



Department
of Health &
Social Care

Busting Bureaucracy

**Empowering frontline staff by reducing excess
bureaucracy in the health and care system in England**

November 2020

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Foreword from the Secretary of State

There is an irreducible minimum level of bureaucracy in any complex system. Rules and processes are essential means to manage risk and, in the context of health and care, keep people safe and help ensure a consistent level of quality care and outcomes across the country. But excess bureaucracy reduces the time that staff have for care and hinders staff and leaders from deciding how to manage risk, being creative, innovating to fix problems, empowering others and being flexible. This negatively impacts staff well-being, morale and retention while hindering the very outcomes the processes aim to support.

While England has a relatively efficient health and care system in some respects, we have heard from stakeholders that opportunities remain to free up time for frontline staff. For instance, around a third of a community-based clinician's time is estimated to be spent on administration and patient coordination, while important processes such as medical appraisals have increased in paperwork over the years.

The COVID-19 pandemic has shown us that streamlining bureaucratic processes can release time for our workforce to prioritise care. Local and national healthcare leaders have introduced changes within weeks that that have been talked about for years. Managers and regulators have paused some data requests and streamlined inspections, liberating and empowering frontline staff to focus on delivering the best care possible. Now is the time to capitalise on these experiences and build back better by creating a post-pandemic world where staff are released from unnecessary bureaucratic burdens, leading to better outcomes and experience for patients and care users.

This document details the key actions that are needed across the health and care system, and the steps this government will take. They are drawn in part from the listening exercise with frontline health and care staff I launched this summer through which we received contributions from more than 600 people with their real-life examples of excess bureaucracy they faced in their day jobs. We also received input from a wide range of other stakeholders in the health and care system, including professional bodies, commissioners, academics, patient groups and providers. I am grateful to all who took the time to contribute their powerful testimony. It provides us an outstanding opportunity to strip back unnecessary burdens so that doctors, nurses, care workers and other frontline staff can get back to providing the best care for all of us.



The Rt Hon Matt Hancock MP

Secretary of State for Health and Social Care

1. What does bureaucracy look like in the health and care system?

1.1 This chapter:

- (a) Sets out what is meant by excess bureaucracy;
- (b) Describes the main manifestations of excess bureaucracy in the health and care system; and
- (c) Explains how wider culture and support can help reduce excess bureaucracy.

What do we mean by excess bureaucracy?

- 1.2 There is an irreducible minimum level of bureaucracy in any complex system. Rules and processes are essential means to manage risk and, in the context of health and care, keep people safe and help ensure a consistent level of quality care and outcomes across the country. But when bureaucracy becomes excessive, it reduces the time that staff have for care and hinders them from deciding how to manage risk, being creative, innovating to fix problems, empowering others and being flexible. This can negatively impact staff well-being, morale and retention while potentially hampering the very outcomes the processes aim to support.
- 1.3 The government's focus is on limiting excess bureaucracy, defined as: excessively complex rules (whether legal, organisational or cultural) or assurance and reporting administrative processes, which either have no benefit, or have no net benefit as they are unduly resource intensive, inefficient and time consuming.

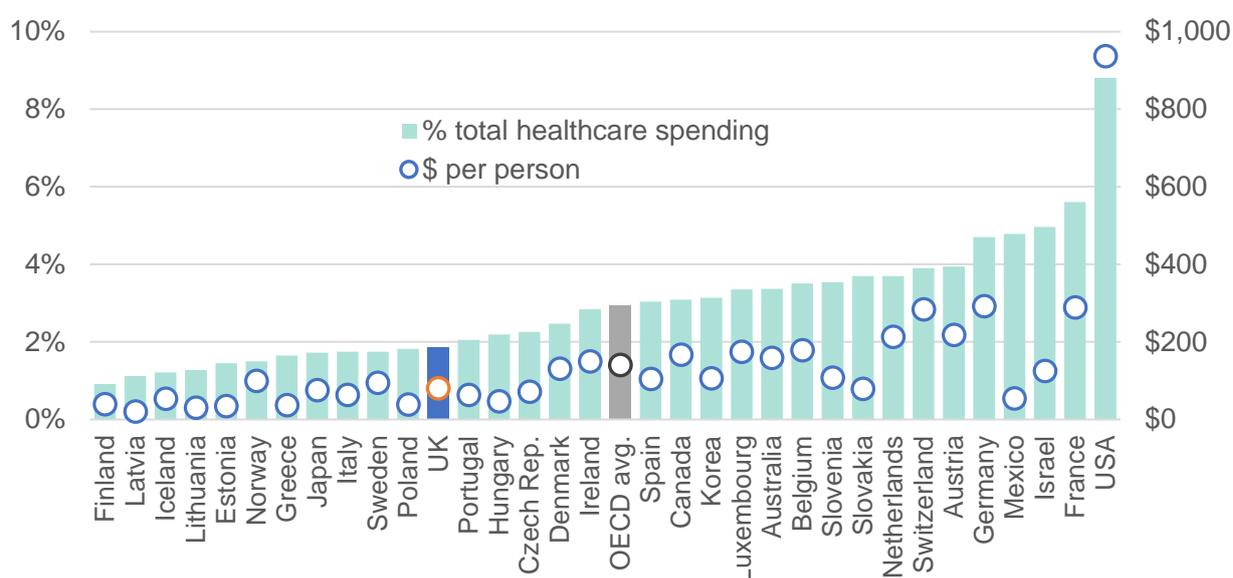
“Our members recognise the need for effective and proportionate regulation, that keeps them safe and drives improvement. But too often we over report, and over regulate in a way that adds little to quality, innovation or patient safety.” NHS Confederation

“We have 152 versions of every wheel that's ever created. 152 contracts for purchasing home care services, adults safeguarding policies and procedures.” UK Homecare Association

Main manifestations of bureaucracy

- 1.4 In many respects there is much to be proud of. The UK spends only around 2% of healthcare expenditure on administration, a third less than the OECD average and under half that of Germany and France (Figure 1). This indicates relatively high levels of efficiency. Only around 3% of NHS staff are non-clinical managers in NHS trusts, commissioners and central organisations or support bodies. The number of managers increased by only 1% in the 10 years to September 2019, at the same time the number of doctors and nurses rose by almost 10%.

