Lifting the Burdens Task Force

Review of Health and Social Care Burdens

Lifting
the burdens
task force

Final Report – recommendations
September 2008

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Foreword

Dear Secretary of State,

Adult social care, more than probably any other service area the Task Force has reported on, is a landscape that is transforming radically not only in the way it monitors, manages or assesses adult social care but in policy direction too. Whilst this has proved a challenge in some respects, as the full implications of complex changes are yet to play out, the transition has enabled the Task Force to play quite a fundamental role in shaping the future for adult social care.

A key debate running throughout this review has been between the need to reduce the burden on councils and yet retain sufficient quality information. Our report shows a maturity within local government with regards to importance of information as an asset which supports service delivery and acknowledges the good work being carried out by the Department to try and streamline data requirements on local authorities. However, the Task Force is alarmed by the feeling expressed by local government that the amount of reporting has actually increased. This just serves to demonstrate for us the importance of actually delivering on the Information Centre's recommendations urgently. Breaking local and central government's reliance on performance indicators and national data returns will also require the ability for local government to be able to measure performance and outcomes sufficiently by other means and for the Inspectorates to accept this. This is why we are very interested in the potential of the National Adult Social Care Intelligence System (NASCIS).

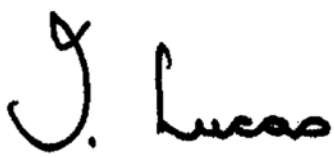
With the advent of a new inspectorate for adult social care and the imminent introduction of Comprehensive Area Assessment, the burden of inspection and regulation activity is an obvious concern for local authorities. As proposals are being finalised, the Task Force will be looking for a social care assessment framework that reduces the data burdens on councils, reflects the new transformation agenda, assesses outcomes and enables innovation. It is also important, in order to minimise the impact on local authorities, for adult social care assessment and regulation to be fully integrated with CAA in terms of how data is interpreted, judgements are reached and conclusions published so that the two frameworks do not duplicate each other. A copy of this report has therefore also been sent to the Chair of the Commission for Social Care Inspection and the Shadow Chair of the Care Quality Commission.

During the course of this review we also had an opportunity to examine the associated burdens stemming from the Supporting People programme, as it comes under the remit of the majority of Directors of Adult Social Services. Supporting People is the responsibility of Department of Communities and Local Government (CLG). We have therefore included several recommendations in this report aimed at CLG and a copy has also been sent to the Secretary of State for Communities and Local Government.

The other key issue on the ground is effective local partnership working between health and social care. Our report shows that even where there is clear will and a commitment between partners to co-operate, a number of barriers remain. Whilst these may not prevent good partnership working, they do place a significant drag on it and add unnecessarily to the inherent challenges in trying to deliver better outcomes for people with complex social and long-term health needs. We are therefore recommending that DH address these systemic burdens as a matter of priority.

I would like to express my thanks to all those who have given generously of their time to contribute to this review. I would particularly like to thank Moira Gibb, Chief Executive of London Borough of Camden for leading this review on behalf of the Task Force, as well as Mary Burguieres (London Borough of Camden), David Johnstone (Devon County Council and ADASS) Sallyanne Johnson and Kevin Quigley (Nottingham City Council) and Rachel Gapp (Lifting the Burdens Task Force) for their committed support throughout. Finally, I would like to thank colleagues in the Department for Health, Information Centre and Commission for Social Care Inspection for the positive and constructive way in which they have engaged with this review. I hope this will carry forward into the future.

I look forward to hearing your response to our report.



Irene Lucas
Chair, Lifting the Burdens Task Force

1. Introduction

The Lifting the Burdens Task Force is an independent practitioner body established in September 2006 by the Rt. Hon. Ruth Kelly, then Secretary of State for Communities and Local Government. This specific review was led by Moira Gibb, Chief Executive of the London Borough of Camden and a member of the Lifting the Burdens Task Force.

The Task Force is charged with undertaking a review of the bureaucratic burdens that exist as a consequence of the current relationship between central and local government. In particular, the Task Force is focusing on the means by which we might improve and streamline that relationship in the areas of performance management, assessment and regulation. The Task Force will identify which central requirements cause the most difficulty on the ground and which add the least value and agree packages of burden reduction with Government.

To that end the Task Force has initiated a series of projects examining the nature of the relationship between individual departments of state and local government with a view to identifying specific recommendations for change in the way in which local services are monitored, regulated and held to account by sponsor departments. Each project undertakes to identify those elements of current reporting arrangements and regulatory requirements that are core to the delivery of effective and accountable service outcomes and seeks to specify changes to those arrangements and requirements that can help both central and local government to deliver those outcomes more effectively and efficiently.

The definition of a 'burden' used by the Task Force includes any central government activity which hinders the effective and efficient delivery of services and outcomes at the local level. This can include; plans, guidance, legislation, approval processes, funding arrangements or performance information as well as inspection activity carried out by independent inspectorates and regulators.

The Local Government White Paper sets out a clear vision for the future role of Local Authorities both as deliverers of modern, relevant and value for money services and as providers of effective and accountable leadership for communities. The White Paper sets this objective clearly in the context of a changed relationship between national and local government and between local government and the communities it serves.

"Our aim… is to reduce radically the number of nationally-required local targets, performance indicators and reporting, and to replace these with new opportunities for citizens to hold their local providers to account for the quality of services" (Section 6.6. Strong and Prosperous Communities October 2006).

It is reassuring that the rhetoric of this vision is now being actively implemented through the provisions of the Local Government and Public Involvement in Health Act 2007.

The practical suggestions for reducing burdens recommended by the Task Force are not just things that should stop happening but are also about those things we can do differently in order to reduce the burden. For these to work and bring about the reduction in burden needed, they must be accompanied by a change in mindset, attitude and behaviour by all the players involved including central and local government, Government agencies and Inspectorates. A change in culture is much harder and takes longer to bring about than a change in policy but it is essential if we are serious about sustaining this new relationship between central and local government. If implemented, we believe the recommendations in this review of the Department of Health will have an immediate impact on reducing burdens, such as through the elimination of some unnecessary data collections and the rationalisation of improvement support, as well as the longer term aim of adjusting the cultural imbalance between health and social care partnerships.

