ANALYSIS OF 2018/19 FEES CONSULTATION

EXECUTIVE SUMMARY

This report analyses the responses to the CQC consultation on regulatory fees for 2018/19. The consultation focused on four sectors: community social care, NHS GPs, urgent care, and NHS trusts. Two hundred and thirty eight respondents provided feedback. The consultation also received responses from national bodies, who represent a large number of providers. The majority of respondents were providers of services, accounting for 88% of responses.

KEY INSIGHTS

COMMUNITY SOCIAL CARE PROVIDERS:

- Five of the six national bodies representing community social care providers were supportive of using a measure of size to determine fee levels. This was supported by 84% of community social care providers responding through the webform.
- Total hours of care was preferred by three national bodies. This was followed by number of service users which was preferred by two national bodies. Total hours of care were preferred by 47% of community social care providers.
- Two national bodies and 42% of community social care providers were in favour of a floor (minimum fee) and ceiling (maximum fee). One national body and 38% of providers were in favour of having no floor and no ceiling.

NHS GP PROVIDERS:

- Two national bodies were supportive in principle of using patient list size. However, only 40% of GP providers were in favour of this approach.

- Only one national body commented on a ceiling or floor, and they were in favour of both. This was also supported by 59% of NHS GP providers agreeing with the proposal.

URGENT CARE PROVIDERS:

- Two national bodies representing urgent care provided feedback on this. One was supportive of basing fees on provider size and charging a percentage of the integrated urgent care (IUC) contract value. This national body supported having a floor and ceiling for fees.

- The second supported retaining the current approach to fees for urgent care providers if no agreement was possible before April 2018.

NHS TRUSTS:

- The national body which responded was in favour of the proposal to continue using turnover to determine fees. This was supported by a majority of NHS trusts that responded.

- The national body recommended no floor and no ceiling which was supported by half of the NHS trusts.

SUGGESTIONS FOR FUTURE FEE REVIEWS:

- Two national bodies recommended sectors that CQC could review fees for. One national body recommended a focused review of individual community healthcare and integrated care providers. The other recommended a review of the hospice sector.

- The most recommended sector for review was the independent GP sector (13%). This was followed by independent hospitals and care homes, both receiving 12% of total recommendations.

- Additional feedback about the consultation approach included criticism of CQC. Some respondents believed that the feedback received would not influence the final decision made by CQC. Several held the view that CQC was not transparent enough with the information provided as part of the consultation process.

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1. INTRODUCTION

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 five proposals for the regulatory fees for 2018/19.

Proposal 1

To change the fees scheme structure for community social care providers by replacing the current banding structure and charging fees in proportion to the size of a provider in the sector.

Proposal 2

To increase fees for the community social care sector for 2018/19. This is the third year of our four year trajectory to full chargeable cost recovery (FCCR).

Proposal 3

To change the fees scheme structure for NHS GP providers by:

- removing the current banding structure based on:
    - patient list size for providers with one location
    - number of locations for providers with more than one location
- charging fees in proportion to the size of a provider in the sector
- using patient list size per location as the sole measure of size for all NHS GP providers.

Proposal 4

To change the fees scheme structure for urgent care providers by:

- removing the current banding structure:
    - for providers with one location
    - based on number of locations for providers with more than one location
- adopting a new method of charging fees, using an option chosen from this consultation.

Proposal 5

To change the fees scheme structure for NHS trusts by:

- removing the current banding structure
- charging fees in proportion to the size of a provider in the sector
- continuing to use annual turnover as the measure of size for all NHS trusts.

In proposals one, three and five we are consulting on two common themes:

- to charge fees in proportion to a provider's size, removing the current banding structure;
- an introduction of a minimum fee (floor) and a maximum fee (ceiling) across providers within a sector.

Suggestions for future fee reviews

CQC asked for suggestions for which services should be reviewed in the future. Additionally, suggestions for how CQC should charge fees in the future were also sought.

Full details of the proposals can be found on the CQC website:

http://www.cqc.org.uk/get-involved/consultations/regulatory-fees-201819-%E2%80%93-consultation

The consultation was live from 26 October 2017 until 18 January 2018 and responses could be submitted via an online form, email or post.

CQC uses this consultation to finalise the fees scheme for 2018/19 with the consent of the Secretary of State for Health and Social Care.

2. RESEARCH DESIGN

RESPONSE RATE

A total of 238 responses were received, 208 from the CQC fees consultation webform and 30 from direct email submissions. Table 1 shows a breakdown of responses by respondent group. Table 2 shows responses by types of providers.

The total number of responses to the consultation is 440 less than those received for the 2016/17 consultation, which received 678 responses. This is a 65% decrease in response rate.

