



Health and social care fees

Analysis of responses to the Care Quality Commission consultation on regulatory fees for 2017/18

March 2017

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1. Introduction

1.1 About this consultation

The Health and Social Care Act 2008 includes powers for the Care Quality Commission (CQC) to set regulatory fees, subject to consultation. CQC is funded through both grant-in-aid from the Department of Health and fee income. CQC is required by Government policy to set fees that cover their chargeable costs, and in doing so reduce their reliance on grant-in-aid. Taking that obligation into account, CQC consulted on three proposals for the health and social care regulatory fees for 2017/18.

Proposal 1

We proposed:

- To increase fees for all sectors, except community social care and dental providers, as the second year of the two-year trajectory to reach full chargeable cost recovery (FCCR).
- To increase fees for community social care providers as the second year of the four-year trajectory to reach FCCR.
- To decrease fees for dental providers maintaining FCCR levels for this sector.

Proposal 2

We proposed to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities.

Proposal 3

We proposed to change a definition in the fees scheme to ensure that single location providers of NHS primary medical services, where all or part of that location is a minor injuries unit or an urgent care centre, are charged on the same basis as single-location providers of NHS primary medical services where all or part of that location is a walk-in centre.

Full details of the proposals can be found in the CQC consultation document:

<http://www.cqc.org.uk/content/regulatory-fees-201718-consultation>

The consultation was live from 24 October 2016 until 11 January 2017 and responses could be submitted via an online form, email or post.

Following this consultation, CQC finalised the fees scheme for 2017/18 with the consent of the Secretary of State.

1.2 Responses received

A total of 678 responses were received, 579 from the CQC fees consultation webform and 99 from direct email submissions. Table 1 shows a breakdown of responses by respondent group.

The numbers in Table 1 below do not include 18 webform responses that were blank. In addition, two webform and six email submissions were found to be duplicates and removed from the total in Table 1. One respondent submitted the same comment on both the webform and email. For this analysis, the webform submission was taken.

Table 1: Number of responses by response category and submission type				
Respondent group	Webform	Email	Total	% of total responses
Community healthcare provider	9	2	11	1.6%
Care home provider	16	8	24	3.5%
Commissioner of services	7	1	8	1.2%
Community social / domiciliary care provider	25	9	34	5.0%
Dental provider	35	2	37	5.5%
Hospice provider	2	0	2	0.3%
Independent healthcare hospital	4	0	4	0.6%
Independent healthcare single speciality service	8	1	9	1.3%
Member of the public	8	0	8	1.2%
NHS GP or NHS out-of-hours service	434	60	494	72.9%
NHS trust or foundation trust	12	3	15	2.2%
Representative of a national organisation	4	12	16	2.4%
Other	15	1	16	2.4%
Total	579	99	678	

The number of responses received varies greatly from those received in the 2016/17 fees consultation. In 2016/17 there was a total of 1,127 responses received, compared to 678 this year; this is a drop of 39.8%. Table 2 below shows the change in the responses received for each of the respondent groups.

The three respondent groups that have seen the greatest decline in number of comments received are care home providers (-82.9%), community healthcare providers (-82.0%) and community social/domiciliary care providers (-77.6%).

Only two respondent groups provided more comments in the 2017/18 consultation compared to the previous year. These were independent healthcare hospitals and commissioners of services. It should be noted however that the total number of responses received are very low for both groups.

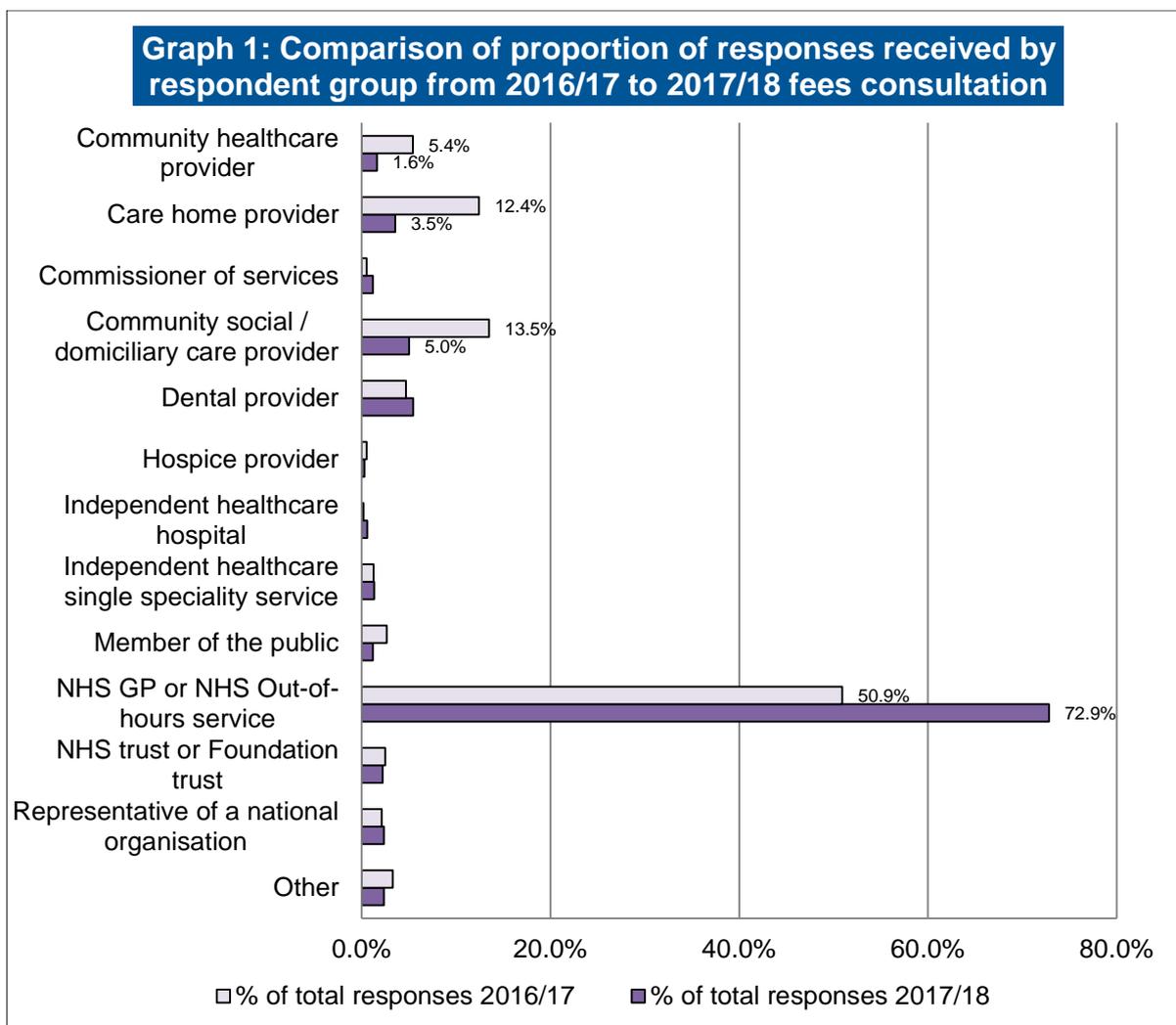
Table 2: Total responses received for fees consultation 2017/18 compared to 2016/17

