Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 25 February 2016

Subject: Health and Wellbeing Update – Part 1

Report of: Strategic Director for Families, Health and Wellbeing

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Summary

This report provides Members of the Committee with an overview of developments across Health and social care.

Recommendation

The Health Scrutiny Committee is asked to note the contents of this report.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

Public Health Update: Health Protection

1 Introduction

1.1 Health Protection, one of the six mandated public health responsibilities for Local Authorities and is primarily concerned with infections and infectious diseases. This summary provides the Health Scrutiny Committee with an update on key health protection issues in Manchester.

1.2 The summary provides a, mostly positive, update on progress and sets out the successful actions that have been taken, as well as highlighting where important further work is needed.

2 Healthcare associated infections: much lower levels of MRSA and C.diff, but new threats such as 'CPE' will continue to emerge

2.1 The number of MRSA bacteraemia cases (Methicillin Resistant *Staph. Aureus* bloodstream infections) has been maintained at a much lower level in Manchester. There were only six cases of MRSA in Manchester residents in 2014/15, a historical low. The policy of our hospitals, and in the community, remains one of 'zero tolerance'.

2.2 Clostridium difficile, also known as C.diff, is a bacterium that can infect the bowel and cause problems and most commonly affects people who have recently been treated with antibiotics. The number of C.diff cases has also fallen greatly over recent years - reducing, for example, by 25% between 2012/13 and 2013/14 - but case numbers have now stabilised. Although targets for C.diff remain in place, it has been acknowledged nationally that it is not realistic to reduce levels of this particular infection much further.

2.3 Whilst those better known healthcare associated infections have declined, a new healthcare associated infection has emerged. The principal concern at present is 'CPE' (Carbapenamase producing Enterobacteriaceae). Enterobacteriaceae are found quite normally in the human gut, but can sometimes cause serious infections.

2.4 The emerging problem is that Enterobacteriaceae have developed a very broad range of antibiotic resistance (and are then called CPE), making them increasingly difficult to treat if they do cause infection. CPEs are a growing problem in the developing world, and more recently in Europe.

2.5 The problem has now become more widespread in the UK, but is most common in London and in Manchester. Both the Manchester Royal Infirmary (MRI) and Wythenshawe hospitals have been notably affected. Although this is a novel and difficult problem to solve, the number of cases has recently fallen as a result of the intensive efforts made by our hospitals with the support of Public Health England, particularly at the MRI, which has had the larger, and longer-standing, problem.

3 Potential new threats: Ebola Virus Disease, MERS and Zika Virus

3.1 The unprecedented, and massive, outbreak of Ebola Virus Disease (EVD) in West Africa in 2014 and 2015 has now abated, although a small number of 'late' cases may still occur. These 'late' cases pose much less of an outbreak threat however.

3.2 Whilst the threat of EVD is now diminishing, new disease problems will always emerge over time. Middle-East Respiratory Syndrome (MERS) has caused considerable concern. Although the risk of an actual MERS case being imported in to the UK is low, possible cases are not uncommon. This is because the clinical picture of MERS in returning travellers is similar to flu or a severe chest infection. Such 'false alarms' have happened on a number of occasions in Manchester, the tests always proving negative.

3.3 More recently, Zika virus in South and Central America has been in the news. Whilst we may see a small number of cases in returning travellers in the UK, an outbreak is not possible as the mosquitoes that carry the virus don't exist in the UK. This disease isn't usually transmitted person-to-person, except mother to foetus or very rarely by sexual transmission.

3.4 The majority of people infected with Zika virus have no symptoms. For those with symptoms, Zika virus tends to cause a mild, short-lived (2 to 7 days) feverish illness. Infection during pregnancy may be linked to birth defects – specifically, abnormally small heads (microcephaly).

3.5 The only significant risk groups in the UK are pregnant female travellers to the affected countries, or, though this is much less likely, pregnant women if their male sexual partners became infected while travelling to an affected country. There is no indication that anyone apart from these two groups of pregnant women, and, of course, their unborn babies, are at any significant risk of harm.