Table 1: Number of responses by response category and submission type

Are you responding as a:	Email	Webform	Total number of responses	% of total responses
Commissioner of services	0	2	2	1%
Member of the public	2	8	10	4%
Provider of services	18	189	207	87%
Representative of a national body	10	1	11	5%
Service user	0	6	6	2%
Service user's carer or next of kin	0	2	2	1%
Grand total	**30**	**208**	**238**	**100%**

There were two commissioners of health services that responded to the consultation. There were no commissioners of social care services or both health and social care services. Community social care / domiciliary care services (51%) and NHS GPs (30%), accounted for the majority of respondents that identified themselves as providers of services.

Table 2: Types of service provider by respondents who identified as providers of services

What type of services do you provide:	Webform	Email	Total number of responses	% of total responses
Care home	15	1	16	8%
Community healthcare	3	0	3	1%
Community social care / domiciliary care	94	12	106	51%
Diagnostic and imaging	1	0	1	1%
Independent consulting doctor / private GP	1	1	2	1%

NHS GP	61	2	63	30%
NHS trust or foundation trust	13	2	15	7%
Did not respond	1	0	1	1%
Total	**189**	**18**	**207**	**100%**

ANALYTICAL METHOD

All responses were either exported from the webform or received directly vie email and assigned to analysts for coding. Coding was completed using MaxQDA, a qualitative coding programme.

Qualitative analysis was undertaken against a framework which featured themes developed from a sample of initial responses. The framework was updated after a pilot to ensure all appropriate data was captured. The final framework used can be found in the appendix.

After the coding was completed insight-sharing sessions were held between analysts and analytical leads to discuss initial findings. The findings for each research question were collated into a data summary. The key findings of the data summary for each proposal have been extracted into section 3 of this report.

QUALITY ASSURANCE

To ensure coding, analysis and interpretation was robust for this project a quality assurance plan was put in place and guided activity across several stages:

- Coding framework: the framework was piloted, reviewed, and received sign off before coding commenced from the Senior Analytical Owner.
- Analysis: all files from coding were subject to a 50% peer-review, which meant that someone other than the initial coder checked accuracy.
- Final report: the analytical lead checked accuracy of the final report, and clearance of the analysis was granted by the Senior Analytical Owner having ensured all quality assurance actions were completed in full.

RISKS AND LIMITATIONS

There are a number of risks and limitations to the insight detailed in this report:

- The response rate has dropped from 678 last year to 238. A lower response rate affects the ability to generalise the results.
- The low response rate also raises the risk of non-response bias. Non-response bias is the potential for differing opinions between people who did and did not respond. For example, people with positive views may choose not to respond as ‘there is nothing else to add’.

- The responses from national bodies receive consideration as representing the collated view of their members.
- All graphs relating to responses to specific options are limited to those that responded in the webforms from the appropriate sector. Email responses did not directly address the options presented, providing more general feedback, so have been excluded. The feedback from national bodies has been separately included within the section. Finally, the preferences from email respondents are included in the thematic analysis sections.
- We have only included in graphs and feedback the responses from providers, national bodies, and the public who are affected by each proposal. This ensured that the views of the sector affected would be considered.

3. FINDINGS

COMMUNITY SOCIAL CARE PROVIDERS

PROPOSAL 1

To change the fees scheme structure for community social care providers by:

- replacing the current banding structure
- charging fees in proportion to the size of a provider in the sector.

National bodies

Five of the six national bodies representing community social care providers were supportive of using a measure of size to determine fee levels. One did not directly address this part of the proposal.

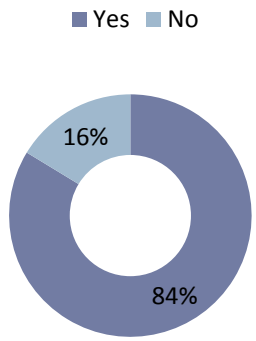
'Total hours of care' was preferred by three national bodies. This was followed by 'number of service users', which was preferred by two national bodies. The other national body recommended retaining the number of locations as the measure.

Two national bodies were in favour of no floor and no ceiling. Two national bodies were in favour of a floor and ceiling. One supported a floor but did not express a view about a ceiling.

Community social care providers

Ninety-two community social care providers responded to question 1 via the webform, with 77 (84%) agreeing to the proposal to change the fees scheme structure for community social care providers. The remaining 15 (16%) disagreed with the proposal. This is displayed in graph 1 below.

