11 September 2020

NHS Providers submission to a DHSC call for evidence on reducing bureaucracy in the NHS

About NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

The nature of bureaucracy in the NHS

The NHS is a complex and often fragmented system, comprised of many organisations delivering services overlaid by structures such as sustainability and transformation partnerships and integrated care systems (STPs/ICSs). There are also 126 bodies with regulatory influence over the NHS, and this adds to the complexity of the organisations working locally and generates substantial regulatory burden on NHS organisations at all levels between directors of trusts, managers, and frontline clinical staff.[1]

Numerous efforts have been made to reduce the fragmentation and bureaucratic burden on the NHS. Despite this, trusts frequently highlight the increasing number of requests for information and data from national bodies, and the increasing volume of regulatory input, and feel that the current system of oversight and regulation is burdensome and not always proportionate to the aim. Unnecessary bureaucracy – that is, bureaucracy where the burden outweighs its value – diverts time and attention away from delivering high quality services, innovation, and frontline care.

[1] https://bmjopen.bmj.com/content/9/7/e028663.full

This is particularly the case for trusts experiencing operational and quality issues, which we fully understand do need increased regulatory attention and intervention. While trusts' experience of special measures varies considerably, they have fed back that the burden of information requests designed to provide the national bodies with greater assurance of the trust's progress towards recovering standards diverts time away from the most important process of improvement.

Overall, trusts report several sources of unnecessary bureaucracy:

- Requests for information which do not add clear value to service delivery or performance
- The same information is requested by multiple bodies, often in different formats
- Trusts face increasing numbers of data requests, without existing recurring submissions being reviewed regularly for their value
- Existing reporting requirements change frequently, requiring changes to the tools and processes used to collect and collate the information.

Reducing unnecessary bureaucracy

While regulation and oversight are vital for a safe healthcare system that delivers the best for patients, unnecessary bureaucratic processes should be identified and removed, and necessary processes which are inefficient or burdensome should be streamlined to ensure they maximise value. The sector's recent experiences of the pandemic in which a number of measures were relaxed or lifted, is instrumental in this regard. Technology also has a role to play in reducing the time required to complete necessary reporting and data collection, and underinvestment in IT systems in trusts has hindered the process of streamlining bureaucratic tasks.

Trusts acknowledge that a degree of data collection is necessary to monitor performance, and to drive improvement in services and outcomes. However, trusts receive a high volume of data requests from national bodies including NHS England and Improvement and CQC, and reporting requirements change regularly. This is in addition to their own internal processes to oversee the standards of care and ensuring that front line staff are equipped to provide high quality services and meet the needs of patients.

The time and cost involved in developing a process for collecting, then submitting, data for a new request is often significant. Trusts also tell us that they frequently receive requests for similar data from multiple national bodies, in different formats, and would welcome more coordination between

national bodies over how and when data is requested, and improved sharing of existing information between teams at the national level to reduce duplication. The national bodies should consider introducing an integrated system for coordinating requests, so that individual bodies do not have to make separate requests for the same information.

Trusts would also value better transparency around how the data they submit is being used to improve services and what they contribute to the national bodies' understanding of performance and outcomes. Where existing reporting processes are no longer required, they should be suspended, to reverse the trend of increasing burden on providers as requests are added but seldom taken away when they are no longer needed. There should be a clear process for regularly reviewing the necessity of individual requests for data and removing those which are no longer needed. Some specific examples of outputs trusts have highlighted which could be streamlined include:

- Annual reports, which are lengthy and arduous to produce, and could be streamlined to include the bottom lines on finance and quality, the chair's and chief executive's report, director's pay and attendance and the statement of internal control.
- Annual governance statements, which could be replaced with statements of internal control which set out the controls the organisation relies on to understand risk to its governance and an assessment of the effectiveness of those controls and actions taken to rectify deficiencies.
- Bi-annual governance self-certification, which could move to reporting by exception rather than reporting compliance.
- Quality accounts, which are time consuming and expensive to produce, and which are not necessarily a helpful format to share information about quality of care with the public.

As the health landscape evolves, with proposals for ICSs to be given more responsibility for monitoring performance in their systems, and for the national bodies to give greater consideration to the impact of system working on trusts' performance, we have highlighted the risk of introducing additional tiers of oversight and bureaucracy to the existing landscape.

As system working progresses, care should be taken to avoid 'mission creep', ensure that any further regulatory input is strictly necessary, replacing rather than adding to the current system. In addition, national bodies should take steps to align definitions and metrics to reduce the burden of overlapping frameworks and remits (such as those between NHS England and Improvement and CQC) using slightly different measures.

The link between regulatory burden and bureaucracy for frontline staff

The bureaucratic burden on frontline staff is often significant and takes away time they could be spending with patients. It is worth noting that, as with all bureaucratic processes, some are necessary and beneficial to ensuring patient safety and quality of care. Where there are inefficiencies and processes could be streamlined, however, efforts should be made to do so. Specific changes such as improving IT interoperability and enabling greater communication and data sharing between departments, and with other organisations such as primary care and social care, would reduce burden on clinical staff. For example, trusts using software such as Hybrid Mail as part of their strategies to become paperless reduce time and costs associated with printing, postage and manually posting letters, as well as more rapid correspondence with GP practices through the use of electronic systems.

