



Department
of Health

Burden Reduction Plan

Department of Health

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Burden Reduction Plan

Prepared by the Department of Health

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1. Introduction

The primary purpose of the health and social care system is to improve outcomes for people who use its services. The new health and care system has been designed to give greater influence to citizens and service users.

Everyone involved in health, public health and social care needs access to accurate and timely information to carry out their duties. We also have a public duty to collaborate in the interests of good care and outcomes, and in the interests of efficiency and productivity. We must obtain that information efficiently, so that it is not at the expense of direct care to people who need the services. As far as possible, this will be done by ensuring the information is captured once as part of the care-giving process and used for multiple purposes in response to co-ordinated requests across the health and care system. Also, that the information is capable of being extracted automatically to remove the need for separate collection or reporting processes.

1.1 Purpose of the Burden Reduction Plan

Following recommendations from the NHS Confederation in “*Challenging bureaucracy*” (2013), a concordat was agreed by the Department of Health (DH) and Arm’s Length Bodies (ALBs) to govern the collection of data from NHS bodies and secure a more collaborative and systematic approach to data collections across the health and social care system.

To further support and strengthen Burden Reduction Plan activity, George Freeman - Parliamentary Under Secretary of State for Life Sciences, wrote to all ALBs Chief Executive Officers requesting commitment to the development of a 2016/17 Burden Reduction Plan.

In summary, the concordat for reducing burden asks DH and its ALBs to:

- collect data which is proportionate and with a clear business purpose
- not duplicate other data collections
- work through the Health and Social Care Information Centre (HSCIC) as the national base for all data
- review the need to collect the data regularly.

This Burden Reduction Plan sets out DH’s actions to date and planned next steps.

1.2 About the Department of Health

DH¹ helps people to live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

Our responsibilities:

- we lead across health and care by creating national policies and legislation, providing the long-term vision and ambition to meet current and future challenges, putting health and care at the heart of government and being a global leader in health and care policy

¹ <https://www.gov.uk/government/organisations/department-of-health/about>

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- we support the integrity of the system by providing funding, assuring the delivery and continuity of services and accounting to Parliament in a way that represents the best interests of the patient, public and taxpayer
- we champion innovation and improvement by supporting research and technology, promoting honesty, openness and transparency, and instilling a culture that values compassion, dignity and the highest quality of care above everything
- above all, DH encourages staff in every health and care organisation, including our own, to understand and learn from people's experience of health and care and to apply this to everything we do.

Our priorities are:

- improving out-of-hospital care
- creating the safest, highest quality healthcare services
- maintaining and improving performance against care standards while achieving financial balance
- improving efficiency and productivity of the health and care system
- preventing ill health and supporting people to live healthier lives
- supporting research, innovation and growth
- enabling people and communities to make decisions about their own health and care
- building and developing the workforce
- improving services through the use of digital technology, information and transparency.

Our priorities for 2016/17 are set out in our Shared Delivery Plan (SDP)² and this is underpinned by a more detailed internal SDP which sets out key deliverables and associated metrics and information requirements.

DH is a ministerial department supported by 15 ALBs and a number of other agencies and public bodies. DH currently employs 2,160 staff who work in locations across the country, although this number will fall in 2016/17 by approximately 30%.

1.3 Data Collections

DH data collection information which has been assessed by the HSCIC's Burden Advice and Assessment Service is available via the HSCIC's Central Register of Assessed Collections (refer to Annex 1 for a list).

DH has a relatively small commissioning role in terms of data collections and does not usually approach NHS organisations directly.

² <https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020>

2. Department of Health Burden Reduction Activities and Plan

DH is committed to minimising burden and to the concordat recommendations which include:

Date	Concordat Requirement	Description of activity	Timescale
March 2015 - present	Only collect information from service providers where there is a clear business purpose which justifies the administrative burden required to provide the information	<p>Governance Oversight</p> <p>A governance process has been underway to consolidate and review all data commissions from DH to HSCIC, and to support work with ALBs to remove duplication and drive down impact on the system.</p> <p>This governance approach covers all DH directorates, with an operational function overseen by a Senior Civil Service Data Collection Governance Forum. It sets and applies principles for commissioning grant in aid and directly funded data collections from HSCIC.</p> <p>Through the DH HSCIC Sponsor Team, DH maintains oversight of HSCIC's statutory functionality for burden minimisation.</p> <p>For 16/17, DH plans to:</p> <ul style="list-style-type: none"> • continue further streamlining DH's data collections working with HSCIC to ensure that data collected once can be used, where permissible, for several purposes and look at the possibility of automated collection • continue supporting HSCIC in efforts to improve the data quality from providers so that the burden of repeat requests and corrections is minimised • build burden minimisation into core DH Policy Development for DH staff and the Sponsorship Accountability Framework • require policy teams and ministerial offices to have due regard to 	Ongoing