Respondent groups	Total 2017/18	Total 2016/17	% change
Community healthcare provider	11	61	-82.0%
Care home provider	24	140	-82.9%
Commissioner of services	8	6	33.3%
Community social / domiciliary care provider	34	152	-77.6%
Dental provider	37	53	-30.2%
Hospice provider	2	6	-66.7%
Independent healthcare hospital	4	2	100.0%
Independent healthcare single speciality service	9	14	-35.7%
Member of the public	8	30	-73.3%
NHS GP or NHS out-of-hours service	494	574	-13.9%
NHS trust or foundation trust	15	28	-46.4%
Representative of a national organisation	16	24	-33.3%
Other	16	37	-56.8%
Total	678	1,127	-39.8%

As well as the total number of responses received declining in the 2017/18 consultation, the distribution of responses received by respondent group has changed.

As shown in Graph 1 below, there was an increase from 50.9% to 72.9% in responses received from people who identified themselves as being from NHS GP or out-of-hours services. In contrast, care home providers (12.4% to 3.5%), community social/domiciliary care providers (13.5% to 5.0%) and community healthcare providers (5.4% to 1.6%) have seen the biggest decline in the proportion of comments received. This aligns with the findings in Table 2 which show these response groups as seeing the greatest decline in total responses received.

All other response groups' figures in Graph 1 show that their proportion has remained unchanged or has not changed as much.



Note: Only percentages are shown for the respondents groups where there was a large change in proportion of responses received

1.3 Analysis of the consultation response

The responses were first coded using the thematic framework from the fees consultation for 2016/17. An additional theme of Opposition – Proportionality was added to the framework as this was identified as a key topic emerging from the responses. The thematic framework can be found in Appendix 1.

Following the coding, the data was analysed to identify the key themes emerging from the responses and these are reported in the main body of this document. The report does not aim to cover all the detail contained in the consultation responses and should be seen as a guide to their content.

It should be noted that the findings from responses are not representative of the views held by a wider population, chiefly because the respondents do not constitute a representative sample. Rather, the consultation was open to anyone who chose to participate.

2. Response to proposal 1

We asked – What are your views on our proposals for fees for 2017/18, which take us to full chargeable cost recovery for most sectors?

We received 672 responses across the webform and email submissions to proposal 1. Six responses were removed – either because they lacked sufficient detail, or because they were not relevant to the proposal.

It should be noted that in responding to the consultation via the webform, some respondents used the space available for responding to proposals 2 and 3 to make additional comments to those they had provided in response to proposal 1. These comments are included in the analysis of proposal 1.

The responses to proposal 1 fall broadly into the following themes:

- Opposition to the proposal – Respondents voiced opposition to the proposals. Where they did so, some made general, non-specific comments about their opposition. Where reasons were given for their opposition to the proposal, these fell broadly into the following subthemes:
 - Impact on service – external pressures on services
 - Impact on service – service provision
 - CQC efficiency, effectiveness and ‘value for money’
 - Proportionality of fees
- Alternative suggestions – Some respondents made suggestions on alternative approaches in relation to the payment of fees.

2.1 Comments about the proposal

2.1.1 Opposition to proposal

The responses to proposal 1 of the consultation were overwhelmingly negative. Most respondents signalled their opposition to the proposed fee changes for achieving full chargeable cost recovery. In opposing the increased fees, many respondents did so in general terms, emphasising their views that the costs should not be passed on to providers.

“It is a liberty that we are being asked to pay for our own inspection. It should be a taxpayer’s expense as the government introduced CQC.” – NHS GP or NHS out-of-hours service

Many of the respondents used strong terms to voice their opposition to the proposed fee increases. This was particularly the case from NHS GP and NHS out-of-hours services respondents who described the level of fees to be paid as ‘extortionate’, ‘excessive’, ‘unacceptable’ or ‘outrageous’.

There was extensive concern among respondents that the scale of the proposed fee increases was substantial. Many respondents emphasised how much they believed the fees would increase for them as individual providers and expressed concern that the increase will jeopardise their economic viability, and potentially put the service out of business. Such comments were framed against the context of existing financial burdens on providers.

