

Title: Fundamental Review of Data Returns Lead department or agency: DH Other departments or agencies: NHS IC	Impact Assessment (IA)
	IA No: 6042
	Date: 31/03/2011
	Stage: Consultation
	Source of intervention: Domestic
Type of measure: Other	

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

Central data returns require time and effort to collect and process thereby placing a burden on NHS services. For some returns, it is possible to identify benefits that justify these burdens. However, there has not been any recent review of the overall suite of data returns in the NHS. As a result, there exist returns which are no longer consistent with the changing roles of the Department of Health and its Arm's Length Bodies. Their remaining value no longer justifies the burden placed on the NHS.

What are the policy objectives and intended effects?

In the Fundamental Review of Data Returns, the Department and the NHS Information Centre for Health and Social Care (NHS IC) have identified central data returns that - by a pre-defined set of criteria - no longer contribute substantially to the achievement of the objectives of the Department and the wider NHS. These returns do not justify the burden they impose on the NHS. The policy objective is to apply the findings of this review and discontinue these returns. This will reduce the burden on the NHS. Ultimately, this is expected to lead to better health outcomes for patients.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Two options have been considered:

Option 1 – 'Do nothing'

Option 2 – implement the recommendations made in the Fundamental Review of Data Returns and discontinue data returns deemed to be of limited value.

Option 2 is the preferred option as it will free up resources in the NHS by discontinuing data returns that do not justify the burden they put on the NHS.

Will the policy be reviewed? It will not be reviewed. If applicable, set review date: Month/Year

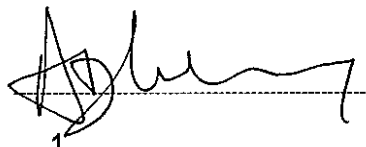
What is the basis for this review? Not applicable. If applicable, set sunset clause date: Month/Year

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	No
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Ministerial Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

 Date: 18/07/11

Summary: Analysis and Evidence

Policy Option 2

Description:

Implement the recommendations of the Fundamental Review of Data Returns

Price Base Year 2011	PV Base Year 2011	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: £44	High: £103	Best Estimate: £66

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	-	-	-
High	-	-	-
Best Estimate	Not quantified	Not quantified	Not quantified

Description and scale of key monetised costs by 'main affected groups'

Other key non-monetised costs by 'main affected groups'

The main costs lie in the loss of value from discontinuing data returns. We have not quantified these losses, but the Fundamental Review was designed to identify returns with limited value.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	-	£10	£44
High	-	£23	£103
Best Estimate	0	£15	£66

Description and scale of key monetised benefits by 'main affected groups'

Reduction in data return requirements will free up resources for alternative use in the NHS. These alternative uses generate health benefits.

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks

Discount rate (%)

3.5

Sensitivity testing has been conducted in the main body of the IA with regard to 1) the translation of freed up resources into effective work, 2) cost inputs, 3) pay bill inflation assumptions.

There is a risk of inaccuracy inherent in any criteria based process: certain returns may have been recommended for discontinuation even though the burden they put on the NHS is actually justified. The IA argues this risk is negligible.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: 0	Benefits: 0	Net: 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?	England				
From what date will the policy be implemented?	01/10/2011				
Which organisation(s) will enforce the policy?	DH, NHS IC				
What is the annual change in enforcement cost (£m)?	0				
Does enforcement comply with Hampton principles?	Yes				
Does implementation go beyond minimum EU requirements?	N/A				
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded: /		Non-traded: /		
Does the proposal have an impact on competition?	No				
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?	Costs:		Benefits:		
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties¹ Statutory Equality Duties Impact Test guidance	No	Separate EqIA
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	13
Small firms Small Firms Impact Test guidance	No	13
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	13
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	13
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	13
Human rights Human Rights Impact Test guidance	No	13
Justice system Justice Impact Test guidance	No	13
Rural proofing Rural Proofing Impact Test guidance	No	13
Sustainable development Sustainable Development Impact Test guidance	No	13