Graph 1: Community social care providers' preference for changing fees being based on provider size

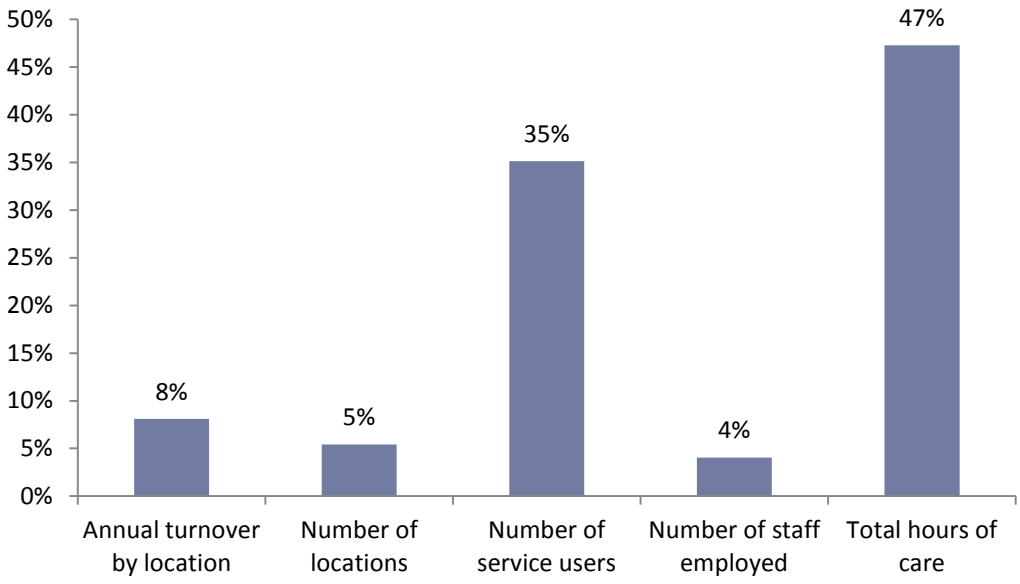


Number of respondents: 92

Respondents who answered "Yes" to question 1 were asked to advise what would be the best way to measure the size of a community social care provider. There were 77 respondents who

selected an option. ‘Total hours of care’ was favoured by 35 (47%) respondents. ‘Number of service users’ was favoured by 26 (35%). Graph 2 below displays the results.

Graph 2: Community social care providers' preferences for options for defining provider size

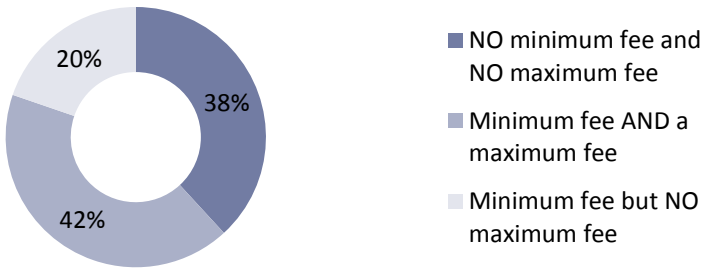


Number of respondents: 74[1]

Three community social care providers provided alternative suggestions: a fixed fee for an organisation’s size with sub-fees for locations, using total hours of care for the last 12 months rather than a week; using a ‘combination of factors’ to determine provider size without specifying what these should be.

Finally respondents were asked about their preference for setting floors/ceilings. A total of 32 (42%) favoured the option of a ceiling and floor. The option of a floor with no ceiling was the least favoured with 15 (20%) respondents wanting this approach. Finally 29 (38%) providers preferred no floor and no ceiling. This can be seen in graph 3.

Graph 3: Community social care providers' preferences for options for setting floor/ceilings based on provider size



Number of respondents: 76

[1] Only 74 of the 77 respondents provided pre-set options. The remaining three an alternative free text option detailed below.

PROPOSAL 2

We propose to increase fees for community social care for 2018/19. This is the third year of our four year trajectory to full chargeable cost recovery (FCCR).

There were no questions related to proposal 2, however, any feedback on the proposal was captured in the additional feedback section.

Additional feedback on proposals 1 and 2 from national bodies and community social care providers

A total of 35 respondents commented about proposals 1 and 2. A majority of the feedback provided insight into the potential benefits and risks of the options offered in proposal 1. There were supplementary comments including alternative suggestions for basing fees.

Basing fees on hours of care

The most common theme discussed was 'hours of care'. Several reiterated their support for the approach believing it to be the fairest method.

While seen as a good model, respondents highlighted concerns around how this would be calculated and potential flaws in this approach. One national body reported that this option had received significant support from members but felt that in practice it would not be practical. Concerns were focused around:

- how regulated and non-regulated care hours would be separated;
- how the seven day 'snapshot' would be determined;
- how the measure would account for fluctuations caused by contract gains/losses.