“[The organisation] is determined that our members’ voice is heard in relation to the consultation on CQC’s full cost recovery proposals at a time when the pressure on social care provision is unprecedented. It is the principle of the Regulator’s fees increasing at a time when many providers are struggling and in real difficulties, which CQC must take into consideration. In response to a survey of our members in November 2016 on CQC fees proposal to increase fees for 2017/18, 78.3% states they would not be able to afford the increase.” – Representative of a national organisation

Some respondents acknowledged the need for CQC to recover costs; however, they highlighted that the service providers were not themselves able to recover the costs of providing care from local authorities or the clinical commissioning group (CCG). Within the social care sector, a representative of a national organisation noted that the situation would result in self-funding clients in particular ‘facing unprecedented increases in fees to compensate for this’.

Several respondents made reference to the fact that the percentage increase in fees this year was above inflation. Some suggested that the fees should be aligned with this and capped at the rate of inflation.

Nearly half of dental provider respondents were supportive of the proposal to reduce the fees proposed for the sector. However, there were examples where dental providers felt that the reductions were not enough. Those reporting this stance felt that CQC inspections demonstrate that the sector performs well and as a result, the fees should be further reduced.

2.2 Potential impact on service

Many respondents voiced opposition to the fee increases because they felt it would potentially have a negative impact across all aspects of care provision. They highlighted in particular the current economic environment in which they operate. It is

in this context that they argued the fee increases add to the financial burden services face, and this will directly impact on service provision.

They made references to the direct impact increasing fees would have on service quality, on their viability to operate, staff recruitment, retention and morale, and ultimately on service users.

2.2.1 Existing financial difficulties

Respondents broadly expressed a negative sentiment towards the proposal, given current financial difficulties. Some respondents were disappointed that CQC had not considered the financial situation and asserted that such an increase was unfair, bearing in mind the current economic landscape.

“The fee increases simply cannot be seen out of context of the wider market conditions; higher pay, higher turnover of staff, higher pension costs, apprenticeship levy alone, we face an additional £180,000 per annum payment (based on current payroll) from April 2017. Whilst I appreciate the pressure on the CQC to increase revenue, unfortunately it cannot simply be addressed by charging more to those receiving less.” – Domiciliary care provider

Many respondents drew a link between the additional financial burden of increased fees and the economic reality of lower budgets, to a decline in service quality. A few respondents expressed that this would impede their ability to provide new services for patients.

Some respondents felt that the fees scheme, either under its current charges or as proposed for 2017/18, was not conducive to ensuring the sector would remain sustainable in the long term. One respondent in particular felt that the fees increase would be ‘unfair’ and would make it difficult for the sector to remain high quality and sustainable. This was a recurring theme that will be discussed in greater detail below.

Some respondents highlighted cost savings that they were already making to remain competitive in response to pressures of reduced funding from local authorities or CCGs. In turn, these respondents believed that the proposed fees increase exacerbates these existing financial burdens and puts a further strain on their viability.

Some respondents went further in highlighting specifically the variety of other costs that contributed to their current financial hardships, such as insurance indemnity fees, fees to other national regulators, fees for defence unions and the cost of running the service (i.e. staff, equipment, national living wage rises, supplies, rent costs etc).

2.2.2 Cuts in funding

Many respondents expressed that increasing fees while there is no equivalent increase in their funding would be unfair.

Respondents regularly commented on the increasing difficulties of delivering a quality service with reduced funding. As a consequence some respondents expressed concerns that funding cuts had led to a reduction in service quality and made staff retention increasingly difficult.

NHS GPs and providers from the social care sector regularly emphasised that local authorities and commissioners were not able to increase their funding, and that there was no alternative means to recover the increased cost associated with higher fees.

Many respondents regularly commented that local authorities and CCGs are also enforcing sector-wide efficiency measures, which are further compromising providers. Respondents generally questioned how providers can afford increased fees when they do not receive sufficient funding from these bodies.

“This is a significant increase in our registration fees at a time when the majority of our business is suffering from a squeeze by cuts to local authority funding and an increase in national living wage ” – Community social / domiciliary care provider

Respondents expressed a diverse range of comments regarding their perception of funding scarcity. Some respondents asserted that fees had been frozen or staggered for a period of time. A few comments suggested that funding has been increased by some local authorities; however, the increase was either deemed to be nominal or in the case of an NHS provider the payments were often frontloaded.

Some NHS GP and out-of-hours respondents expressed concerns that salaries for medical professionals were decreasing, in addition to the income of the wider organisation.

Some respondents from large national stakeholder groups commented on the issue of funding, highlighting that ‘when and if the government puts more funding into social services, then CQC could consider covering its costs in these areas’.

2.2.3 Impact on service quality

People across many of the respondent groups stated that raising fees would have a negative consequence on service quality. They spoke both in general terms of the impact across the sector, and specifically about their own service.

Respondents frequently made broad comments about how the proposed fee increase will impact upon their service provision, often mentioning a potential decline in their ability to provide an adequate service to their patients.

“There is huge frustration that, regardless of whether costs are recovered centrally from government or directly from practices, CQC fees divert overstretched funds from frontline patient services.” – Representative of a national organisation

Many respondents were very specific when identifying which part of their service would inherit the most pressure as a consequence of increasing fees. Front of house services, staff retention, and staff recruitment were among the most frequently cited as areas which would be affected.

There was a broad concern among respondents regarding the preservation of frontline services, where they often argued that increased fees would destabilise service provision and lead to a decline in service quality, which would inherently have an impact on people using services. A representative of a national organisation commented that ‘an increase in fees constitutes to a decrease in resources for frontline services’.