Figure 1: Healthcare administration costs in OECD countries, 2019 (or nearest)



Source: [OECD](#)

- 1.5 Administration costs, however, are not the sole measure of bureaucracy and bureaucracy cannot necessarily be equated with the number of managers. Indeed, good managers are critical to any well-functioning organisation or system, ensuring the right tasks are done by the right people. But frontline staff report that too much of their time is still spent on administrative tasks, meaning less time for the direct care of patients and service users. For example, around a third of a community-based clinician's time (or 88 days per working year) is estimated to be spent on administration and patient coordination. Similarly, over half of doctors report that at least one hour of their work each day could be carried out by non-clinical staff.
- 1.6 That health and care staff are often time poor, with bureaucratic burdens taking up too much of their time, is also what we heard from our engagement across the system from: stakeholders, focus groups and our [Call for Evidence](#). We heard that time spent on "unnecessary bureaucracy" takes staff away from patients and

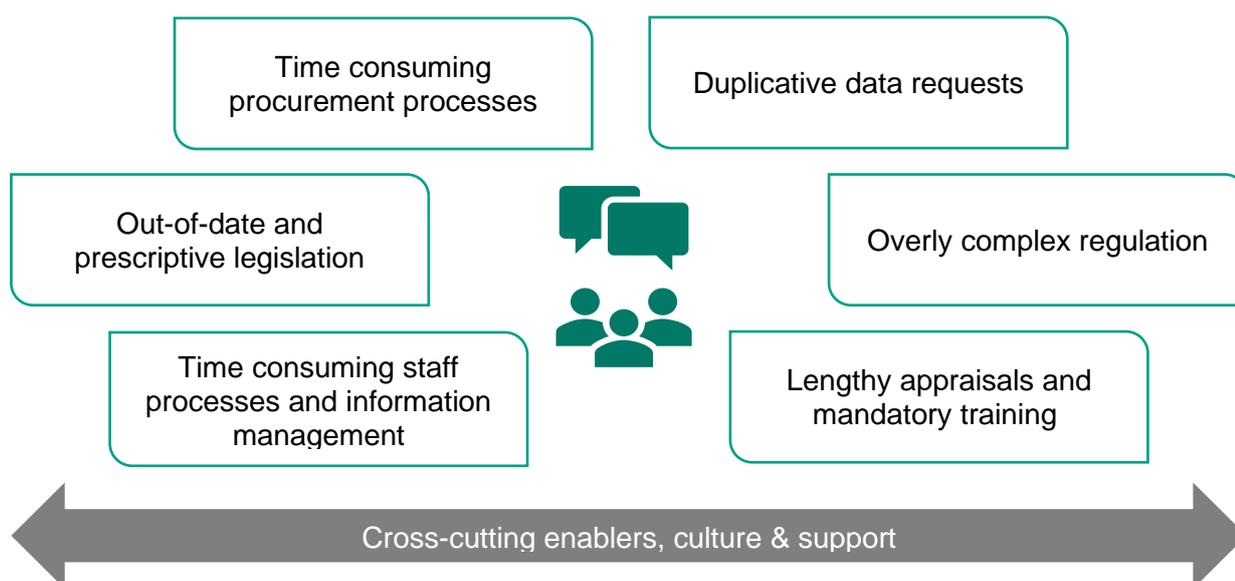
service users, and [is likely to reduce the potential for innovation and staff wellbeing and satisfaction](#), impacting on job retention and productivity. With demand continuing to increase on the health and care service, and the additional burden of COVID-19, giving time back to staff and improving their wellbeing is vital both for the workforce and those they care for.

“It’s quite stressful, because you feel like sometimes instead of caring, you spend more time doing other stuff. That just adds stress because you’re not providing the best care you can.” Healthcare assistant

“To an extent we’re paid to do some of this stuff. But a lot of the information we’re asked for ... we do have to go out to services, clinical services, and ask the manager for the information. And they really have got better things to be doing.” NHS administrator

1.7 Quantifying bureaucracy in a system is challenging. Over the summer, the Department of Health and Social Care (DHSC) undertook wide ranging engagement with health and care partners including: a Call for Evidence open to health and care staff to submit responses of their experience of bureaucracy, structured stakeholder interviews with key representative bodies and focus groups with frontline staff. This has provided an up-to-date picture of the common bureaucratic problems faced by different groups, what impact COVID-19 has had on levels of bureaucracy, and what "good" looks like in terms of busting these burdens. A list of stakeholders interviewed, summary analysis of the Call for Evidence and headline focus group findings are included in Annexes A-C.

Figure 2: Six main manifestations of bureaucracy in health and social care



When it comes to bureaucracy, frontline staff and stakeholders raised specific concerns in six main areas (Figure 2).

i) Duplicative data requests

- 1.8 In 2013, [NHS Confederation estimated cost of data collection and processing was around £1-2bn a year](#). Today, we know this data burden stems in part from the various assurance processes that are completed at a local, regional and national level. Whilst assurance is vital in maintaining a high performing health and care system, stakeholders told us that reporting to multiple bodies can seem overly burdensome for commissioners and providers who have to respond to these different layers of assurance.

A focus on performance indicators and outcomes has overshadowed the need to support clinicians and improve the quality of their work. Current approaches focus too narrowly on the performance of individual organisations, without sufficiently accounting for the impact of problems in the wider health system.” British Medical Association

- 1.9 Professional regulators, unions, royal colleges, regulators, commissioners and providers all clearly articulated that data collections are sometimes unnecessarily repetitive. This can be coupled with a lack of routine feedback loops to those who have provided the data on how it is used. Respondents to the Call for Evidence stated that there is a lack of joined-up thinking between organisations, leading to multiple requests for the same data to be provided in different formats, often with a great deal of manual data input. Data collection systems can sometimes fail to function properly because of delays in authorisation, because data formats need to be changed or because they conflict with other systems that ask for the same data in a different format.

