

<b>Title:</b> Information Sharing Duties <b>IA No:</b> <b>Lead department or agency:</b> Department of Health <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	<b>Date:</b> 29/09/2014
	<b>Stage:</b> Final
	<b>Source of intervention:</b> Domestic
	<b>Type of measure:</b> Primary legislation
	<b>Contact for enquiries:</b>

**Summary: Intervention and Options** **RPC Opinion: GREEN**

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Two-Out? Measure qualifies as
-£0.89m	£1.61m	-£0.15m	Yes   Zero Net Cost

**What is the problem under consideration? Why is government intervention necessary?**  
 Sharing of information between organisations responsible for an individual's care supports the delivery of safe, effective and integrated care. However, the 2012 Caldicott review of information governance found that there is a culture of anxiety which prevents information sharing between organisations. The current legislative landscape was found to be a significant contributory factor, with a risk-averse response to data protection law in particular being cited as a barrier to sharing. The review recommended that the duty to share information should be as important as the duty to protect patient confidentiality. Government intervention is required to introduce new legislation to create an express duty to share.

**What are the policy objectives and the intended effects?**  
 The policy objective is to encourage health and adult social care organisations to share information for direct care purposes, and use consistent identifiers. The intended effect is that this will increase the quality of health and care services by ensuring relevant, accurate and current information is available to those directly involved in an individual's care, increase the efficiency of commissioners and providers by reducing duplication of work, and contribute to removing the disconnect between health and social care information systems, which will improve the efficiency and quality of care for people who transfer between different care settings.

**What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)**  
Option 1: Do nothing. No changes to the legislation would be made to introduce a duty to share information. The government would rely on existing policies and levers to encourage organisations to share information more effectively (including the use of consistent patient identifiers). This option is judged to be unlikely to achieve the policy objectives as it would fail to address the legislative barriers described above.  
Option 2: Introduce new statutory duties to share information and use consistent identifiers (Preferred Option). An express legislative provision requiring information sharing for direct care purposes would create legal parity between the need to protect information and the need to share it as part of care. In addition, requiring the use of a consistent identifier in records and correspondence will ensure that, when that sharing occurs, the right information is shared. This option is judged to be most likely to achieve the policy objectives and address the legislative barriers identified above.

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

Does implementation go beyond minimum EU requirements?	N/A				
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	<b>Micro</b> Yes	<b>&lt; 20</b> Yes	<b>Small</b> Yes	<b>Medium</b> Yes	<b>Large</b> Yes
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded:</b> N/A		<b>Non-traded:</b> N/A		

**I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.**

**Signed by the responsible Minister:** George Freeman **Date:** 03/10/2014

# Summary: Analysis & Evidence

# Policy Option 1

Description: Do nothing

## FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	0	0	0

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline

Key assumptions/sensitivities/risks	Discount rate (%)	3.5
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In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline. Under the do nothing option, concerns about information governance and information protection will continue to impede the sharing of information resulting in lower quality care and inefficient handovers.

## BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:	In scope of OITO?	Measure qualifies as
Costs: 0	Yes	Zero net cost
Benefits: 0		
Net: 0		

# Summary: Analysis & Evidence

# Policy Option 2

**Description:** Create a new express duty to share information for care purposes, using consistent identifiers.

## FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: -£0.89m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£11.22m	£0m	£11.22m

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

All potentially affected health and adult social care organisations will face familiarisation costs of approximately £0.58m. Where organisations do not already meet the proposed duties, they will incur one-off costs associated with making changes to their information sharing processes and training staff. This is estimated to cost approximately £10.6m across all affected organisations.

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

Improved information sharing may alter the unit cost of sharing information. We have been advised by various health and adult social cost organisations that these cost changes are likely to be low, and may be balanced by a reduction in other administrative costs associated with information sharing (for example, a reduction in the time required to deal with queries for information from other organisations, or other efficiencies in the information management process).

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£0m	£1.2m	£10.33m

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

Organisations which are 'net recipients' of information will experience benefits from improved information sharing. Social care providers in particular are anticipated to benefit from reduced administrative costs associated with obtaining information from the NHS. These savings are conservatively estimated to be approximately £1.2m annually.

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

Improved sharing of information will help to support the delivery of safe, effective and integrated care, which will ultimately lead to improved health outcomes for service users, and reduce the risk of patient harm arising from incomplete information. People's experience of their care may also improve as they will avoid the frustration of having to answer the same questions repeatedly as they move within and between care settings.

<b>Key assumptions/sensitivities/risks</b>	<b>Discount rate (%)</b>	3.5
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A key risk is the extent of engagement undertaken to support the estimates of cost and benefits to business. The consistency of views expressed in the course of evidence gathering, confirming low expected costs of compliance, and the potential for efficiencies and other valuable benefits to business, means that the Department considers this engagement to be proportionate to the scale of impact. The estimates of cost and benefit are based on very conservative interpretations of the evidence gathered.

## BUSINESS ASSESSMENT (Option 2)

<b>Direct impact on business (Equivalent Annual) £m:</b>			<b>In scope of OIOO?</b>	<b>Measure qualifies as</b>
Costs: £0.82m	Benefits: £0.97m	Net: - £0.15m	Yes	Zero net cost

# Evidence Base (for summary sheets)

## Background

1. This impact assessment considers the impact of two clauses in the Health and Social Care (Quality and Safety) Private Member's Bill. The two clauses would impose a duty on providers and commissioners of publicly funded health and adult social care to:
  - Share relevant information for the purposes of an individual's direct care, and in the individual's best interests, and;
  - Use a consistent identifier in individual's health and care records, and include this information when sharing records with other providers and commissioners directly involved in an individual's care (with the intention that the required consistent identifier be specified as the NHS number in secondary legislation).
2. The Government supports the Private Member's Bill, which is being introduced by Jeremy Lefroy MP as a Government Hand-out Bill, and which includes other provisions relating to patient safety (but which do not concern the regulation of business). This impact assessment considers the impact of the two information-sharing provisions outlined above, including the impact on affected businesses (businesses which contract with NHS or local authority (LA) commissioners to provide publicly funded health or adult social care).

### **The evidence base of this impact assessment is structured as follows:**

Section A: Definition of the underlying problem and rationale for government intervention

Section B: Policy objectives and intended effects

Section C: Description of the options

Section D: Costs and benefits assessment of the options

Section E: Summary of specific impact tests

Section F: Summary and conclusion

### **Section A: Definition of the underlying problem and rationale for government intervention**

3. Timely, accurate information is essential to the delivery of safe and effective care. Most people who use health and social care services accept and expect that doctors, nurses and other professionals will need to share information about the medical history or care needs of the people they care for, if they are going to provide optimum care. Sharing of information within and between organisations responsible for an individual's care supports the delivery of safe, effective and integrated care and treatment. In contrast, poor quality information may lead to sub-optimal care, increasing the risk of errors and unsafe or unsuitable care, leading to less than optimal outcomes. Sharing of information along the care pathway also improves people's experience of their care and support – avoiding the frustration of having to answer the same questions repeatedly as they move within and between care settings. By avoiding errors and reducing duplication of effort, timely sharing of relevant information will also help to ensure that the most effective care and treatment is delivered first time, reducing inefficiencies.
4. The Department of Health has undertaken extensive consultation and engagement with professionals, providers, commissioners, patients and the public on the importance of information to the provision of care. A key theme of the NHS Future Forum's listening exercise was the use of information for care and support<sup>1</sup>, followed by the consultation *Liberating the NHS: An Information Revolution*<sup>2</sup>. The culmination of this engagement was the production of the *DH Information Strategy*<sup>3</sup>, which set out the Department of Health's ambitions to harness the potential of information

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<sup>1</sup> Information: a report from NHS Future Forum, NHS Future Forum, January 2012.