A few respondents argued that there was a degree of counter-productivity in the proposed fee increase. It was argued that service quality may decrease as a result of fees and that this would contravene CQC’s purpose of improving service quality.

Impact on service quality was not limited to individual services, but discussed in terms of the impact this would have across the health and care sector.

“Ultimately cost pressures in the system, including in this area, do affect patient care because there are not unlimited sums of money in the system and a cost pressure to one part of the NHS affects the whole system.” – Representative of a national organisation

Several representatives of national organisations highlighted that the NHS GP and community social care sectors were being particularly impacted by the increased fees to the extent that it may force them out of business. As a consequence of this, it would have a ‘double whammy’ effect on hospital services having to absorb extra demand for care as a result of other services being forced to close.

Hospital services were identified as being at risk of needing to carry the burden if providers in the primary care and social care sectors were to close, as this would potentially increase demand on hospital services, increasing bed-blocking and ultimately impact service quality further across the system.

Across the sectors, respondents noted the specific changes to service provision that would result from increasing fees. The implication is that the increased fees would lead to poorer care outcomes as services struggle to maintain quality under the financial burdens.

Certain issues were raised with reference to specific types of provider; however this list is not exhaustive:

- Community social/domiciliary care providers
 - Limit prospects of expanding service provision to other areas of social care
 - Consolidating locations to cover wider geographical areas at cost of local care provision at time when care needs are increasing in complexity and staff pressures
 - CQC's fee uplifts make it difficult for providers to cope with rising demand for social care services
 - The fees structure will put a stop to small local provision as the smaller offices in rural locations will not be able to afford registration.
- NHS GP and NHS out-of-hours services
 - Decrease in consistent care following losses of full time GPs and scaling back other services
 - Inability to invest in innovations.
- Care home providers
 - Limit integration of services and encourage smaller organisations to 'go it alone'.

2.2.4 Impact on ability to operate

Many respondents expressed concerns that the fee increases would impact on their ability to operate. NHS GP or NHS out-of-hours services, care home providers and community social/domiciliary care providers raised concerns that the fee increases risked their services becoming bankrupt and lead to closures.

Many of the respondents who commented spoke about their current financial hardships. Respondents commonly intimated that increased fees would compound their existing hardship and would be the catalyst for failure in their ability to operate.

“I do believe the proposed increase in fees is being unfairly passed onto us at a time when we are struggling to meet the forever increased costs of running a care home... I can no longer sustain this practice and it's so unfair that privately funded residents have to pay more to prop up the social services funded residents.” – Care home provider

A few respondents, particularly from community social/domiciliary care services, also expressed concerns that the proposal has a significantly greater impact upon smaller providers than their bigger counterparts. Some respondents argued that no consideration has been given to the fact that smaller organisations have less

capacity to be financially self-sustained and had lower profit margins, thus the impact on service provision would be that much greater.

Services, both NHS GP and out-of-hours and community social/domiciliary care services, that had small branch sites where care is provided also highlighted the issue that they were being charged fees in line with large multiple-location providers. As a result of this, some of these services stated that they would need to close these small branch sites in order to remain financially viable at the cost of patients. This was a particular issue in locations where these branch sites served a small local population. The implication being that the fees would lead to closures in order to remain viable, and that patients would not be able to access care services locally.

One representative of a national organisation stated that this would lead to an increase in variable quality of care at the expense of the best interests of patients. Another commented that the increase in fees could:

“...create a perverse incentive for providers to close branches as a cost containment exercise. This could have the effect of centralising homecare services in some locations for no other benefit than to minimise the costs of registration and regulation potentially without any added value to the care of service users.” – Representative of a national organisation

In addition, the increased fees could also impact on future investment in services. One national organisation stated that the social care sector in particular would be in a position where expansion of branch networks would be an ‘unattractive prospect’.

Some NHS GP or NHS out-of-hours providers in particular expressed fears regarding the impact of fee increases on their ability to attract prospective partners. They stated that potential investors would be deterred from investing in practices as they would not be deemed as financially viable, and would not be able to pay potential partners a healthy dividend.

2.2.5 Impact on staff

Many respondents from NHS GP or NHS out-of-hours services expressed concerns regarding the impact of increased fees upon staff morale, retention and recruitment. Respondents frequently stated that increased fees would negatively impact upon these three issues which would ultimately have a detrimental impact on overall service quality.

General concerns regarding recruitment were that the increase of fees would significantly reduce annual budgets, and as such inhibit providers from recruiting new employees and paying salaries.

“I strongly ask you to consider the impact on already financially stretched GP care budget so that this will not impact on staffing salaries recruitment or frontline services.” – NHS GP or out-of-hours services

Respondents also commented on staff retention issues; expressing that staff may elect to leave practices following increased fees or be forced into early retirement because of concern that salaries would be reduced.

A number of large external stakeholders have commented on the issue of recruitment and retention.

“Recruitment and retention is worsening as employment figures improve and there are a number of critical employment ‘hot-spots.’ Already extremely tight operating margins look set to deteriorate further and this critically impacts on staff pay, and influences recruitment and retention.” – Representative of a national organisation

A few NHS GP respondents stated that an increase in fees may either deter prospective staff/partners from joining practices or would discourage salaried staff from becoming partners as they could expect little dividend for their efforts.

A few respondents from the domiciliary care sector argued that they have to try to keep costs and overheads to an absolute minimum while paying staff the national living wage and paid travel time. It was expressed that an increase in fees would impede their ability to do this. Another topic mentioned by these respondents were issues regarding staff training; respondents expressed that an increase in fees would likely mean that they would have to roll back training for staff. They stated that this is reflective of a sector which is at tipping point, where staff are under-paid, and the national living wage is adding further pressure.