		<p>DH's burden impact, and to review policies for inadvertent burden generation as well as ensuring all proposed measures are clear, simple, expedient and the minimum required</p> <ul style="list-style-type: none"> • implement a programme of work in response to recommendations from Lord Rose's Review "<i>Better Leadership for Tomorrow</i>" (2015). This includes work with NHS England (NHSE) and HSCIC to further challenge the burden minimisation potential of the NHS Standard Contract, to develop burden minimisation criteria for the Clinical Commissioning Group (CCG) scorecard, workforce workshops to audit local burden status and changes / challenges in practice to identify further areas to address. <p>Red Tape Challenge</p> <p>DH is working in partnership with the Department for Business, Innovation and Skills and the Department for Communities and Local Government on a Cutting Red Tape review of care homes.</p> <p>A response and high level action plan will be published alongside the review in 2016. DH will work closely with health and care sector bodies, providers and commissioners to tackle areas where providers have identified that they feel unnecessary burdens are placed on them through data requests and inspections.</p> <p>As part of its stated actions to tackle the volume of information requests, DH will look at how to build on existing examples of good practice in the collection and sharing of data, and consider how to simplify data requests and returns, and what scope there is to share more information to reduce overall demands.</p> <p>Parliament challenge - £10 billion savings</p> <p>DH is supporting the government to meet its manifesto commitment to deliver £10 billion savings for business over this parliament.</p> <p>DH is working to identify a forward programme of de-regulatory activity, in the public and private sectors of health and care over the rest of the parliament. In doing this, we are looking at opportunities to tackle unnecessary burdensome reports and information requests from DH to health and social care providers.</p>	
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<p>March 2015 - present</p>	<p>Work with the HSCIC as the national base for all information which is collected or extracted from local systems.</p>	<p>DH HSCIC Sponsorship Liaison with HSCIC</p> <p>Continue work with HSCIC when designing new data collections to ensure that they are not duplicating other existing data collections and that they are designed in a way to minimise burden on the service.</p> <p>DH is represented on HSCIC's Burden Advice and Assessment Service Board to provide support and challenge to associated work - includes work on HSCIC's three-yearly review of data collections to minimise burden.</p> <p>Continue work to lead cross-system discussions to stop moving costs around the health and care system for collections, consolidate existing collections from other ALBs to HSCIC and support more effective data linkage.</p> <p>DH plans to work with HSCIC's Burden, Advice and Assessment Service on improving the transparency of HSCIC's methodology for assessing burden and assessments, strengthening the methodology to ensure it continues to be fit for purpose. Also, to ensure more universal assessment of collections currently bypassing this process including from DH.</p> <p>Annex 1 sets out a list of 2015/16 DH-sponsored data collections which have been burden assessed by HSCIC's Burden Advice and Assessment Service.</p>	<p>Ongoing</p>
<p>March 2015 - present</p>	<p>Establish clear criteria which can be used to measure the administrative burden arising from each national request for information</p>	<p>DH HSCIC Sponsorship Liaison with HSCIC</p> <p>Continued involvement in an HSCIC-organised panel of representatives across the health and social care sectors which looks at new and existing applications to ensure that their burden levels are sensible and reflect local practice and that collection methods are also appropriate and not duplicated. Applicants are required to explain fully the purpose of the collection, the burden level by organisation i.e. Local Authority, NHS Trust, GP practice etc, whether sampling would be appropriate and any plans for publication.</p>	<p>Ongoing</p>
<p>March 2015 - present</p>	<p>Through HSCIC, publish details of all the national collections and extractions, and the</p>	<p>HSCIC Register</p> <p>DH's sponsored collections undertaken by HSCIC are listed on HSCIC's Central Register of Assessed Collections (see Annex 1).</p>	<p>Ongoing</p>

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	criteria that are used to justify each decision.		
March 2015 - present	Where appropriate, ensure that all aggregated and non-personal information that is collected is made available for others to use, in the interests of transparency and avoiding duplication.	HSCIC This information is available via the HSCIC.	Ongoing
March 2015 - present	Agree with HSCIC an annual MOU which sets out each organisation's commitment to an agreed reduction in data collections that are undertaken outside the national process managed by HSCIC.	HSCIC/DH Liaison This recommendation does not apply to DH as a Department of State and given DH's role as system convener, holding the HSCIC to account.	N/A
March 2015 - present	Ensuring that the collections and extractions are aligned with robust professional practice such as NICE or other professional guidelines and	DH/HSCIC Accountability Adherence to professional practice and guidelines / information standards is a routine item of assurance that is checked at least once annually at an accountability pre-meeting between DH and HSCIC.	Ongoing

