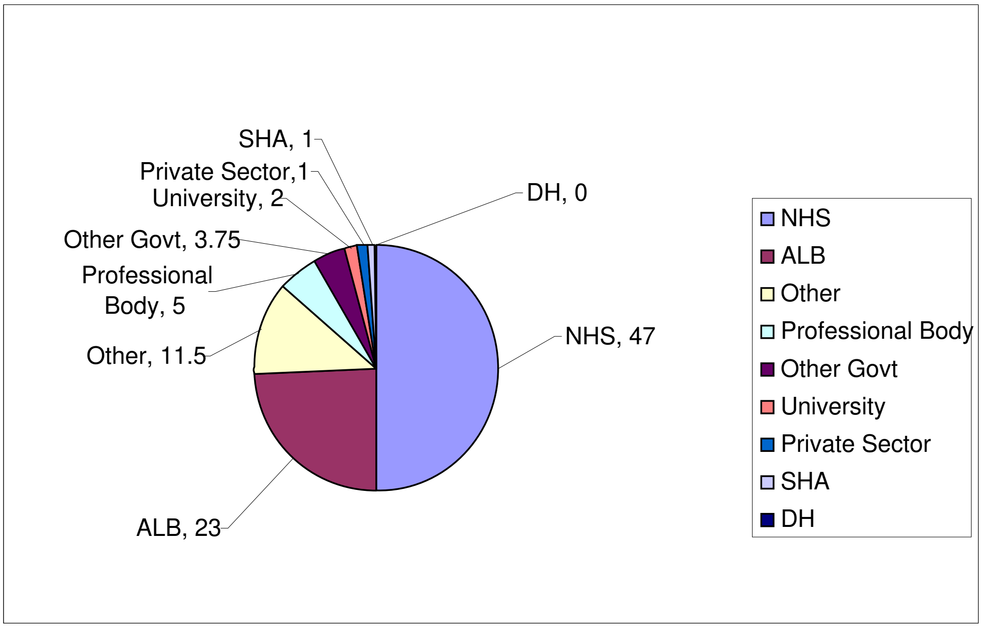
Table 3 – Returns identified in survey phase, by organisation and staff group

Organisation	**Clinicians**		**Information staff**		**Management**	
	Participants	**Returns identified**	**Participants**	**Returns identified**	**Participants**	**Returns identifed**
Acute trust	43	65	11	84	68	200
Ambulance trust	0	0	4	26	15	41
Mental health trust	4	6	6	33	15	35
PCT	2	3	7	11	16	33
SHA	0	0	5	6	19	25
GP practice	1	1	0	0	4	19
Total	50	75	33	160	137	353

Of 22 staff that said they were not involved in collection activity, 12 were clinicians, supporting the view that this group were least burdened by data collection. However, survey response rates were lowest amongst clinicians at 21%, compared to 50% for information staff and 42% for management staff.

The real time data collection exercise provided further evidence of how clinical staff were involved in collection activity. Chart 3 gives aggregated results from the 27 clinicians who kept a record for a month of the time they spent on data collections.

Chart 3 – Clinical staff time spent on collection activity by organisation (hours)



This shows that about half the information collected by clinical staff over the course of the month was for local NHS organisations, and just under a quarter for ALBs.