Some respondents also commented on the potential impact of increased fees on staff pay. Many expressed concerns that staff wages would be sacrificed in order to pay for fees, meaning that increased fees would in effect serve as a pay decrease for staff members.

A large proportion of these responses focused on NHS GPs’ earnings in particular. They argued that because their income comes out of their practice budget, they are not salaried, and they are unable to pass on their costs to other parties, so the increased fees would effectively be a pay cut. Some stated that if the fees were to increase as proposed they would have to reduce their available hours.

A small proportion of respondents made general comments about potential impacts on staff pay across the health and social care sector. They commented that staff would have to deliver the same level of high quality care for reduced pay. They also

argued that if efficiencies had to be made to adjust to the fee increases, staffing hours and salaries would be the most likely targets.

A few respondents from the social care sector expressed concerns that increased fees would deter professionals from working within the industry, chiefly because staff salaries would be the most likely casualty to offset this overhead. The knock-on effect of this would be a decline in service quality.

“Recognition needs to be given to the fact that funding margins can impact on the attractiveness of the sector to staff, through their working terms and conditions, and therefore on the impact of care delivery.” – Community social / domiciliary care provider

2.2.6 Passing cost on to people using services

One representative from a national organisation expressed concerns that the cost of additional fees would fall on the shoulders of people using services. The respondent argued that local authorities do not pay the true cost of care, and an increase in fees would further affect people using services who are self-funded who are already struggling to cope with current charges.

A few respondents from the domiciliary care sector also argued that the fees would require them to increase their fees to clients.

“The reality is that cost rises such as this increase in CQC fees must be passed on to customers as otherwise either quality or financial sustainability will be further weakened in the social care provider sector.” – Community social / domiciliary care provider

2.3 CQC efficiency, effectiveness and ‘value for money’

Many people across the respondent groups made direct reference to the performance of CQC linked to their opposition to the increase in fees for 2017/18.

Many respondents stated that they did not believe that they received ‘value for money’ for the fees paid to CQC. ‘Value for money’ was considered in terms of the inspection process itself, and their opinion that the inspections had minimal impact on improving quality of care.

Many of the individuals responding, particularly those from NHS GP and NHS out-of-hours services and social care services, made direct reference to their previous CQC inspections to demonstrate their views of the poor ‘value for money’. A few respondents commented that fee increases should be halted until ‘CQC is fit for purpose’.

The frequency of inspections was also highlighted as an example of the poor ‘value for money’ received from paying fees. Respondents made reference to the likelihood that they would only be inspected once every 2-5 years, and that the fees paid on an annual basis were not only poor ‘value for money’, but money taken away from employing staff and delivering frontline services.

One respondent in particular, who stated they worked for an organisation rated as ‘outstanding’ by CQC, noted that the fees they paid were in effect a ‘regime of cross-subsidy’. The implication being that services rated as ‘good’ or ‘outstanding’ are subsidising poorer performing providers.

“It is essential that regulatory fees are seen by both the public and health and care providers as offering genuine value for money, and that they demonstrably deliver a robust and cost-effective inspection regime that supports quality improvement and timely intervention in situations where care quality failings are identified.” – Representative of a national organisation

2.4 Proportionality

An issue raised frequently across the different respondent groups focused on the proportion of fees paid relative to other organisations or sectors. Commentary around this issue covered four main topics:

- Fees paid relative to the size of the organisation.
- Fees paid by care organisations with multiple locations.
- Fees paid relative to the CQC ratings of the organisation.
- Fees paid relative to other health and social care sectors.

Fees paid relative to the size of the organisation

Respondents highlighted the disparity in the amount they have to pay compared to other organisations. Some respondents gave examples of these disparities, including the proportion paid relative to larger providers or to providers that operate in different localities with different economic and financial environments.

Many respondents throughout the different response groups considered that fees are not apportioned and allocated equitably within their relative sectors. Some respondents commented that smaller services are being unfairly charged the same fees as much larger organisations, which places an additional burden on them and could negatively impact on their ability to operate effectively.

"I don't believe it is realistic for a small company to self-fund everything, at the same level, that a huge company does. There seems to be no consideration about the effects it will have on us as a micro company, and the consequences this may have to our business and furthermore the service users, local hospitals and families associated to our service." – Domiciliary care service

One NHS GP respondent went further, detailing the disparity of the cost of fees that providers have to pay relative to their patient list size.

"We understand that CQC are required to take fees to full chargeable cost recovery for most sectors but the increase of approximately 75% for £2,978 to £5,918 in our case is considerable. On revised charges scaling for single site practices the cost per patient for up to 5,000 is up to 76p per patient for up to 10,000 it is up to 45p per patient and for up to 15,000 it is up to 35p per patient. For a 20,000 one the cost per patient drops to 30p per patient. A more equitable solution for single site General Practice we feel is to base the charge on the number of patients as at 1st of April in any one year." – NHS GP or NHS out-of-hours service

Some respondents argued that the fees are calculated at a national level, meaning that providers who operate within a lower income catchment area pay the same level of fees as those within high income areas. This is seen to be inequitable, as funding is set at local rates and is dependent on the income level of each area. As a result, the impact of the proposed fee increases are inherently more taxing on providers in low income areas.

"All of our costs (National Living Wage, CQC fees etc.) are calculated on a National level, yet fees paid are set at a local level and the North East pays far less than in other parts of the UK." – Community social / domiciliary care provider

Fees paid by care organisations with multiple locations

Several respondents expressed concern regarding the fees structure, taking specific issue with the charges apportioned to providers according to the number of locations they have. Respondents stated that CQC had measured the size of an organisation merely by counting how many locations it has, and had failed to factor individual characteristics based on local demographics and sector, such as size of catchment area, profit margin, and patient list size. Respondents from NHS GP or NHS out-of-hours services that raised concerns about proportionality tended to also argue they were being unfairly charged more than other organisations with much larger patient flow, by virtue of the fact they have more locations.