This is therefore an opportune moment for the Task Force to issue its report, from the practitioner's perspective on how we feel the current and future arrangements for social care can be improved so that they add value and improve efficiency and effectiveness.

2. Overview of the Review

Adult social care, more than probably any other service area is a landscape that is transforming radically and this will have a knock-on effect to how social care is managed, reported, delivered, regulated, inspected and improved. Demographic projections indicate that there will be significant shifts in the age and disability profile of the population, in addition to changes resulting from economic migration, asylum seekers and refugees and thus commissioning and provision will be affected. The policy commitment to choice and personalisation will bring changes to the patterns of service, the providers of service and the nature of commissioning at both the aggregate and individual level. The changes to the way citizens choose to receive service support will also impact on the detail of how regulatory and performance regimes can operate.

We are operating in a fast changing environment. Since we started this review the Health and Social Care Bill has been passed into law creating the new Care Quality Commission from April 2009; the 'Putting People First' Concordat has been signed; a debate has been launched on the future of care and support services to inform a green paper on social care funding due in 2009; a new social care skills academy is being set up; the Information Centre, an arms length body of the NHS has undertaken a major consultation to review national social care data collections in the light of the NIS; and DH are introducing a new presence in Government Offices.

The scale and pace of change means that this review has provided a great opportunity for the Task Force and local government to feed into and influence the current debate around how the performance of commissioners and providers of adult social care should be monitored, managed and assessed and ensure unnecessary burdens are eliminated. However, we also recognise that, in the time between our call for evidence in February and the publication of this report in September, many things have moved on. We have tried to acknowledge as much of this change as possible in the report. However, we believe that the local authority views reflected in this report remain relevant and legitimate concerns until the full impact of these changes is fully implemented and understood.

Whilst adult social care interacts with many parts of government, not just the Department of Health, this review focuses on those burdens that are a direct result of the local government/Department of Health relationship as well as those that emanate from the Commission for Social Care Inspection (CSCI) as the current regulator and inspector for social care. Furthermore, it became clear during the course of the review that we also had an opportunity to examine the associated burdens stemming from Supporting People which falls under the remit of Department of Communities and Local Government (CLG); we have therefore also drawn several recommendations from this investigation and included them in this report.

Within this context, the objectives of this review were to:

a) Identify areas where a more streamlined approach between DH and local government could favourably impact upon the efficiency and effectiveness of delivery by local government.
b) Reduce the complexity and improve the quality of data sets and improvement and efficiency support.
c) Identify any lessons from current arrangements which could helpfully inform the final arrangements for future regulatory and performance assessment regimes.
d) Highlight barriers to effective partnership working where practical changes by Government are needed.

During the course of this review the Task Force has engaged with and gathered evidence from a wide range of people within local government, from the operational to the strategic via the call for evidence and collectively from the Association of Directors of Adult Services (ADASS) and their sub-groups such as the Information Management Group and regional groups. This ensured that a balanced view of the issues has been taken. A full list of those who participated is included in appendix B.

In undertaking the review a number of different activities informed the final recommendations.

- **Review of previous publications** – we conducted a literature review of recent capability reviews, simplification plans and other documents such as IDeA research into joint health and social care working and CSCI consultations on the 2008/09 assessment methodology and contract monitoring, to identify the areas of concern where we could add most value.

- **Group meetings** – Five meetings of the review panel took place to define the scope of the review and provide a forum in which to engage with colleagues from CSCI, the Department of Health and ADASS (membership of the review panel is in appendix B).

- **NIS and national social care data returns** – Throughout the course of this review the Task Force has been working in conjunction with DH and ADASS around future revision of social care national indicators and with the Information Centre on their review of social care data returns to ensure the strands of work joined up and complimented each other.

- **Call for evidence** – This was issued in February, and responses were received from 16 individual local authorities as well as several collective groupings which together cover a sizable majority of local authorities with responsibility for adult social care in England.

- **Further research** – The Task Force conducted further research into the Supporting People programme to understand the basis of the burdens cited by local government.

3. Information for Performance Monitoring, Management and Assessment

a. Performance Management Information:

The 2006 Local Government White Paper said that the Government's aim was to 'reduce radically the number of nationally-required local targets, performance indicators and reporting and to replace these with new opportunities for citizens to hold their local providers to account for the quality of their services.' Accordingly, the 198 national indicator set was launched in February 2008 to replace BVPIs, social care Performance Assessment Framework (PAF) indicators and other programme specific indicators as the only measures Government would use to performance manage local authorities.

Similarly, in the Comprehensive Spending Review announcement Government committed to reducing the amount of data that it requires from frontline services by 30% by 2010. The Task Force was keen for progress to be made as quickly as possible towards meeting this target as a way of reducing the burden on local authorities, and that it is achieved on an understanding of what information is needed locally to manage and improve services and not just central Government's view of its data needs. We therefore engaged fully with the Information Centre's review of national social care data collections as the key opportunity for progressing our concerns in this area.

The main issues regarding data collections expressed by local authorities at the time of consulting back in February 2008 were around:

- The amount of duplication within and between returns
- That national data returns outside of the NIS would be used to performance manage councils
- Confusion around the role of the Government Office in collecting and assessing local performance data
- Much of the information collected and submitted was not useful, meaningful or of sufficient quality

In addition to working with the Information Centre, the Lifting the Burdens Task Force asked a number of questions of local authorities in its call for evidence in February 2008 about centrally-driven performance and management information reporting. The key questions we asked were intended to find out:

- Whether there was an expectation that the amount of reporting to the centre would be reduced as intended by Government
- How local authorities were planning to meet national reporting requirements and the development of local performance targets
- How useful to local authorities were a range of specified national data returns
- Views of local authorities about the potential to use standard information systems e.g. standard care management records, or finance and activity data, as the basis for reporting to DH and to national regulator

There was surprising consistency in the responses to all of the questions with the main findings being:

- Local authorities expected there to be an increase in the amount of reporting to meet national reporting requirements from central government and the national inspectorate and regulators.

- Local authorities did not expect the national regulatory and inspection bodies to restrict their information requirements to the 198 National Indicator Set (NIS) and LAA performance data. Consequently, local authorities were planning and developing their information systems to record more information than this to meet national reporting requirements.

- In addition, local authorities were undertaking additional work to report on new performance indicators in the NIS and also to develop locally determined performance targets and measures.