	information standards.		
March 2015 - present	Reducing and retiring those national requests for information that are no longer needed or justifiable.	<p>DH HSCIC Sponsorship</p> <p>As referred earlier, DH is working with HSCIC to ensure a comprehensive consultation on changes to official and experimental statistics. This will ensure ongoing collections have a clear purpose and audience.</p> <p>DH's HSCIC Sponsor Team continues to support cross-system discussions to stop moving costs around the health and care system for collections, consolidate existing collections from other ALBs to HSCIC and support more effective data linkage.</p> <p>DH has a role in seeking a Ministerial steer on which collections should continue / the relative prioritisation of major collections and will ensure this takes place during 16/17, working with HSCIC and ALBs to take key decisions in support of achieving greater efficiencies and decreasing burden minimisation associated with data collections.</p>	Ongoing
March 2015 - present	Keep these arrangements under regular review and contribute to HSCIC's annual report detailing their progress in reducing burden, with clear reference to the targets agreed in the MOU.	<p>DH/HSCIC Liaison</p> <p>Continued work with HSCIC's Informatics and Analytics Directorate.</p> <p>Continued work with HSCIC's Burden Advice and Assessment Service.</p> <p>Plan to undertake a formal review of HSCIC's statutory duty on reducing burden at least annually via the accountability process, under the direction of the Senior Departmental Sponsor.</p>	Ongoing
March 2015 - present	Work closely with HSCIC on the three year review of existing data	<p>DH/HSCIC Liaison</p> <p>Continued work with HSCIC's Burden Advice and Assessment Service.</p> <p>As referred earlier, DH is working with HSCIC to ensure a comprehensive consultation on changes to official and experimental statistics. DH's HSCIC</p>	Ongoing

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	collections to make sure that collections are still necessary, are not being collected elsewhere, and are collected in the most efficient and least burdensome way possible.	Sponsor Team will work with DH Policy Teams to ensure a consolidated DH response.	
March 2015 - present	Work closely with HSCIC when designing new data collections to ensure that they are not duplicating any other existing data collections and that they are designed in a way to minimise burden on the service.	<p>DH/HSCIC Liaison</p> <p>DH policy teams to ensure that HSCIC experts are involved in the early stages of development of policy to design appropriate and proportionate metrics and collections.</p>	Ongoing
March 2015 - present	Making better use of technology to introduce more efficient ways of acquiring the information especially by moving away from manual collections to	<p>Strategic Objectives</p> <p>DH will issue a remit^[1] to HSCIC which encompasses DH's requirement for HSCIC to make progress on big data, automation and data access solutions instead of multiple data releases. This remit will inform HSCIC's business planning.</p> <p>A number of the informatics and digital technology programmes that will support delivery of a paperless health and care system will contribute to reducing the</p>	Ongoing

^[1] "Remit" is the new name for the previous "Letter of Priorities/Mandate".

	<p>automated extractions of data directly from local systems, and using existing data held nationally.</p>	<p>administrative burden for front line services. This includes more effective utilisation of existing national infrastructure such as the NHS e-Referral system and the Electronic Prescription Service (EPS), wider adoption of local clinical IT systems such as electronic health records and e-prescribing systems in hospitals, as well as new programmes introduced as a result of “<i>Personalised Health and Care 2020</i>”, for example to ensure inter-operability of records. DH’s ALBs lead the work to commission and deliver this portfolio of programmes and where relevant these should be reflected in their own Burden Reduction Plans.</p> <p>GP Burden Reduction</p> <p>DH is working with NHSE which has lead responsibility for helping general practices reduce avoidable workload and free up time, with a view to helping resources go further in terms of outputs and outcomes. Future plans include streamlining payment systems so that practices do not have to chase different organisations for payment, and helping surgeries become paperless. Work is ongoing and we will be publishing further details later in the year.</p> <p>The 2016/17 GP contract was agreed in February and sets out actions on patient online services which include an emphasis on supporting burden minimisation wherever possible. For example:</p> <ul style="list-style-type: none"> • GP practices will be encouraged to transmit prescriptions electronically using EPS Release 2, unless the patient asks for a paper prescription or the necessary legislative or technical enablers are not in place. DH, other government departments, NHSE, NHS Employers and the General Practitioners Committee of the British Medical Association have agreed to aim for at least 80 per cent of repeat prescriptions to be transmitted electronically by 31 March 2017 • GP practices will be encouraged to make referrals electronically using the NHS e-Referral Service aiming for at least 80 per cent of elective referrals to be made electronically by 31 March 2017 • to support the increased use of inter-operable records, the NHS Standard Contract requires providers to send their discharge 	
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		<p>summaries electronically to GP practices from 1 October 2015. From April 2016, GP practices will be required to receive all discharge summaries and subsequent post-event messages, electronically.</p> <p>Changes to Existing Data Collections</p> <p>The provider of the “degree days” data collection has offered to work with DH and HSCIC to provide the data in a format which can be loaded in one operation rather than being inputted manually. This would save time within DH and HSCIC in the medium to longer term but is subject to funding.</p> <p>DH is working with HSCIC to ensure a comprehensive consultation on changes to official and experimental statistics. This will ensure ongoing collections have a clear purpose and audience.</p>	
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3. Next Steps

Through the range of actions set out in this Burden Reduction Plan, DH is committed to ensuring that information is collected in the most efficient and productive way to support people delivering and using health and care services.