Chart 4 - Time spent on data collection by clinical staff

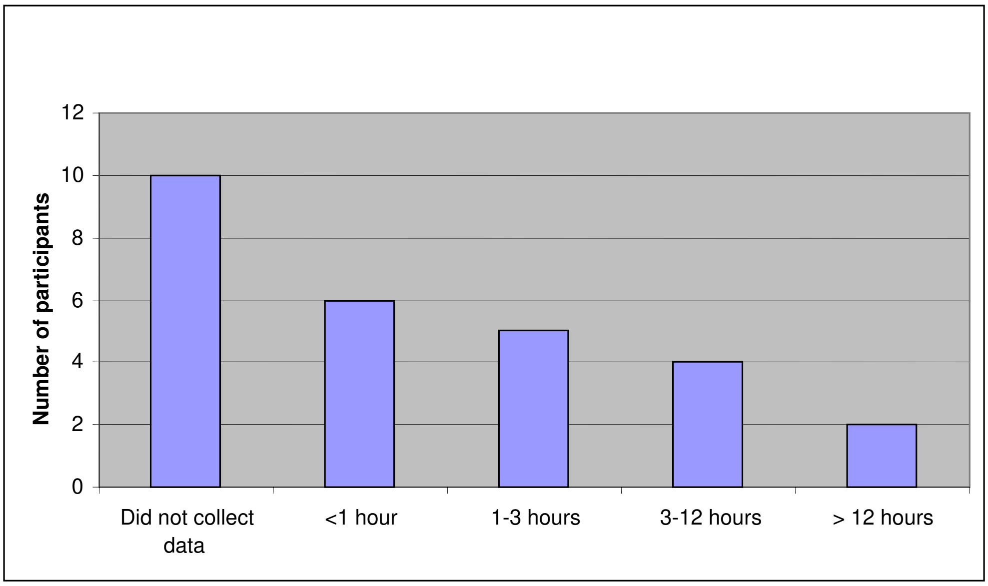


Chart 4 gives a breakdown of this time; over half the staff (16 out of 27 participants) spent an hour or less on collection activity over the course of the month, and 10 staff spent no time.

Do NHS staff feel that the collection of data is overly burdensome?

The staff survey also asked a number of attitudinal questions about collections identified.

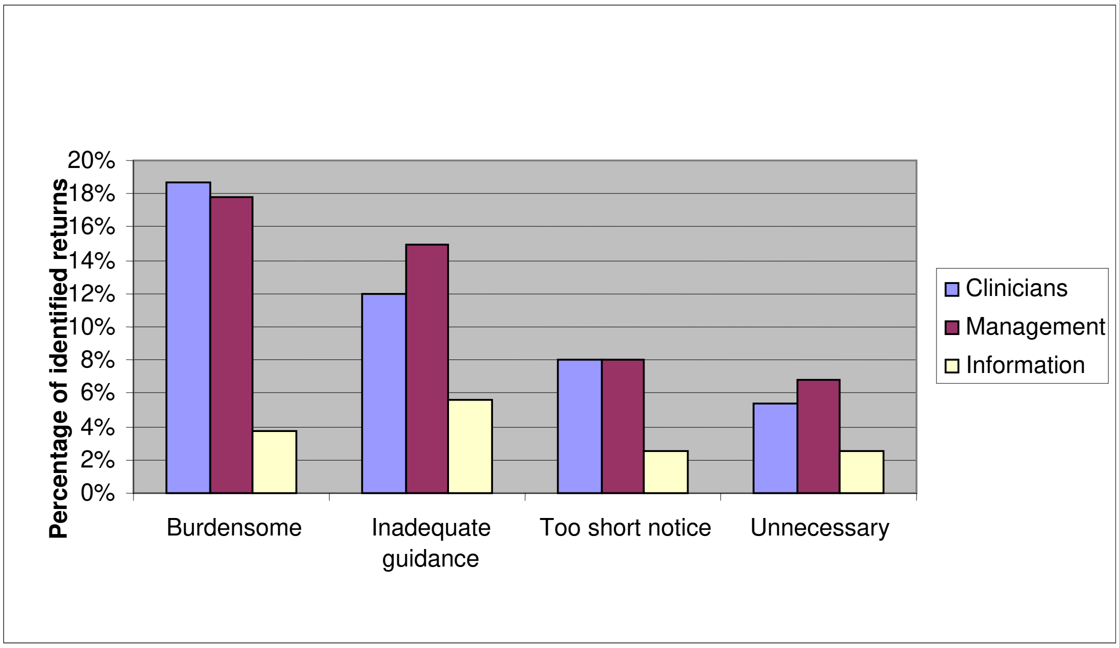
The most frequently expressed concern was that requests were overly burdensome; the next most common was that the guidance accompanying requests for data was inadequate.

Attitudes varied according to staff group, as Chart 5 shows. Generally, clinical and management staff had more concerns than information staff – rates of dissatisfaction were similar for both groups.

The interviews and workshops phase also provided some views;

- Information staff identified 15 requests they felt to be unnecessary (about 2.6% of the total) – for 8 of these their concern was the high frequency. They also had reservations about the usefulness of the data collected for the requesting organisation.
- Of the 26 frontline staff interviewed, 14 felt there had been a significant increase in collection over the last three years, 9 a slight increase, 2 thought the burden had remained the same and 1 felt it had decreased.
- 10 of these staff gave one or more specific examples of collections they believed to be unnecessary. Examples of their concerns generally related to internal trust management, routine patient care, or wider policy initiatives.
- The overwhelming feeling of participants in the workshops was that general bureaucracy had significantly increased over the last year, but not in relation to data collections as defined in this survey.