One representative of a national organisation commented on this issue, where they provided a hypothetical case study showing the disparity in the fees structure towards organisations with multiple locations in the community social care sector. In their example, they compared the impact on fees for an urban-based organisation that had a large service user base against across five locations, against a rural-based organisation that had a lower service user base spread across more locations.

Their case study reinforced their concerns that the current fees structure measures organisation size by the number of locations it has, as opposed to the number of patients it provides care to. Consequently, providers who are based in sparsely populated catchment areas who have multiple locations pay higher fees than those who are located in densely populated areas that may have fewer locations but have a much larger patient flow.

The outcome of the hypothetical case study found that one provider was paying £0.18 per service user in fees each year while the other would pay £8.12 per service user each year. The representative of the national organisation was concerned with the potentially disparity; particularly as CQC has acknowledged in its *State of care* report that the social care sector was reaching a ‘tipping point’.

Some respondents expressed that the bands within the fees scheme structure were unfair. Some respondents expressed that the bands were too wide or that the fee increase from one band to the next was too high. Several community domiciliary care services noted that this would discourage expansion, for fear of entering a higher fees band.

“A provider with 12 community social care locations need only register one more and they would pay double the £24,370 in registration fees from being in the 13-25 locations band.” – Community social / domiciliary care

Fees paid relative to the CQC ratings of the organisation

A few respondents argued that organisations that perform well (who are inspected less often) are supplementing the inspection cost of poorly rated organisations (who are inspected more frequently). Some providers questioned the fairness of fees distribution, arguing that having a good inspection rating means that they will be inspected less frequently (according to the CQC five year strategy 2016 to 2021), therefore fees should inherently decrease in line with this principle. To that effect, a few providers stated that providers are effectively being penalised for good care provision, and that the proposed fees structure incentivises bad performance as a result.

“I feel the surgeries who require the most input from special measures should pay more and the surgeries who are good all round or outstanding should pay less as they require less input”. – NHS GP or NHS out-of-hours service

Fees paid relative to other health and social care sectors

Several comments suggested that the proposed fees distribution was unfair and imbalanced from a cross-sector perspective. Many respondents made comments regarding fee disparities between various sectors.

“CQC set out in its fees strategy, the need to demonstrate fairness to all sectors by eliminating variances between sectors. However, this proposal continues to show that social care is contributing more than any other sector towards cost recovery. This shows, as it did last year, social care providers contributing more than either of the other two major directorates.” – Representative of a national organisation

Several NHS GP or NHS out-of-hours services' comments in particular suggested that practices were being unfairly charged when compared to dental practices. A few respondents expressed concerns that dental practices are not facing the same financial difficulties and funding issues, but are being afforded a reduced fees charge. Commentary occasionally stated that NHS GPs are facing the greatest percentage increase throughout all sectors.

“As a single handed list size GP why are we getting an increase in cost? When an equivalent single handed one chair dentist has a cut in costs and only pays 7 times less than a GP.” – NHS GP or NHS out-of-hours service

2.5 Alternative suggestions

CQC efficiencies

A common trend among all sectors was the suggestion for CQC to focus on and demonstrate becoming more efficient itself. Many respondents noted that it would be beneficial for them if CQC showed it operates within its budget.

Many of the NHS GP and NHS out-of-hours providers who responded were concerned that CQC appeared excluded from the strain of making efficiencies as demonstrated by increasing its fees. Furthermore several respondents were unsure why fees were being increased when the rate of inspections will be reduced.

A care home provider respondent noted that it was unclear from the document how CQC is aiming to reduce its costs. The respondent also felt that CQC showing it can keep its costs down would help them feel 'that we are all in this together'. One community domiciliary care provider suggested fewer registrations, with regional managers as a method for CQC becoming more efficient.

NHS trust provider respondents also felt CQC should show the continuous improvement culture that it seeks to embed in the health and social care sectors.

Two NHS trusts also felt that fees should decrease in future years as CQC becomes more efficient.

A representative of a national organisation questioned the sustainability of the fees increases and emphasised CQC reviewing cost management. Another recognised CQC also has financial pressures but felt its focus should be on core regulation and its efficiency.

A representative of a national organisation sought assurance that CQC will make regular assessments of its efficiency and engage with providers for feedback as part of this process.

“Meeting the fee increase through the 2016/17 GP contract is a stop-gap measure that does not provide a longer term, sustainable solution. Instead, the CQC should review how costs can be managed through efficiency gains and internal rationalisation.” – Representative of a national organisation

Variable increase based on turnover

Several respondents recommended an alternative fees formula linked to turnover of each provider. One NHS trust respondent suggested half of the fees based on 0.05% of turnover and the other half on the amount required to regulate that service.

Variable increase based on organisation size

Another alternative fees structure suggested was to link fees to the number of people using services or organisation size. The number of people using the service was recommended more often, mostly by NHS GP and NHS out-of-hours and community social/domiciliary care providers.

Variable increase based on provider performance

Provider performance was also suggested as an alternative fees structure. One care home provider felt that such a system would provide an incentive to improve performance. A hospice provider also raised concern about penalising high performing providers with the proposed structure.

Accept fees at lower rate or over a longer period

Several providers preferred an alternative timeframe for fees to increase, such as four years. One care home provider proposed holding fees at the current level to help prevent providers failing. Several national organisations felt that CQC fee increases should be achieved over a slower timer period such as by staggering their implementation.