Providers also raised concern about this measure not taking into account factors such as 24 hour live in care, or for providers that only cover calls of less than an hour. A third concern raised was that this approach could act as a disincentive for longer calls.

"Based on hours is not fair when most providers only cover calls of less than a hour. This works as a disincentive to have longer calls which goes against the principles of trying to stop 15 minute or shorter calls." – Community social care provider

Basing fees on number of service users

There were several respondents who reiterated their preference for this option. One noted that this would be beneficial for them as they only supported three people but the care was intense. Another thought that this approach would be preferable but only in combination with an overall reduction in fees.

One national body reported that network partners found 'number of service users' would not be fair as some providers could have equally large number of service users but very different hours of care provision. There was also a query about how CQC would define 'service user' as some providers included respite care for carers as part of some care packages and were unsure whether this would also be included.

Individual providers raised similar cautions about this approach. They raised concerns that this approach would risk providers either only taking service users who self-fund or will deter them from taking on small care packages.

"A service provider might be providing more hours with fewer service users due to 1:1 support. However, these are much at risk as a drop in service user number in any given year would sharply affect turnover and size of business." – Community social care provider

Basing fees of provider performance

One theme was linking fees to provider performance. This would avoid good or outstanding providers subsidising those rated inadequate or requires improvement. It would also incentivise providers to improve the quality of care so both fees and inspections would be reduced. This view was supported by three individual providers.

Basing fees on number of staff

The general feedback of this approach was negative. One issue raised was that the number of staff employed could vary greatly throughout the year. The impact of gaining or losing a contract would directly affect the number of staff a service employed. Another issue, similarly found within hours of care, would be how CQC would disaggregate regulated and unregulated activity.

A couple of respondents raised concern that this measure would encourage providers to change levels of staff to reduce costs. Similarly there was uncertainty about how size would be defined, as small providers can vary from one to several staff. It was also queried how CQC would define the number of staff.

"Number of staff is extremely difficult to measure as hours are variable. What is a full time equivalent – 37 hours per week, 40 or 45? Is it based on contracted hours or actual worked hours? Does it include travel time?" – Community social care provider

Basing fees on number of locations

This method received mixed responses. A couple of respondents felt that it was not an appropriate measure as two providers could be operating from the same number of locations but significantly different hours of care. Another view presented was that this measure would not be appropriate as it would not represent CQC's activity costs. However this was countered by the view of six respondents that CQC inspections were on a per location basis and that this approach was an appropriate measure of CQC costs.

"However, inspections are carried out on a 'per location' basis. Therefore, the cost of the CQC's service is directly related to an organisation's number of locations. It is anomalous to base an assessment of fees on the volume of hours, service users, or any other volume measure, as this does not affect the cost of inspections" – Community social care provider

Basing fees on annual turnover

A concern raised about using annual turnover was how it would be calculated. In particular it was not clear if and how CQC would separate turnover generated by regulated activity and non-regulated activity. For example, one provider received only 5% of their overall turnover from regulated activity. If this approach was adopted there would need to be guidelines from CQC on how this would be calculated to ensure consistency.

Another concern raised was that the burden on small to medium businesses for collecting the data would be disproportionate. It was also noted that market fluctuations, such as gaining or losing a contract, would mean that short term financial positions may differ from figures provided to CQC.

In contrast, six providers held positive views about using turnover as a measure of size. One advantage presented was that providers report turnover to Her Majesty Revenue & Customs (HMRC) allowing verification of figures sent to CQC.

View on floor/ceiling for fees

The additional feedback discussing a floor or ceiling for fees was reflective of the preferences (See graph 3). Views on these were not as frequently discussed as other aspects of the proposal.

Where there was support for a floor being set for fees, respondents highlighted that each provider should at least pay the minimum cost to regulate their services. In addition, one respondent noted that having a floor would act as a positive barrier against ‘fly by night organisations’.

While less prominent it was argued that having no floor would help support small providers who often experience volatility of growth and shrinkage.

Support for a ceiling was based on the argument that the costs to regulate a service would plateau regardless of the size of the organisation. Furthermore, an argument was made that having no ceiling would be inconsistent with the assertion that the fees are set to cover the cost associated with regulation.

A criticism of having a floor and ceiling was the view that the smallest and largest providers would not pay proportionate fees.

One national body recommended CQC give clear feedback how a floor and ceiling would be set.

Affordability of Proposal 2

Six respondents provided feedback on proposal 2 which is related to the third year of the four year trajectory for FCCR. Generally the view was that the 15% increase was high, particularly in relation to inflation and other financial pressures. Some respondents stated that this increase would directly impact service delivery and result in the potential closures. However, there was acknowledgement from one national body that this proposal was mandatory.