<sup>2</sup> *Liberating the NHS: an information revolution – summary of consultation responses*, Department of Health, August 2011.

<sup>3</sup> *The Information Strategy: the power of information*, Department of Health, May 2012.

to transform health and care. The Strategy set out the importance of the sharing of information for the provision of care, and the importance of using consistent identifiers to ensure that the right information follows the patient or service user along the care pathway. The NHS number is already the patient identifier for the vast majority of transfers, with 85% of NHS Trusts using the NHS number in more than 75% of their external communications<sup>4</sup>. Reinforcing this as the required identifier will facilitate access to comprehensive and accurate information about a patient or service user as his or her condition and treatment changes, and generates positive spill-over effects between organisations.

5. This engagement also confirmed that, in some cases, while the sharing of information is universally considered to be essential to the provision of safe, effective and integrated care, it is not always happening as it should. It found that, all too often, concerns about information governance and data protection rules impede the sharing of information as part of the delivery of care, even when sharing would have been in the individual's best interests. As a result, the NHS Future Forum recommended that a review be undertaken of information governance rules and their application across health and care, to ensure that the right balance is being struck between the protection of people's information, and the sharing of information to improve care.
6. The Secretary of State for Health asked Dame Fiona Caldicott to lead this review, to span information governance across the whole health and social care system in England. The review reported in March 2012<sup>5</sup>.
7. The review considered information governance matters across all aspects of the use of information in health and care, including for research and commissioning, but included a specific focus on the sharing of information as part of the delivery of direct care.
8. Direct care is provided by health and social care staff working in 'care teams', which may include doctors, nurses and a wide range of staff on regulated professional registers, including social workers. As part of the provision of safe, effective and high quality care, relevant information should be shared within the care team, when they have a legitimate relationship with the patient or service user. Care teams may also contain members of staff who are not registered with a regulatory authority, but who may need access to a proportion of someone's personal data to provide care safely.
9. Through extensive consultation and engagement with the sector, patients, service users and the public, key findings of the review included:
  - People expect the various professionals in the care team to communicate with each other and to share the information that is needed to provide safe and effective care.
  - When information is shared for direct care purposes, it is mainly done on the basis of 'implied consent'. For example, doctors and nurses will share personal, confidential data during medical and nursing handovers without having to ask for the patient's explicit consent.
  - That in some cases of direct care, the transfer of necessary and relevant information between organisations was poor. This often caused frustration and distress for patients, and could potentially affect the quality of care they receive.
  - That a registered and regulated professional's primary concern must be for the health and wellbeing of the individual to whom they are providing direct care and the presumption should be in favour of sharing for an individual's direct care.
  - That organisations should pay closer attention to the appropriate transfer of information when people cross organisational boundaries.
10. The review also concluded that 'When it comes to sharing information, a culture of anxiety permeates many health and social care organisations'. The current legislative landscape was found to be a significant contributory factor, with a risk-averse response to data protection law in particular being cited as a barrier to sharing by staff delivering care directly to individuals. Information governance rules and legislation were often cited by professionals and staff as a reason not to share, even when this would be in the individual's best interests. This was despite a strong

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<sup>4</sup> NHS Number Survey conducted by NHS England, 2014

<sup>5</sup> The Information Governance Review: Information – to share or not to share?, Dame Fiona Caldicott, March 2013.

consensus across the health and adult social care sectors and the public in favour of a presumption of sharing information for direct care purposes – for the default position to be to ‘share for care’.

11. As a result, the review concluded that an extra seventh principle should be added to the well-established information governance principles set out by Dame Fiona Caldicott in her 1998 review of information governance:

***The duty to share information can be as important as the duty to protect patient confidentiality.*** *Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.*

12. At present, the statutory position does not reflect this recommendation of the review – the equal importance of sharing information and protecting patient confidentiality is not explicit in current legislation. While the Data Protection Act 1998 sets controls for how personal information is used by organisations, businesses or the government, and strict rules for the use of information, there is no express statutory duty to share for care purposes. Instead, sharing for direct care is mainly done on the common law (i.e. non-statutory) basis of ‘implied consent’. An express legislative provision which gives effect to this consensus, and expressly requires sharing for direct care purposes, would shift from a permissive common law basis for sharing (implied consent) to an express statutory requirement to share, creating legal parity between the need to protect information and the need to share it as part of care. In addition, requiring the use of a consistent identifier in records and correspondence will ensure that, when that sharing occurs, the right information is shared. Therefore, Government intervention is required to correct this legislative imbalance, and to reflect the parity of treatment of the two duties in keeping with the seventh Caldicott principle.
13. In order to fully realise the benefits of information sharing to improve care, it is vital that the information shared is accurate, relevant and timely. In order to provide safe and effective care, especially where that care is urgent, or is part of a complex care pathway with multiple care teams or organisations involved, information needs to follow the patient along their pathway, so that staff (and patients) can have access to the right information at the right time. Using a consistent identifier in all patient and user records and correspondence is essential to this aim, to ensure that the information being shared relates to the right individual. It is a longstanding priority of DH, confirmed in the Information Strategy, that the consistent identifier which should be used across health and adult social care is the NHS number.
14. Because the value of identifiers hinges so significantly on their universal adoption and use, the Department considers that requiring the use of a consistent identifier in the recording and sharing of information for direct care is a proportionate intervention.

#### *Alternatives to regulation*

15. The Caldicott Review found that several barriers to information sharing were cited – for example, a lack of investment in infrastructure to support sharing, cultural barriers between health and social care, and between the public and private sectors, and a lack of training and awareness among professionals and front line staff, as well as risk aversion in response to the current legislative framework. Although information sharing, and the use of consistent identifiers to support accurate sharing, have clear benefits for care outcomes, and may generate efficiencies, not all of the benefits will accrue to the health and care professionals and organisations which perform the sharing. Positive externalities accrue to the professionals or organisation which receives the information, and to the individual receiving care. As such, professionals and organisations do not recoup full benefit of sharing information and using identifiers, and as such can be expected to under-invest in information structures and staff time necessary for wider efficiency.
16. The Department of Health, with NHS England and in partnership with local government, is taking forward a comprehensive set of measures to require and support the sharing of information for direct care purposes, and the use of the NHS number in the recording and sharing of such information:

#### *Contractual levers*

- All organisations contracting with NHS commissioners are required to use the NHS number to identify all activity relating to service users (NHS contracts 2014/15);

- When procuring, renewing or refreshing IT systems, organisations must use the NHS number as the primary identifier (NHS contracts 2014/15);
- All NHS organisations and organisations contracting with NHS commissioners must comply with the requirements of the Information Governance Toolkit<sup>6</sup>, which includes requirements to use the NHS number, that personal information is shared for care purposes, and that staff are provided with clear guidance on how to do this securely and confidentially (NHS contracts 2014/15);
- IG Toolkit assessments must be completed and published by all bodies that process the personal confidential information of people who access health and adult social care services, including NHS organisations, local authorities and primary care providers. Other organisations are required to provide assurance via the IG toolkit as part of the contractual terms with NHS commissioners of services;
- NHS England Planning Guidance (Everyone Counts) – requires that local areas confirm they are using the NHS Number as the primary identifier for health and care services, and, if not, when they plan to;

#### *Financial incentives*

- Better Care Fund - Access to the £3.8bn fund in 2015/16 requires NHS commissioners and local authorities to submit joint plans on how the NHS number will be used as the primary identifier for health and care services, and their plans for ensuring that local information governance processes meet the recommendations of the Caldicott Review;
- Technology Fund – a fund worth £1bn (£500m with match funding by receiving organisations) is being made available to NHS Trusts and local authorities for the development of interoperable digital care records. Use of the NHS number is a condition of being awarded funding. Payments to organisations which make successful bids for funding are expected to be made by the end of the year;

#### *Guidance and support*

- DH is working closely with the Health and Social Care Information Centre, NHS England, the Local Chief Information Officers Council, the Society of Information Technology Management, and the Association of Directors of Adult Social Services to strongly encourage local authorities to use the NHS number, and is producing joint guidance for the NHS and social care to better explain how local authorities can obtain the NHS Number;
- The Centre of Excellence for Information Sharing, supported by DH and other government departments, is focused on providing practical solutions to barriers to sharing to local bodies;
- The Information Governance Alliance is a group of national health and care organisations, including DH, who are working with health and social care bodies to provide a single, authoritative source of information and guidance on information governance matters, and;
- NHS England is leading a number of programmes to support NHS organisations to capture and use the NHS number as early as possible in the care pathway, and for it to be used in all clinical correspondence.