“It would be nice to know what different organisations are requiring the information and why they’re requiring it. Putting it into some sort of context for me would perhaps help me understand why it’s all being collected. Usually it’s a case of, you collect this information, you send it on, but then you never hear why, you never get a feedback of what it’s been used for.” Allied health professional

ii) Overly complex regulation

- 1.10 A recent survey found that over [two thirds of NHS providers do not agree](#) that the current NHS regulatory framework is working well, a trend that is getting worse. Frontline health and care staff told us that a lot of time can be spent on inspections and reporting incidents. Whilst both are crucial for maintaining patient safety and quality, having to respond to similar yet different requests from a wide range of regulators, commissioners and sometimes management, can give the impression of an overly burdensome regulatory landscape.

iii) Lengthy appraisals and repetitive mandatory training

- 1.11 [Medical appraisal](#) is an important process for doctors to enhance their professional development and discuss their performance against the General Medical Council's (GMC) 'Good Medical Practice' principles, as well as to satisfy GMC revalidation requirements. Medical appraisal is separate to any performance appraisal in the workplace by individual employers for doctors and other health and care workers such as nurses. The [majority of doctors](#) report that medical appraisals are a valuable tool to improve care and their own personal development.
- 1.12 Our Call for Evidence, however, revealed the clear need to reduce the amount of bureaucracy in the process. In addition, the [burden of collecting evidence is too often placed on the individual](#), when it could be more efficiently and appropriately collated by their employer. Some staff told us that they can spend hours, up to a whole day, collecting paperwork with seemingly little overall benefit. Other professionals, such as community nurses, reported that their annual performance appraisals were required more for their employer's administration, rather than their professional development.

"Collecting the evidence nonetheless takes a day or more of my time, and the appraisal itself takes the bulk of half a day - so out of a team of 300 consultants in a hospital, the equivalent of one whole-time post is spent preparing or doing appraisals... Although it can be useful to reflect on our year's progress, challenges overcome etc, the time spent trying to gather evidence and data is burdensome, and the overall benefit is very limited." Doctor

"I am not arguing that doctors don't need to be performance managed but would suggest that the appraisal bureaucracy has gotten out of hand." General practitioner

"With appraisals, those are boxes you have to tick... It's all got to be done to Trust standard, to be a certain way, but it doesn't really tell you anything about a person half the time." Community midwife

- 1.13 In addition, clinicians told us that too much 'Mandatory and Statutory Training' is either irrelevant to their role or too frequent. They reported often having to re-take all mandatory training when moving between organisations/agencies because information is not shared across the system. This disproportionately impacts staff who move frequently, such as F1 and F2 doctors on rotation, and goes against the [flexible working practices that the health system needs to develop](#).

iv) Time consuming staff processes and information management

- 1.14 Frontline staff listed patient/client record management as the area where they experience the greatest bureaucratic burden in our recent Call for Evidence

(Figure 3), and in our focus groups, with excessive forms and multiple systems mentioned most. Nurses and midwives reported this particularly frequently. Having to navigate multiple systems that often do not effectively interact with each other to enter and retrieve information was cited as a common source of stress.

Figure 3: Main sources of bureaucracy



- 1.15 [Nearly six in every 10 doctors have reported that IT infrastructure significantly increased their day-to-day workload](#), with over a quarter reporting more than four hours per week lost due to inefficient hardware or systems. While the maintaining of accurate care records for patients is vital [staff and patients expect joined up care facilitated by joined up information](#). Digital solutions offer a remedy, however, they are only a solution if they are approached from a user-first perspective. Time saved by moving processes online can be lost if it means more information is asked for, sometimes making the process longer than it was while paper based.

“...all this recording [means there is] no time to feed a patient or talk to a patient. ALL frontline staff know the problem - but like King Canute we cannot stop the tide.”

Community social worker

“For outpatients you’ve got one system to book in, one system to book out, you’ve got a different system to record their electronic record, you’ve then got another system to write their letter, and none of these systems speak to each other.” Allied health professional

v) Out-of-date and overly prescriptive legislation

- 1.16 Stakeholders said that legislation is currently overly detailed and prescriptive in some areas. Professional regulators have called for legislation to be reformed so they have the flexibility to redesign and simplify their processes. For example, fitness to practice investigations affected less than 0.53% of registrants, but [cost 45% of the Health and Care Professions Council budget](#) in 2013. In some circumstances, legislation is a barrier to information sharing and digitisation. For example, some forms and processes still require wet signatures because of statutory requirements and technical barriers.
- 1.17 Legislative burdens on GPs are particularly high, both from DHSC and other government departments, as layers of regulations continue to be added while few are removed. Most of the weight of this regulatory burden falls on GPs despite regulations often referring to broader groups of healthcare professionals. Improved guidance and support from other professions can help to mitigate this burden.

“Our legislation is very prescriptive and contains a significant amount of unnecessary procedural detail.” Nursing and Midwifery Council

vi) Time consuming procurement processes

- 1.18 The government is committed to ensuring value for money in public procurement processes. Given the level of expenditure within the health and care system, it is clearly important that systems are robust. However, frustration exists around the time-intensive bureaucracy involved in procuring services or infrastructure. Often re-procurement timescales mean substantial periods of time are taken up repeating processes, even though the market may not have changed.
- 1.19 The NHS is currently subject to two main sets of procurement regimes; the regulations that sit under Health and Social Care Act 2012 and public procurement rules that transposed the EU Directive on Public Procurement into UK law. Under the latter, contracts for clinical health care services over a certain amount (currently £615,278 over the lifetime of the contract) need to be advertised and the applicable procurement procedures must be followed. The NHS Long Term Plan prioritises a push for greater integration across the NHS and local government. However, stakeholders say the current legislative framework can frustrate attempts to integrate care at scale, therefore disrupting the development of stable collaborations and lead to protracted processes with wasteful administration costs.

Wider system culture and support

- 1.20 Bureaucracy grows in hierarchical systems and can manifest itself at all levels: from national government down to local employers. We have heard from stakeholders that the scale and complexity of the health and care system can result in a paralysis of decision making. This can be exacerbated by a risk-averse and siloed culture in some areas.
- 1.21 While removing unnecessary bureaucracy is the focus of this document, the right support can minimise the bureaucratic burden associated with necessary bureaucracy. Improving support is therefore a key element in the overall feeling of the reduction of bureaucracy. The key levers to increase support include:
- Technology, including IT infrastructure, remote monitoring and digital skills;
 - Sufficient appropriate workforce and resource; and
 - Empowering leadership at all levels.

“For me, it’s about reducing the bureaucracy habit.” Registrar

2. Changes during COVID-19

- 2.1 COVID-19 has posed unprecedented challenges to the system. Frontline staff alongside national bodies have stepped up to the challenge, focused on a uniting mission to care for all communities during this crisis. This has often altered risk appetites around change, which has been a key driver behind the reduction in some areas of excess bureaucracy, as well as an increase in support. We heard from frontline staff that the impact on day-to-day bureaucracy has been varied, but that now is the time to learn lessons and lock-in positive changes while protecting safe and effective health and care delivery.
- 2.2 Streamlining processes and the removal of some bureaucratic demands have invigorated and empowered staff. We have heard a clear message that there is an appetite not to go back to “old ways”. Action is already underway to learn from and embed positive changes. For example, the [Beneficial Changes](#) programme was set up in May 2020 by NHS England and Improvement (NHSEI) to [identify innovations](#) that have resulted in improvements to care, safety, patient experience, staff health and wellbeing, and efficiency.