3.6 Vigilance against serious imported infections will continue to be necessary, and there is ongoing work with PHE and the specialist Infectious Diseases Unit at NMGH to make sure such patients are managed well and safely.

4 Vaccination coverage: a recent fall in coverage needs to be tackled; a change in policy on BCG vaccination; and flu vaccination in children

4.1 Manchester has historically had lower than average vaccination coverage levels when compared to other parts of the country. Vaccination coverage in younger children did however improve very substantially, driven by a specially developed Immunisation Promotion Project, initiated when public health was part of the Primary Care Trust.

4.2 In 2013/14, vaccination coverage was over 90% for all six of the key indicators in children aged under 5 in Manchester. Coverage was over, or near to, the 'gold standard targets' (90% or 95% depending on the age group), set by the World Health Organisation for all these key indicators.

4.3 These vaccination coverage levels fell however during 2014/15. As an example, Measles, Mumps and Rubella (MMR) vaccination coverage at age 2, which reached a height of 92.9% in 2013/14, has fallen to 87.9% in Q2 2015. This is disappointing, but is however largely due to data issues, rather than a substantial fall in the *actual* number of children vaccinated.

4.4 The reasons for the fall in coverage were clearly identified at a recent review meeting (led by the NHS England Screening and Immunisation Team, who now commission immunisation services for Greater Manchester), and centre on various difficulties in data recording, collation and processing, a familiar problem in vaccination programme management. This is a particular issue in Manchester because our local population is so highly mobile.

4.5 The difficulties include the temporary cessation of the Immunisation Promotion Project, which, although very successful, proved not to be sustainable in its original form. This project has now been commissioned from the local NHS Child Health department, and, after an unavoidable 'lag' period, should soon help increase vaccination coverage again.

4.6 We should see a resurgence in vaccination levels from Q3 2015/16, when data for that quarter becomes available, and continuing through 2016/17, as the identified data problems are dealt with.

4.7 BCG vaccination against tuberculosis (TB) has previously been offered to all new babies in Manchester, although in most parts of the country BCG is only offered to protect babies who are more likely to come into contact with someone with TB (typically children born in to families who hail from countries such as Pakistan or India, or from sub-Saharan Africa).

4.8 Public Health England recommends that if the number of TB cases in an area is greater than 40 cases per 100,000 population, then all babies living in that area can be offered BCG vaccine. Previously the City of Manchester was above this rate. In recent years the number of cases of TB in the City of Manchester has been consistently falling, hitting a historical low of 31 cases per 100,000 population in 2014.

4.9 TB experts across Greater Manchester have reviewed the evidence and believe it is no longer necessary to offer BCG vaccine to all babies born in the city. From 1st February 2016 NHS England has implemented the change, so that the City of Manchester area BCG vaccination will be offered only to those babies who are at higher risk of coming into contact with TB. This is in line with the policy for the rest Of Greater Manchester.

4.10 Although final data has not yet been published, the indications are, as is the case nationally, that flu vaccination uptake will not improve significantly this winter, and has probably fallen by a small amount. This will be in part due to the mildness of this winter and the relatively low levels of flu so far this year, and also adverse publicity regarding flu vaccination effectiveness last winter.

4.11 Manchester is unlikely to reach the 75% target for flu vaccination for the over 65s this winter, and a review meeting to discuss this problem will be led by NHS England in March.

4.12 However, we are pleased to inform the committee of the further 'roll-out' of intranasal flu vaccination in younger children. This winter, as part of the national efforts to reduce flu, flu vaccination was offered to all children in Y1 and Y2 of primary schools. It was already being offered annually to children aged 2, 3 and 4.

4.13 The vaccination of younger children, whilst protecting the vaccinated children directly, will also have a 'herd immunity' impact, indirectly protecting the siblings, parents and grandparents of vaccinated children. Early data suggests this community-wide protection should help reduce the overall flu levels in our local population.