¹ Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	Department of Health 2010: Equity and excellence: Liberating the NHS http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
2	Department of Health 2010b: NHS Outcomes Framework http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944
3	Department of Health 2010c: An Information Revolution http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
4	University of Kent, Personal Social Services Research Unit (PSSRU) 2010: Unit Costs of Health and Social Care 2010 http://www.education.gov.uk/publications//eOrderingDownload/PSSRU-1368-230X.pdf
5	Better Regulation Executive 2005: Measuring Administrative Costs: UK Standard Cost Model Manual http://www.bis.gov.uk/files/file44505.pdf
6	

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Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅
Transition costs						
Annual recurring cost		/	/	/	/	/
Total annual costs		/	/	/	/	/
Transition benefits						
Annual recurring benefits		6	14	17	17	18
Total annual benefits		6	14	17	17	18

* For non-monetised benefits please see summary pages and main evidence base section

Evidence Base (for summary sheets)

A. The underlying problem: the value of some central data returns does not justify the burden put on the NHS

1. Availability of good quality information is crucial for the NHS to deliver good outcomes. However, each central data return generates a burden that is borne by the NHS: time spent on collecting, compiling and maintaining the required data diverts staff in hospitals or GP practices from other activities. If the benefits arising from a data return do not outweigh the costs generated by this return, then associated resources could be better used elsewhere
2. There are several reasons why the current suite of data returns is not optimal:
 - (i) Estimation of costs and benefits for any 'business as usual process' cannot be exact and periodic in-depth reviews might reveal cases where benefits do not justify costs
 - (ii) At their creation, the value of returns is generally considered individually so there is a risk of duplication.
 - (iii) The functions of some Arm's Length Bodies (ALBs) and aspects of the role of the Department of Health have changed. Thus, the initial value of some data returns no longer exists or has been reduced as the returns serve a function that has changed or ceased. For instance, more emphasis is now put on data relating to patient outcomes.
3. For these reasons, the Government made a commitment in the White Paper *Equity and Excellence: Liberating the NHS* to: "...initiate a fundamental review of data returns, with the aim of culling returns of limited value."
4. The present policy does not consider national data collections the NHS performs at the request of other institutions such as Royal Colleges and non-health ALBs. This is because Government intervention, and the benefits arising from it, can be realised more swiftly by focussing initially on those data collections for which the Department of Health and its ALBs are directly responsible. This review also did not consider any additional data returns requested by commissioners (Strategic Health Authorities and Primary Care Trusts) from other NHS bodies.
5. Note also that the present policy recommends a second stage of work reviewing data returns that have been retained or highlighted for further action. The aim of this second stage will be to analyse those returns in more detail in order to identify elements of data returns that are no longer required and to explore the scope for more efficient and less burdensome collection systems and processes.

B. Policy objectives: discontinuing unjustified data returns to allow efficient use of resources in the NHS

6. The Department is looking to discontinue any data return whose value does not justify the burden it puts on the NHS. In doing so, the Department aims to free up NHS resources so that NHS services can be delivered more efficiently. Ultimately, this is expected to generate health benefits to patients.

C. The options: do-nothing vs. implementation of the recommendations of the fundamental review of data burdens

7. In order to identify data returns whose use value does not justify the burden put on the NHS, the Department of Health and the NHS Information Centre for Health and Social Care have engaged in a fundamental review of data returns.
8. Given perfect information, one would ideally assess the burden of data returns against all the resultant benefits such as increased efficiency in delivering services thanks to the availability of information. In practice, there is a balance to be struck between the appropriateness of

assessment criteria and the ease and speed with which they can be applied. Therefore, the first step of the review process consisted of the development of a small number of core criteria for the retention of data returns – which could be easily and swiftly applied.