"On the 15% increase incorporated in proposal 2, some Network Partners did comment that this is not proportionate with inflation, at a time when providers are already struggling with other financial pressures. However, [name removed] and Network Partners recognise that the increase proposed is because CQC have been tasked with achieving full chargeable cost recovery by the government." – National body (Community social care)

NHS GP PROVIDERS

PROPOSAL 3

To change the fees scheme structure for NHS GP providers by:

- removing the current banding structure based on
  - patient list size for providers with one location
  - number of locations for providers with more than one location
- charging fees in proportion to the size of a provider in the sector
- using patient list size per location as the sole measure of size for all NHS GP providers.

National bodies

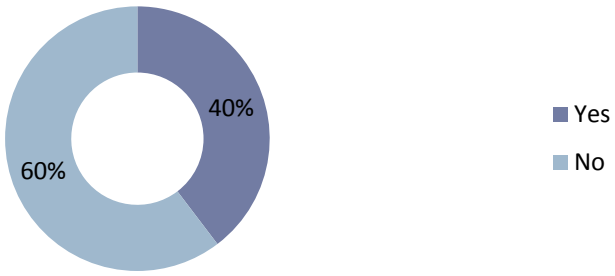
Three national bodies representing GPs were supportive of using patient list size either as an initial measure or 'in principle'.

One national body was in favour of a minimum and maximum fee as this would reduce the impact of artificial distortions caused by sub-contracting.

NHS GP providers

Fifty-eight GPs responded to question 3, with 35 (60%) disagreeing with the proposal to change the fees scheme structure for GPs. Twenty-three (40%) agreed to the proposal as displayed in graph 4 below.

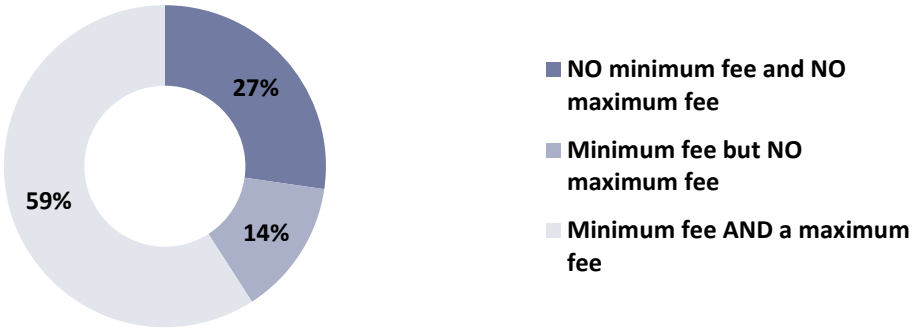
Graph 4: GPs' preferences to using patient list size to measure size



Number of respondents: 58

Of the 22 GPs that commented on their preference for a floor or ceiling, 13 (59%) preferred the option of both a floor and ceiling for fees. No floor and no ceiling was preferred by 6 (27%) and a floor but no ceiling was preferred by 3 (14%).

Graph 5: GP only responses to options for setting floor/ceilings based on provider size



Number of respondents: 22

Additional feedback from national bodies and NHS GP providers

Two national bodies provided additional commentary on proposal 3. Thirty-seven GPs provided feedback on proposal 3.

One national body, while supportive of moving to provider size to charge fees, cautioned that this approach did not necessarily reflect the complexity of providers. Exploration of a better measure in the future was advised as providers were increasingly operating across multiple sectors, therefore, increasingly complex and larger.

Basing fees on GP patient list size

National bodies supported using GP patient list size as a measure, but there were concerns from providers. One was how CQC would define the GP patient list size. Two providers were concerned about using raw list size, as opposed to weighted patient list size which is how they are recompensed as an organisation (known as the Carr-Hill formula). Therefore, it was recommended that CQC charged fees based on a weighted patient list.

Another comment was that this approach could deter collaborative working with other NHS GP providers.

Basing fees on provider performance

Using provider performance was suggested as an appropriate measure for fees. The premise being that good and outstanding providers would be inspected less, therefore, they should pay lower fees. A benefit raised was that it would act as an incentive to drive improvement as providers would be rewarded with lower fees.

"Fees for the 90% of practices that are Good or Outstanding like us should be reduced – use this as an incentive as of course we work out our fees based on the frequency of inspection, eg 5-yearly, not annually." – NHS GP provider

Other themes

One provider felt that inspection costs would only be higher for larger providers if CQC had to visit multiple sites, as governance (i.e. policies) would be similar to smaller providers.