- The existing national social care data collections were considered to have limited value by local authorities. Where they had value it was in limited data subsets within large and complex returns. Often local authorities were undertaking additional work on the data to derive benefits, for example to provide benchmarking information. The view was that subsets of different returns could be merged into a single return.

- A number of the returns were consistently defined as being of no benefit to local authorities.

- Information provided to Government departments and regulators has often been derived from stand-alone returns and from data collection exercises specifically developed for this purpose. We asked a question, therefore, whether local authorities thought that there

was scope within standard local authority information systems, e.g. care management records, financial records and activity-based records, to provide both central government and regulators with their information needs. There was a consistent and positive response to this option, subject to caveats about there needing to be a development programme to achieve this.

The responses to the call for evidence indicated that local authorities recognised the importance of information and intelligence both for themselves and for the Department of Health in order to understand and demonstrate the outcomes of social care investment and activity. However, councils were very critical of the value and volume of current and continuing data returns. This means the perception of data as a 'burden' is not solely about the quantity but equally about the quality.

The Task Force was very concerned that local authorities expected the burden of reporting and regulation to remain at a significant level, with little if any reduction. We believe this view will have been compounded by the subsequent letter to all councils in April 2008 asking them to continue collecting the current range of data and information during the period of transition, in addition to those of the new National Indicators for social care. Therefore, should councils continue to monitor PAF voluntarily we would want to seek assurances over what this information will be used for and whether and how it would inform judgements.

Against this, the Task Force does recognise that the Department of Health has made good progress with a number of initiatives that should ultimately result in a tangible reduction in the volume of performance reporting once fully implemented. We also expect to see regulatory monitoring based on information which is more relevant and useable by local authorities and the Department of Health. If this activity delivers the expected reduction in burden experienced by local authorities on the ground, then the Department and CSCI should be applauded and seen as an example to other Government Departments. These initiatives include:

- The Information Centre led review of existing Social Care Data Collections which has recommended the deletion of several items from national data collections and the consolidation of other data items into a single return. DH believe this will result in the amount of data being collected nationally to reduce by about 60%;

  A DH Review of the major social care finance data return PSSEX1, which was listed as one of the top five most burdensome data returns in the Task Force Finance review published in May 2008. The aim is to make significant improvements to the quality and usefulness of the return for 2009/10.

- A DH led programme with local authorities to review and improve the suite of performance indicators for adult social care in the NIS as part of the next Spending Review.

- An Information Centre feasibility study of a National Adult Social Care Information Service (NASCIS) which would aim to be a hub for information that councils want to gather and use themselves for their own management purposes over and above the one-off data returns to government.

- In June 2008 CSCI issued a consultation on changes to the performance assessment of adult social care in 2008-09. The document helpfully sets out proposals to streamline the Self Assessment Survey (SAS) principally by removing any duplication with data already submitted by councils to the Information Centre and providing greater scope for councils to supply their own local evidence, which we hope will be adopted.

Information for performance management is needed by local authorities to manage their own business and by Government departments to be assured about implementation of Government policies. At present, most of this information comes from stand-alone returns. The Task Force commends the strategy to derive information and intelligence about social care's performance and achievements from day-to-day business systems and processes and not from centrally-determined data returns. The Information Centre feasibility study for NASCIS will be an important step towards this goal. We would encourage Government Departments and local government to monitor its development and if successful consider the merits of extending the concept to other policy areas.

b. Inspection and Regulation Information:

The new local performance framework aims to reform the way in which public services are delivered by providing a clear statement of Government's priorities in a smaller more focussed set of national indicators thereby allowing more space for innovation and delivery of local priorities. It places less emphasis on set piece performance reviews and more emphasis on the performance management capacity of local authorities, the information they already use for self assessment and performance management and an on-going relationship between councils, Local Strategic Partnerships, other local partnerships and the Government Offices and inspectorates. Government is committed to finding ways to achieve their outcomes in ways that fit with the new local performance framework. It is therefore concerning that a clause in the Social Care Act seems to open the door for the Secretary of State to request additional indicators thereby undermining the principles at the heart of the National Indicator Set and the new performance framework for local authorities. This reads:

Health and Social Care Act Part 1 — The Care Quality Commission

Chapter 3 — Quality of health and social care

(3) In respect of each English local authority the Commission must—
  (a) conduct reviews of the provision of adult social services provided or commissioned by the authority,
  (b) assess the authority's performance following each such review, and
  (c) publish a report of its assessment.
(4) The assessment of a body's performance is to be by reference to such indicators of quality as the Secretary of State may devise or approve.
(5) The Secretary of State may direct the Commission to devise indicators for the purposes of subsection (4) and submit them to the Secretary of State for approval.
(6) The Commission must—
  (a) prepare a statement describing the method that it proposes to use in
  assessing and evaluating a body's performance under this section, and
  (b) submit the statement to the Secretary of State for approval.
(7) Different indicators may be devised or approved, and different methods may be described, for different cases.
(8) The Commission must publish—
  (a) the indicators devised or approved from time to time by the Secretary of State, and
  (b) the method statement approved from time to time by the Secretary of State.

The Task Force would not want to see the practical application of the clause result in the undermining of the National Indicator Set. The Task Force believes the ability to create extra indicators outside of the NIS must be absolutely resisted and questions whether under the new performance framework the enshrining of extra indicators in legislation should be allowed at all. There is work currently underway to improve the social care indicators in the NIS and the focus must be on delivering a 'fit for purpose' NIS of 198 or less, rather than on augmenting it further.

The Task Force recognises the tension that exists at the moment between the need to reduce the burden on councils and the inspectorate needing to maintain sufficient information in order to be able to make meaningful assessments (particularly given clause 64 in the Health and Social Care Act 2008 that allows the Care Quality Commission to require persons to provide it with the information it considers necessary to carry out its functions). The Task Force firmly believes that the principle of reducing the burden of inspection and assessment on local authorities must be upheld, particularly as our call for evidence reveals a scepticism within local government authorities about whether the amount of reporting will actually decrease. Our call for evidence flagged up that local authorities would like to see CSCI adopt a much more flexible and innovative approach to data gathering that focuses less on standard data returns (particularly as information and priorities will not be the same everywhere), and more on the information used locally by councils to manage their performance and self assess. This will enable a far greater reduction and streamlining of national data returns.