9. The chosen criteria reflect the usefulness of each data return and are informed by what was perceived as the strategic needs of the health system as determined by the Information Strategy and the Outcomes Framework. The chosen criteria – as outlined in the consultation on the Information Revolution - were:
 - help drive the achievement of a key priority with the focus on outcomes and the quality standards that deliver them, safety and patient experience;
 - provide comparable information about the quality of services;
 - support patient choice and empowerment;
 - required to demonstrate public or parliamentary accountability for the efficient stewardship of public money, or
 - generated as a result of the care giving process.
10. It was assumed that a data return was of limited value if it could not be shown to fit with any the chosen criteria. Such a return would not justify the burden put on the NHS. Therefore, in a two-staged process, data returns were challenged based on the above criteria. Firstly, data owners were asked to complete a justification form demonstrating how each data return complied with the above criteria. Retention or discontinuation of a data return were recommended if the data owner and the review project team formed by DH and the NHS Information Centre agreed on the application of the criteria. Where there was disagreement, data owners were invited to attend a workshop to discuss the return further with representatives from the NHS and subject matter experts. The final decision to recommend a return for discontinuation was then taken by the DH and NHS IC project executive team.
11. This process and its overall findings have been ratified by National Quality Board's Quality Information Committee. The full methodology of the review is detailed in the accompanying consultation document.
12. Note that Arm's Length Bodies deliver work that supports their statutory functions passed through Parliament. Therefore, in the review process, ALB data returns were not reviewed against the above list of criteria, but against a core list of statutory functions. ALB data returns were recommended for retention if they supported a statutory function.
13. As a result of the review process, 75 data returns were recommended for discontinuation. The preferred option is to implement these recommendations and discontinue the identified data returns.
14. This option is compared to a baseline – i.e. the 'do nothing' approach - in which these data returns are retained and use up NHS resources, thereby causing less than optimal results for patients. It should be noted that we assume that four of the 75 data returns that have been recommended for discontinuation are effectively time-limited data returns which would have been discontinued even under the 'do nothing'-scenario. Cost savings of these returns are therefore not included in our savings estimates under option 2.

Risk: impact on national statistics

15. Some of the discontinued returns contribute to published National Statistics (NS) or Official Statistics (OS). These products are published under arrangements set out in the Code of Practice for Official Statistics, which includes requirements to consult with users of the statistics before making substantive changes to the published product, including discontinuation.
16. If returns are stopped, it will no longer be possible to produce the accompanying published statistics.
17. The consultation document which accompanies this IA contains a statistical annex to show the impact of these recommendations on OS and NS. The annex has been developed by statisticians in the Department of Health and NHS Information Centre and has been signed off by the Statistics Heads of Profession of each of those organisations. This will ensure that the recommendations and consultation meet the requirements of the Code of Practice.

D. Costs and benefits of implementing the recommendations made in the review (option 2)

18. This option proposes to implement the recommendations of the review process (see above). It is expected that this will free up time for NHS staff members who have previously spent time on these data collections. At the same time, information that would have been recorded under the baseline will now either not be recorded or, at the very least, will not be centrally recorded. This may have impacts on future policy decisions in the NHS as the information in the discontinued returns will not be available – at least not in a readily comparable format.
19. Note that costs and benefits will be assessed over a period of 5 years. Given the ever changing nature of information technology and information requirements, but also the fundamental changes occurring in the NHS, it would not have been appropriate to make assumptions about the impacts of the present policy beyond this time frame.

Opportunity cost of exchequer funding:

20. To fully reflect the impact of any particular policy, it is important to consider the effect of reallocating funds away from alternative uses in the NHS. This impact of reallocation is the policy's true cost – or “opportunity cost”.
21. To calculate the impact of reallocating funds out of the fixed budget of the NHS to a new policy, it is necessary to determine how much benefit would have been realised from the alternative use of those funds. This can be done using DH's standard estimates of the benefits generated by NHS treatments “at the margin”, i.e. treatments that may be withdrawn if the availability of funding is reduced.
22. These marginal treatments have been estimated to provide health benefits - measured in Quality Adjusted Life Years (QALYs) - at a cost of £25,000 per QALY. Importantly, however, society is currently estimated to *value* these QALYs more than twice as highly - at £60,000. This means that any policy which involves spending £1 from the NHS budget will deprive society of benefits worth £2.40. Conversely, each £1 saved in the NHS is assumed to be used elsewhere in the NHS to a benefit of £2.40.

i. Costs of implementation: direct costs and loss of information

23. The present policy proposes to discontinue data returns, to reduce the burden of central data returns on the NHS. Still, there will be costs. The discontinuation of central data returns may generate some transitional implementation costs. In addition, the use value of the discontinued returns will be lost. Finally, discontinuation of central returns may imply costs at the local level if the underlying data collections are continued or reduplicated locally.

a) Transitional organisational costs

Redeployment and redundancy of staff

24. Specialised clerical staff work on the discontinued data returns. When selected data returns are discontinued, organisations may find themselves in the position of having to implement redundancies or having to redeploy staff. As table 1 shows, 78.7% of the NHS labour time spent on the data returns recommended for discontinuation falls on clerical and administrative staff.