“Over the past 5 months bureaucracy went out of the window. Covid in some way caused terrible things but it was also a disruptor and it gave us a once in a lifetime chance to think about what we’re doing and how we can make a difference.” East London Foundation Trust

- 2.3 While not all changes will be appropriate to keep fully in the long term, they offer important lessons for the future. Some key changes we can learn from include:
- (a) **Changes to inspections and revalidation.** The [suspension of routine CQC inspections](#) freed up clinicians' time to focus on urgent patient care. During COVID-19 the Care Quality Commission (CQC) created the [Emergency Support Framework](#). This temporarily replaced routine inspections with a lighter-touch system where the CQC used data and information sharing to target support where it was most needed. Since routine inspections were suspended as part of this new framework, staff reported feeling empowered to seek help when needed. [Professional regulators also paused revalidation requirements and medical appraisal was suspended](#) to allow clinicians more time to carry on with urgent work;

“In some ways the emergency has been liberating for clinicians – essentially no hoops to jump through. So, clinicians need to get to a position where there is greater empowerment to get on and do things. It’s been refreshing.” HCSA - the hospital doctors' union

- (b) **Optimising data requests and data sharing.** The pandemic saw [the suspension of certain data requests](#) from national bodies such as NHSE/I, NHS Digital and the CQC. Where data collection was vital to the pandemic response, [existing powers were used to publish notices requiring health and care bodies to share data](#) to help manage and control the spread of COVID-19 within local systems. This has raised questions about how we can optimise the value of our data through focussing on collecting the most important information and enabling it to be shared widely and used many times, thus minimising time-consuming or duplicative data requests;
- (c) **Providing support via better use of digital tools.** The pandemic saw the [health and social care system innovate and accelerate the use digital tools to an unprecedented extent](#). Alongside the progress made through virtual consultations and appointments, we saw simple innovations help manage bureaucratic burdens. The [NHS Capacity Tracker app](#), for example, was used at an increased scale during the pandemic to track care home capacity, staff absences and PPE availability. Data from the app was then able to provide insight to national and local systems to help manage outbreaks;
- (d) **Changes to discharge processes.** During COVID-19 the [discharge to assess model](#) was rolled out nationally at speed. This allowed providers to free up bed capacity with less bureaucratic processes than usual and, according to various stakeholders, it was received positively by staff;
- (e) **Streamlining of recruitment and onboarding processes.** Temporary changes to onboarding and recruitment requirements helped the health and social care system to manage resource flexibly and better meet requirements for patients and care users; and
- (f) **Mission-orientated decision making.** During COVID-19 there has been clear guidance from the centre about what to prioritise, allowing organisations to make their own decisions. This has reduced excessive clearance steps. For example, the Human Tissue Authority developed a plan during the COVID-19 crisis to shift decision-making to the most appropriate levels within the organisation, empowering executive staff and their expertise to move processes forward more quickly. This has also helped to frame collective objectives and responsibilities shared by all staff within the organisation.

“The last five months have empowered leadership teams across all sectors and the non-executive community to make dramatic changes to the way they operate. [This has] sharpened and accelerated decision-making and radically altered NHS working cultures.”
[Lean, light and agile](#), NHS Confederation (2020)

“Covid has shown that if you give a system a single goal to rally around and give trusts and systems freedom to do what’s needed to reach that goal, you remove some of those blocks to operating well and see better performance.” NHS Providers

“I feel actually how it was when I first qualified, when I could get out there and do my job instead of being sat in an office and all the time typing.” Allied health professional

3. Next steps to bust bureaucracy

- 3.1 Trying to reduce bureaucracy in the health and care system is not a new idea, and there have been many previous reports and reviews which recommended improvements. As a result, some stakeholders have welcomed this work but also expressed concern over whether any real change will materialise. Stakeholders have also told us that COVID-19 has presented a unique opportunity to drive real change in this area, building on the disruptive innovation and cultural shift that has already occurred. This change must lead to greater trust being placed in frontline staff, delivering better outcomes and experiences for people that use health and care services.
- 3.2 This chapter will therefore set out the Government's strategy for reducing excess bureaucracy. These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system.

“The ultimate aim should be that it’s good for patient care. It’s not always easy to see why these things that we have to do are going to result in good patient care.” Community midwife

“When patients come to visit us in hospital for various reasons, it’s about ensuring they get the care they need, and everything else runs seamlessly. Putting the patient first, that’s where our care and attention should go.” Healthcare assistant

- 3.3 We have eight priority areas for action:
- (a) Data and information will be requested, shared and used intelligently;
 - (b) System and professional regulation will be proportionate and intelligent;
 - (c) Day-to-day staff processes will be simple, helpful and effective;
 - (d) The government will legislate to make procurement rules more flexible;
 - (e) GPs will have more time to focus on clinical work and improving patient care;
 - (f) Appraisals will be streamlined and their impact increased;
 - (g) There will be greater digitisation of services; and
 - (h) A supportive culture is needed at a national and local level.

A) Data and information will be shared, asked for and used intelligently

3.4 Health and care organisations need to operate under proportionate and well understood principles of information governance which empower staff to access, use and share appropriate data easily. Across the health and care system, data must be asked for once but used many times. Where organisations ask for data or information, they must use it in a way that maximises benefit to patients and care users while reducing burden on staff. National and local leaders must drive systematic change to reduce the drivers of repetitive data requests and build a trusting culture, leading to a reduction in assurance requests.

Data access and information governance

3.5 **NHSX will launch and then implement a Data Strategy for Health and Social Care in the coming months.** This will capitalise on the good practice from the response to COVID-19 by building on the permissive approach to data sharing, such as the use of Control of Patient Information (COPI) notices, while protecting the need for patient confidentiality. The strategy will set out a vision on how we can share data effectively and efficiently, for the benefit of better patient outcomes and to reduce burden in the system and will identify any needed legislative changes.