Two providers commented on the floor and ceilings options. Both favoured having a floor but no ceiling as the fairest method. Both held the view that larger practices could absorb costs more easily.

"If current proposals are going ahead then a floor but not ceiling would be the fairest option, as larger practices should be able to afford larger fees and will involve more inspection work, but very small practices will still need a day's visit from CQC as per moderate size practices." – NHS GP provider

URGENT CARE PROVIDERS

PROPOSAL 4

To change the fees scheme structure for urgent care providers by:

- removing the current banding structure:
  - for providers with one location
  - based on number of locations for providers with more than one location
- adopting a new method of charging fees, using an option chosen from this consultation.

National bodies

Two national bodies provided feedback on the proposal. One was supportive of broadly basing fees on provider size and charging a percentage of the integrated urgent care (IUC) contract value.

They also supported having a floor and ceiling for fees. They acknowledged that there will be a minimum level of cost to regulation. Furthermore the costs of regulation will plateau beyond a certain size.

"We believe that a floor in fee levels is important because there will always be a minimum level of activity necessary to inspect and regulate any given provider. Similarly, beyond a certain size, the costs of regulation will plateau, and therefore we support a ceiling." – National body (Urgent care)

The second national body supported retaining the current approach to fees for urgent care providers if no agreement was possible before April 2018.

Urgent Care providers

There were no responses from urgent care providers during this consultation.

Additional feedback from national bodies

A national body argued that by 2019 most contracts would be procured under IUCs rather than standalone contracts. Another reason was that funding from commissioners was mostly based on historically or regionally agreed figures so providers would be penalised if they had contracts with lower unit costs.

It was suggested this approach would ensure each provider pays the same proportion of their contract value when compared to a patient-based approach.

NHS TRUSTS

PROPOSAL 5

To change the fees scheme structure for NHS trusts by:

- removing the current banding structure
- charging fees in proportion to the size of a provider in the sector
- continuing to use annual turnover as the measure of size for all NHS trusts.

National bodies

One national body responded and it broadly accepted the proposal to charge providers based on size and using turnover to determine this. The organisation supported the option of no floor and no ceiling believing it was the most equitable and fair model.

NHS trusts

Twelve NHS trusts responded to the consultation. Ten favoured the proposal for charging providers based on size. Due to the low number of responses we have not used graphs to display the results.

"Whilst there are complexities and nuance of service provision from provider to provider irrespective of size, turnover will generally be a good guide of activity levels undertaken and range of service provision and it seems fair that this is reflected in fees charged." – NHS trust

Ten providers commented on whether to have a floor or ceiling for fees. Five favoured the option of no floor and no ceiling, four favoured having a floor and ceiling. One provider favoured having a floor but no ceiling.

Additional feedback from national bodies and NHS trusts

Only one NHS trust provided additional feedback. It felt that the category of NHS trusts as a category was too simple.

"Whilst the proposals are described as sector-based the use of NHS trusts as a sector in itself is very wide ranging given that this is a catch-all covering very different types of service provision from acute provision, to community health service provision through to ambulance service providers such as ourselves. The categorisation of NHS trusts alone therefore is too generic and ignores the specific and varying requirements across types of NHS trusts and the services they provide and consideration needs to be given to how the fee schedules can reflect this." – NHS trust

FOR ALL PROVIDERS

General feedback on proposals

As well as providing feedback on the proposals, respondents gave additional views on a range of topics relating to fees in general and the impact these have on services.

There were strong views about the impact fees would have on sectors affected by the proposals. The views implied that the current fragility of all sectors was caused by increased costs, and a general drop in funding compounded the issue.

View of fees

A common theme across respondents was that CQC fees were too high, particularly in the current financial climate. One concern, raised by national bodies and providers across all sectors, was that services would struggle to absorb the fee increases. Another concern was that if fees remained high some providers might not register and, operating illegally, potentially put clients at risk.

Another theme raised was that the fees for CQC take away resources from frontline services or efficiency programmes. However, while this was noted across the sectors there was no elaboration from any respondents.

Another theme was the expectation that CQC should reduce fees. This would be seen as a reflection of the inspection process which was slowing down after the comprehensive inspection programme. It was also suggested that CQC seeks funding from the government. For GPs it was noted that NHS England currently reimburses providers but it would save time and money if NHS England funded CQC directly.