Table1 – Data burden of discontinued returns by staff group¹

	Senior Managers	Managers	Clerical & Administrative	Maintenance & Works	Healthcare Assistants and other support staff	Healthcare scientists	All Nurses, Midwives and health visiting staff	Scientific, therapeutic & technical staff (ST&T)	Consultants	GP practice staff	Hospital Doctors	CEO	Director	Total
Person Days	2.1%	14.3%	78.7%	0.1%	0.0%	0.0%	0.2%	0.1%	0.1%	3.7%	0.2%	0.0%	0.5%	100.0%
Value of Person Days in £s	4.1%	21.4%	55.7%	0.1%	0.0%	0.0%	0.2%	0.1%	0.4%	15.5%	0.4%	0.1%	1.9%	100.0%

25. Given the scope of the returns in question, it appears unlikely that the overall reduction in burden will lead to redundancies in individual trusts or other NHS organisations. The overall burden put on the NHS is diffused among a wide range of institutions and different professions. Consequently, in any given location, the reduction in burden is unlikely to have workforce implications.

26. As an indication, consider that the clerical and admin work generated by the returns currently recommended for discontinuation add up to more than 35,000 days, i.e. more than 150 full-time equivalent years². However, potential reductions in this burden will occur across a multitude of organisations so that only a small fraction of a full-time position is saved at each location.³ This suggests that it is unlikely for the present policy to release cash to the NHS by reducing total workforce numbers. Rather, we expect that local decision makers will find an alternative productive use for freed up labour and other (mostly non-cash) resources.

Redevelopment of databases

27. Data returns may not necessarily be stand-alone collections. Rather, they may form a part of larger datasets. It is possible that discontinuing a data return that forms part of a larger data set forces the owner of that data set to adjust their data set. This would generate transition costs. The size of these costs is unknown. However, the NHS Information Centre and Connecting for Health are engaged in monitoring the impact of any discontinuation on the overall NHS Information Systems.

b) Loss of informational value

28. Some informational value will be lost when data returns are discontinued.

29. Data returns that have been correctly identified in the review as having limited use will have some minor value attached to them. This limited value may not justify the burden put on the NHS, but as that burden is released, any value will be lost.

30. As with any criteria based process, there is a risk of inaccuracy inherent in the present review process. The criteria used may not be wide enough to encompass all data returns of substantial value. The information encompassed in some of the data returns recommended for discontinuation may be of substantial value and may actually justify the burden put on the NHS.

31. However, it should be noted that the review process has comprised engagement with the data owners, i.e. it has given the primary users of the data returns opportunities to indicate if they felt the discontinuation of particular data returns caused a major loss of information.

¹ Table provided by the NHS Information Centre

² Note that this is not a precise estimate, but an indication of the size of local effects at play. For all data returns that have undergone the the Review of Central Returns, the data burden measured in working days has been provided by the NHS Information Centre. It adds up to 32,092 days or 150 years of work assuming there are 215 working days in a year. As described in the Benefit section below, some data returns have not undergone the Review of Central Returns process and therefore are not included in this estimate.

³ There are more than 1,600 hospitals in England (NHS Choices 2010: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>). Even if data burden did not fall on any other kind of organisation, hospitals on average, would save only about 10% of a full-time equivalent admin or clerical position.