However there is a direct link between the bureaucracy faced by trust leaders, and the impact this has on what is required of clinicians, ward managers and other front line staff. For example, information requests that come from NHS England and Improvement involve data collection from the bottom up, and it often falls to these front line staff to compile the necessary information to submit to the trust's leaders, who in turn provide it to NHSE/I. For this reason we do not see it as being possible to separate frontline bureaucracy from the burden placed on trust leaders by national bodies.

In order to reduce the burden on frontline staff, it will be important to consider how reducing systemic inefficiencies and regulatory burden on trusts at large will have a positive effect on the time frontline staff have available to spend on patient care, and enable clinically led transformation and innovation.

Beneficial changes following COVID-19

During the initial stages of the COVID-19 pandemic, there was a wholesale reduction in the amount of regulatory activity and overall burden on trusts, in recognition of the need to give front line services bandwidth to focus on the operational response to COVID-19. There are a number of specific positive changes that trusts have highlighted as being helpful, and have prompted questions about whether these processes are essential for patient care.

- It was confirmed at the start of the pandemic that there would be no contracting round between providers and CCGs in 2020/21. This was welcome, as it would have been an unhelpful distraction in March/April, and a mid-year contracting round would be disruptive, more complex than normal, and a distraction from the priorities the service needs to focus on more immediately. We note that NHS England and Improvement is seeking to move away from the transactional relationship between many trusts and CCGs under the move towards system working and 'system by default.' Trusts broadly welcome the opportunity to develop a more strategic commissioning function, and to move away from the inefficiencies of the transactional back and forth of traditional contracting rounds. Many providers and their CCGs are already working together to achieve this and there are helpful examples, for example, in specialised mental health where provider collaboratives have achieved improvements in quality and efficiency with greater control of commissioning budgets for key services
- Flexibility for trusts to redeploy staff, and recruit new clinicians including fast-tracked final year students, enabled trusts to quickly scale up their workforce in areas needing additional resource. The reduced administration requirements, flexibility in staffing ratios and greater flexibility to provide 'on the job' training allowed trusts to respond to the changing needs of patients quickly.
- Streamlining of discharge processes to community services allowed trusts to free up acute beds and meet rising demand. While there were well-documented challenges related to care home discharges, the discharge-to-assess model has delivered benefits and trusts are eager to maintain this approach going forward. The removal of delayed discharge (DTOC) fines and continuing healthcare assessments (CHC) during the pandemic have also been cited as fundamental in supporting better integrated working. Further consideration of whether these measures genuinely deliver sufficient value given the burden, and the cultural barriers, they create for families and operational staff, would be welcome.
- Reduction of regulatory activity enabled trusts to focus their attention on addressing the immediate challenges of COVID-19. For example, CQC suspended core inspection activity and NHSE/I paused information requests. Trusts have highlighted the need to use this opportunity to consider which elements of the activity suspended during COVID-19 could reasonably be stopped permanently or reintroduced in a streamlined form. CQC have indicated, for example, that they intend to adopt a more risk-based and proportionate approach going forwards and in their new strategy from April 2021, and trusts welcome this change.

While there are clear examples of where COVID-19 has been the catalyst for positive change in the NHS, there is a need to consider how these changes can be safely and appropriately adapted for longer term reform. We would support a leaner, more streamlined approach to the processes

described above with learnings from COVID-19 taken forward, however would emphasise the need to robustly evaluate the impact of such changes and ensure longer term transformation is properly resourced and given time to bed in.

Conclusion

In a high risk sector such as health care, a degree of data collection, regulation and oversight will always be necessary to monitor the performance and safety of NHS services, and to provide nationally comparable information to underpin full transparency and accountability to the public and support trusts to drive their own improvement. However, the volume of reporting requirements faced by trusts is substantial and our members highlight the impact this has on the time they have for other important priorities. Even necessary bureaucracy can be delivered in a burdensome manner for a variety of reasons, and what may appear to be a simple national or regional data request can be time consuming and costly for trusts to collect.

Trusts face substantial bureaucracy at all levels, from regulatory input from the national and regional bodies, to bureaucratic processes undergone by frontline staff. These form part of the same spectrum of bureaucracy and there is a direct link between bureaucracy faced by trust leaders, and the impact this has on what is required of clinicians, ward managers and other frontline staff.

Bureaucracy, where necessary, should contribute valuable insight both for the national bodies and for trusts themselves. Where the national bodies require a data submission, they should be able to demonstrate the value of that information and how it will be used, make available any national level outputs for transparency and for local use. When specific reporting requirements are no longer needed this should be communicated promptly to trusts.

In many ways the relaxation of regulation during the pandemic has been a catalyst for positive change in the NHS with many examples of bureaucracy being reduced to serve the aim of responding to patients during the pandemic. We would support a leaner, more streamlined approach to the processes described above with learning from COVID-19 taken forward. We would also emphasise the need to robustly evaluate the impact of such changes, and to work directly with trusts to ensure the practical benefits of alleviating burden are realised at the frontline.