There is also an issue about how data is then interpreted. CSCI/CQC, Government Offices (GOs) and Strategic Health Authorities (SHAs) may not carry out performance monitoring or assessment activity together but they do need to be in regular dialogue to share findings on those indicators which are in both the NHS Vital Signs and the NIS on the basis of common principles so that local authorities and Primary Care Trusts (PCTs) experience a consistent and joined up approach. It is important that health and social care data is subject to the

same interpretation and that there is agreement between CSCI/CQC, GOs and SHAs on what constitutes a good outcome or a cause for concern otherwise it risks creating conflict and tensions around improvement priorities which would undermine joint working between local authorities and PCTs.

A number of respondents to the call for evidence also identified the way and timeliness with which CSCI share information as an issue. Councils felt that CSCI should write up and share appropriate data from regulatory inspections as quickly as feasible. The responsibility of local authorities to assist this process is also acknowledged.

c. Conclusions

There is a sense that local authorities associate centrally determined performance management with performance assessment and regulation and not with performance development or performance improvement. The Task Force did not find evidence that the considerable effort put into providing this information resulted in a product that was used either by local authorities or by DH as a source of intelligence to inform activity or to manage performance. The consensual feedback was that centrally driven data collection was not fit for this purpose.

There was, however, a consistently positive response to the question about local authorities working with DH to produce information and intelligence on performance and outcomes.

The comments from local authorities did not indicate any resistance or hostility to providing information. The impression from the call for evidence was of a maturity in seeing the importance of good quality information for Government in relation to meeting policy requirements, for regulators and inspectorates in ensuring safe practice, and for Local Government in managing its own business and comparing progress with others. There was a sense of frustration, however, at the lack of quality, precision and relevance in the sheer amount of information required by Government, inspectorates and regulators at present. We therefore acknowledge the actions underway to reform and reduce centrally prescribed data collections.

Recommendation 1:
As a result of the DH review of the social care national indicators, any immediate changes DH wish to make to the current NIS must be on the basis of 1 in 1 out within the social care set. Any future changes to the NIS as part of the next spending review process must be made on the basis of an overall 1 in 1 out rule in order to maintain the integrity of the 198 as a whole and not allow the overall number of indicators in the NIS to increase.

Recommendation 2:
That DH and the Information Centre continue to work to remove and improve data returns that are not used and that returns which do contain useful information are reviewed and simplified, with retained sections combined into a smaller number of returns. The Task Force notes with approval the review of Social Care Collections and the Review of PSSEX 1.

Recommendation 3:
It is recommended that DH makes every effort to derive performance management information from standard data recording activity which is undertaken by all local authorities in the course of their day-to-day business. (Some work will be necessary to standardise core data requirements, but work to scope out the potential in care management systems has already begun with the initial scoping and business case for a National Adult Social Care Information Service being developed by the Information Centre.)

Recommendation 4:
That CSCI/CQC work to identify ways that the inspectorate can become more flexible in their approach to data gathering. CSCI / CQC, should make far greater use of the information used locally by councils to manage performance and self assess rather than large stand alone centrally determined data returns in making assessments of social care performance, thereby enabling a far greater reduction and streamlining of national data returns.

Recommendation 5:
That CSCI/CQC, Government Offices and the Strategic Health Authorities work together to ensure they do not reach different interpretations of the same data causing conflict and tensions for improvement priorities and undermine joint working between local authorities and Primary Care Trusts (PCTs).

Recommendation 6:
That CSCI/CQC look at the time and process whereby they share information about regulated provision to see if they can find ways of writing up and sharing appropriate data with local authorities as quickly as possible.

4. Service and Regulation Inspection

a. Alignment and Integration of Social Care Inspection and CAA:

The Health and Social Care Act 2008 allows for the merger of the Mental Health Act Commission, the Healthcare Commission and CSCI. The aim is to have a coherent approach to inspection and regulation across health and adult social care, to place the new 'Care Quality Commission' in the context of an overall system that is led and managed locally and to minimise the cost and impact of inspection and data collection on local authorities. However, the eventual impact and alignment with CAA is yet to be fully understood for both regulation and performance assessment regimes. It is believed that there will not be a rolling programme of inspection for adult social care, but the CAA area assessment will trigger risk-based CQC fieldwork. The Task Force supports this position.

Regulation and inspection aims to safeguard adults in vulnerable circumstances and ensure that care services are improved and maintained to a high standard. The Task Force appreciates the role that regulation and inspection has played in improving services but feels that the focus now needs to be more on how assessment can assess outcomes and support innovation. We must also ensure that the regulatory and inspection regime is appropriately streamlined and duplication between the inspection process, general performance reporting and regulation is eliminated. The aim should be a regulatory and inspection process for social care that sits in harmony with the new performance framework for local government and enhances it.

It is appropriate for CSCI/CQC to be responsible for assessing and reporting on social care issues, providing they work effectively with the other inspectorates, align their frameworks and do not duplicate work. The way in which this 'alignment' between social care assessment and CAA has been described in the CSCI consultation on its 2008/09 framework is that: 'CSCI's assessment of delivering outcomes and for leadership and commissioning will be passported into CAA.'

The second joint inspectorate's consultation on CAA published at the end of July does not offer much more of an insight. It says that 'Inspectorates will share evidence and analyses,' that evidence from CSCI about social care will be used so that the Organisational Assessment can comment directly on the performance of key local services and that the 'Inspectorates will work in partnership to undertake joint inspection planning.' The document also talks about how the links between the area and organisational assessments will be managed and cross-referenced to support partnership working and individual accountabilities, for instance a red flag will be reported in more detail in the relevant organisational assessment. How the joint-inspectorate drafting of the final reports will work in practice and whether or not there will be a stand-alone report on adult social care is still not totally clear to local authorities.

The truth therefore, as to whether joint inspectorate working will add value or result in duplication will only become apparent as we start to work with the new framework. The ten trial sites for CAA are therefore incredibly important in actually demonstrating what the day-to-day working with CAA will be like, how it operates with the CSCI social care framework and where the reduction in burden will actually come from. We would urge CSCI and the Audit Commission to pay particular attention during the trialling work to the practical issues surrounding the joint inspectorates working so that it does not end up imposing undue burdens on local authorities.