To achieve this, DH will continue to work as system convenor leading and supporting collaboration across ALBs and partners to manage the burden of data collection better - from processes used to collect and record data, through to the extraction of data and smarter technology solutions to streamline data collections.

Specific work programmes are underway to review DH's own collection requirements and consider where further reductions in burden can be achieved. DH will continue work with ALBs and other partners to understand the system-wide impact of this work, ultimately focusing on achieving a clear position on what data is collected and the methods in which it is collected are of value in assessing and improving patient care, and not unnecessarily burdensome to staff delivering these important services.

As we take this work forward, DH will ensure Ministerial advice is sought to inform changes about which collections should continue and their relative prioritisation. DH will also work with other government departments to ensure due regard is taken at the outset of policies / requests for data from the health and care system.

DH's Burden Reduction Plan will be monitored via close liaison with HSCIC's Burden Advice and Assessment Service.

Annex 1: Department of Health Collections on the Burden Advice and Assessment Service Online Catalogue

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Estates Return Information Collection (ERIC)	Annual Ambulance Foundation Trust; Ambulance Non Foundation Trust; Acute Non Foundation Trust; Acute Foundation Trust; Mental Health Non Foundation Trust; Mental Health Foundation Trust; Care Non Foundation Trust; Care Foundation Trust	ERIC collects data annually on NHS estate and related services e.g. cleaning, energy and food. It is the only collection that does this for the NHS Estates & Facilities which costs £8.3 billion annually to run and is the largest asset in the NHS at £38 billion. DH sponsor it to support policy development, investment planning and efficiency improvement. The current key usage of the ERIC data is to deliver £1 billion of savings by 2020. In addition, the NHS want the ERIC data collected locally as they use it for benchmarking, contract planning and efficiency improvement.	3,336	906,998

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Non-medical device defects and failures reporting system	Ad-hoc Mental Health Foundation Trust; Acute Foundation Trust; Acute Non Foundation Trust	DH sponsored collection of data about estates related safety. Incidents are reported by the NHS enabling policy improvement and National Safety Alerts to be issued covering a wide range of Estates related safety incidents. Examples have included addressing the death of vulnerable patients and neonates from Pseudomonas in water supply, and fatalities caused by falls from height. NHS Trusts are required to report defects and failures relating to the safety of non-medical equipment to allow action to be co-ordinated centrally and other users to be warned of any safety implications	4.88	1,473.37
Quarterly Monitoring of Cancelled Operations (QMCO)	Quarterly Commissioning Support Units (CSU); Acute Foundation Trust; Acute Non Foundation Trust	This is a quarterly collection to monitor ongoing performance against the cancelled operations standard that patients should be re-admitted within 28 days of a cancellation for non-clinical reason. It includes information on the number of cancellations, number of 28 day breaches and also number of operating theatres.	48.16	10,963.14

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
National Joint Registry	Annual Acute Foundation Trust; Acute Non Foundation Trust	Established in 2003 with the purpose of improving the health and wellbeing of the population of England and Wales through the early identification of failing hip and knee prostheses. Ankles were added to the Registry in October 2009 and Elbows and Shoulders in April 2012.	1522.58	699,399.72
DC01 - Dental Commissioning	Quarterly Clinical Commissioning Group (CCG)	The DC01 is a collection of dental commissioning figures. This allows progress in meeting local demand for NHS dental access.	112.53	25,617.09
Reference costs collection	Annual Acute Non Foundation Trust; Acute Foundation Trust; Ambulance Non	Reference costs are the average unit costs to the NHS of providing defined services in a given financial year to NHS patients in England, collected and published annually since 1997-98. The most high profile use of reference costs is to underpin the calculation of the national tariff. Reference costs have a number of other uses besides informing the national tariff, including benchmarking, accountability to parliament and the public for the use of NHS resources, and academic	22687	105,756,55.59

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		research.		
General Practice (including dental) written complaints (K041B)	Quarterly NHS England - Local Area Teams; GP Practice	The collection gathers data on the number of written complaints received by the NHS by organisation, categorised by subject profession and service area. They indicate what proportion of complaints were resolved locally, the broad subject areas into which complaints fall, and the timescales for resolution. Complaints handling is a key priority for the NHS and this data is used as part of the evaluation process. It allows the public to see how organisations are performing in respect of complaints, and assists in identifying potentially poorly performing ones. If the data was not collected, there could be serious implications for patients, and deprive NHS England and DH of valuable intelligence on the performance of the NHS.	800.2	229,122.28