Chart 5 – Response to attitudinal questions by staff group



Where is there most scope for reducing the impact of data collection on NHS staff?

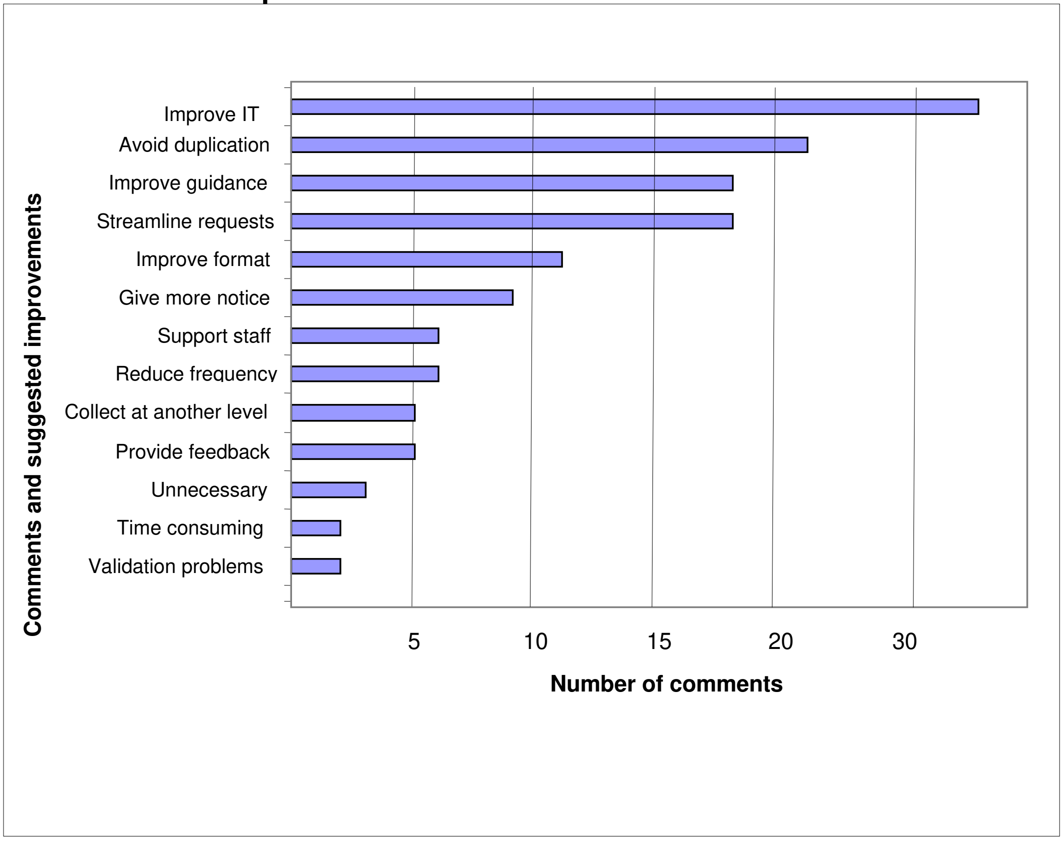
Staff were asked during the interviews what improvements they would like to see made to data collection.

60% of information staff wanted improved IT systems, and several of those interviewed felt that recently introduced systems had led to improvements. They were confident that the introduction of the Secondary Uses Service would lead to further improvements with concomitant reductions in burden on their organisations.

Other suggested improvements from information staff were streamlined, standardised requests, and one of those interviewed wanted to see a centralised data collection organisation. These issues are currently being addressed by the HSCIC and its new Omnibus Survey collection tool.

The most frequent comments made by all staff groups during the interviews are shown in the chart below.

Chart 6 – Most frequent comments from interviews



Again improved IT was the most frequent suggestion; others common ones were

- Avoid duplication – ensure that similar requests were not made by staff within the same organisation or by two organisations

- Improve guidance – ensure that it is clear and issued in time

- Streamline requests – ensure that requests are as concise and fit for purpose as possible.

These fall into the remit of the HSCIC and the ROCR process, and are being addressed.