"While CQC has a requirement to cover its costs by charging fees, it is also accountable for working in a fair, efficient, effective and proportionate manner. For this reason, CQC should carefully consider both direct and indirect costs relating to regulation and reduce the burden this places on providers. As CQC

embeds a more targeted, risk-based and digital approach to inspections, we would expect the changes to its operating model to have an effect on the costs of regulation and ultimately reduce fees for providers over time." – National body (NHS)

Though less prominent, another theme discussed was for CQC to fix its fees. One national body suggested CQC recovers costs from all sectors by increasing current fee levels by 2.5%.

Several providers also highlighted that small organisations are impacted disproportionately by fees, irrespective of how size is assessed. However, large providers felt penalised and also warned that it should not be assumed that they could absorb high fees. One national body for community social care commented that one of its members felt that they were effectively subsidising the regulation of the sector.

"Larger providers, like this, feel that they are effectively subsidising the regulation of the sector and would like to see incentives for better performers, either in terms of rebates or for a fee structure more closely aligned to the quality rating achieved by a business." – National body (Community social care)

Another noted that larger GP practices are paying higher fees despite the inspection process being the same irrespective of the size of the practice.

Finally, another suggestion was differentiating commercial and voluntary providers. One elaborated that as a small charity being not for profit, they do not have the money to pay large fees compared to commercial businesses.

Another theme raised was that the financial viability of providers across all sectors were at risk as a result of CQC fees. It was also noted within the community social care sector that any costs from fee increases would likely be passed on to service users.

Other pressures

There was a view from all sectors highlighting various external pressures, which would be compounded by CQC fees.

Income reductions were cited by the community social care, NHS trust and GP sectors. The squeeze in income, as well as the inability to increase income, was seen as a threat to the sustainability for providers.

"At the end of Q2 in 2017, 152 (64%) of 238 providers reported a financial deficit, and the overall growing deficit risks financial recovery building. In this context, providers face difficult choices as they strive to continue to provide high-quality care and maintain performance against the delivery of the national standards" – National body (NHS)

A common theme in the community social care sector was the impact of the increased cost of staffing, including increases in the National Living wage (NLW), apprenticeship levy, and automatic pension enrolment. Another, less cited issue, was the rise in cost of goods imported.

"As a small provider of domiciliary care (250 hours / week), we have found the jump in fees from 2016/2017 to 2017/2018 significant. It has had a huge financial impact particularly when you are working to the UKHCA's minimum fees guide of only 3% profit. It seems unfair to have a provider of 250 hours pay the same as a provider that may have several thousand hours based on a single location." – Community social care provider

Costs incurred through rent, insurance, and registration fees were also seen as challenges. The fragility of sectors, particularly adult social care, was also mentioned.

"Similarly, you will be very aware of the reducing amount of investment in social care from local government over the past few years and, not withstanding the Better Care Fund, this reduction in funding has placed further pressures on the social care sector. Indeed, your own State of Care Report has highlighted these pressures." – Community social care provider

Views about CQC

CQC was acknowledged by providers as crucial to ensure high-quality and safe care. However, there was a prevailing view across all sectors that CQC could further improve efficiency to justify its fees. One respondent noted that CQC encourages technological improvements in providers but the inspection process is mostly paper based.

Providers, across all sectors, found inconsistences with the inspection process and that CQC was not always effective in improving healthcare standards. Furthermore there was criticism of the fact that fees are paid annually but a provider may only be inspected every two years and this was not seen as value for money.

FEEDBACK ON FUTURE FEES CONSULTATIONS

What sectors do you think we should review in future fee consultations? You can select as many as you want.

- ambulance
- care home
- community healthcare
- diagnostic and imaging
- dental
- hospice
- independent consulting doctor / private GP

- independent hospital
- online / digital / remote clinical advice
- prison healthcare
- substance misuse (residential and community)