5 Tuberculosis cases are now falling, but will hopefully fall further as a new screening programme is rolled out

5.1 The incidence of TB has fallen significantly in Manchester in recent years. In 2011, the rate of new cases of TB was 43.9 per 100,000 population, above the 40/100,000 threshold used by the World Health Organisation to define an area of high TB incidence. In 2014, the rate dropped to 31 cases per 100,000 population, a fall of more than quarter. However, Manchester still has a relatively high rate of TB.

5.2 This fall is very welcome, and the local TB services work hard to prevent TB cases. There is no room for complacency however, and probably the main cause of the fall is a change in the demographic make-up of new entrants to Manchester. So it is important that we improve our efforts to prevent TB still further.

5.3 Most of those who develop TB disease were infected as children, and have had latent ('silent') TB for many years. Using a blood test, we can now screen for latent TB in high-risk groups and offer effective treatment. Manchester is establishing a new entrant screening programme for Latent TB infection, starting on a small scale, this year.

5.4 This blood test screening will be undertaken in general practice and anyone proving positive referred to a TB specialist clinic. We have attracted national funding to roll-out this programme – which is being developed collaboratively with Greater Manchester partners – more widely in 2016/17.

5.5 The homeless will be more vulnerable to infections, and this is particularly the case in those who are roofless. Serious infections, such as tuberculosis (TB), are a potential problem.

5.6 Although this has not been previously a significant problem in Manchester, homelessness is known to be a risk factor for TB, particularly in those who have problems with substance misuse. For example, there has been a

particular TB problem in this population group in London over recent years. Although outbreaks of TB amongst the homeless in Manchester have not been reported, this possibility is now a significant threat.

5.7 What has already occurred is a small number of cases of TB in homeless individuals whose circumstances make treatment very difficult. Although TB is normally fully curable, a lengthy course of treatment is needed, typically six months.

5.8 Compliance with such a long course of treatment is a particular problem in those with no home and various other social problems. If treatment is partial or inadequate, the patient may relapse or, worse, develop a drug-resistant form of TB. Stable accommodation may have to be arranged so that patients can be successfully monitored and followed up.

6 Continuing to improve our local health protection system

6.1 The Health Protection Expert Advisory Group, reporting to the Health and Wellbeing Board, is now well-established and assists the Director of Public Health in ensuring oversight of health protection issues in Manchester.

6.2 The overlapping roles and responsibilities for the various elements of health protection can be complex, and this became more so following the 2013 NHS and public health reorganisation. It is particularly important that we are clear about how we respond to outbreaks and public health emergencies.

6.3 A Memorandum of Understanding (MoU) was agreed in 2014/15, between key public health and NHS partners, to further clarify the operational response arrangements in the event of an outbreak. Following a peer-led review in 2015, further work will be done to ensure our arrangements are further reviewed and assured.

7 Conclusions

7.1 There have been some notable improvements in the health protection situation in Manchester, particularly in the continued low levels of MRSA and C.diff cases, in further developments of our vaccination programme - for example, the introduction of flu vaccination for more children - and in the continued fall in the number of TB cases locally.

However, further work is still needed and new problems have, and will, emerge. New infection threats now exist, including the new healthcare associated infection, ‘CPEs’, which is a problem locally. We must rectify the data problems that have led to an apparent fall in immunisation coverage in younger children. And, we must redouble our efforts to tackle TB by introducing testing and treatment for Latent (‘silent’) TB.

8 Cap on Care and Care Accounts

8.1 Scrutiny members requested more information on the above. The Care Act 2014 represented the most significant reform of social care and its funding for decades, consolidating a plethora of existing social care legislation as well as updating and introducing new requirements. Phase two of the Care Act proposals originally included a significant change to the income threshold (from £23,250 to £118,000) and the introduction of a cap on care costs. This cap was intended to mean that for people aged 65+; their contribution towards their eligible needs would be capped at £72k (adults of a working age would benefit from a lower cap and those eligible for support before the age of 18 would receive free care). These proposals were subject to consultation and were subject to much debate across local authorities. The original intention was to implement care accounts and apply the new income threshold and the cap on care from April 2016.