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Hospital and Community Health Services (HCHS) Complaints (K041A)	Quarterly Acute Non Foundation Trusts; Acute Foundation Trust; Ambulance Non Foundation Trust; Ambulance Foundation Trust; Care Non Foundation Trust; Care Foundation	The information obtained from the K041A collection monitors written Hospital and Community Health Service complaints (by service area and type) received by the NHS each year.	498.13	180,237.09
Financial Monitoring & Accounts	Quarterly Ambulance Non Foundation Trust; Mental Health Non Foundation Trust; Acute Non Foundation Trust	The data items are required to allow DH to monitor the financial performance of the NHS and to hold each organisation to account at year end.	559.29	127,316.52

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Referral to Treatment Monthly Returns	Monthly Acute Non Foundation Trust; Acute Foundation Trust; Care Non	To monitor consultant-led Referral to Treatment (RTT) waiting times for patients who were treated during the month and patients waiting to start treatment at the end of the month. Data is used to monitor delivery centrally and locally of waiting time operational standards.	12144	3,060,740.64
PharmEx - electronic collection of hospital pharmacy purchasing data	Monthly Acute Foundation Trust; Acute Non Foundation Trust; Mental Health Foundation Trust; Mental Health Non Foundation Trust	The Pharmex system – the electronic capture of NHS Trust medicines purchasing information from their pharmacy computer systems - was established to support the delivery of the NHS Supply Chain Excellence Scheme.	156	35,511.84
Financial Accounting Consolidation Schedules	Quarterly Special Health Authorities	Preparation of statutory DH Annual Report and Accounts. Collection of in-year budgetary monitoring data. The data is collected primarily for the	864	196,680.96

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		purpose of accountability to parliament and the taxpayer. Additionally, it supports the effective management of resources within the departmental group and NHS.		
General Ophthalmic Services Workforce Statistics for England and Wales Annual Return of Practitioners and Premises	Annual Clinical Commissioning Group (CCG)	Used to monitor availability of practitioners to carry out NHS sight tests. Assists in deliberations of considering sight test fee for Optometrists and Ophthalmic Medical Practitioners. Used in sampling frame for Opticians Workload Survey (OMP Data).	20.63	5,073.97
General Ophthalmic Services Activity Statistics - Sight Tests, Vouchers and Repairs SBE515	Annual NHS England – Local Area Teams	This collection provides information to the DH to monitor the provision of ophthalmic services and plan ophthalmic expenditure and services. These data are used in negotiations about the sight test fee.	59.39	16,038.98
Mandatory HCAI surveillance - orthopaedic SSIs	Annual Acute Foundation Trust; Acute Non Foundation Trust	This concerns the mandatory surveillance of healthcare associated infection (HCAI) - for orthopaedic surgical site infection (SSIs). Mandatory data from Trusts on the incidence of orthopaedic SSI for a minimum of one quarter per financial year. The incidence surveillance dataset includes any SSI that occurs in a patient after the operation. Surveillance data on SSIs have three main	1277.39	491,548.73

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		uses; one is for Trusts to monitor and improve their own performance, as it allows them to benchmark themselves against equivalent organisations, and another is to provide the national picture. The third is to inform patient choice. Data on SSIs are used primarily by Trusts. However, the data are available to the public and used by NHS Choices to provide information about risks of infection following orthopaedic surgery at individual Trusts.		
Neonatal Critical Care Minimum Dataset (NCCMDS)	Monthly Acute Non Foundation Trust; Acute Foundation Trust	NCCMDS is the minimum dataset that is required to allow the assignment of Neonatal Critical Care Healthcare Resource Groups (HRGs), which will include data relating to episodes of Neonatal Critical Care for patients discharged.	1460.69	332,512.23
Paediatric Critical Care Minimum Dataset (PCCMDS)	Monthly Acute Non Foundation Trust; Acute Foundation Trust	PCCMDS is the minimum dataset that is required to allow the assignment of Paediatric Critical Care Healthcare Resource Groups (HRGs).	3099.52	1,051,686.15

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Workforce Minimum Data Set - Acute, AQP, Independent, Secondary sectors	Quarterly Acute Foundation Trust; Any Qualified Provider; Independent and Voluntary Sector; Social Enterprises	Detailed individual staff member level data about the workforce employed across the country in organisations providing NHS funded services across the acute, any qualified provider, independent/'private' and secondary care sectors. Purpose of this collection is principally to inform the workforce planning agenda nationally, regionally and locally to provide data to Health Education England and Local Education & Training Boards via the HSCIC (who will conduct the process) for workforce planning and education and training commissioning. To enable the collation of workforce data 'once and once only' for other users in order to reduce burden on providers, commissioners and all users of this data.	365.28	101,279.84