In our call for evidence we asked local authorities to estimate how much time and money they spent on preparing for service inspection. All respondents reported that that the demands in terms of staff time in particular were considerable. Estimates were in the region of £50k per authority. The most common spend was on additional staff to assist the process of data gathering and delivery. Local authorities also reported that they had to put in place additional systems and resources to deal with the self assessment. Generally, local authorities in our call for evidence anticipated that social care inspections were likely to remain very demanding in the future.

There were a number of suggestions put forward as to how inspections could be made less cumbersome but the one consistent theme was for inspectors to make more use of existing council performance information and data systems. This will mean that the inspection is not an additional resource intensive collection and collation task. Another aspect to making inspection less cumbersome is to ensure that it aligns fully with the CAA and that the streamlined approach to national data does not trigger an inspection due to 'lack' of evidence to prove performance.

These recommendations regarding inspection are entirely consistent with the recommendations of the previous chapter of this report around performance monitoring, management and assessment information.

Recommendation 7:
That CSCI/CQC continue to consult and work with local authorities and other health partners to consider ways in which existing council performance data can be used to support inspection thus further reducing the need for additional secondary data for inspection purposes and reduce the overall burden on councils at the time of inspection.

Recommendation 8:
That CSCI/CQC continues to work on the alignment of approaches with the Comprehensive Area Assessment in order to eliminate any potential duplication for local authorities.

b. Regulatory Inspection

The call for evidence looked at the issue of duplication between council contract monitoring and CSCI regulation as it had been bought to our attention that providers felt there was a shifting of the burden onto them as a result of these overlapping activities.

The responses to our call for evidence did not highlight a common or persistent issue between council care contract management contract monitoring and CSCI regulation. This is not to say there is not an issue as individual councils did report problems and since our consultation, the issue has been picked up by the Better Regulation Executive. The result of which is that CSCI and ADASS have agreed to work together to design a protocol which would focus on practical ways for local co-operation which would have the effect of minimising the burden on providers and reducing the waste in public resources that duplication causes. The views of providers and other stakeholders will be sought in developing the protocol. The Task Force supports this approach on the basis that the protocol does not create an unnecessary bureaucracy and that its implementation and effectiveness is reviewed after twelve months.

Furthermore, local authorities, through our call for evidence also called for more effective sharing of regulatory inspection information at a local level to help ensure that workloads were not unnecessarily duplicated.

Recommendation 9:
That CSCI/CQC together with ADASS review the implementation and effectiveness of the contract monitoring/regulation protocol after twelve months.

Recommendation 10:
That CSCI/CQC and local authorities share more effectively regulatory inspection information at a local level so as to avoid unnecessary duplication of effort.

5. Regional working to support performance improvement

During the course of this review, the Task Force heard repeatedly from councils that the regional landscape around health and social care was far too complicated and confusing. Even a passing glance at the agencies operating at a regional level reveals Joint Improvement Partnerships (JIPs), Regional Improvement and Efficiency Partnerships (RIEPs), Strategic Health Authorities (SHA), Government Offices (GO), CSIP, CSED (the DH Improvement and Efficiency units) and IDeA. To date, the onus has been on local authorities to join up the guidance, advice and support stemming from all these players. The Task Force firmly believes this should be done at a regional level so that local authorities have a seamless point of contact for support.

The National Improvement and Efficiency Strategy (NIES) published in December 2007 also recognises that the improvement landscape is confusing for local authorities and commits both central and local government to simplify and rationalise arrangements. In addition, greater clarity is needed about the roles and responsibilities of the various agencies with many local authorities in our call for evidence feeling that the value that regional support could most add is around promoting good practice and helping share good practice between authorities.

The NIES and the introduction of RIEPs in April 2008 both recognised that local authorities and their partners were best placed to drive efficiency and improvement. As RIEPs continue to develop and evolve they will have a key role in being the single point of access for improvement support for councils, acting as a hub, signposting councils to the right support and helping to share good practice between authorities at a regional and sub-regional level and across regions.

In line therefore with the NIES and what respondents to our call for evidence overwhelmingly requested, the Task Force recommends further efforts are made by DH to streamline their improvement and efficiency work for social care and recognise that for councils and local partnerships the RIEP will provide a single point of contact for advice and discussions around improvement need. We understand that some initial research has been undertaken around improvement programmes and relationships between various agencies. This is positive, and extending this work to include a more thorough analysis of DH sponsored improvement agencies and programmes, associated spend and governance and links between these programmes and sector led support in this area would be a useful basis from which DH can identify where existing arrangements can be rationalised and devolved, thus simplifying the architecture.

There was a range of views about how the DH presence in regional Government Offices could be most effective and useful. Key themes were around promoting consistency of government strategy for health and social care in the regions; acting as a channel for local authorities' priorities to be communicated to central government; and helping to promote more relevant and joined-up performance targets for health and social care. The Task Force recognises that over the course of this review, DH has been working to integrate the new regional DH leads within the regional landscape, taking a commissioning approach via RIEPs. We believe this is a positive development and one which should aid streamlining if effectively implemented.

Recommendation 11:
That DH commits to rationalising and devolving existing improvement and efficiency arrangements, where appropriate, thus simplifying the architecture for social care at a regional level. This should include extending the initial review work already undertaken to include an analysis of DH sponsored improvement agencies and programmes, associated spend and links between these programmes and sector led support in this area with a view of rationalising the system. This should be followed by a review of the effectiveness of regional improvement support one year on from any changes and addressing the lack of clarity that exists at times between the roles and responsibilities of the various bodies.

Recommendation 12:
That RIEPs work to develop their role as a hub for councils' social care improvement needs and provide support to DH in promoting and sharing good practice between agencies and local authorities.

6. Supporting People

During the course of the review, burdens stemming from the Supporting People programme, which falls under the remit of Department of Communities and Local Government (DCLG) and is the responsibility of many Directors of Adult Social Care, were brought to our attention. It was felt that it was appropriate (given that a review of DCLG had already taken place) to include the issue in this report given the policy links with health and social care.

Supporting People is a funding programme that brought together various disparate funding streams into one coherent programme in 2003 to support vulnerable people to live more independently and maintain their tenancies. The Task Force heard criticism of the national data requirements for Supporting People, with some local authorities questioning what value the data set added, the duplication of contract monitoring and reporting arrangements that Supporting People introduced and the inconsistency and duplication of Supporting People inspections with social care inspections. More generally, there was criticism of maintaining Supporting People as a separate ring-fenced funding stream.