“If a renegotiation cannot be achieved by the CQC our preference would be that more modest fee rises are made and that they are staged or staggered, to

enable organisations to be able to pay them.” – Representative of a national organisation

Link fees to inflation

Several respondents from NHS GP or NHS out-of-hours believed that fees should be capped at the level of inflation and queried the level of increase noting that inflation currently stands at around 1%.

Reduce the amount of regulation

Reduction in the level of regulation, particularly for good and outstanding providers, was frequently suggested. This view was also supported by a national stakeholder respondent. One NHS GP or NHS out-of-hours provider suggested reducing time during inspections themselves. Another recommended increasing the time between inspections.

One representative of a national organisation noted that increased compliance monitoring carried out by other authorities was having an impact on services and that these authorities were more valued than CQC.

“All care providers are struggling with an increase in compliance monitoring from Local Authorities (LA) and Clinical Commissioning Groups (CCG), this is an extra burden in addition to CQC inspections, however providers suggest compliance monitoring by LA and CCGs is more relevant than CQC.” – Representative of a national organisation

Several other alternative suggestions were recommended by respondents. An NHS provider suggested comprehensive inspections should be reviewed due to their cost and the ‘negative experience’ they had of a previous inspection. Another respondent suggested that a consultancy day rate system should be implemented. Other providers suggested that CQC should publish its costs to reassure providers they have not been overcharged. Several also suggested that fees should be decreasing as inspection frequency is due to be reduced.

One suggestion from a NHS GP or NHS out-of-hours provider was that there should be a compensation system if CQC does not deliver effectively.

A domiciliary care provider suggested that the social care sector as a whole should be exempt from the full cost recovery rule in light of the pressures throughout the sector.

“We remain of the view that CQC should be making a case to both the Department of Health and Treasury for the adult social care sector to be exempt from the full cost recovery rule. [Organisation name removed] would

be happy to work with CQC and our sector representative body, [organisation name removed], to make an argument to HM Government on removing the pressure on CQC to aim for full-cost recovery at such a sensitive and critical time for our sector” – Community social / domiciliary care provider

Government should pay full cost

A common theme among respondents was that CQC funding should be sourced centrally from the Government. It was argued that it was the Government’s choice to create CQC so it should be responsible for funding it. Others noted that funding through taxation would be appropriate as CQC is designed to serve the public.

Some NHS GP or NHS out-of-hours providers suggested that NHS England should be the source of funding for CQC instead of providers. Others felt any fee charges should be reimbursed to the providers through the Department of Health or other government bodies.

Government should pay some of the cost

Other respondents acknowledged that services should bear some of the cost though only partially, with the rest provided centrally. This view was supported by two national stakeholders.

“The regulation and inspection of services is an activity which is primarily driven by public interest and therefore should be part-funded through taxation. Providers have a part to play in meeting these costs, but not exclusively. This basic premise has been consistently disregarded by both the Treasury and CQC.” – Representative of a national organisation

2.6 Consultation

Criticism of the consultation process

When describing the consultation process, there was a trend with respondents who perceived that their views would not have an impact on the implementation of fees. Several cited that the majority of respondents from last year’s consultation recommended a four-year implementation period but CQC chose a two-year plan.

“Despite CQC’s helpful calls to government, [name removed] has had to accept the CQC adult social care fees trajectory that has been determined as a fait accompli: in moving to full cost recovery for regulation, the CQC will have to raise provider fees again this year, and the brevity of this letter reflects only our concerns for the stability of our members’ provision and the wider social care provider market, as we do not feel any more detailed response we could

provide would alter the fees trajectory.” – Representative of a national organisation

Requesting more information

One common trend among respondents was the perceived lack of transparency by CQC. Several respondents made comment that it was not clear to them how much the fees were for "full chargeable cost recovery" when they did not have a breakdown of CQC costs.

Other respondents made comment about the regulatory impact assessment that accompanied the consultation. One representative of a national organisation noted that the risk impact assessment did not look into the impact of the fees on individual sectors, and expected this information in any follow-up work.

“The CQC has previously stated in its Impact Analysis that it was unable to fully identify, cost or account for how the new system will impact on the sector. In the current Impact Analysis you state that “we are continuing to use the model to report on and analyse the cost of our operating model and the activities that result from this” without the benefit of identifying how, in the interim, the costing model has been improved sufficiently to assure providers that the CQC will not be in a position where it has to make further adjustments to its fees regime in subsequent years.” – Representative of a national organisation

3. Response to proposal 2

We asked – What are your views on our proposal to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities?

A total of 435 responses were received. Analysis removed responses that expressed 'no view', leaving 185 responses. Comments classified as 'no view' were defined as responses which expressed a lack of knowledge of the area or felt the proposal was not applicable to them.

Only community healthcare providers would be affected by the proposal, therefore responses from all other sectors were removed from the analysis. A total of two responses to proposal 2 were analysed. Only the comment disagreeing with the proposal was thematically analysed as only it contained information beyond agreement/disagreement with the proposal.