8.2 The cap was due to be based on a notional local authority cost, not the person's contribution. For residential care cases, a 'hotel cost' proposed at £230 per week would not count towards the cap and the service user would remain responsible for contributing this once any cap was met (subject to affordability). In Manchester, if the average weekly rate for residential care was £420, then £190 would count towards their 'cap' (£420-£230). Therefore, it would take over seven years for the individual to reach the £72k cap on care (based on current rates).

8.3 In July 2015, the government decided to defer the implementation of the new income threshold and cap on care costs until 2020, due to cost of implementation and because the expected development of private insurance products has been slower than expected. In addition, the pause also confirmed the delay in local authorities picking up the costs of self-funders in care homes, who would benefit from the cap, until April 2020.

8.4 By April 2020, the capped cost reforms will cost even more than the present estimates due to an ageing population and rising demand. A further review of what was originally proposed is likely as we get closer to April 2020. Something which will need to be resolved is the differences paid for care between councils and self funders, and the requirement to contribute towards living costs in residential care.

8.5 Before the announcements local authorities had looked at the potential costs and impacts of self funders in their area. Self funding operates at a wide variety of levels, from people who use family, friends, and local contacts to deliver low level domestic support, through to those who purchase residential care with nursing. ADASS North West commissioned the Institute of Public Care at Oxford Brookes University (IPC) to try and ascertain a benchmark figure for self funders across the North West.

8.6 IPC estimated that 44.9% of registered care home places in England were self-funded. The residential and nursing providers of three local authorities across the North West were surveyed by IPC. (Manchester, Oldham and

Lancashire). For Manchester the range of self funders within individual homes was reported as being between 11% and 53% for residential care and between 15% and 42% for nursing care. This is likely to be a reflection of the differing wealth/deprivation of parts of the city and it should be noted is lower in the main than the 44.9% reported across England. Most residents were financing their care placement through the sale or rent of their home, although providers reported that some people had sufficient savings to be able to avoid using their home to fund their care. A self-funders group was set up to look at the issue for Manchester and through the work of commissioners and others much of the work of IPC was verified. For residential and nursing providers, commissioners were able to verify total capacity of homes within Manchester and the number of places we commissioned, leaving a balance as those beds offered by self funders.

8.8 In terms of those who fund their own home care, because of the breadth of services this may include, it is difficult to assess accurately the numbers or needs of this group. IPC referred back to the English Longitudinal Survey of Ageing (ELSA) which indicated that across England 168,701 pay directly for their own care. By looking at general population data and those in receipt of attendance allowance, the estimate for Manchester is between 1,027 and 2,862 individuals who could be funding their own home care. It should be noted that home care providers were reluctant to share data on the number of self funders they had on their books, so the above numbers are harder to substantiate.

8.9 If the cap on care costs had been implemented from 1st April 2016, the estimated costs for Manchester would have been significant. Costs would have risen from £3m in 2016/17 to £11m by 2025/26 as shown below. The policy was expected to be a fully funded new burden.

CARE ACT FINANCIAL MODELLING

IMPACT OF CAP ON CARE AND EXTENDED MEANS TEST FROM 2016/17

	Adults aged 65 and over				Adults aged 18-64 years old	Total
	Care Cap		Extended Means Test	Total		
Year	Care Homes	Home-care				
	'000	'000	'000	'000	'000	'000
16/17	£0	£0	£2,067	**£2,067**	**£949**	**£3,016**
17/18	£0	£0	£2,212	**£2,212**	**£1,004**	**£3,216**
18/19	£0	£0	£2,329	**£2,329**	**£1,057**	**£3,386**
19/20	£0	£0	£2,446	**£2,446**	**£1,300**	**£3,746**
20/21	£0	£7	£2,575	**£2,575**	**£1,890**	**£4,465**
21/22	£49	£33	£2,714	**£2,763**	**£3,679**	**£6,442**
22/23	£1,060	£40	£2,563	**£3,623**	**£5,025**	**£8,648**
23/24	£2,047	£44	£2,389	**£4,436**	**£5,176**	**£9,612**
24/25	£2,331	£47	£2,478	**£4,809**	**£5,896**	**£10,706**
25/26	£2,480	£50	£2,628	**£5,108**	**£6,263**	**£11,371**