32. Therefore, we assume that the loss of informational value will be limited and therefore have not quantified it. However, we invite comments on this topic in the consultation, notably from secondary users of the data, e.g. in academia, or information intermediaries.

c) Costs of continued data collection without central returns

33. As noted above, some of the discontinued data returns may have substantial value. If, at a local level, this value is substantial enough, local decision makers, both present and future (e.g. GP consortia), are free to continue data collections where they see fit without the additional costs generated by a central return.
34. Still, local decision makers may see particular value in the existence of centrally comparable data. Without the central return, they may face increased costs in guaranteeing comparability between different local collections as this would require time and effort to coordinate a multitude of local collections.
35. In addition, there may be cases in which the end of a central data return will effectively bring about the end of the collection as a whole. Future decision makers may thus find themselves in the position to re-imagine the previous data collection, which will generate costs setting up the replacement collections.
36. These risks have been taken into consideration in the review process and generally, returns for which concerns about continuing local collections were raised, were among the returns that were found of sufficient value to justify their retention. Therefore, we expect the described risks to be small. We invite comments on cases where risks may exist so further mitigation can be sought.

ii. Benefits of implementation: a reduction in data burden

37. The ultimate benefits of implementing the recommendations of the review are the health benefits to patients that can be generated with freed up resources such as labour time and overheads (i.e. equipment, building maintenance, heating, electricity etc).
38. We assume implementing the recommendations of the Fundamental Review will not be cash releasing. As noted above, we also assume there will be no redundancies because of the proposed discontinuations of data returns: freed up staff time will instead be used on other productive activities. In addition, staff will also use other available resources such as computers, office space etc to a more productive end. Ultimately, these activities are assumed to generate health benefits in the NHS. The below paragraphs will derive our central, as well as lower and upper estimate for the value of these benefits.

a) The reduction in data burden

39. In the ongoing Review of Central Returns (ROCR), the NHS Information Centre assesses new central data returns with regard to the burden they put on the NHS. To do so, ROCR estimate the time effort required by members of different staff groups to comply with a data return request. This burden estimate is monetised using the value of staff time. This value is composed of both staff salaries and the additional costs of employment faced by the employer (i.e. overhead costs and on-costs such as national insurance contributions). The ROCR burden estimates for the data returns recommended for discontinuation are the starting point for our calculations.
40. However, 15 of the discontinued data returns have not been assessed by ROCR. This amounts to about one in five discontinued returns. Consequently, the actual reduction in data burden that can be achieved by implementing the recommendations made in the Fundamental Review will be higher than the sum of the available ROCR data burden estimates. Thus, to fully assess the reduction in data burden generated by the present policy, we need to make assumptions about the data burden generated by those returns.

41. We assume, as a central estimate, that these returns are no more or less costly than the returns that do have a ROCR estimate. Thus, we assume the burden of each return to be equal to the median burden of the returns for which we have ROCR estimates.⁴
42. It is possible to imagine that returns without a ROCR estimate generate a consistently lower or higher burden than those with a ROCR estimate. Therefore, we test the sensitivity of our assumption by using upper and lower bound estimates for the burden of a data return without ROCR estimate at 75% and 125% of the median of all known burden figures.
43. We expect the implementation of the recommendations of the Fundamental Review will lead to an overall **reduction in data burden** – including returns that do not have a ROCR burden estimate - ranging between £9.2m and £9.7m with a best estimate of **£9.5m**.
44. Note that the ROCR burden estimate for all data returns that are not discontinued amounts to £34m. Assuming as above that returns without a ROCR estimate generate a burden equal to the median burden of all other non-discontinued returns, we estimate the total burden of non-discontinued returns to be £53m. If implemented the Fundamental Review will reduce the data burden resulting from DH and ALB central returns by **approximately 15%**.

b) Gains in effective work: transitional inefficiencies and speed of implementation