17. These initiatives are each focused on a particular barrier to information sharing, using the NHS number. However, none of these can address the current lack of an express statutory basis for sharing, which has been demonstrated to be a key factor in the reluctance to share for care purposes. The Department therefore considers that new legislation is the most effective way to remove this particular barrier to sharing.

## **Section B: Policy objectives and intended effects**

18. The policy objective is to use legislation to remove the current uncertainty about how information governance rules and legislation affect the sharing of information for direct care purposes, using

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<sup>6</sup> <https://www.igt.hscic.gov.uk/>

consistent identifiers. This will encourage providers and commissioners of publicly funded health and adult social care to share information for direct care purposes, and use consistent identifiers.

19. The intended effect is that this will:

- Increase the quality of health and care services by ensuring relevant, accurate and current information is available to those directly involved in an individual's care;
- Increase the efficiency of commissioners and providers – e.g. by reducing duplication of work where more than one team or organisation is directly involved in a user's care, and;
- Greater use of the NHS number will contribute to removing the disconnect between health and social care information systems, which will improve the efficiency and quality of care for people who transfer between different care settings.

## **Section C: Description of the options**

### **Option 1: do nothing**

20. Under this option, there would be no new statutory duties. Instead, the Department of Health, with NHS England and in partnership with local government, would continue to encourage more data sharing, using the NHS number, through the comprehensive suite of measures outlined above in Section A.

### **Option 2: Introduce new statutory duties to share information and use consistent identifiers**

21. The various measures and programmes outlined above all contribute to our twin objectives of information sharing for direct care, using consistent identifiers.
22. However, the findings of the Caldicott Review, plus the best available information about the use of the NHS number, demonstrates that there is still a considerable way to go before information is always shared for direct care purposes and in people's best interests.
23. This demonstrates that further intervention is required. While the initiatives set out above will continue, the Department considers that there remains a compelling case to legislate to require information sharing for direct care, and as part of that, the use of consistent identifiers in all user records and correspondence.
24. On this basis, the Department supports the following proposed duties in the Health and Adult Social Care (Safety and Quality) Bill (a Government Hand-out Bill). The proposals would impose a duty on all providers and commissioners of publicly funded health and adult social care to:
- Share relevant information for the purposes of an individual's direct care, and in the individual's best interests, and;
  - Use a consistent identifier in individuals' health and care records, and include this information when sharing records with other providers and commissioners directly involved in an individual's care, with a regulation making power to specify the prescribed identifier in secondary legislation (the Government's intention is to specify the prescribed identifier as the NHS number).
25. The proposed duty to share would create an express statutory duty to share information for care purposes. The legislation would require that, when providing care to an individual, relevant information is shared with staff directly involved in that individual's care, and that relevant information is shared with other organisations directly involved in that individual's care. The duty would only apply where this would facilitate the individual's care, and where it would be in his or her best interests.
26. The proposed duty to use the NHS number would require that organisations within scope include consistent patient identifiers in the records of patients and people who use service, and include the identifier in information when it is shared with other providers and commissioners directly involved in the individual's care.
27. The proposed legislation would not be prescriptive about how compliance is to be achieved. As such, no specific information technology or other infrastructure is necessary for affected organisations to comply with the proposed duty. It would be up to the affected organisation to determine how to meet the duty.

28. There would be several exceptions from the duties:
- The duties would not apply when a patient or service user objects to his or her information being shared, or his or her NHS number being used, or where it is reasonable to consider that the individual would be likely to object;
  - The duties would not apply when a patient or service user receives services anonymously (e.g. sexual health services), or may receive such services anonymously;
  - Where an individual does not have an NHS number, the duty to use it does not apply, and;
  - If for any other reason, a provider or commissioner is not reasonably able to comply with the duties, the duties would not apply. For example, this would mean that the duty would not apply should a business be required to incur an unreasonably high cost in order to comply.
29. The legislation would not create any new offences, or impose any penalties or sanctions.
30. The Department considers that an express duty to share for care, using the NHS number, would redress the current imbalance in the legislative framework between protection of information and sharing of information, and in combination with the other initiatives outlined above, will provide a clearer and more certain legal basis for sharing than the current common law basis.

#### **Section D: Costs and benefits assessment of the options (including specific impacts)**

31. The new duties will require affected organisations to share relevant information in support of people's direct care and to use consistent identifiers across health and care organisations (the intention is that this will be defined in secondary legislation to be the NHS number).
32. These new duties would create an express duty to share information, using consistent identifiers, and as such would provide greater clarity and certainty about the need to share for direct care purposes. Where organisations do not currently share information in accordance with the duties, it is expected that they will need to take further steps in order to ensure that they do so. This may result in both one-off costs associated with setting up or making improvements to their information sharing systems, or on-going costs associated with implementation of the new system.
33. In terms of the benefits of the proposed policy, improved sharing, using the NHS number, will increase the quality of health and care services, by giving professionals and staff better information on which to base decisions about care and treatment, leading to better care outcomes for patients and service users, and a reduced risk of errors. By reducing duplication of effort across teams and organisations, and reducing costs and inefficiencies arising from sub-optimal care, the duties will release resources which can be redirected to more valuable uses. There will also be positive spill-over effects between organisations – for example, better information sharing by one organisation is also likely to benefit the information recipient, reducing the time and effort spent in gathering relevant information.
34. As described previously, the policy will not be prescriptive in how providers should meet the duty. We expect providers will take the most cost effective course of action for them in order to meet the duty. As a result, we anticipate that there may be a large variety of different approaches taken to meet the duty. In the course of developing this Impact Assessment, we have gathered insight from ten different parties (further information can be provided on request). They represent a range of organisations including the NHS, local authorities, both small and large adult social care providers and umbrella bodies for social care. Given the consistency of the message we received from the organisations, and the umbrella organisations in particular, we consider this a sufficient sample on which to base our estimates of the likely costs and benefits of information sharing and use of the NHS number.
35. Although the organisations we spoke to suggested a range of approaches to meet the duty, all were confident that the costs of meeting the duty were likely to be low, and that there were other benefits to be realised from improved information sharing and use of the NHS number.

#### *Numbers of providers affected*

36. As previously discussed, the new statutory duties will apply to NHS commissioners and local authority commissioners of health care, public health and adult social care, and providers of health

or adult social care contracted by an NHS or local authority commissioner. Independent sector providers who do not provide any publicly funded services would therefore not be affected. In addition, the duties would not apply to any school or Ofsted registered body, or to providers or commissioners of children’s social care.