What is significant from the table above is that for Manchester, it is not the introduction of the cap which would have the greatest financial impact but rather the increase in the extended means test. This is the impact of people paying less for their care following a revised financial assessment, which would affect both existing service users who contribute towards their care and self funders. In particular it is those in residential care where their property value is less than the proposed new threshold of £118,000, when it was previously only £23,250.

Appendix 1 - Manchester City Council Monitoring

Update on public CQC reports on residential care homes.

Provider Name	Sure Care UK	Community Integrated Care	Abbotsford Care Home Ltd	Beech House Care Homes Ltd	Mosaic Community Care Ltd
Home Name	Brocklehurst	The Dell	Abbotsford Nursing Home	Chestnut House	Fresh Fields Nursing Home
Home Address	65 Cavendish Road, Withington	55 Sibley Street, Gorton, Manchester	8-10 Carlton Road, Whalley Range.	69 Crumpsall Lane, Crumpsall, Manchester	50 Southmoor Road, Wythenshawe, Manchester
Registered Beds	41	40	44	19	41
Current Occupancy	35	36	42	0	26

1.1 The Council undertakes contract monitoring based on risk analysis informed by a range of qualitative and quantitative sources, including complaints and safeguarding investigations. In addition, quality is monitored through hearing the views and experiences of citizens who use services. The Quality, Performance and Compliance Team (QPC) meet regularly with Care Quality Commission (CQC) representatives to share intelligence on a quarterly basis. Officers in the team also speak with CQC Inspectors on a frequent basis to share concerns and progress about providers across the City. CQC is invited to partake in safeguarding strategy meetings and the relationship between the council and CQC is a positive one.

1.3 This briefing updates Health Scrutiny Members on the monitoring of Brocklehurst, the Dell, Abbotsford Nursing Home, Breech House and Fresh Fields.

Below are some examples of key CQC findings following recent inspections.

2. Brocklehurst Nursing Home

2.1 Brocklehurst was included in a previous scrutiny report from the visit made by CQC to the home on 16th June and again 6th July 2015, where the home's outcomes were inadequate. CQC has further visited the home as their follow up on 15th and 16th December 2015. The most recent report recognises a number of improvements in the home, but states there are still areas for improvement being worked through by the provider. The rating for Brockhurst has now been moved to requires mprovement.
2.2 The Quality, Performance and Compliance Team have kept Brocklehurst as a red risk rated home and has visited Brocklehurst in December 2015, with a further visit due during February. We continue to see improvements in the home's operation and

a commitment from the provider and their workforce to continue to work towards receiving a good outcome for residents.

3. The Dell

3.1 The Quality, Performance and Compliance Team has rated the home as green, and has during this financial year undertaken a total of 3 monitoring visits to The Dell. The last monitoring visit was performed on 11th May 2015 and the latest spot visits on 17th November 2015. CIC is a very proactive provider that works well with MCC to ensure their services are designed to meet the outcomes of residents in their care. The QPC team has a copy of the action plan addressing the concerns raised and is working with the provider on its successful completion.

3.2 The Dell is a residential care home in the Gorton area accommodating up to 40 people over the age of 65. The home is run by Community Integrated Care which currently runs 3 other care homes in Manchester. CQC inspected the service on 7th December 2015 and although finding the home 'good' in three of the five inspection areas overall, rated the home as requiring improvement. The areas identified as requiring improvement are as follows:

- Personal Protection Plans did not inform staff about how to evacuate people safely in the event if a fire
- People were not fully protected from the risk of harm from substances hazardous to health
- People's assessments and care records kept by district nurses were not accessible by staff which meant staff were not always aware of people's clinical care needs.