A central point for data: a single front door (covid-19datasharing@nhsx.nhs.uk) was stood up to manage data requests required for COVID-19 response. This covered requests for access, and additions to, data held in the NHS Data Store, and requests to access data held in national organisations such as: NHS Digital and Public Health England. Requests were triaged collaboratively by key organisations such as NHSE/I, NHSX, NHS Digital and Public Health England.

3.6 Further action will be taken to reduce bureaucracy associated with data and information governance, including:

- **The COPI notices issued by the Secretary of State in response to COVID-19 until March 2021 will be kept under review and NHSX will recommend they are extended if needed;**
- **NHSX is leading the simplification of information governance (IG).** NHSX established the [Health and Care IG Panel](#) for those who provide statutory guidance on IG including: the National Data Guardian and Information Commissioner's Office. NHSX launched the [IG online portal](#) in October 2020 to host [simplified IG guidance \(including COVID-19 IG guidance\)](#) for patients

and service users, health and care staff and IG professionals. In parallel, NHSX launched a Red Tape Challenge to refine existing national IG guidance so it is clear and consistent; and

- **NHSX is convening a new Data Alliance Partnership**, bringing together key bodies such as the Care Quality Commission, NHS Business Services Authority, Public Health England and NICE, to agree principles on data collection, sharing and use to minimise the burden of data collection and processing. It will facilitate increased access to data, by making aggregate/anonymised data accessible by default, for legitimate purposes and within existing legislation.

CQC as a central point for data. In April 2020, the CQC worked across multiple organisations to ensure that they only asked for essential information from residential and homecare providers once and established rapid mechanisms to share information appropriately. This means that providers could get the support needed, and that local authorities and Local Resilience Forums (LRFs) had the intelligence they needed to ensure business continuity and to make business critical decisions.

Incident reporting

- 3.7 **NHSE/I have created a new patient safety incident reporting framework** to [support local level change and encourage organisations to strike the balance between examining incidents and implementing improvements](#) to promote data being asked for and used intelligently. The ultimate test of success is to ask: Have changes been made which led to a measurable and sustainable reduction in recurrence of repeat incidents?

National and local level leadership

- 3.8 **DHSC will seek to consolidate national frameworks and top-down performance metrics.** DHSC is exploring options to ensure we use a manageable number of metrics at a national level to track implementation of the NHS Long Term Plan. But there is further to go in reviewing our accountability approach alongside considering future legislative reform.
- 3.9 **Local level change.** Organisations are encouraged to review their own data and information requests for internal governance purposes to capitalise on the streamlining of processes achieved during COVID-19. [NHS Confederation](#) report how local leaders want to encourage leaner and lighter governance structures, with fewer committees, shorter and simpler board reporting, which look forward and plan for the future, and spend less time assuring and looking backwards.

Importance of the removal of financial constraints alongside altered governance arrangements: [University Hospitals of North Midlands NHS Trust](#) deployed thermal imaging cameras to identify people with high temperatures. The removal of financial barriers was essential to make this happen, and clear guidance on how to use the innovative technology ensured buy-in from staff. *“During the pandemic a number of financial barriers were removed, [this] was liberating. And the fact that we had discussions with our board and altered our governance and decision-making arrangements during the COVID period allowed us to work at pace. It meant we just got on with it.”*

B) Regulation will be proportionate and intelligent

3.10 Regulation is a necessary part of health and care. But it needs to be focused and intelligence-driven, working in partnership with those who provide care and other system players. Its primary purpose should be on improvement and high-quality care - based on a foundation of trust and collaboration.

The Care Quality Commission (CQC)

3.11 **A new CQC strategy in 2021 will adopt a population and systems approach to bring its regulatory approach up to speed with the evolving health and social care landscape.** A draft strategy has been [published](#) for discussion, ahead of a formal consultation in [spring 2021](#). Through the new strategy, the CQC will help to reduce bureaucracy for health and care providers by becoming a smarter and more proportionate regulator by moving away from periodic inspections and employing data from a range of sources to proactively assess quality of care and determine risk. This includes exploring better data and information sharing with local authorities and other partners.

3.12 **The CQC will keep the fees scheme the same for 2021/22**, providing a provider's registration or size does not change, and may consider its approach to fees from 2022/23 as it adapts its inspection methodology with access to more and better data.

CQC regulation. The CQC is already actioning a new style of regulation through the introduction of its [Transitional Regulatory Approach](#) in September 2020. This uses monitoring and data to inform a risk-based approach to regulation and inspection.

Professional regulation

3.13 **The Department of Health and Social Care will launch a public consultation on detailed proposals to reform the professional regulation framework in early 2021.** Further work is needed to simplify, streamline and modernise the legal framework of the nine health and care professional regulators, including through:

- **Improvements in fitness to practise:** DHSC will make it easier for regulators to resolve complaints about a registrant's conduct or competence more quickly and in a less adversarial way. This will support a culture where professionals can learn and improve from their mistakes, while ensuring that the necessary steps are taken to protect the public from professionals who are not safe to practise;
- **More agile regulation:** DHSC will introduce a new system of regulation which will be able to respond to future changes in healthcare. We will remove unnecessary and overly detailed legislation that stifles improvement and flexibility, allowing regulators to remove bureaucracy from their processes;
- **Better collaboration between regulators and the wider system:** DHSC changes will increase collaboration between regulators, making regulation a part of the system, not something that happens in isolation;
- **More scope for regulators to respond to emergencies:** regulators played a key role in responding to the COVID-19 emergency, identifying and contacting former registrants to support the national response – we will place these emergency powers on a permanent footing, making it quicker for all regulators to respond to an emergency;
- **Regulation of Physician Associates and Anaesthesia Associates:** DHSC will bring physician associates and anaesthesia associates into regulation, strengthening the safe development of these new professions. We are planning to start our reforms with changes for the General Medical Council, which will update the regulatory framework for doctors and introduce two medical associate roles into regulation, which will support greater workforce flexibilities across the UK; and
- **Review the number of regulators:** we heard from stakeholders that having nine separate professional regulators is inefficient and confusing for the public. We therefore want to work with the public, the professions and the regulators to understand how we could simplify the regulatory landscape.

C) Day-to-day staff processes will be simple, helpful and effective

- 3.14 Patient record management processes must be digital, shared across care settings, including between health and social care, and quickly accessible through single sign on capability. Staff need more efficient HR systems to facilitate smoother moving between trusts, or locations within trusts, to maximise time available for clinical review.