Based on these criteria we anticipate the proposed new duties would affect the following types of organisations:

**Table 1: number of affected organisations**

Organisation type	Numbers*	Source
NHS Trusts	250	Health and Social Care Information Centre – Organisational Data Service <a href="http://systems.hscic.gov.uk/data/ods">http://systems.hscic.gov.uk/data/ods</a>
Independent Hospitals	800	Health and Social Care Information Centre – Organisational Data Service <a href="http://systems.hscic.gov.uk/data/ods">http://systems.hscic.gov.uk/data/ods</a>
GPs	7,630	Number of GPs registered with the Care Quality Commission in 2012/13 <a href="http://www.cqc.org.uk/content/cqc-annual-report-201213">http://www.cqc.org.uk/content/cqc-annual-report-201213</a>
Other independent health providers (such as Physiotherapists, Chiropractors and Optometrists)	14,700	Interdepartmental Business Register – Businesses listed in the Standard Industry Classification “Other Human Health Activities” as at March 2013
Dentists	8,060	Number of Dental practices registered with the Care Quality Commission in 2012/13 <a href="http://www.cqc.org.uk/content/cqc-annual-report-201213">http://www.cqc.org.uk/content/cqc-annual-report-201213</a>
Organisers and Providers of Social Care	17,100	Number of organisations involved in the provision or organisation of social care activities – Skills for Care report “The size and structure of the adult social care sector and workforce in England in 2013”

\*Rounded to nearest 10

37. Commissioners of health care will be out of scope of the proposed duties as none of the current purposes for which a CCG uses an individual’s NHS number, or shares information about them with other parts of the system, should be considered to be ‘direct care’.
38. Local authority commissioning of adult social care services will be in scope of the proposed duties as they are more likely to be involved in the ‘direct care’ of service users. Social workers will directly assess and review the needs of people who use services, and make referrals to providers on the basis of this information. We have amalgamated the categories of commissioners and providers of social care in the above as the Skills of Care National Minimum Dataset on which much of the information for social care we use in our calculations is based does not differentiate between providers and organisers of social care. This is unlikely to have a large impact on cost estimates (and in particular the separation of costs to public and private organisations for the purposes of calculating the EANCB) as Local Authorities make up a small proportion of the total number of organisations in this category (there are 152 Councils with Adult Social Service Responsibilities)<sup>7</sup>.
39. In terms of the impact on private and voluntary organisations, we anticipate that the following organisations would be classified as private or voluntary organisations:

<sup>7</sup> Local authorities are already directly subject to several initiatives to support data sharing and use of the NHS number (as set out in Section A). In particular, local authorities are already taking steps in response to the national requirements of the Better Care Fund, and to comply with the IG toolkit. As such, any further steps they take to ensure compliance with the legislation are likely to be small.

**Table 2: number of affected private and voluntary organisations**

Organisation type	Private or Voluntary Organisations*	Rationale
NHS Trusts	0	NHS trusts are considered to be publically owned and controlled
Independent Hospitals	800	By definition, independent hospitals are considered to be private organisations
GPs	150	Laing and Buisson 2013/14 Healthcare Market Review found 2% of GPs were publically funded but independently owned
Other independent health providers (such as Physiotherapists, Chiropractors and Optometrists)	14,700	By definition, these organisations are considered to be part of the private sector
Dentists	5,480	DH analysis of the Annual Population Survey suggests that approximately 68% of Dental Practitioners worked primarily for the private sector
Organisers and Providers of Social Care	15,390	Data from 31st March 2010 (under CSA care sector) on providers by ownership type in the adult social suggests that approximately 90% of adult social care providers are voluntary or private organisations. Similarly the Laing and Buisson 2013/14 Healthcare Market Review estimated that between 6% and 13% of adult social care providers were Local Authority or NHS run organisations

\*Rounded to nearest 10

## Costs

### *Familiarisation costs*

40. All affected providers are anticipated to incur some familiarisation costs associated with understanding the new duties and determining what the organisation will need to do in response.
41. Providers from large organisations (three representatives) advised us that there would likely be a central team which would compile the necessary information and issue advice to the rest of the organisation, while smaller providers advised that the main task of familiarisation would be to read any guidance issued by DH or the relevant industry body. Five of the organisations we spoke to were able to give estimates of the likely costs of familiarisation. They advised that these tasks would be relatively straightforward and that on average, for any new legislation or policy initiative, this would require approximately half an hour of a manager's time. Based on the median gross wage of £24 for a corporate manager or director from the Annual Survey of Hours and Earnings (ASHE) survey 2013<sup>8</sup> (including 15.3% non-wage costs<sup>9</sup>), this would imply a total familiarisation cost of approximately £0.58m across all of the organisations outlined above. **Of this, we anticipate that approximately £0.44m would fall on private or voluntary sector providers.**

### *Other one-off costs*

42. The changes an organisation will need to make in order to comply with the proposed duties will depend on their existing level of information sharing and use of the NHS number.
43. Within the NHS, there are already a large number of policies and initiatives in place to encourage good information management and sharing. In particular, all NHS organisations are required under the NHS Standard Contract to comply with the requirements of the Information Governance Toolkit, which includes a requirement that personal information is shared for care purposes. Recent self-assessed compliance figures showed that, across the NHS, 91.6% of organisations judged themselves to be compliant with the NHS number requirement and 98.4% with the sharing

<sup>8</sup> This survey estimates average earnings for the period 2012/13. See <http://www.ons.gov.uk/ons/rel/ashes/annual-survey-of-hours-and-earnings/2013-provisional-results/index.html>

<sup>9</sup> See [http://epp.eurostat.ec.europa.eu/statistics\\_explained/index.php?title=Wages\\_and\\_labour\\_costs&stable=1](http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=Wages_and_labour_costs&stable=1)

requirement. Similarly a survey carried out by NHS England<sup>10</sup> on the use of the NHS number found that 84.9% of organisations used the NHS number in external communications more than 75% of the time and 92.7% of organisations used it more than 50% of the time. This shows that high proportion of NHS trusts may already be meeting the proposed duties and thus not require any additional action.

44. However, as previously discussed, both the Future Forum's listening exercise and the subsequent Caldicott Review found evidence of poor levels of information sharing *across institutional boundaries*. For example, the review found that "There is also a lack of trust between the NHS and local authorities and between public and private providers due to perceived and actual differences in information governance practice". This issue was also raised by a number of social care providers during the informal evidence gathering process for this IA. They reported that they often do not receive a timely and comprehensive set of information relevant to a patient's care.
45. Overall, this suggests that, while the NHS already has good systems and processes in place for information management and to facilitate information sharing, in practice there are instances where these procedures are not translating into effective information sharing in practice. Discussions with NHS nurses (two staff grade nurses with recent ward experience) have confirmed that whilst it is normal practice to conduct a thorough handover and ensure the correct information is shared where patients are transferred between NHS organisations, the same level of sharing is not carried out for NHS to social care transfers.
46. Based on this assessment, we conclude that the NHS are unlikely to incur any additional one off costs in terms of making improvements to their information sharing practices, as these appear to be well established. The main costs for NHS providers are therefore likely to be limited to ensuring that staff follow similar procedures to share information with social care as within the NHS. However, these costs are anticipated to be minimal since it is likely that this could easily be incorporated into existing staff training on information governance and sharing (under the IG toolkit, this is a mandatory requirement and across the NHS 93.4% of organisations reported that they were already compliant with this).
47. For other sectors, there is less evidence available on existing levels of information sharing. Discussions with various providers [five representatives of small to large social care providers] have suggested that in social care, there could be a very mixed picture. Very small providers may rely on paper files and have no formal policies regarding information sharing. Use of the NHS number was also anticipated to be low, as many providers would be likely to develop their own patient identifiers.
48. It is difficult to predict what action an organisation might decide take to in response to the duty and the likely cost of this action. For example, as above, some organisations may judge themselves to be largely compliant with the duty and perhaps choose to have a short discussion with staff to inform them of their duties and remind them of the existing processes and policies in place to share information. Others may choose to take more action to review their existing processes, or even to purchase new IT products or reconfigure their systems in order to facilitate better information management and sharing. As the proposed new duties are not prescriptive in how the duties are to be achieved, providers will be able to choose the most cost effective and beneficial method for them.
49. Based on our conversations with providers as part of the informal evidence gathering process for this IA, we have developed the following assumptions about how activity is likely to change in response to the new duties for social care providers. Overall, all those we spoke to remained confident that the costs would not be significant.
  - Approximately 50% of providers we spoke to suggested that they felt that they would already meet the new duties and so would not take any further action.
  - Of those who felt that they would take further action in response to the new duties, the main activity providers suggested they would need to do would be to take time to review and prepare a strategy and/or other documentation in relation to information sharing. This was anticipated to require approximately one day of a manager's time to complete.
  - In addition, most providers also suggested that they would need to discuss and provide training for their staff in order to understand the information sharing duty. Approximately half of providers anticipated that this would require additional staff time to carry out, whilst the

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<sup>10</sup> NHS Number Survey Report, NHS England, September 2014.

remaining felt that they would carry out this task as part of the normal course of staff meetings and other communications so this would not incur any additional time. Where additional training was felt to be required, this was anticipated to be approximately one hour long.