4. Allendale Nursing Home

4.1 The Quality, Performance and Compliance Team have Abbotsford as a red risk rated home. The home had been monitored by Contracts and Compliance on 17 November 2015. There have also been 6 spot visits carried out on 20th April, 30th April, 27th May, 23rd June, 8th September 2015 and 14th January 2016. Abbotsford has recently been successful in recruiting a new manager to post, who has been very engaged and committed to making the necessary improvements to the homes operation. The Manager has implemented a number of systems and checks in the home and The QPC team are monitoring how successful these are in making the necessary improvements.

4.2 CQC inspected this service on the 13th, 14th and 15th May 2015. The home last had a full inspection in June 2014. A follow up inspection was undertaken in September 2014.

Abbotsford Nursing Home Manchester is a large four storey detached building set in its own grounds. The home provides residential and nursing care for up to 44 people. The home has a diverse cultural mix with approximately half of the people being of Chinese decent and the remaining people being of either Caribbean or British decent.

- Staff did not have all the information they needed to support people effectively

- Assessments had not been completed to ascertain if people lacked capacity to make any decisions
- Assessments did not include comprehensive plans of care
- Staff were not giving people choices or acknowledging people's preferences
- Communication difficulties were identified for residents that were none English speaking
- Not all staff had been supervised
- Evidence of staff training in safeguarding could not be evidenced
- People did not receive the support they needed to ensure they had enough hydration and nutrition
- There were no effective systems to monitor the service against the regulations. Systems were not in place to seek the views of people using the service.

The home continues to have a number of areas that will need continuous improvement and these are captured as part of their ongoing Action Plan.

5. Chestnut House

5.1 The home had been monitored by Quality Performance and Compliance Team on 26 June 2015. The home is currently rated as green. The home has had 3 visits this financial year, the last monitoring visit having been on 26th June and the last spot visit on 19th October 2015. Chestnut House was also inspected by the Quality and Review Officer on 17th September 2015. From this report Chestnut House was rated silver 74.26% with dignity.

The manager at the home has been in place a number of years and is very well engaged with residents and families, during the QPC visits, feedback from staff, residents and families has always been positive.

5.2 Chestnut House has accommodation for persons who require nursing or personal care. Caring for adults over 65 yrs. Chestnut House is a care home providing personal care and accommodation for up to 19 older people. No nursing care is provided. Chestnut House was visited by CQC on 13th October 2015. Prior to this the home was last inspected by CQC 14th July 2014 and it was fully compliant in all areas.

- There was a system of audits in place but these did not always identify areas for improvement
- Staff appraisals had been held with staff but these weren't always in line with company policy.

6. Fresh Fields

6.1 The Quality, Performance and Compliance Team have visited Fresh Fields 11 times during this financial year, 3 of these for full monitoring visit, the last being 03 November 15 and 8 further spot visits, with the latest being 04 February 16. The QPC have spent a considerable amount of time at Fresh Fields, in an attempt to support the provider in improving its operational performance. The owner has committed considerable financial input but has not been successful in identifying and recruiting a full time manager for the home. This continues to have a detrimental long term impact on the homes performance. The owner of Fresh Fields is committed to

making the home an outstanding provider of care, with positive outcomes for residents. The home has been subject to two formal suspensions in the year 2015, which has recently been removed and all admissions are being closely monitored. The next visit to Fresh Fields is due in February 2016. The home is operating to an improvement action plan, being monitoring by the QPC team.

6.2 This inspection took place across three dates 21 and 22 July and 5 August 2015. The last inspection of Fresh Fields was 20 and 23 January 2015 and the service was rated as inadequate.

6.3 Fresh Fields is registered by the Care Quality Commission to provide accommodation and nursing care and support for up to 41 older people. The home is located in the Wythenshawe area of Manchester. The home is situated across two floors with lounge facilities on both floors and dining facilities on the ground floor. Each floor has bedrooms and small lounge areas known as bays. The first floor is accessed by a lift. The home is a large detached property set in its own grounds with off road car parking available.