Cost-effective electronic patient records. In evaluating the effectiveness of the [East London Patient Record \(eLPR\)](#) which aims to provide a view to clinicians of patient information from across local health and social care providers, it was found that the system was considered favourable. The costs of running the eLPR each year equated to 57p per patient per year, but the savings equated to at least 121p per patient per year. A reduction in referrals led to annual savings of £122k and use of the record led to perceived improvements in patient engagement and patient-doctor relationships.

Shared care records

- 3.15 **NHSX expects all areas will have a basic minimum viable shared care record solution in place by September 2021**, focused on the integration of NHS Trusts and GPs and for use in provision of direct care.
- 3.16 **NHSX are aiming to have all social care providers to have access to digitised care records that interoperate with locally Shared Care Records by 2024.** NHSX will also support the sector by enabling all local areas to access linked health and care data to a standard national specification. NHSX will facilitate the exchange of standardised care provider records with the NHS, breaking down the barriers between health and social care.
- 3.17 **NHSX will accelerate the deployment of shared care records**, providing cross-organisational patient records and care plans to facilitate the planning and delivery of integrated person-focused care across local health and care systems. This work is building on the [Local Health and Care Record programme](#) and will provide access to patient records across organisational boundaries, improving the planning and delivery of integrated and person-centred care.
- 3.18 **NHSX will drive uptake of basic technology in social care.** This includes connectivity, hardware and digital social care record software to deliver immediate productivity and quality gains.

Shared care record portal increases time for clinical and social care staff. [Access to Social Care information for health at the touch of a button - Nottinghamshire County Council \(NCC\)](#): this portal gives access to the NCC Social Care database directly to the Emergency Department and Integrated Discharge Team staff within Doncaster and Bassetlaw Teaching Hospitals. The short-term benefits were 90 hours of clinical time at the trust saved due to more efficient access to patient information, and a 5% efficiency saving for social care staff from time saved not having to supply basic information to health. Patient deterioration is also prevented where hospital admissions are avoided.

Single sign on and staff passporting

3.19 **NHSX is developing Identity and Access Management capabilities** to enable staff to log into systems without multiple passwords and providing clinical staff with access to shared records. This will reduce unnecessary duplication and provide staff with better tools that interoperate with workforce systems. The single sign on will provide secure access to workforce and clinical systems and reduce clinician time moving between systems and applications.

Single sign on in Liverpool. At Alder Hey Hospital, implementation of single sign-on technology reduced time spent logging into multiple computer systems from 1 minute 45 seconds to just 10 seconds. With almost 5,000 logins a day, it saved over 130 hours of staff time a day and freed up their time to focus on patient care.

3.20 **NHSE/I, NHSX and HEE are working to provide multiple staff groups with access to digital staff passports** in line with People Plan commitments to improve workforce agility and to support staff training and development.

- **Junior doctors, who frequently rotate to different healthcare providers, are being prioritised and the ambition is that they will have access to staff passports in 2021/22.** The passports will hold digital credentials representing their skills, competencies and occupational health checks.
- **Other target groups include specialists such as maternity and stroke care staff** who often need to be rapidly deployed to a neighbouring hospital or care home. The use of digital staff passports will save agency fees and release time for care.

Recruitment and international registration

3.21 **DHSC will work with the GMC to simplify the international registration process.** Specialist doctors, including GPs, from outside of the UK wanting to work in the NHS currently need to submit up to 1,000 pages of evidence to support

an application to join the UK register. Legislative reforms will reduce this by granting GMC freedom to move from a one size fits all approach to the development of different registration routes that assure the same standards, making the process more adaptable to an individual's knowledge, experience and skills.

Streamlined DBS checks. During the first wave of COVID-19, and recently extended, staff being recruited to roles in health and social care to work on COVID-19 are able for [free, fast-tracked DBS checks](#). This will continue for the foreseeable future and continue to play an important role rapid recruitment, especially into the social care workforce.

D) The government will legislate to make procurement more flexible

- 3.22 **DHSC will bring forward legislative reform to reduce bureaucracy and promote collaboration across the health and care system**, working with the NHS. The options will build on [previous NHS recommendations](#) to remove the two current procurement regimes which apply to clinical healthcare services and replace them with a new procurement regime, alongside numerous changes to the roles of competition and the national tariff within the NHS.
- 3.23 **NHSE/I will shortly be consulting on how a new procurement regime would operate.** This will take into account the views of local government, local commissioners, providers, patients and the public to explore future legislation that streamlines the current procurement rules, reduces the need for unnecessary competitive tendering and reduces uncertainty for providers, freeing up NHS and local authority time and resources.

Streamlined procurement in Manchester. Following the 2012 reforms, re-tendering and re-procurement have become much more frequent to meet competition regulations, even when they are won repeatedly by the same organisation. In order to overcome this hurdle, the Local Government Association shifted the procurement window of a project on homelessness in Manchester from 3 to 7 years. The new re-procurement period allowed the organisation to retain staff, think longer term about the project and to consider innovative solutions that had been impossible before because of time constraints.

E) GPs will have more time to focus on patient care

- 3.24 **DHSC and NHSE/I have been conducting a joint review of bureaucracy in general practice.** Changes will begin to be made by the end of the year and DHSC will continue to work across government and with the NHS to implement the

solutions that emerge. Reducing the bureaucratic burden on those who work in general practice, to have time released to care for patients and to continue to improve services will have wide-reaching positive impacts. Some of the processes that the review seeks to reform include:

- **DHSC is working with DWP to look at alternative arrangements for issuing fit notes.** [The number of Med3 \(or fit notes\) issued in England increased by 7% in 2019/20](#) compared to the previous year but has decreased significantly in first quarter of this year by 26% compared with the same quarter last year likely due to COVID-19. DHSC is working with the Department for Work and Pensions to reform the fit note, including extending the certification to a wider group of health care professionals and exploring digital solutions.
- **The government will permanently remove the Cremation Form 5 requirement** and will accept emailed or scanned copies of the Medical Certificate Cause of Death as part of the [new statutory medical examiner system](#).

3.25 By freeing up clinical time, the GP Bureaucracy Review will contribute to an additional 50 million appointments in general practice every year. The actions will also aim to boost job satisfaction, retention and role attractiveness and grow the number of doctors and primary care professionals working in general practice and Primary Care Networks.