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Surveillance of Healthcare Associated Infections	Annual Acute Foundation Trust; Acute Non Foundation Trust; Clinical Commissioning Group (CCG); NHS England	<p>This concerns the mandatory surveillance of healthcare associated infections (HCAI) - C. difficile infection (CDI), MRSA, E. coli (from June 2011) and MSSA (from January 2011) blood stream infections. These data are to monitor progress on controlling these infections and to provide epidemiological evidence to inform action to reduce them. It also enables benchmarking and performance management for MRSA and CDI.</p> <p>The system also currently collects quarterly returns on the following items:</p> <ul style="list-style-type: none"> - Total blood cultures examined - Positive blood cultures - Number of Staphylococcus aureus positive blood cultures - Total stool samples examined - Number of C. difficile toxin tests - Number of C. difficile positive tests >= 65 	860.81	337,684.93

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		years - Number of C. difficile positive tests 2 - 64 years		
NHS Dental Epidemiology Programme	Annual	Annual surveys of differing groups of children and adults each year, to measure oral health; including levels of tooth decay in 5 year olds alternate years (PHOF indicator) in all Local Authorities.	1400	568,946
Surplus Land for Housing	Annual Clinical Commissioning Group (CCG)	The data collected is the land and buildings, identified by NHS Trusts, which are classified as either currently surplus or potentially surplus up to 2025. The purpose is to monitor the level of contribution the NHS can make to the government initiative to release enough public land to build as many as 150,000 new homes. This will determine the local and national level of surplus land and buildings across the NHS. This collection is to support the DCLG's " <i>Accelerating the Release of Public Sector Land for Housing</i> " initiative which has the personal support and attention of the Prime Minister, HM Treasury and the Secretary of State for Health.	96	47,616.96

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		The original initiative lasted until 2015. However, at the Autumn Statement 2012, a new one was launched for the period between 2015-20 to deliver additional sales of public sector land including that for homes.		
Adult Screening Programmes Cervical Screening (KC53)	Annual Clinical Commissioning Group (CCG)	KC53 includes information about the cervical screening call and recall programme, test results of cervical screening samples and time from test to notification of result. Contributes to monitoring progress towards achieving the OHN cancer target and to ensure that the screening programme is managed effectively.	81.07	18,454.02
Colposcopy clinics, referrals, treatments and outcomes (KC65)	Annual Clinical Commissioning Group (CCG); Acute Non Foundation Trust; Acute Foundation Trust	KC65 includes information about investigations undertaken in colposcopy clinics, subsequent biopsy results and time to notification of results. Contributes to monitoring progress towards achieving the OHN cancer target and to ensure that the screening programme is managed effectively.	1379.77	406,634.18

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Diagnostic Departments- Radiology, nuclear medicine and medical physics	Annual Acute Non Foundation Trust; Acute Foundation Trust	Support the provision of radioactive emission data for an European Commission directive (Council Directive 96/29/Euratom - the Basic Safety Standards Directive, Article 45 and Council Directive 97/43/Euratom - the Medical Exposure Directive Article 12).	60.12	16,872.76
NHS Stop Smoking Services Quarterly Monitoring Return	Quarterly Clinical Commissioning Group (CCG)	This information monitors the number of people setting smoking quit dates and number successfully quitting at 4 weeks. It includes information about people using the services e.g. age, gender, ethnicity.	445.87	221,154.33
Critical Care Minimum Dataset	Quarterly Acute Non Foundation Trust; Acute Foundation Trust	Data on critical care activity to support 'Payment by Results' and the implementation of critical care Healthcare Resource Groups.	259.78	75,071.03

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
National Direct Access Audiology PTL and WT Dataset	Monthly Commissioning Support Units (CSU); Acute Non Foundation Trust; Acute Foundation Trust	The national Audiology PTL and WT dataset is intended to collect a set of performance information on Referral To Treatment (RTT) pathways of patients receiving audiology treatment in England, who are not already included in the 18 week RTT data collection.	250.67	57,061.76
Reporting data about necessary and planned treatment of overseas visitors from the European Economic Area (EEA)	Monthly Mental Health Foundation Trust; Acute Non Foundation Trust; Mental Health Non Foundation Trust; Acute Foundation Trust; Care Foundation Trust; Care Non Foundation Trust	To ensure NHS Overseas Visitor Managers follow DH arrangements for recording and reporting treatments (including planned treatments) of visitors from the EEA and Switzerland. To ensure that DH maximise the money collected from other EEA Member States for treatment carried out by the NHS.	1491.2	339,456.77