- In terms of implementing the NHS number requirement, providers felt that this would be a relatively straightforward task, and only require creating an additional field to be filled in on their existing data capture systems. Providers felt that this task would only take a nominal amount of time (perhaps 5 minutes) to carry out, and so we have not quantified this figure.
  - Finally, approximately 20% of those providers we spoke to suggested that they may wish to make further changes to their information systems in order response to the new duties, for example purchasing new information management systems or other re-designs of their IT. In other cases, providers suggested that any necessary changes to their IT could be rolled into other updates as part of business as usual, and so would not have any additional costs. Overall we anticipate that these updates would require the equivalent of 2 days of manager time to implement.
50. For other healthcare organisations (including dentists, GPs, independent hospitals and other healthcare providers), there is little evidence available to suggest how they might react in response to the proposed new duties. In theory, all healthcare providers contracted with the NHS face the same requirements as NHS trusts in terms of the IG toolkit; although evidence on levels of compliance with these groups is available, it is based on relatively low rates of completion of a self-assessment, and may not be a representative and reliable estimate of compliance rates. Since these providers are subject to the IG toolkit requirements as part of their contractual terms, an assumption that their compliance costs would be similar to providers not subject to the IG toolkit would tend to overstate costs. Therefore, we make the conservative estimate that these providers would incur similar costs to social care providers, which are not currently subject to the IG toolkit. As a further precaution, we do not estimate that any benefits accrue to these providers (see Benefits section below).
51. Overall, based on these assumptions, we estimate the total one off costs of meeting the proposed new duties to be approximately £10.6m, **of which £8.3m will fall on the private or voluntary sector**. The full details of these calculations are set out in Annex A, with full workings attached in a separate spreadsheet (Appendix 1 – Master Spreadsheet).

### *Cost of Information Sharing*

52. Overall, our discussions with health and social care organisations (ten parties, as described previously) suggested that increased information sharing may be associated with increased administrative costs associated with collecting the information and making it available. However, there was also consensus that, by making changes to information sharing processes, there is scope for efficiency savings for organisations. Further, it is likely that the recipient organisation will also experience cost savings associated with more timely receipt of data relevant to a patient's care. Our discussions with social care providers in particular suggested that these savings would both be in terms of reduced staff time spent requesting and chasing information, and efficiency savings through being able to better plan for a patient's care when information is received earlier. The reduction in staff time spent requesting information may also translate into a saving for the information sharer, as they will need to spend less time responding to such requests. Overall, providers reported that the on-going costs of meeting the information sharing duty were likely to be lower as a result.
53. In terms of the potential cost impact of the requirement to use the NHS number, the providers that we spoke to were of the opinion that this task would be relatively straightforward as it would only involve the recording of an additional piece of information on their patient records. The cost associated with doing this was felt to be therefore minimal. Where this information is not provided, the provider would need to contact the referring organisation to request it. Providers felt that the cost of doing so would be minimal, and would be the best long term solution to accessing more information as the patient's or service user's condition or needs evolve over time.
54. Overall, as there is little information available on the number of times information is required to be shared between organisations in relation to the direct care of a patient, and based on the assessment by providers that any cost impact of the information sharing duty is likely to be minimal, and are likely to be offset by efficiencies, we choose to leave these ongoing costs unquantified.

## Benefits

55. The benefits of improved information sharing, using consistent identifiers, fall into two broad categories – direct positive impacts on health and care outcomes for patients and service users, and efficiency gains for organisations within scope. We discuss each in turn below:

### *Benefits to businesses*

56. As discussed in the previous section, there are potentially large savings to businesses from the receipt of timely and accurate patient information. For example, many social care providers told us that, upon transfer of care from NHS to social care, social care providers often do not receive a timely and comprehensive set of information relevant to care. Instead information must be requested through staff having multiple conversations with different sectors of the NHS resulting in significant administrative costs. One provider reported that it would typically take a month to get all the relevant information picture, and sometimes this is later found to contain errors and omissions as things 'fall through the gap'. In addition to the potential administrative savings, organisations anticipated that they would benefit significantly if more timely and accurate information were made available to them by allowing them to organise individuals' care more efficiently (one provider gave the example that information mistakes led them to order the wrong equipment to meet a patient's needs, leading to considerable additional costs to rectify).
57. Although it is not possible to estimate the number of incidents of poor information sharing at present, as an illustrative example, data from the Hospital Episodes Statistics show that in 2012/13, there were approximately 92,000 discharges from a NHS hospital to a social care provider. This is a very conservative estimate of patients who move from NHS care to social care, because it does not include any patients who are discharged to their own home but have a social care package of care assigned (e.g. domiciliary care arrangements). The total number of people receiving social care from local authorities in 2013/14 was approximately 1.3 million, with around 800,000 of these referred to local authorities from primary/community health or secondary health settings during 2012/13<sup>11</sup>, and so 92,000 is a fraction of the total number of transfers taking place each year.
58. Based on the information we received that it can take typically take a month to receive all the relevant information from the NHS about a patient, we estimate that the total staff time required to collect this information might equate to approximately half a day's work in total (i.e. just under 1 hour per week being spent gathering or requesting information over 4 weeks).
59. Discussions with providers advised that nurses (or staff working at an equivalent level) would most likely be responsible for collecting and requesting information about patients. Based on the a median hourly wage for a nurse of £19 from the Annual Survey of Hours and Earnings (ASHE) survey 2013 (including 15.3% non-wage costs), this would suggest that the current cost of requesting and collecting information for a social care provider is approximately £71.25 (£19 multiplied by 3.75 hours).
60. Over the 92,000 estimated transfers from the NHS into social care organisations, this would equate to a time cost of £6.55million.
61. If the information sharing duty were to improve sharing between the NHS and social care, so that only an hour of staff time is required to request and process patient data for the recipient organisation (this might occur if, as already occurs between NHS organisations, a data pack with all the relevant information were automatically put together, so that the social care provider would only need to process the data) this would equate to an annual saving of approx. £4.8 million saving across the 92,000 transfers from hospital to social care providers that occur in a year<sup>12</sup>.
62. As previously discussed, this may be an underestimate of the true saving as the figure does not take into account patients who are discharged to their own home but have a social care package of care assigned. On the other hand, this figure could also be argued to represent an overestimate as it assumes that all 92,000 transfers between the NHS and social care organisations result in a time saving of 2.75 hours. In reality this figure is likely to vary depending on the initial quality of data sharing, and the level of improvement in data sharing that might arise from the proposed new duty.