Time for Care. The [Time for Care programme](#) started in 2016 as part of the GP Forward View, and it has delivered a range of service improvement interventions to improve productivity in general practice and enhance resilience. Over the first three years of the programme, nearly 300,000 hours of clinical time and over 400,000 hours of admin time across over 2,000 practices have been released, reducing pressure on staff, improving morale, and increasing time for patients. NHSE/I continues to build on its progress and increase impact as part of a single dedicated access improvement programme.

F) Appraisals will be streamlined and their impact increased

3.26 Medical appraisals must be streamlined so doctors can use the process for professional development, rather than 'ticking boxes'. DHSC also encourages all employers to ensure separate performance appraisals are a meaningful assessment of professional development and progress rather than a bureaucratic burden for their employees.

New 'Appraisal 2020' model

3.27 **NHSE/I, together with Academy of Medical Royal Colleges, the GMC and the British Medical Association (BMA) have introduced a new streamlined appraisal process, as of October 2020.** The new 'Appraisal 2020' model for doctors will [focus on professional development and wellbeing, whilst simplifying expectations](#) around supporting information and pre-appraisal paperwork. Professional development is the focus of the appraisal, rather than satisfying revalidation requirements. Specifically, changes include:

- **A new format which takes about 30 minutes to prepare**, compared to 3-5 hours previously;
- **A significant reduction in supporting evidence.** In the new model, doctors are expected to update their scope of work, review previous personal development plans, achievements, challenges, aspirations and reference details of significant events or complaints in which they were named. However, no further additional supporting information from the individual is expected for their appraisal;
- **Questions on health and wellbeing will be emphasised** in the appraisal discussion, as well as verbal reflections rather than written submissions; and
- **Appraisal discussions will be conducted on-line**, where appropriate.

3.28 The Academy of Medical Royal Colleges is evaluating the effectiveness of the 2020 Appraisal model in the forthcoming 12-month appraisal cycle with NHSE/I and the responsible officers in England. If the evaluation concludes that more supporting information is required for revalidation purposes, serious consideration must be given to whether organisations take on more of that burden than previously, rather than simply to pass it back to the doctor.

Annual Review of Competency Progression (ARCP) reform

3.29 **Health Education England has reformed and streamlined ARCP delivery in 2020.** HEE have accelerated the implementation of the recommendations from the 2018 ARCP [Review](#) during the pandemic. For trainee doctors, the ARCP broadly equates to medical appraisal. These changes will be an enduring part of the future ARCP process, including:

- Convening virtual panels and feedback conversations (rather than convening these in a host's learning environment);

- Reducing the number of panellists to a minimum of two (in exceptional circumstances such as COVID-19); and
- Placing greater emphasis on the Education Supervisor's Report to inform progression assessments by the panel, reducing additional supportive information required.

Employers helping doctors gather information for their appraisals. In 2016, [a large Foundation Trust in the North West](#) developed a mechanism for sharing a doctor's Serious Untoward Incidents, Serious Incidents Requiring Investigation, and complaints with them three months before their appraisal, for them to reflect on at their appraisal rather than having to record these themselves. In addition, if a doctor is recommended any support following a concern, or any communication about this such as a letter from the medical director to the doctor, this is automatically uploaded on the doctor's appraisal folder. The trust's medical director said this was an effective way of being confident that their doctors include these important events in their appraisal.

G) Supporting greater digitisation of services

3.30 Some bureaucracy will always exist in the health and care system due to its complexity and size, so the system must aim for ways of working to become more efficient and flexible, representing the current and future needs of health and care. For this necessary bureaucracy, investment in digital technology will make processes more streamlined, intelligent and accessible to those who need care.

Remote monitoring

3.31 **The NHS Outpatient Transformation programme is assessing care pathways, from optimising referrals to post-consultation care, to identify opportunities to increase remote monitoring at every point.** The programme is learning from local examples of remote monitoring, such as [virtual wards in Northampton](#), to scale up patient empowering, clinician time-saving and remote monitoring solutions.

3.32 **In September 2020, NHSX launched a system and procurement framework to support buying remote monitoring equipment.** This makes it easier for NHS and social care organisations to select and use the right remote monitoring platform for patients through a needs-based approach, which takes into consideration the preferences and capabilities of the patients to manage their digitally enabled care at home.

Busting bureaucracy through remote monitoring. Local health systems are leading adoption of remote monitoring tools to ensure that patients who have respiratory or cardiac symptoms can benefit from remote monitoring and clinical teams are able to identify who is deteriorating at an early stage. This helps reduce bureaucracy by automating appointments for those patients whose symptoms and results are getting worse and empowering patients to deal with their conditions. This avoids unnecessary appointments which all result in 2-5 letters per appointment and frees up clinical time.

3.33 **The AI in Health and Care Award, launched in February 2020, is supporting market-ready technologies for funding and robust evaluation to assess their readiness for adoption at scale.** In the first ten awards, announced in [September 2020](#), there are pioneers of remote monitoring, which will remove intermediate steps in the provision of vital signs monitoring to clinicians.

Healthy IO will spread their AI-powered app that turns a smartphone into a clinical grade medical device capable of detecting albuminuria, an early warning sign of Chronic Kidney Disease which could help patients with diabetes.

iRhythm Technologies will spread their wearable ECG monitoring patch and service that utilises AI-led processing and analysis to help diagnose atrial fibrillation.

Digital tools for prescription

3.34 **Electronic prescribing for in-patients in hospitals will cover 100% of in-patient beds by 2024.** In the past three years [£78 million](#) has been invested, with £8.7 million confirmed in September 2020 for 8 more trusts, to increase electronic prescribing in hospitals. As a result of this investment, electronic prescribing for in-patients in hospitals has increased from 19% to 69% coverage of in-patient beds. Trusts are increasingly able to quickly access potentially lifesaving information and build a more complete, single electronic patient record, which reduces duplication of information-gathering, saves staff time and can reduce medication errors by up to 30%.

H) Supportive culture at a national and local level

3.35 A supportive culture, at every level, is just as important as specific actions to bust bureaucracy. In fact, the success of the actions listed above will be impacted by how leadership at every level of the system embraces them. Each part of the system must question and call-out organisational habits or local rules which increase excess bureaucracy. Everyone needs to play their part in busting bureaucracy, from national government to local providers and frontline staff.