- People were not always protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at potential risk of harm and neglect
- A number of premises issues that compromised residents' safety, these included hazardous areas, for example, sluice rooms left open and failure to action maintenance checks
- Insufficient evidence of staff training and development
- People's dignity was not always considered. People were not always responded to in a timely manner and CQC observed people to have unmet requests for support, such as calling out, asking for drinks and requesting support
- People's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered
- Staff had not previously been provided with effective support, induction, supervision, appraisal or training.

Appendix 2 - Manchester's response to CQC Consultation on 'Building on Strong Foundations'

Introduction:

This report summarises recent changes to the health and social care inspection regime, and CQC's proposals on how they will continue to refine and strengthen the process in a number of ways. CQC monitors registered services in adult social care, hospitals and primary medical services. This report also compares the CQC proposed regime to the current contract and quality monitoring processes in Adult Services. The consultation questions are listed at the end of this report.

1. Overview of current CQC inspection regime for adult health and social care services

Following criticism of CQC in 2013 after a number of high profile failings of the inspection regime, including serious institutional abuse at Winterbourne View, the organisation undertook a major exercise to rebuild trust, improve the robustness of the inspections and refocus. They moved away from inspections focussing on legal compliance to a more quality based approach with a view to answering five fundamental questions:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well-led?

CQC shifted their approach to listen more to the experiences of customers, their families and carers, and began to use Experts by Experience in inspections. They widened the range of information collected to direct where they deployed their resources, and introduced four ratings to assist the public in identifying good services. CQC also introduced a process of 'special measures' for inadequate services and channels to disseminate good practice across the relevant sectors.

CQC have identified areas where further improvements in their regime can be made and proposals these are described in their next phase of work. .

2. The proposals: Building on Strong Foundations

CQC see a continuing role for independent quality regulation but recognise the need to collect and provide better information, operate a more targeted and efficient inspection programme; increase customer involvement and improve partnership working. The organisation also recognises that it itself needs to provide better value for money to the providers who are charged to register their services.

CQC's proposals include:

- introduction of provider self assessments ('co-regulation')
- risk based registration
- smarter monitoring and insight from data
- more responsive and tailored inspections.

CQC would use the information gathered to target their resources to areas of highest risk or to particular sectors or geographic areas, and this may in future mean a reduction in on the ground inspections and a possible move away from provider based inspections to sectors or populations.

CQC have also recognised that the current financial constraints on commissioners and providers are not only having an impact on staffing levels and front line service delivery, but they are impacting on the types of services being commissioned. Commissioners and providers are becoming more creative and innovative in how good quality care can be provided, and CQC acknowledge they must find ways of monitoring services which differ from those they are used to inspecting. Additional regulatory powers mean that from April 2016 CQC will inspect hospitals' use of resources eg: staff, equipment and facilities.

CQC propose to continue to focus on how person-centred the care is for individuals, but they also propose to develop this by monitoring how smoothly customers can move between services and how partners, providers and agencies work together to improve the customer experience.

CQC also propose to carry out more rigorous investigations when a new service registers, to risk rate and enable reduced monitored once registration has been completed.

3. Comparison to Manchester's contract and quality monitoring of Adult health and social care services

Manchester has used three themes in our approach to monitoring services and providers for well over ten years. Equal value is placed on:

- compliance with contract terms (financial viability, employment checks, safeguardings and complaints)
- service performance (outcomes and outputs for customers and commissioners, value for money) and
- the quality of service delivery (person centred services, well trained staff, the living environment)

The views and data collected through this triple track approach inform our risk log, which in turn informs our monitoring regime.