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Advisory Committee on Clinical Excellence Awards (ACCEA) - Employer Based Awards Reports	Annual Ambulance Non Foundation Trust; Ambulance Foundation Trust; Acute Non Foundation Trust; Acute Foundation Trust; Mental Health Non Foundation Trust; Mental Health Foundation Trust; Care Non Foundation Trust; Care Foundation Trust	For Trusts to provide us with details of Employer Based Award holders & those eligible to apply via an Annual Report.	48.4	11,017.78
Advisory Committee on Clinical Excellence Awards (ACCEA) - Collection of non-ESR items	Annual Ambulance Non Foundation Trust; Ambulance	For Trusts to provide us with details of Employer Based Award holders & those eligible to apply via an Annual Report.	32	15,872.32

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
	Foundation Trust; Acute Non Foundation Trust; Acute Foundation Trust; Mental Health Non Foundation Trust; Mental Health Foundation Trust; Care Non Foundation Trust; Care Foundation Trust			
Patient Safety Incidents (formerly known as Patient Safety and Healthcare Incidents)	Ad hoc GP Practice; Acute Non Foundation Trust; Mental Health Non Foundation Trust; Acute Foundation Trust; Mental Health Foundation Trust; Independent	Collated for the purpose of deriving national learning and improvements in patient safety, as part of the function of the patient safety domain at NHS England. CQC also use the serious incidents within their remit of managing the performance of NHS organisations within England. This data is also used to populate several indicators in the Outcomes Framework. The data we gather through the National Reporting and Learning System enables us to identify emerging risks and patterns in	489.78	111,493.01

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What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
	and Voluntary Sector	patient safety incidents at a national level, which may not be obvious at a local level. We review all incidents reported as resulting in death and severe harm to identify the highest risk areas. The data also provides a rich source of information for patient safety research teams at universities and in hospitals, galvanising innovation in safety care. We are also able to share the data with key national partners and regulators such as the CQC and the Medicines and Healthcare Products Regulatory Agency, as required by statute.		
Mixed Sex Accommodation (MSA) Monthly Return	Monthly Care Non Foundation Trust; Care Foundation Trust; Acute Non Foundation Trust; Mental Health Non Foundation Trust; Acute	In August 2010 the Secretary of State for Health announced new steps to ensure that NHS organisations eliminate mixed sex accommodation (MSA) where there is no clinical justification. The definition is: “Mixed-sex accommodation will be eliminated except where it is in the patient’s overall best interest, or reflects their personal choice”.	981.89	376,014.98

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
	Foundation Trust; Mental Health Foundation Trust	Since January 2011, routine reporting of NHS organisations' MSA breaches has been introduced so that patients and members of the public can see which Trusts are the worst performing organisations.		
National Capabilities Survey	Biennial Clinical Commissioning Group (CCG); Care Non Foundation Trust; Ambulance Foundation Trust; Ambulance Non Foundation Trust; Acute Foundation Trust; Acute Non Foundation Trust; Mental Health Non Foundation Trust; Mental Health Foundation Trust	The survey will go to all Category 1 and 2 Health responders, which are organisations at the core of the response to national emergencies and subject to duties in the Civil Contingencies Act.	62.17	39,772.37

Burden Reduction Plan

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
Ambulance Quality Indicators	<p>Monthly</p> <p>Ambulance Non Foundation Trust; Ambulance Foundation Trust</p>	<p>NHS England publishes data monthly and HSCIC publish data annually. The measures on ambulance response in 8 and 19 minutes are in the Handbook to the NHS Constitution. Other system indicators include abandoned 999 calls, and calls resolved without dispatch or patient transportation. There are also measures of clinical outcomes including return of spontaneous circulation and survival to discharge following cardiac arrest. The addition of clinical outcomes in 2011 was welcomed by NAO (www.nao.org.uk/report/transforming-nhs-ambulance-services) and the College of Emergency Medicine (www.unisoneastern.org.uk/news/patients-to-be-at-the-heart-of-ae-and-ambulance-care).</p>	288	65,560.32

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
PLACE (Patient Led Assessments of the Care Environment)	Annual Acute Foundation Trust; Acute Non Foundation Trust; Mental Health Foundation Trust; Mental Health Non Foundation Trust; Care Foundation Trust; Care Non Foundation Trust	In January 2012, the Prime Minister announced that new patient-led assessments of NHS-funded non-clinical care would be in place by April 2013. The PLACE assessment gives patients a definitive voice in the assessment of privacy and dignity, cleanliness, food and facilities in order to inform patient choice and drive improvement. The project: <ul style="list-style-type: none"> • delivers a valid and reliable assessment process from the perspective of patients or users of the standards of cleanliness, food and privacy and dignity • clearly identifies areas that patients believe are in need of improvement • offers a framework for 	7888	3,0000003

³ Note, this figure has been disputed as inaccurate. HSCIC's Burden Assessment and Advice Service has agreed to undertake a fresh assessment with a view to confirming; suggested that a more accurate figure is £1,400,000.