45. However, this reduction in data burden does not necessarily translate one to one into health benefits to patients. In deriving the ultimate benefits to patients, we need to take into consideration how effectively freed up resources will be redirected towards other productive activities.
46. For instance, where a doctor saves 5 minutes each month on a specific data return, she may not be able to use all of that time for enhanced patient care (e.g. because she loses time to go to the patient she needs to see). If 12 doctors in a hospital each save 5 minutes per month, the reduction in data burden adds up to 60 minutes while, in reality, not much additional work can be done.
47. Thus, initially, freeing up resources may not translate into much efficient work. Eventually, however, all resources will be used efficiently as work is re-organised to take into account the reduction in data burden. To assess how quickly this happens, we need to take into consideration which staff groups are affected by the reduction in data burden. For instance, admin staff may find it much easier than doctors to replace work on the discontinued returns by other productive activities (as these will be of much a similar nature). Similarly, as noted above, where work on the discontinued data return constituted a large share of someone's work, they will find it easier to re-allocate their time.
48. The ROCR burden estimates suggest that much of the discontinued data burden is indeed concentrated in a small number of returns. In fact, more than half of the reduction in data burden is generated by discontinuing six major returns. Furthermore, as table 1 shows the data burden is largely borne by clerical and administrative staff. On the other hand, many of the discontinued returns generate only small burden. For instance, there are eleven returns each generating an annual burden of less than £5,000 spread across many organisations. These discontinuations will free up small portions of time for individual members of staff. It can be expected to take longer for these savings to translate into efficient work.
49. Considering this, we assume that initially 70% of freed up resources will be used efficiently elsewhere. This is then expected to increase linearly over time until all resources will be used efficiently after three years. As there is considerable uncertainty around this scenario, sensitivity testing is required: we have thus developed a lower bound scenario (initially 60% efficiency reaching 100% after four years) and an upper bound scenario (initially 80%, 100% after two years).
50. In addition, we need to take into consideration that there will be delays in the implementation of the recommendations of the review. Where it is known that individual returns will continue for a given time before discontinuation, this has been accounted for. Furthermore, as the implementation of the recommendations will only begin in late 2011, we assume that only 50%

⁴ The use of the median reflects the presence of some very large data returns which would bias an average statistic based on the mean.

(with a lower bound of 35% and an upper bound of 65%) of all discontinuations will manifest themselves during 2011/12.

51. Table 2 summarises the results of this section.

Table 2 – The degree to which estimated reductions in data burden translate into efficient work

	2011/12 ⁵	2012/13	2013/14	2014/15	2015/16
Best Estimate	35%	85%	100%	100%	100%
Lower Bound	21%	73%	86%	100%	100%
Upper Bound	52%	100%	100%	100%	100%

c) Sensitivity testing around cost assumptions

52. In addition to the above adjustments, we need to consider the sensitivity of our estimates around the cost assumptions used in the estimation of data burden by ROCR. This is necessary as many of the underlying cost variables, such as overhead costs, “are very difficult to establish with any accuracy”⁶. Thus, it is prudent to consider a range of values for these crucial values.

53. **On-costs** refer to costs faced by the employer on top of the nominal wage. These costs include contributions to pensions and National Insurance or sick pay. While not part of the employee’s wage, they are part of the opportunity cost – to the employer – of a data return. Given a known level of wages, a higher on-cost estimate results in a higher savings estimate for discontinued data returns.

54. **The number of working days per year** are another important metric in the calculation of the data burden. We do not have information about hourly (or daily) wages, but annual salaries. Thus, given known salary levels, more working days per year suggest a lower monetary value of each day spent working on a data return.

55. **Overhead costs** refer to non-labour resources used by an employee such as heating and electricity, buildings, computers and other fixed capital as well as more flexible factors of production such as stationary. When staff members work on a data return of limited value, it is not only their labour that is lost, but also the productivity inherent in those other resources. Given a known level of wages, a higher estimate of overhead costs will thus suggest a higher data burden (and by extension higher savings).

56. Table 3 presents our best estimates for these variables, the upper and lower bound estimates used and their sources.

Table 3 – Cost-assumptions and sensitivity testing

	Best Estimate	Low Value	High Value
On-costs	20% (DH)	20%	30% (ROCR)
Working days	215 ⁷	200 (ROCR)	224 ⁸
Overhead costs	1.53 ⁹	1.25 (BRE ¹⁰)	1.8(ROCR)

⁵ Note that figures for 2011/12 not only reflect the fact that freed up resources will not readily be moved to other uses, but also the delay in implementing the recommendations of the Fundamental Review (i.e. some of the discontinues may only manifest in the 2012/13). For instance, the best estimate for 2011/12 is derived by assuming that 50% of all discontinuations will happen in 2011/12 and that 70% of the resulting reduction in data burden will actually manifest itself as effective work elsewhere (50%* 70% = 35%).