Whilst information and data gathering is fundamental to calculating risk, Manchester has sought the views of customers, their families and carers, strategic and operational partners and stakeholders to inform our risk based approach for over ten years. Through the self–assessment quality tools we have developed, including former Supporting People Quality Assessment Framework, the innovative Dignity Award and the Bronze, Silver and Gold awards, views are used to inform risk and future commissioning/contracting arrangements and to shape and improve service quality.

Our risk based approach with providers enables us to have early warning of provider failure, and regular contact with providers through monitoring, spot visits and best practice meetings enables us to use our local knowledge to get the best results from

the market and our providers. Manchester can also respond more quickly and flexibly to safeguarding issues and complaints, although the majority of whistleblowing alerts come to Manchester via the CQC. CQC have regulatory powers, local authorities do not.

Manchester already has a strong relationship with CQC; information is sought and exchanged on a regular basis and we frequently work together on safeguarding investigations and in response to the identification - by either organisation - of poor quality or non-compliant services. CQC information on national providers operating in Manchester is invaluable to give us oversight on the viability and operational approach at local level.

CQC propose to move towards more desktop analysis rather than fieldwork whereas Manchester carry out visits both to point of service delivery and to providers' registered or head office. The number of visits is based on risk so can be monthly (if the risk rating is red) to annual (for green risk status). Manchester also monitor non-registered services such as day care and housing related support services (eg refuges for survivors of domestic abuse, hostels for homeless families and sheltered housing), which CQC have no plans to monitor.

4. Conclusion

The proposed new CQC approach is moving more towards Manchester's existing triple track and risk based approach by shifting emphasis towards quality and customer views, and there is potential for duplication. However, the proposed approach will add a different, very useful dimension through monitoring the customer journey between services and carrying out monitoring by sector or population. Information from these inspections will be very useful for Manchester and will compliment our monitoring and commissioning.

We know there will always be a need to monitor provider organisations, and there is an element of concern that for other areas where the local authority's contracts unit is not as robust as Manchester's these authorities will have less warning of provider failure or poor employment practices, for example, as CQC propose to reduce the level and frequency of provider monitoring.

There are opportunities for Manchester to have greater insight into service delivery if the proposed new approach by CQC is implemented. The stronger emphasis on a more robust registration process will be of benefit to all.

In summary, Manchester welcomes those proposals which will compliment our existing regime and enable us to further focus our resources toward areas we have concerns.

Building on strong foundations CQC
Shaping the future of health and care quality regulation

October 2015

Tell us what you think

1 Are there any other important issues, relating to our approach to regulation and the context in which we are working, that we need to consider?

2 Given that regulation is just one influence on care quality, how do you think CQC can best work with others to encourage improvement in the quality of care over the next five years?

3 We have described what **risk-based registration** could look like. a What do you like about this? b What do you not like about this?

4 What impact would risk-based registration have on you?

5 We have described what **smarter monitoring and insight from data** could look like. a What do you like about this? b What do you not like about this?

6 What impact would smarter monitoring and insight from data have on you?

7 We have described what a **greater focus on co-regulating with providers** could look like. a What do you like about this? b What do you not like about this?

8 What impact would a greater focus on co-regulating with providers have on you?

9 We have described what **more responsive and tailored inspections** could look like.
a What do you like about this?
b What do you not like about this?

10 What impact would more responsive and tailored inspections have on you?

11 In this section we have detailed four areas which will help successfully achieve the next phase of our regulatory approach. In order of importance, which will have the most impact in encouraging improvements in the quality of care?

12 We have described how we could assess how well organisations are working together to provide health and care services for specific populations and in specific local areas. a What do you like about this? b What do you not like about this?

13 How useful would this information be for you?

14 Should it be a priority for CQC, given that it would mean allocating resources from other activities?

15 We have described how we could assess the use of resources in NHS trusts. a What do you like about this? b What do you not like about this?

16 In terms of the three ways we could develop our regulatory approach, which one would you most like us to focus on, given that CQC has to prioritise where it allocates its resources?

17 As an organisation, we embed equality and human rights in our regulatory approach. What impact do you think the ideas in this document would have in terms of people's equality and human rights?