The Task Force decided to consider in particular the reporting burden on local authorities in meeting the Supporting People requirements. In doing so the Task Force consulted with ADASS representatives, policy leads responsible for Housing and Supporting People and met with CLG representatives.

The number of data items that councils have to submit with regards to Supporting People has been reduced from 27 to 22. The Task Force understands that CLG is currently reviewing these requirements again in the light of the new national indicator set. It is hoped this will result in further reductions.

The Task Force felt that the model of outcomes reporting for individuals that takes place in Supporting People was a positive development in the light of the new 'outcome' based national indicator set and the move away from process reporting. With local authorities having to take on much more responsibility for their own performance management and improvement, it is felt that local authorities should be supported more and best practice promoted in how use of this data could further enhance joint commissioning and the delivery of improved outcomes.

With regard to the issues around contract monitoring between local authorities and providers and any potential for rationalisation, it is felt that this issue would be best picked up and resolved by ADASS. However, some councils have reported that the Audit Commission Housing Inspectorate expectation of contract monitoring seems to be highly intensive when compared to for example social care contract monitoring. We would therefore welcome some clarification on the expectations on local authorities for monitoring all contracts based on a realistic risk assessment and performance assessment across the board.

As for the future of the Supporting People grant CLG's intention is to include the grant in Area Based Grant from 2009/10, depending on pilots in 2008/09 not raising serious concerns. The Task Force would encourage CLG to do everything possible to ensure that Supporting People grant does move into Area Based Grant (ABG) as from April 2009 thereby removing the ring-fence and allowing local authorities greater flexibility in how to effectively use the resources locally. The Task Force also welcomes the fact that the programme of Supporting People inspections comes to an end in April 2009 and urges CLG and the Audit Commission to ensure that any future re-inspections are only triggered by a risk flagged up in the CAA and adhere to the principles of light touch and proportionality.

Recommendation 13:
CLG reviews the extent of data required within Supporting People returns and align this with the Department of Health's review of its information returns being undertaken by the Information Centre to identify and eliminate duplicate reporting.

Recommendation 14:
DH to consider the Supporting People model of outcomes reporting for individuals for its applicability within social care.

Recommendation 15:
DH and CLG should promote greater awareness of the 'Outcome' reports and the Information Centre should consider how this information could be incorporated into information derived from social care and NHS information returns.

7. Enhancers and Inhibitors to Partnership Working

The Task Force recognises that delivery of the health and social care agenda is predicated on effective local partnership working. But even where there is clear will and a commitment between partners to co-operate, the review identified a number of barriers which act as inhibitors to achieving this outcome. The evidence strongly suggests that whilst these barriers may not prevent good partnership working, they place a significant drag on it and add unnecessarily to the inherent challenges in trying to deliver better outcomes for people with complex social and long-term health needs.

a. Systemic burdens

There was a strong consensus that incompatible and conflicting systems and processes impose burdens on health and social care partnerships. All responses to the call for evidence cited examples of systemic barriers, from incompatible IT systems to lack of alignment of financial and planning cycles. It seems implausible in the 21st century that staff working in joint teams would have two PCs on their desks, yet this is a common and grudgingly accepted practice as health and social care IT systems cannot communicate with each other. The burden and inefficiency inherent in this is evident, however many councils also pointed out the more subtle outcome is the perpetuation of the message that health and social care are different and separate. This in turn reinforces many of the cultural barriers that persist between social care and health, such as lack of a common language and practice. Again, the Task Force found none of these barriers in themselves insurmountable, but powerful disincentives to good partnership working.

As a result, the Task Force believes that it should be a priority to have electronic care records that interface, and that DH must put its weight behind programmes that will make this a reality as quickly as possible. This should include drawing out the learning quickly and identifying and sharing good practice.

Alongside the barriers to information sharing, issues of confidentiality were raised frequently as a major stumbling block. Whilst the Task Force acknowledges the work being undertaken to develop a common assessment framework and the Connecting for Health pilots we see little point if confidentiality protocols remain in place that preclude information passing between social care and health. The barriers in data sharing exist at both an individual and aggregate level. Being able to effectively share information of services and outcomes in a timely way is essential if we are to deliver high quality needs information to inform joint commissioning and service planning.

A Local Authority Circular is expected shortly setting out the use of a £48m grant (over 3 years) "for or in connection with the improvement to the quality of social care services provided by local authorities with social services responsibilities, by enabling and enhancing the abilities for information sharing. In particular it should allow for the development of IT infrastructure to enable rapid rollout of the Common Assessment Framework for Adults (CAF) from 2011 following the completion of the CAF Demonstrator Site Programme ". The purpose of the demonstrator sites is to:

i. test and develop a set of principles relating to the assessment and care planning arrangements for all adults;
ii. develop IT solutions that enable health and social care practitioners to share assessment and care/support planning information within and between, social services, the NHS, the wider council and other local partner agencies, including user led organisations, involved in supporting people in the community to achieve independent living; and
iii. evidence their effect on outcomes for "service users" and carers, professional practice , effectiveness, and cost effectiveness.

The Task Force supports this development and looks forward to seeing the roll out of the CAF and the impact it will have.

Perhaps the most pervasive systemic barrier to date has been the lack of alignment between the drivers of PCT performance management, such as Health Checks and World Class Commissioning, and timescales and those of councils, pulling health and social care in different directions. The Task Force recognises that DH is seeking to address this through the new PCT operating framework Vital Signs. The new generation of LAAs and CAA provides a real opportunity to bring health and social care together around a common set of outcomes and performance drivers. The Task Force calls on DH to ensure that the drivers pulling apart are removed and that there is full alignment at national level around LAAs and CAA.

We believe that there is no single model of an effective health and social care partnership. Indeed, our investigation revealed a number of different partnership arrangements working well, within the context of the burdens outlined above. Whilst some authorities have moved to highly integrated structures with senior level joint appointments, notably Herefordshire, others retain separate structures that function effectively, such as Stockton.

The Task Force, in looking ahead at the developments of a new performance framework for health and social care, is keen that DH and the inspectorates guard against prescribing an ideal model for partnerships; rather this should be left to local discretion and judgements restricted to outcomes not processes. This is important if the promise to shift from a centralised, top down performance framework to one that is driven by local priorities is to be achieved and some of the unnecessary data burden lifted.