It would be nice at a meeting to bring up what is working well ... To ask us what's working well and for ideas for how we could move forward. This is the best time to do a change really, ask us, from the grass roots." Community nurse

E-signatures. This year, the Health and Care Professions Council (HCPC) updated their methods for registration, allowing [registration by email](#) for the first time. COVID-19 was a catalyst for this behaviour change, but the concept and systems had been designed already to streamline the process. Many areas of the health and care system rely on “wet signatures”, and some of this is prescribed in regulations from DHSC, the Medicines and Healthcare products Regulatory Agency or from other government departments. The government must review these regulatory requirements for wet signatures and remove them where they are barriers to secure technological innovation. In addition, local leaders must equally revisit their own requirements and understand where e-signatures could be implemented instead.

‘Breaking the Rules’ locally. In March 2017, [East London NHS Foundation Trust](#) encouraged their staff to “*break the rules*” to highlight bureaucratic or unnecessary rules that got in the way of them doing their jobs. The campaign cultivated a culture of constructive challenge, transparency and continuous improvement. Two thirds of the ideas raised by staff were not actually *rules*, but myths that had become engrained into organisational culture.

4. Conclusions

- 4.1 We have heard from the frontline and stakeholders that excess bureaucracy places a significant burden on health and care staff. This can take the frontline away from patient care, impacts wellbeing and job satisfaction, and stunts innovation.
- 4.2 COVID-19 has demonstrated the benefits that lifting bureaucratic burdens can offer and given us some learnings in terms of the best ways to do so.
- 4.3 To permanently reduce bureaucracy in the health and care system, we must tackle the drivers and sources of bureaucracy. This will require some legislative change: reducing bureaucracy reduction is a central strand of on-going legislative reform work.
- 4.4 However, significant gains can be achieved through non-legislative cultural and behavioural changes. This document outlines the actions we can take to drive changes to our culture and leadership, simplify assurance and accountability processes and review the system architecture to drive better integration of services. Ultimately empowering people to get on with their jobs and deliver better outcomes.
- 4.5 These changes will require a commitment from every level of our system to be sensitive to the burden of the bureaucratic processes they create and promote a culture of innovation, challenging process and questioning the rules.
- 4.6 Some bureaucracy will always be necessary, but its burden can be minimised through providing the right support. Here, the continued investment in digital tools that simplify and automate bureaucratic tasks will be vital as will the commitment to develop our workforce's capability.
- 4.7 This publication sets out our public commitment to reducing bureaucracy and calls on our colleagues across the health and social care system to share our ambition and do their part in capitalising on the lessons learned from COVID-19, and the opportunity we now face, to drive lasting change.

Annex A: Stakeholder interviews

We spoke with over 30 different stakeholder groups from across health and social care, including (in alphabetical order):

Professional Bodies, Unions and Royal Colleges	Regulators	Commissioners and providers	Arms-Length Bodies / non departmental public bodies	Academics / patient groups
Association of Directors of Public Health	Care Quality Commission	A General Practitioner	NHS Business Services Authority	Healthwatch England
British Medical Association	General Medical Council	East London NHS Foundation Trust	NHS England and Improvement	National Voices
College of Podiatry	Health and Care Professionals Council	National Care Forum	NHSX	Personalised care stakeholders
Hospital Doctors' Union	Human Tissue Authority	NHS Confederation		The King's Fund (fellow)
Local Government Association	Nursing and Midwifery Council	NHS Providers		
Managers in Partnership		NHS Nottingham and Nottinghamshire CCG		
NHS Employers		Norfolk and Suffolk NHS Foundation Trust		
Royal College of Nursing		Social Partnership Forum		
Royal College of Midwives		United Kingdom Homecare Association		
Skills for Care				
Unison				

Annex B: Call for Evidence

DHSC ran a call for evidence between 30 July and 13 September 2020 for frontline staff to send their experiences of bureaucracy. We received 619 submissions from staff, providing a total of 1,029 examples, and 23 organisational responses.

Summary of findings

- The most common type of bureaucracy cited was patient/client record management, followed by data requests and performance assessment/management of clinical staff. This varied between professions, with nurses and midwives citing patient/client record management as the most common types of bureaucracy experienced; doctors citing performance assessment / management of clinical staff; and management citing data requests;
- 'My employer' was the most cited source of bureaucracy, followed by DHSC / government, regulators, CCGs, NHSE/I, local authorities, ALBs, and Public Health England (in that order);
- Respondents were mostly white (80%) and female (66%). Most respondents were employed as midwives / nurses (25%), doctors (22%) or management (16%). The most frequent place of work was in community care services (23%), followed by GP surgeries and hospital wards (16% and 15% respectively).

Annex C: Focus groups

To complement the Call for Evidence and explore specific issues in more detail, focus groups (carried out by Research Works Ltd) were held with health and care workers.

Research methodology and sample

The method was entirely qualitative and comprised 10 triads (groups of 3 participants, 1.5 hours duration) with hospital and community-based healthcare staff and social care workers. The sampling approach was purposive, designed to capture feedback from groups who were less likely to have participated in the Call for Evidence, such as social care staff, but also include key staff groups from NHS acute and community settings.

The sampling also achieved a mix of: gender; age; BAME representation; geography (excluding London and the South East, areas which were over-represented in the Call for Evidence responses); and length of experience.

Summary of findings

- **View on the current status of bureaucracy:** NHS staff found unnecessary bureaucracy time-consuming, frustrating and stressful, largely because they felt it took them away from patient care. Social care workers agreed. Social care managers were less vocal about the frustration of unnecessary bureaucracy.
- **Impact of COVID-19 on bureaucracy:** Health professionals felt that the experience of delivering care differently during the COVID-19 crisis had created an appetite to create genuine change. They felt much less empowered to change bureaucracy, which was perceived to be outside of their remit. A return to examples of unnecessary pre-COVID-19 bureaucracy supported this belief. NHS administrators / managers had mixed views about whether the COVID-19 experience had the power to drive longer-term change. Social care managers and workers did not recognise the idea that COVID-19 related changes have created a moment of change. In their experience, COVID-19 had increased their bureaucratic burden (as well as many others).
- **Priorities to bust bureaucracy:** Duplication (created by multiple record-keeping systems and excessive forms) when recording patient/client information was identified as the most burdensome type of unnecessary bureaucracy for all respondents. Although other types of bureaucracy were mentioned less frequently, they were still felt to have a significant impact on staff. For all working in the NHS and social care, achieving the best patient care was a clear goal. For NHS staff, improving understanding of why staff are being asked to follow certain processes could make the experience of bureaucracy 'more palatable'.

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