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<sup>11</sup> Community Care Statistics, Social Services Activity, England - 2012-13, Final release, Health and Social Care Information Centre

<sup>12</sup> This benefit to social care providers is not outweighed by the increased cost to the NHS of providing the information, as we have argued in paragraph 53 that the additional costs of providing information may already be outweighed by other efficiency savings in information sharing processes, and the reduction in time required responding to requests and queries from other organisations

63. As a more conservative estimate, we use threshold analysis to demonstrate that even if the true annual savings for privately owned social care providers were a quarter of that estimated above (at £1.2m per annum), there would still be a modest net benefit to business, with a business NPV figure of £1.61m and an EANCB of -£0.15m. This would equate to approximately a £13 saving over each of the 92,000 estimated transfers between the NHS and social care organisations, or just over 40 minutes of staff time saved.
64. As the proposed policy is a regulatory proposal with a net benefit to business, we therefore consider it to have ZERO NET COST in accordance with the Better Regulation Framework Manual. We are confident in this assessment as we have demonstrated above the very conservative cost savings required in order to generate a net business benefit. In addition, these estimates only concern the potential cost savings in relation to improved information sharing where patients are discharged from an NHS hospital to a social care organisation. They do not include the potential savings where patients are discharged from an NHS hospital into their own home with a social care package (e.g. domiciliary care arrangements). We also have not included any potential cost savings from better information sharing elsewhere in the health and social care system (e.g. between the NHS and independent healthcare, or between social care providers and the local authorities). Finally, these savings estimates only include the direct time savings for providers from better information sharing. They do not include any other savings that might arise (e.g. better information preventing ordering the wrong equipment or medication for a patient).

*Benefits to patients and service users*

65. This modest efficiency in managing patient information flows is not, however, the prime mover for this legislative change. As previously discussed, timely and accurate information is essential to the delivery of safe and effective care. The extensive engagement with commissioners, providers, professionals, patients, service users and the public conducted as part of the NHS Future Forum engagement, the Information Revolution public consultation, and the evidence gathered in the course of the Caldicott Review, all conclusively found that improved information sharing, using consistent identifiers, will yield the following benefits for patients and service users:

Health benefits via:

- Better informed clinical and care decisions, leading to care and treatment better tailored to the needs and preferences of patients and people who use care and support, leading to better health and care outcomes;
- Safer care, with a reduced likelihood of errors, adverse events and sub-optimal care stemming from poorly informed clinical and care decisions. The opportunity for improvement is greatest for the increasing number of patients and service users who have complex, multiple needs, long-term conditions or co-morbidities.

Improved patient experience via:

- Improved patient and service user convenience and confidence – individuals have a better experience of care when they are not called upon to repeat their story along their care pathway, and have increased trust that at each contact the person caring for them has the information they need, and;

66. We have not attempted to quantify the benefits to patients to justify the policy, but provide the following illustrative examples of the potential scale of the benefits.
67. In terms of the potential health benefits for patients, a previous Impact Assessment for the 2012 NHS Information Strategy<sup>13</sup> estimated a total health benefit of around £330m (in Present Value terms over a period of 10 years) deriving from Themes 2 and 3 of the Strategy. These themes focused on information sharing across boundaries and information following the patient or service user, and as such align most closely with the objectives of the legislation.
68. These estimates were derived as follows:

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<sup>13</sup> The power of information: giving people control of the health and care information they need  
<https://www.gov.uk/government/publications/giving-people-control-of-the-health-and-care-information-they-need>

- Evidence from the National Patient Safety Agency found that communication delays are associated with delayed cancer diagnoses. Improved information sharing was postulated to reduce these delays and thus lead to better health outcomes for patients. Based on the evidence that up to 10,000 deaths in England could be avoided each year if patients were diagnosed earlier<sup>14</sup>, and a conservative estimate that 1% of delays in diagnosis were due to correspondence delays, this suggested that approximately 100 cases each year might be affected by improved information sharing. Relying on the good evidence of the relationship between delayed diagnosis and prognosis for cancer, the Information Strategy IA found that around 5,033 Quality Adjusted Life Years (QALYs) could be saved over the appraisal period (10 years). Based on a societal willingness to pay of £60,000 per QALY, this would equate to a societal benefit of approximately £300m.
  - The Information Strategy IA also developed an estimate of the QALY benefit of reductions in medical errors. Using evidence of adverse incidents from the National Patient Safety Agency, and based on the assumption that four types of incident could result from inadequate information (treatment, documentation, clinical assessment and consent/confidentiality incidents), the IA estimated a total QALY benefit worth £30m over a 10 year period.
69. However, the Information Strategy covered a much wider range of interventions and activities than are proposed by this Bill, and as such would be expected to generate a much wider set of benefits. The figures discussed above should therefore be taken as an illustration of the potential maximum scale of health benefits that could arise from improved information sharing.
70. On the more modest end of the scale, we can calculate the societal value associated with small changes in health using the EQ-5D framework<sup>15</sup>. This framework asks individuals to rate their health from 1 to 5 in five different domains, including the experience of pain, mobility and anxiety. These ratings can then be converted into QALY values using standard mapping tools based on surveys of the general population on their preference over different health states. The EQ-5D domain operates between the range of 1 (which represents perfect health) and 0, which is a state equivalent to death. Based on this methodology, any reduction in quality of life away from perfect health for one year equates to a QALY loss of at least 0.094 points. Thus if one service user is able to avoid one month's worth of less than perfect health due to poor quality care, there would be at least a 0.008 QALY gain. Based on a societal willingness to pay of £60,000 per QALY, this would equate to a societal benefit of at least £470 per patient.
71. Although it is not possible to know how many users of health or adult social care services might be affected in this way due to the proposed legislation, if, over 10 years, approximately 2,500 (0.3%) service users were to receive the modest health gains described above, then the total societal benefit would be in the region of £1m, and outweigh the current estimated net present value to society of -£0.89m. Compared to our estimate of 92,000 transfers between the NHS and social care occurring each year, this would appear to be a very modest assumption.

#### *Other benefits*

72. Better use of information creates efficiencies which release resources, which can be used to further drive improvements in health and social care outcomes
73. In addition to the cost savings described above, we note that
- A reduction in staff time spent duplicating or reassessing records will increase the amount of time available for health professionals to spend on each patient or service user, which will increase patient experience and allow carers to have improved interaction with patients
  - Any reduction in medical and care errors will also have cost implication for organisations (e.g. reduction in resource costs of dealing with the consequence of errors).

#### **OITO Assessment**

74. The following table summarises the costs and benefits estimated above and the calculated NPV, Business NPV and EANCB figures.

<sup>14</sup> This was taken to be at the same stage of their disease as in other European Countries

<sup>15</sup> <http://www.euroqol.org/>

75. The policy proposal is assessed to be a regulatory proposal with a net benefit to business. We therefore judge the policy to have ZERO NET COST in accordance with the Better Regulation Framework Manual.