⁶ PSSRU 2010, page 16.

⁷ Calculated as follows: out of 365 days in a year, 104 are weekends, i.e. assumed to be non-working days. In addition, there are 8 bank holidays and an annual entitlement of 29 days of annual leave. This leaves 224 working days in a year. However, we assume that, on average, employees take 9 days of sick leave leaving 215 effective working days per employee. I

⁸ As for the best estimate, but assuming no sick leave.

⁹ This is a mid-point estimate between the lower and upper value.

¹⁰ BRE (2005) estimate an overhead value of 1.3, but this includes sick leave, which is already covered in our on-cost estimate. The lower value of 1.25 is also consistent with international evidence presented by BRE (2005).

d) Pay bill inflation

57. As much of the data burden reflects labour costs, we need to make an assumption about the rate of pay bill growth in the NHS. For 2011/12 and 2012/13, we know there is a public sector wage freeze. However, this does not suggest zero pay bill inflation due to an existing commitment for guaranteed minimum increases for low paid staff as well as pay drift over and above the headline pay settlement. Therefore, we apply a pay bill inflation rate 2% (range: 1.5% - 2.5%) for 2011/12 and 2012/13. There is much uncertainty beyond that time horizon which is reflected in a wider range of 3% - 6%.

58. Table 4 summarises the pay bill inflation assumptions used:

Table 4 – Pay bill inflation assumptions

	2011/12	2012/13	2013/14	2014/15	2015/16
Best Estimate	2%	2%	4.0%	4.0%	4.0%
Lower Bound	1.5%	1.5%	3.0%	3.0%	3.0%
Upper Bound	2.5%	2.5%	6.0%	6.0%	6.0%

59. The above are stylised assumptions to generate reasonable estimates of the evolution of data burden savings over time, not a view on the salary evolution of any particular staff group.

60. We assume a headline inflation rate of 2%. Therefore, our best estimate above suggests that salary growth returns to a rate of 2% over inflation, i.e. a rate equal to the average expected growth in productivity and real GDP¹¹.

e) Overall benefits

61. Based on the above analysis, table 5 – 7 summarise the savings which we expect to be generated through the discontinuation of data returns.

Table 5 – Expected benefits in constant prices (2010/11)

	2011/12	2012/13	2013/14	2014/15	2015/16
Best Estimate	£2,370,000	£5,803,000	£7,027,000	£7,195,000	£7,341,000
Lower Bound	£1,082,000	£3,765,000	£4,528,000	£5,325,000	£5,393,000
Upper Bound	£4,963,000	£9,700,000	£10,193,000	£10,610,000	£11,034,000

Table 6 – Expected benefits in current prices

	2011/12	2012/13	2013/14	2014/15	2015/16
Best Estimate	£2,417,000	£6,038,000	£7,457,000	£7,788,000	£8,105,000
Lower Bound	£1,104,000	£3,917,000	£4,806,000	£5,763,000	£5,955,000
Upper Bound	£5,063,000	£10,091,000	£10,817,000	£11,484,000	£12,182,000

¹¹ cf. HM Treasury Green Book 'Appraisal and Evaluation in Central Government', Annex 6

Table 7 – Present value of benefits using a 3.5% discount rate

	2011/12	2012/13	2013/14	2014/15	2015/16
Best Estimate	£2,370,000	£5,607,000	£6,660,000	£6,490,000	£6,397,000
Lower Bound	£1,082,000	£3,637,000	£4,227,000	£4,802,000	£4,700,000
Upper Bound	£4,963,000	£9,372,000	£9,515,000	£9,569,000	£9,615,000

62. Using an interest rate of 3.5%, our best estimate of the **net present value** of the present policy is **£27m** (range: £18m - £43m).