We did find strong evidence that whilst greater local integration between health and social care is increasingly common, this presents some problems for regulators whose frameworks are not able to respond to this new way of working. They often still require data to be disentangled, which is burdensome and increasingly difficult to do. The review of data returns discussed previously in this report must seriously address this issue. When the national direction of travel is towards jointly commissioned services driven by outcomes for service users, returns should not be specifying the separation of health and social care data.

The interface between health and social care also means that unintended consequences can derive further up or down the care pathway when new or amended policies or guidance have not been developed in a holistic manner between health and social care. A recent example is where DH changed its guidance about deaths in hospital which effectively resulted in transferring a resource and financial burden onto local authorities without local government being consulted on it. If partnership working is to produce the efficiencies and improvements to services expected then these sorts of examples must be avoided. The Task Force would therefore recommend that DH must as a matter of course undertake an impact assessment to consider and quantify the impact of any new or amended policy and guidance on the other partner.

The Task Force also found lack of clarity in the role of health scrutiny in relation to local partnership working. We received some examples where scrutiny is useful in reinforcing good partnership working, but likewise examples where scrutiny can be an inhibitor. We believe further work is needed to develop models of effective health scrutiny along with capacity-building. DH can assist by providing a clear statement about the outcomes scrutiny should be seeking to achieve with local discretion on how to deliver.

Finally, the Task Force recognises the added challenges local partnerships face in those areas where PCT and council boundaries are not coterminous and conversely, co-terminousity can aid partnership working. However, this is set against the burden placed on partnerships by the previous PCT reorganisation.

Recommendation 16:
DH should address systemic barriers as a matter of priority, and in particular having electronic care records that interface and also ensuring that legislation to support partnership working facilitates simple and straightforward arrangements to be put into place.

Recommendation 17:
DH should introduce consistent social care information governance standards as is now required for the NHS, to facilitate health and social care working to the same information sharing agreement and enable information to be shared locally across both with confidence

Recommendation 18:
DH should ensure that the direction of travel in terms of greater alignment of priorities at national level, through the introduction of the PCT operating framework Vital Signs and new LAAs, continues and monitor progress against this. The new Government Office DH leads, working with Strategic Health Authorities, should have an explicit role in facilitating partnership working by reinforcing this greater alignment around common priorities and priority setting processes (through the LAA).

Recommendation 19:
Where DH is introducing new or changes to policies and or guidance, whether in the health sector or social care, it should undertake an impact assessment to consider and quantify the impact on the other partner. This should address information needs, finance issues, changes in practices, as well as long-term service provision and be shared locally with council and health partners as part of the communication about policy developments.

Appendix A - Summary of Recommendations

Recommendation 1:
As a result of the DH review of the social care national indicators, any immediate changes DH wish to make to the current NIS must be on the basis of 1 in 1 out within the social care set. Any future changes to the NIS as part of the next spending review process must be made on the basis of an overall 1 in 1 out rule in order to maintain the integrity of the 198 as a whole and not allow the overall number of indicators in the NIS to increase.

Recommendation 2:
That DH and the Information Centre continue to work to remove and improve data returns that are not used and that returns which do contain useful information are reviewed and simplified, with retained sections combined into a smaller number of returns. The Task Force notes with approval the review of Social Care Collections and the Review of PSSEX 1.

Recommendation 3:
It is recommended that DH makes every effort to derive performance management information from standard data recording activity which is undertaken by all local authorities in the course of their day-to-day business. (Some work will be necessary to standardise core data requirements, but work to scope out the potential in care management systems has already begun with the initial scoping and business case for a National Adult Social Care Information Service being developed by the Information Centre.)

Recommendation 4:
That CSCI/CQC work to identify ways that the inspectorate can become more flexible in their approach to data gathering. CSCI / CQC should make far greater use of the information used locally by councils to manage performance and self assess rather than large stand alone centrally determined data returns in making assessments of social care performance, thereby enabling a far greater reduction and streamlining of national data returns.

Recommendation 5:
That CSCI/CQC, Government Offices and the Strategic Health Authorities work together to ensure they do not reach different interpretations of the same data causing conflict and tensions for improvement priorities and undermine joint working between local authorities and Primary Care Trusts (PCTs).

Recommendation 6:
That CSCI/CQC look at the time and process whereby they share information on regulated provision to see if they can find ways of writing up and sharing appropriate data with local authorities as quickly as possible.

Recommendation 7:
That CSCI/CQC continue to consult and work with local authorities and other health partners to consider ways in which existing council performance data can be used to support inspection thus further reducing the need for additional secondary data for inspection purposes and reduce the overall burden on councils at the time of inspection.

Recommendation 8:
That CSCI/CQC continues to work on the alignment of approaches with the Comprehensive Area Assessment in order to eliminate any potential duplication for local authorities.

Recommendation 9:
That CSCI/CQC together with ADASS review the implementation and effectiveness of the contract monitoring/regulation protocol after twelve months.

Recommendation 10:
That CSCI/CQC and local authorities share more effectively regulatory inspection information at a local level so as to avoid unnecessary duplication of effort.

Recommendation 11:
That DH commits to rationalising and devolving existing improvement and efficiency arrangements, where appropriate, thus simplifying the architecture for social care at a regional level. This should include extending the initial review work already undertaken to include an analysis of DH sponsored improvement agencies and programmes, associated spend and links between these programmes and sector led support in this area with a view of rationalising the system. This should be followed by a review of the effectiveness of regional improvement support one year on from any changes and addressing the lack of clarity that exists at times between the roles and responsibilities of the various bodies.