**Table 3: Summary of costs and benefits**

		<b>Total (£, Rounded to nearest 100)</b>	<b>Private Total (£, Rounded to nearest 100)</b>	<b>Para ref</b>
Familiarisation Costs		582,600	438,200	See para 41
One off costs of implementing the duty	Preparing strategy/documentation	4,346,100	3,286,800	See para 51 & Annex A
	Staff training	4,551,800	3,678,500	See para 51 & Annex A
	Update/refresh current systems	1,738,400	1,314,700	See para 51 & Annex A
Ongoing costs of data sharing		Unquantified		See para 54
<b>Total Costs</b>		11,218,900	8,718,400	
<b>Total Benefits</b>		£1.2m p.a. or £10,329,200 PV over 10 years		See para 63
<b>NPV</b>		<b>-889,700</b>		
<b>Business NPV</b>		<b>1,610,900</b>		
<b>EANCB</b>		<b>-151,200</b>		

### Risk Assessment

76. The Department considers there are two main risks associated with this assessment of impact:

- **Evidence to support the estimates was gathered informally from a small number of affected organisations, rather than a public engagement exercise:** the evidence gathered to support this IA generated consistent messages, confirming the view that the costs of compliance would be low, and that efficiencies and other valuable benefits were expected. As such, the Department considers that the engagement undertaken to date is proportionate and sufficient. The evidence gathered on the value of legislative change, and the scope for efficiencies, also aligns with the extensive, systematic engagement performed in the course of the Information Strategy consultation, and key messages from the Caldicott Review.
- **The lack of an enforcement regime or penalties for non-compliance may result in lower than expected benefits for business, due to inaction by affected bodies.** The Department's aim in supporting this legislation is to address the current risk aversion which prevents legitimate and valuable information sharing in the interests of patients and people who use services. As such, the Department considers that penalties or sanctions for non-compliance would be heavy-handed. The non-prescriptive nature of the proposed duties mean that affected organisations will be able to comply in the most cost-effective way for them, and the Department will produce guidance that will emphasise the potential benefits of improved information sharing, and provide clear advice on ways to comply. We also believe compliance will be in the direct economic interest of affected organisations, and conclude that enforcement is unnecessary.

### Choice of appraisal period

77. The proposed new duties are estimated to have high one off costs to the NHS and businesses, balanced by modest annual benefits to organisations (and to patients, although we have not sought to quantify this). Over a standard 10 year appraisal period, this results in a slight net present cost to society of approximately £0.89m (although the net impact on business is anticipated to be positive).

78. Threshold analysis to vary the length of the appraisal period demonstrates that, assuming no benefits to patients are realised (see above), the annual benefits to organisations would begin to outweigh the initial costs of the proposal after 12 years. If a 15 year appraisal period were to be applied instead of the default of 10 years, the estimated societal NPV would be £3.1m. Although it is not possible to predict the likely duration of any new policy or legislative change, given the longstanding and increasing focus on the importance of information sharing, and the use of the NHS

number as an identifier, to the quality and safety of care, it is reasonable to expect that the duties would remain in place for 15 years or longer.

## **Section E: Summary of specific impact tests:**

### Equality Impact Assessment

79. The proposed legislation impacts on providers and commissioners of publicly funded health and adult social care. The costs will not impact patients, people who use care and support or any individuals.
80. The benefits of improved quality and safety of care through improved information sharing and use of consistent identifiers will be realised by users of health and adult social care across the protected characteristics.
81. As part of the development of the Information Strategy, extensive engagement was undertaken with patients, service users and members of the public, including through organisations representing people with protected characteristics. This engagement suggested that there may be particular gains for certain group of improved information sharing and use of the NHS number:
- The benefits to be realised from the sharing of information may be even greater for disabled people, as ‘many disabled people find themselves having to repeat the same information to lots of different services, all working in isolation from each other’. There is an opportunity to reduce the inequality that currently exists for disabled people by having their information shared securely by the services they interact with, so that they do not have to repeatedly give it.
  - A paper published in the Journal of Clinical Nursing states that many older adults, discharged from hospital with complex post-operative and rehabilitation plans have limited understanding of their discharge instructions. This can lead to high complication rates and costly readmissions. Better information sharing upon discharge into rehabilitation care offers an opportunity to reduce health inequalities for this group.
  - In their response to the Information Revolution consultation, The Royal College of Midwives told us ‘The use of information across organisational boundaries is particularly important for mothers and babies within maternity services. The information can be used to compare services by pregnant women, whilst organisations tend to share information regarding vulnerable women and children and best practice’ – Similarly there may be an opportunity to improve access to information for nomadic families where maternity care can break down. Gypsies and Travellers have 3 times higher infant mortality than the average.
  - We heard from the Princess Royal Trust for Carers during the Information Revolution consultation that carers often have to coordinate complex care that involves many professionals and agencies and could greatly benefit from meaningful access to and use of information across boundaries
82. As such, the duties are likely to have the greatest impact in improving the health and care of those who have the most complex health and care needs, and who may find their care pathway more difficult to navigate, which traditionally includes groups who experience worse health and care outcomes – older people, disabled people, and those with complex and multiple long term conditions.
83. Engagement with stakeholders also suggested that increased information sharing and a requirement to use the NHS number may also create risks for certain groups:
- Confidentiality and consent for sharing may be more of a concern for certain groups – for example, a person who is Lesbian, Gay, Bisexual or Transgender may not wish for their personal information to be shared with all the health and care professionals involved in their care;
  - There is a risk that duties to share and use identifiers may discourage people in receipt of sensitive services (e.g. sexual health services) or who may not wish to be identified when accessing health and care services, for whatever reason.
  - Individuals who have had limited or no contact with the NHS may not have an NHS number. For example, around 15% of homeless people are not registered with a GP, and will often not have

an NHS number, or know how to get one. There is a risk that some providers or commissioners may incorrectly interpret the proposed duty to use the NHS number as grounds to refuse care and treatment to people without NHS numbers, exacerbating existing health inequalities;

84. These risks are mitigated through the following express provisions in the legislation, which will be amplified through the guidance to be produced by the Department in partnership with stakeholders:
- The duties would not apply when a patient or service user objects to his or her information being shared, or his or her NHS number being used, or where it is reasonable to consider that the individual would be likely to object
  - The duties would not apply when a patient or service user receives services anonymously (e.g. sexual health services), or may receive such services anonymously
  - Where an individual does not have an NHS number, the duty does to use it does not apply
  - Where a provider or commissioner has taken reasonable steps to learn the patient or service user's NHS number, and has not been able to do so, the duty would not apply

### Competition

85. In any affected market, would the proposal:
- Directly limit the number or range of suppliers?
86. No. The proposals do not involve the award of exclusive rights to supply services, procurement will not be from a single supplier or restricted group of suppliers.
- Indirectly limit the number or range of suppliers?
87. No. The proposals will not apply any indirect limits to the number or range of suppliers.
- Limit the ability of suppliers to compete?
88. This duty is not expected to have any impact on suppliers. It will impact all providers and commissioners of publicly funded health and adult social care.
89. This duty does not limit the scope for innovation for the introduction of new products or supply existing products in new ways. It does not limit the sales channels a supplier can use, or the geographic area in which a supplier can operate. It does not limit the suppliers' freedoms to organise their own production processes or their choice of organisational form. It does not substantially restrict the ability of suppliers to advertise their products.
- Reduce suppliers' incentives to compete vigorously?
90. The proposal does not exempt the suppliers from general competition law. They do not require or encourage the exchange between suppliers, or publication, of information on prices, costs, sales or outputs.

### Small and Micro Business Assessment

- How does the proposal affect small businesses, their customers or competitors?
91. The 2013 Skills of Care report on the size and structure of the adult social care workforce<sup>16</sup> used ONS data to estimate that there were a total of 17,100 adult social care providers, of which 86% would be considered small or micro businesses.

Service type	Size group (employees)							
	Total	0 - 4	5 - 9	10 - 19	20 - 49	50 - 99	100 - 249	250 +
Residential services (SIC2007 87)	7,900	1,600	900	1,600	2,300	1,000	400	200
Non-residential (SIC2007 88)	9,200	4,000	2,000	1,300	1,100	500	200	100
<b>Total adult social care</b>	<b>17,100</b>	<b>5,600</b>	<b>2,800</b>	<b>2,900</b>	<b>3,400</b>	<b>1,400</b>	<b>700</b>	<b>300</b>

Individual rows may not sum to totals due to rounding

<sup>16</sup> Skills for Care, *The size and structure of the adult social care sector and workforce in England, 2013*

92. Across all health and social care providers, the BIS Annual Business Population Survey found that in 2013 there were approximately 50,000 employers in England with the Standard Industrial Classification (SIC2007) Human Health and Social Work Activities, of which 94% would be considered a small or micro business.