3.1 Disagreement

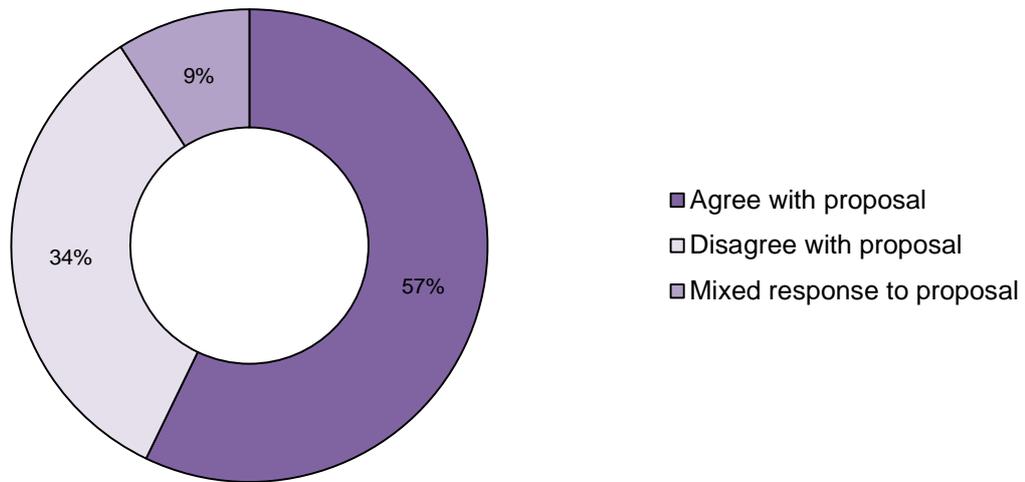
The respondent voiced concern about stretching substance misuse services. This included both the financial impact of the fees and time impact of completing 'CQC inspection hoops'.

4. Response to proposal 3

We asked – What are your views on our proposal to change a definition in the fees scheme to clarify charges for providers of services in minor injuries units and urgent care centres?

A total of 423 responses were received. Analysis removed responses which expressed 'no view', leaving 118 responses. Only NHS GP or out-of-hours services would be affected by the proposal, therefore responses from all other sectors, including GPs which did not identify as NHS GP or out-of-hours services, were removed from the analysis. A total of 78 responses to proposal 3 were analysed.

Graph 2: Preferences for Proposal 3



The graph shows that 57% (44) of respondents agreed with the proposal. However 34% (27) did not agree with the proposal. There were respondents who provided mixed reaction to the proposal which accounted for 9% (7) of the sample.

4.1 Agreement

There were nine comments which provided detail beyond agreement and were thematically analysed.

Themes that emerged from the respondents included seven noting that this proposal would also provide clarity and felt that the services needed to be regulated.

“Sites should be charged according to the services that they provide. As these units provide primary care services, it is reasonable that they should be classified & charged accordingly.” - NHS GP or NHS out-of-hours service

One respondent felt these services were often run by private companies and should be charged similarly to NHS services. One respondent supported the definition change where there would be no cost implication.

4.2 Disagreement

There were 12 comments which provided detail beyond disagreement and were thematically analysed.

Three respondents felt that the proposal would penalise services unfairly. Two providers viewed the fees as making their service financially unviable; one believed

this was to set up private providers to 'step in and rescue the services'. Four respondents felt that the redefinition was not necessary and that it will not be beneficial for the services.

“If multiple locations are working together, the risks are less than individual sites as standards will increase? Single sites are more of a risk than multiple sites, yet you are penalising transformation, which massive increases in regulatory charges will put at risk!” - NHS GP or NHS out-of-hours service

One provider questioned that the proposal had not considered patient safety. Two providers believed CQC would be ineffective regulating these services and would only add bureaucracy.

4.3 Mixed responses

Seven responses voiced mixed reaction to the proposal. Three respondents acknowledge that the services provide healthcare and need to be regulated. Another respondent noted that the classification was 'in line with the national direction of travel with transforming acute hospitals'.

However several different concerns were raised by these respondents. One respondent felt that CQC needs to improve their methods and approach to regulating emerging models of care. Another did not support CQC regulating services. One respondent thought that it was 'another revenue stream'.

Three respondents raised concerns about the impact the fees would have on the budgets of such services. Finally one respondent warned about implementing rules fairly and equally or CQC policies would be 'inconsistent'.

5. Appendix 1

Thematic coding framework for fees consultation

1. Opposition
 - 1.1. Oppose fee increase / passing costs to providers
 - 1.2. Oppose concept of fees
 - 1.3. Reduce current fees
2. CQC service
 - 2.1. Inefficient / bureaucratic / poor value for money
 - 2.2. Ineffective / does not improve service quality
 - 2.3. Positive comments
 - 2.4. Offer more support to providers
3. Impact of proposals
 - 3.1. Impact on service quality
 - 3.2. Impact on cost for service users
 - 3.3. Impact on staff morale
 - 3.4. Impact on staff pay
 - 3.5. Impact on ability to operate
 - 3.6. Impact on service type - domiciliary care
 - 3.7. Impact on service type - GPs
 - 3.8. Impact on service type - social care
 - 3.9. Impact on service type - charities
4. Alternative suggestions
 - 4.1. Make CQC efficiencies
 - 4.2. Variable increase by turnover / profit margin
 - 4.3. Variable increase by number of service users / size of organisation
 - 4.4. Variable increase by provider performance
 - 4.5. Would accept a lower rate of increase

- 4.6. Link fee increase to inflation
- 4.7. Suggestion regarding timeframe
- 4.8. Reduce frequency of inspections / amount of regulation
- 4.9. Other specific suggestion
- 5. Policy
 - 5.1. Government should pay full cost
 - 5.2. Government should pay some of cost
 - 5.3. Prioritise spending on healthcare
- 6. Context
 - 6.1. Funding / income reduction
 - 6.2. Increased cost of staffing
 - 6.3. Other fees are static / in line with inflation
 - 6.4. Existing financial difficulties
 - 6.5. Reason for preference - option 1
 - 6.6. Reason for preference - option 2
- 7. Consultation
 - 7.1. Public should be consulted
 - 7.2. Criticism of consultation questions
 - 7.3. Query / request for more information
- 8. Dental
 - 8.1. Oppose reduced fees
 - 8.2. Support reduced fees
 - 8.3. Profitability of dentistry sector / ability to afford higher fees
 - 8.4. High safety standards / less inspection needed
 - 8.5. Comparison with GPs / other services
 - 8.6. Variable increase by practice size
 - 8.7. Query / request for more information