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Appendix B - Acknowledgements

In researching and drafting this report we are indebted to the assistance and submissions given by the following colleagues and organisations:

Review Panel:
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Earl Dutton – Assistant Director Older People and Physical Disability, Hertfordshire County Council
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Peter West, CSCI
Robert Lake, Information Centre
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Claire Mallett, NHS Confed
Rachel Gapp, LBTF
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Brendan Clifford, Dudley
Alan Rosenbach, CSCI
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Tom Surrey, CLG
Deb Appleby, Dorset County Council/County Councils Network (CCN)

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Bolton MDC
Bury MBC
Cumbria County Council
East of England/East Midlands ADASS IMG Group
Hackney LBC
Hampshire County Council
Kent County Council
Leicester City Council
Local Government Association (LGA)
North Yorkshire County Council
Nottingham City Council
Nottinghamshire County Council
Shropshire County Council
South East ADASS Regional Performance Management and IMG group
Suffolk County Council
West Berkshire Council
West Sussex County Council
Worcestershire County Council

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Michael Frater – Previous Chair
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For further information please visit:
www.communities.gov.uk/liftingburdens

Appendix C - CSCI consultation on the performance assessment of adult social care in 2008/09

8th August 2008

To whom it may concern,

The attached response reflects the position of the Lifting the Burdens Task Force – an independent, local government practitioner body set up by the Secretary of State for Local Government to recommend ways in which central government burden on local government can be reduced. The Lifting the Burdens Task Force welcomes this opportunity to comment formally on the CSCI proposals and hopes to be able to continue the dialogue with CSCI as part of our review into health and social care burdens.

The Local Government White Paper made it explicitly clear that local authorities would experience a reduction in burden, cost and time spent on inspection. This is an important recognition of the fact that councils have demonstrated year on year through the CPA that they are the most improving and efficient part of the public sector. Also, the on-going drive for efficiencies means that, every pound not spent on inspection could go towards improving outcomes for people through front line services. We must not lose sight of these facts as we get into more detailed discussions about the methodology for adult social care assessment and inspection.

The Local Government White Paper also stated that 'social care star ratings will not continue beyond March 2009.' And yet the proposals for 2008/09 are startlingly similar to the star ratings in all but name, not least because they will 'continue to rate councils on a four point scale'. This does little to allay the fears expressed in our call for evidence to councils, for our health and social care burdens review, about the continued burden of inspection. Moreover, this seems to be at odds with CAA which will not rely on service ratings but use flags and commentary to highlight areas of concern or success.

The Task Force and the wider local government sector feel very strongly that rhetoric and reality are shaping up to be two very different things with regard to inspection and we fear that the much promised reduction in inspection burden will not actually happen. In fact, our call for evidence highlighted a strong consensus of opinion in local authorities that they expect there to be an increase in the amount of reporting to meet national reporting requirements from central government and the national inspectorate and regulators. This must not be allowed to happen.

We believe that part of the reason we are not experiencing the level of burden reduction many in local government have been led to believe there will be, is because it is not just a system that is changing, but a culture too. Both the inspectorates, Government Departments and local government are having to move from a tightly prescribed, micro-managed process and target driven culture to a more subjective outcomes, area and locally driven priorities culture, which is much more difficult to implement and measure and cannot be brought about by just changing the methodology alone.

The Task Force will therefore be looking for a social care assessment framework that significantly reduces the data burdens on councils, reflects the new transformation agenda, assesses outcomes and enables innovation. It is also important, in order to minimise the impact on local authorities, for adult social care assessment and regulation to be fully integrated with CAA in terms of how data is interpreted, judgements are reached and conclusions published so that the two frameworks do not duplicate each other. Therefore, in responding to your consultation, the Task Force would like to set out three key areas which we believe require further consideration by CSCI if the promise of reduced burden of inspection is to be delivered:

1. Scoring:

We acknowledge the role that scored assessments have played in improving performance to date. However, it is widely acknowledged by Government and inspectorates that assessment and inspection must now move to a more sophisticated assessment of complex outcomes and encourage further innovation as prescriptive scoring systems are perversely creating disincentives to innovation and service improvement. Therefore, a simple score is now insufficient and reporting outcomes as

a narrative is far more appropriate as it would allow for a far greater appreciation and understanding of the issues related to a particular outcome. This is especially important given the fact that the new performance framework for local government means that priorities will vary according to local circumstances making national comparisons or league tables less meaningful.

We understand CSCI still intends to rate leadership and commissioning and use of resources on a four point scale. Comprehensive Area Assessment will also be producing a scored assessment of an organisation's performance and use of resources. The publication of two separate scores, albeit one for social care and the other for the organisation as a whole, could prove to be a confusing duplication. The nature and timing of reporting adult social care assessments alongside CAA is still to be determined, so we would encourage CSCI and the other inspectorates to give further consideration to this issue and use the CAA focus groups and pilots to test out reaction to single or multiple scores.

2. Self Assessment:

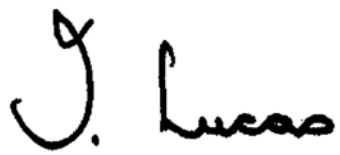
The proposals to streamline the Self Assessment Survey (SAS) by removing any duplication with data already submitted by councils to the Information Centre, thus adhering to the Collect Once Use Numerous Times (COUNT) principle, and provide greater scope for councils to supply their own local evidence, is a positive step forwards and we would encourage CSCI to deliver a much more streamlined version of the SAS for 2008/09.

Beyond this, the Self Assessment Survey is seen as a real burden for councils because it is impenetrable and inflexible meaning councils do not find it of use locally and often have to prepare separate covering reports to sit alongside it. Much of this possibly stems from the fact that the SAS is more a mixture of data collections and surveys than real self-assessment. By clarifying the purpose of the self assessment we believe CSCI could make even greater reductions in the volume and therefore burden of the return. Self assessment is a good management discipline and greater emphasis and use of a councils own robust assessment against outcomes would negate the need for the inspectorates to require additional information or national data returns as it would serve provide the majority of the evidence required to satisfy the inspectorates. Our report into health and social care burdens due out in September expands on this issue in more detail and we would urge CSCI/CQC to work towards implementing a proper self assessment in time for 2009/10.

3. Integration with CAA:

A final way in which the burden of inspection can be reduced on local authorities is to ensure that the adult social care framework and CAA align and do not duplicate each other and their demands on local authorities. From what is written we believe it is not possible to tell yet whether this will be the case or not. It will only become apparent as we start to work with the new frameworks. Therefore, the ten pilot sites for CAA are incredibly important in actually demonstrating what the day-to-day working with CAA will be like, how it will operate with the CSCI social care framework and where the reduction in burden will actually come from. We would urge CSCI and the Audit Commission to pay particular attention during the piloting phase to the practical issues surrounding joint inspectorate's working so that it does not end up imposing undue burdens on local authorities.

Yours sincerely



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