**Count of number of private businesses within SIC2007 Q - Human Health and Social Work Activities in England**

All employers	50,295
1	5,285
2-4	14,305
5-9	10,025
10-19	9,505
20-49	8,115
50-99	1,975
100-199	650
200-249	110
250-499	175
500 or more	150

Source 2013 BIS Business Population Survey

93. As a result, it is likely that a large proportion of businesses affected by the proposed new duties will be small or micro businesses.
94. Although the policy is not deregulatory in nature, we anticipate that the proposals are likely to result in net benefits for providers, as discussed above. These benefits are equally likely to accrue to small and micro providers as to larger providers and this was reflected in the consistency of responses we received from the sector. Overall, we spoke to providers of all sizes and no providers expressed any particular concern about the costs of the policy and all felt that there could be significant benefits arising out of improved information sharing.
95. Based on this evidence, the Department considers the most appropriate actions to mitigate the risk of disproportionate burdens falling on small or micro businesses are to:
- Ensure that the legislation is not prescriptive in how the duties are achieved, so that providers can choose the most cost effective and appropriate action for their particular organisation, and;
  - Produce tailored guidance to help smaller providers understand what would constitute a proportional and reasonable response under the legislation.

Legal Aid/ Justice Impact

- Will the proposals create new civil sanctions, fixed penalties or civil orders with criminal sanctions or creating or amending criminal offences? **No**
- Any impact on HM Courts services or on Tribunals services through the creation of or an increase in application cases? **No**
- Create a new right of appeal or route to judicial review? **No**
- Enforcement mechanisms for civil debts, civil sanctions or criminal penalties? **No**
- Amendment of Court and/or tribunal rules? **No**
- Amendment of sentencing or penalty guidelines? **No**
- Any impact (increase or reduction on costs) on Legal Aid fund? (criminal, civil and family, asylum) **No**
- Any increase in the number of offenders being committed to custody (including on remand) or probation? **No**
- Any increase in the length of custodial sentences? Will proposals create a new custodial sentence? **No**
- Any impact of the proposals on probation services? **No**

Sustainable Development

96. The proposals are not expected to have a wider impact on sustainable development. There will be no impact on climate change, waste management, air quality, landscape appearance, habitat, wildlife, levels of noise exposure or water pollution, abstraction or exposure to flood.

#### Health Impact

- Do the proposals have a significant effect on human health by virtue of their effects on certain determinants of health, or a significant demand on health service? (primary care, community services, hospital care, need for medicines, accident or emergency services, social services, health protection and preparedness response)
97. The potential impacts on health have been considered above in the cost benefit analysis of this impact assessment, see Section D above
98. There are no expected health risks in association with, diet, lifestyle, tobacco and alcohol consumption, psycho-social environment, housing conditions, accidents and safety, pollution, exposure to chemicals, infection, geophysical and economic factors, as a result of the proposals

#### Rural Proofing

- Rural proofing is a commitment by Government to ensure domestic policies take account of rural circumstances and needs. It is a mandatory part of the policy process, which means as policies are developed, policy makers should: consider whether their policy is likely to have a different impact in rural areas because of particular circumstances or needs, make proper assessment of those impacts, if they're likely to be significant, adjust the policy where appropriate, with solutions to meet rural needs and circumstances.
99. The proposals will not lead to potentially different impacts for rural areas or people.

#### Wider impacts

100. No wider impacts are anticipated.

#### Economic impacts

101. The costs and benefits of the proposals on businesses have been considered in the main cost benefit analysis of this impact assessments, see Section D above.

#### Environmental impacts and sustainable development

102. The proposals have not identified any wider effects on environmental issues including on carbon and greenhouse gas emissions.

#### Social impacts

103. No impact has been identified in relation to rural issues or the justice system.

### **Section F: Summary and Conclusions**

104. Based on the above impact assessment, the preferred option is Option 2 – the creation of express duties to share information for care purposes, using consistent identifiers. Sharing of information between organisations responsible for an individual's care supports the delivery of safe, effective and integrated care and treatment. There is a body of evidence which indicates that risk aversion, driven by the current legislative position, is preventing sharing from happening between health and social care organisations, even where this would be in a patient or service user's best interests. As such, the Department of Health considers that a new duty to share information for care purposes, using consistent identifiers, would redress the current imbalance in the legislative framework and provide a clearer and more certain legal basis for sharing than the current common law basis for sharing.
105. Engagement with health and adult social care organisations indicates that any familiarisation costs and one-off costs to ensure compliance will be low. Complying on an ongoing basis with the requirement is likely to generate long term recurrent savings. Better quality information will flow more smoothly and quickly, and use of the NHS number will make this improvement permanent and robust to changes in individuals' circumstances and changes to systems. The estimate of net benefits to business is based on conservative assumptions with only direct time savings quantified. Dividing this conservative estimate by four still yields a net benefit to business overall. The

Department is confident that the proposals will have a positive impact on business and the quality of care and treatment for patients and people who use services.

## Annex A

	Preparing strategy and documentation for new policy (including adding section to forms for NHS number)		Familiarisation/training of relevant staff		Update/refresh current systems		Total (£)	% Private	Cost Private (£)
Staff group	1 x manager per org		Nurse level, all involved in direct care		1 x manager per org				
Their cost per hour (£) (Source: ASHE 2013, Median Gross Hourly Pay per Occupation)	24		19 (£34 used for GP & £36 for Dentists)		24				
Time (hrs)	7.5		1		15				
Proportion of providers affected	50%		25% (50% of those taking further action)		10% (20% of those taking further action)				
Numbers in NHS (acute and community) & Cost (£)	300	£0 as already IG Toolkit Compliant	N/A	£0 as already IG Toolkit Compliant	N/A	£0 as already IG Toolkit Compliant	0	0	0
Numbers in Social Care & Cost (£)	17,100	1,539,000	488,600	2,321,000	17,100	615,600	4,475,600	90	4,028,000
Numbers of Independent Health Providers & Costs (£)	800	72,400	116,200	552,000	800	28,900	653,300	0	653,300
Numbers of GP's & Costs (£)	7,600	687,100	61,100	534,300	7,600	274,800	1,496,200	2	29,900
Number of Dentists & Costs (£)	8,100	725,100	40,800	367,300	8,100	290,100	1,382,500	68	940,100
Number of Other Health Providers (£)	14,700	1,322,600	163,600	777,200	14,700	529,000	2,628,800	100	2,628,800
Total		4,346,100		4,551,800		1,738,400	10,636,400		8,280,140

NB: figures may not sum due to rounding. Rounded to the nearest 100.

## Annex B: Staff Number Sources

Name	Staff Number (Rounded to nearest 100)	Source
<b>NHS</b> (Qualified nursing, midwifery, and health visiting staff)	348,600	The NHS Information Centre (2013) - NHS Hospital & Community Health Service (HCHS) Monthly Workforce Statistics.
Social Care (Direct Care roles only)	488,600	Skills for Care, Open Access NMDS-SC Dashboards. Data as at Sep 22 2014.
Independent Health Providers	116,200	England Skills and Labour Market Intelligence Assessment 2011. Although no comprehensive survey data was available for independent health providers, a 2011 report by Skills for Health on the labour market for healthcare estimated that the public sector healthcare workforce is three times larger than the private sector. This was used to estimate Independent Health Provider staff numbers.
GPs	61,000	General Medical Council, GP Register 2012.
Dentists	40,800	General Dental Council, GDC Register September 2014.
Other Health Providers (Direct Care roles only)	163,600	Quarterly Labour Force Survey, January – March 2014. The number of ‘Health professionals’, and ‘Nursing and Midwifery professionals’ recorded under ‘Other human health activities’ in this Quarterly Labour Force Survey was used to estimate the Other Health Providers staff number.