63. As explained previously, each £1 spent in the NHS is estimated to generate health benefits worth £2.40. Thus, where the present policy frees up labour resources worth £1, they will generate health benefits worth £2.40. Thus, **the net present value of the full social benefit** expected to be generated by the proposed option is **£66m** (range: £44m - £103m).

E. Summary

64. We expect that there will be little costs to the implementation of option 2. While it is not possible to quantify the value of the information that will be lost when discontinuing the selected data returns, we assume this loss to be limited and strongly outweighed by the benefits.

F. Specific Impact Tests

65. **Statutory equality duties:** The impacts of the proposed changes on statutory equality duties are outlined in a separate equality impact assessment accompanying the consultation. This document can be downloaded from the DH website.

66. **Competition:** Any reduction in administrative burden may reduce entry barriers and thus foster competition. Given the size of the proposed reduction, we do not assume any impact on competition.

67. **Small firms:** Where this proposal affects small firms – such as GP practices – it will reduce burden on them.

68. **Greenhouse emissions and wider environmental issues:** We do not expect any impact on greenhouse gas emissions as freed-up labour resources will be redirected towards other productive use.

69. **Health and well-being:** As described in the main body of evidence, we expect that the proposed changes will free up resources for productive use in the NHS. This will ultimately generate health benefits to patients.

70. **Human rights:** We expect no impact.

71. **Justice system:** We expect no impact

72. **Rural proofing:** Discontinuing data returns will lead to a reduction in administrative burden and a (limited) loss of information. These impacts do not fall specifically on rural areas.

73. **Sustainable Development:** The data returns chosen for discontinuation have been agreed to be of limited use value for the NHS. They are not consistent with the changing role of the Department and its ALBs. Therefore, the proposed changes do not affect the capacity to make appropriate decisions in the future.

G - Post Implementation Review

74. Although the benefits of conducting a post-implementation review are clear, it is felt that a PIR for the Fundamental Review of Data Returns would not be appropriate. This is mainly due to the existing NHS IC Review of Central Returns (ROCR) process. The ROCR process shall continue to be applicable for all DH returns, and subject to Parliamentary approval, the Health & Social Care Bill will make the NHS IC the central repository for all health data returns. This shall ensure that individual data returns are evaluated for strategic fit with health policies, and that the collection method is conducted in the least burdensome way. Data returns are given a time-limited ROCR licence, which effectively constitutes a constant cyclical review of all existing data returns. Therefore, conducting a separate PIR is seen to be disproportionate and duplicating existing processes.

Annex 1: Consultation questions

Q1: Are there any other data returns that the review has not identified that are requested by the Department of Health or its Arms-Length Bodies?

(see Annex D and F available alongside the consultation document)

Q2: Do you agree with the findings of the review, in terms of retain recommendations?

Q3: Do you agree with the findings of the review, in terms of discontinue recommendations?

Q4: Do you agree with the findings of the review, in terms of further work required recommendations?

(please see annexes D and F for detailed information relating to individual data returns)

Q5: Will these recommendations have any other impact, positive or negative, that we have not identified?

Q6: Will the proposed changes to Official or National Statistics have an impact on the uses you make of statistics?

If so, in each case:

- Identify the return and publication affected
- State whether you accept or object
- Explain what you use the affected publication for
- Describe the impact on your use, taking into account the availability of alternative sources
- Give details of any presently unpublished sources you know of that, if published, might be used instead.

Q7: Where you object to changes can you suggest alternative collections which you feel are of lesser value which might be considered for discontinuation instead?

Q8: Do you have any other views on related statistical issues?

Q9: In terms of either themes or individual data returns, what should the priorities be for the second phase of work?

Q10: Do you have any comments on the ROCR burden estimates identified for data returns?

Q11: Do you have any comments on the costs/benefits identified in the consultation stage Impact Assessment?

Q12: Do you have any other comments on the evidence presented in the Impact Assessment?

Q13: Are there any equalities related issues that our recommendations may impact, in terms of:

- Disability?
- Gender?
- Race?
- Age?
- Gender Reassignment (including transgender)?
- Sexual Orientation?
- Religion or Belief?
- Pregnancy and Maternity?
- Carers?
- Other?

Q14: Do you have any other comments regarding this consultation?