Burden Reduction Plan

What do DH collect?	How often and from whom?	Why do we collect it?	Estimated annual burden 2016	
			Average person (full-time equivalent) days	£
		individual hospitals to plan improvement <ul style="list-style-type: none"> • is broadly cost neutral once in use • is aligned with, and supportive of, other inspection, monitoring and performance regimes including CQC commissioners and HealthWatch. 		

Annex 2: DH Data Collection Burden Reduction Activities

Burden Reduction Activity	Description	Timescale
DH governance of grant in aid and directly funded data collections	<p>Continue work across DH, with HSCIC and ALBs to remove unnecessary duplication and look at achieving more efficiencies in the way these data collections are processed i.e. sequencing of publications.</p> <p>Look at ways of moving to a more strategic automated system for data collection and extraction.</p> <p>Broader activities include:</p> <ul style="list-style-type: none"> • build burden minimisation into core DH Policy Development for DH staff and the Sponsorship Accountability Framework • commit ministerial teams to reducing inadvertent burden generation, making better use of existing resources to further lessen DH's impact as a national body • implement a programme of work in response to recommendations made by Lord Rose's Review "<i>Better leadership for tomorrow</i>" (2015). 	Ongoing
Review DH's Burden Reduction Plan	Work with HSCIC to review delivery against commitments and to minimise burden on a regular basis whilst updating the Plan on an annual basis.	Annual

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Burden Reduction Activity	Description	Timescale
3 Year Review	<p>Work with HSCIC on its 3 year review of existing data collections to make sure DH collections are still needed, not being collected elsewhere and are collected in the most efficient and least burdensome way possible.</p> <p>Look at whether and how collections including those from DH have circumnavigated HSCIC's Burden and Assessment Advice Service and ought to be included in the least burdensome but necessary / helpful way.</p>	Ongoing
New collections	Work with HSCIC when designing new collections to ensure they are not duplicating any other collections and are designed in a way to minimise burden on the service.	Ongoing
Burden Advice and Assessment Service Panel	Involvement in HSCIC-organised panel of representatives across health and social care sector which looks at new and existing applications to ensure their burden levels are sensible and reflect local practice and that collection methods are also appropriate and not duplicate.	Ongoing
Publications	Work with HSCIC to ensure publication of all national collections and extractions including criteria to justify.	Ongoing
Personal information management	Work with HSCIC to ensure all aggregated and non-personal information that is collected is made available for others to use.	Ongoing
Professional guidelines / information standards adherence	Work with HSCIC via accountability mechanism to ensure adherence to professional guidelines / information standards.	Quarterly

Burden Reduction Activity	Description	Timescale
Red Tape Challenge	<p>Look at how to build on existing examples of good practice in the collection and sharing of data.</p> <p>Consider how to simplify data requests and returns.</p> <p>Consider what scope there is to share more information to reduce overall demands.</p>	Ongoing
Business Impact Target	Identify a forward programme of de-regulatory activity, in both the public and private sectors of health and social care over the rest of the parliament.	Duration of this parliament
Provision of degree day data to NHS for use by energy managers	The need for the provision of this data is reviewed annually. Subject to this review the contract for the provision of the data is renewed.	Every year
Non-medical device defects and failures reporting system	<p>There is a “1st Alert” issued in January each year. The content of the Alert is reviewed each year to ensure it only requests the information that is required to help ensure estates related safety and business continuity incidents are investigated. All NHS healthcare providers, commissioners, dental practices and GP surgeries should also report defects and failures involving engineering plant, infrastructure and non-medical devices to DH. This enables the sharing of information across all NHS service providers via the Central Alerting System.</p>	Every year
Patient-Led Assessment of the Care Environment (PLACE)	<p>This collection is reviewed by HSCIC, DH and NHS England in partnership every year. Each individual change is assessed in terms of the burden, with a reduction in burden as a prime aim.</p> <p>PLACE is tailored so that hospitals only answer questions directly relevant to them. Where a specific service does not exist in a hospital, it is excluded so that each site is assessed on the absolute minimum data set. Subject to agreement, we plan a full review of PLACE after the fifth annual round (2017).</p>	<p>Every year</p> <p>After five years</p>

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Burden Reduction Activity	Description	Timescale
<p>Estates Return Information Collection (ERIC)</p>	<p>A Working Group of stakeholders including the NHS oversees the ERIC collection and advises on its coverage and definitions etc. They provide advice on the practicality and burden of data items.</p> <p>Each year, the data items collected in ERIC are reviewed to ensure they best meet the needs of stakeholders. In addition, formal independent reviews are undertaken occasionally with the last ones occurring in 2014.</p> <p>In addition to reducing the burden in terms of the number of data items in ERIC, coverage of the collection has been tailored so that organisations are not asked for data that is not important to them e.g. Ambulance Trusts are not asked for data on patient meals.</p>	<p>The Working Group meets three times a year.</p> <p>Annual reviews undertaken</p> <p>Undertaken as part of the Annual review.</p>