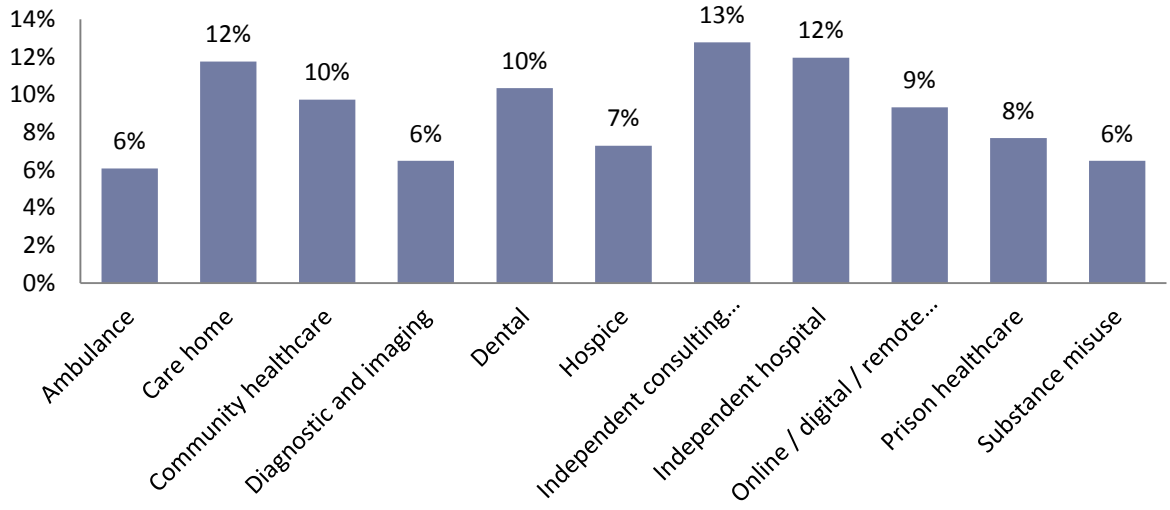
National bodies

One national body recommended a focused review of individual community healthcare and integrated care providers. The other recommended a review of the hospice sector.

Other respondents

Of the 221 respondents a total of 493 recommendations were made. The independent consulting doctor/ private GP sector was the most recommended by 13%. Graph 6 (below) displays all results.

Graph 6: Respondents' recommendations for which sectors CQC should review fees



Do you have suggestions for how we might charge fees for these services?

Seven respondents provided general suggestions about how CQC should charge fees. Suggestions included using the number of people seen by a service and linking to provider performance. However, respondents did not elaborate on these suggestions. One respondent suggested linking fees to service user list for prison services.

Some respondents suggested sectors to review. Two respondents thought that all sectors should subsequently be reviewed. One recommended hospices while also suggesting dentists should be charged by turnover. Finally, one specified nursing agencies for review.

Do you want to give any additional feedback about our approach to reviewing the fees scheme?

Consultation process

One national body was critical of the consultation process. They felt the information provided was not clear enough for providers to calculate the impact any fee changes would have on

budgets. This view was supported by five respondents. Another five believed that their opinion would be ignored and not affect the decisions made.

Five respondents felt that CQC needed to be more transparent in regards to the consultation. Two specifically saying that CQC should be more open about its costs as they believed the costs would not be proportionate to fee increases. There was a view that CQC should provide more evidence of its costs for public scrutiny.

"We believe that there is a lack of transparency in CQC's operating costs and the potential increase in unit inspection fees highlighted by this consultation has led a number of our members to question whether the CQC's proposals do, indeed, represent the recovery of the costs associated with regulation of the sector" – National body (Community social care)

One respondent recommended reviewing the usefulness of CQC inspections to providers. The outcome of the review should allow CQC to set fees that 'relate to the gain to the healthcare population served'. One provider recommended separating consultations between changing structure and changing fee levels. Another challenged CQC's assertion that it "does not underestimate the impact on providers of paying fees" believing CQC was not conscious of the impact the fees would have.

4. APPENDIX

CODING FRAMEWORK

Code
Fees based on
Fees based on\Variable increase by provider performance
Fees based on\Link fees to hours of care
Fees based on\Link fees to service user list size
Fees based on\Link fees to number of locations
Fees based on\Link fees turnover
Fees based on\Link fees number of staff
Fees based on\Other specific suggestion
Floor / Ceiling view
Floor / Ceiling view\No min and no max
Floor / Ceiling view\Min and max
Floor / Ceiling view\Min and no max
Floor / Ceiling view\Other suggestion
Consultation approach
Consultation approach\Criticism of consultation process
Consultation approach\Query \ Request for more information
Consultation approach\CQC Transparency
Consultation approach\Adopt alternative method
Consultation approach\ Sector suggestions
View of fees
View of fees\Fees take away from frontline services
View of fees\Positive comment
View of fees\Fees too high
View of fees\ Fees should be fixed
View of fees\Comparing fees to other sectors
View of fees\Comparing fees between provider sizes
View of fees\Fess should be centrally funded
View of fees\No Fees
View of fees\Reduce current fees
Impact of proposal
Impact of proposal\Impact on service quality
Impact of proposal\Impact recruitment

Impact of proposal\Impact on staff morale
Impact of proposal\Impact on staff pay
Impact of proposal\Impact on ability to operate
CQC service
CQC service\Inefficient \ Bureaucratic \ Poor value for money
CQC service\Ineffective \ Does not improve service quality
CQC service\CQC should make efficiencies
CQC service\Other suggestions
Context
Context\ Funding \ Income reduction
Context\Increased cost of staffing
Context\Other pressures on providers
Context\Existing financial difficulties