Public Document Pack

Supplementary Agenda for Scrutiny Board (Adult Social Services, Public Health, NHS) on 19 April 2016

Item 8 – Chairs Update

- Care Quality Commission response to consultation of future fees structure

Item 9 – NHS Provider Updates – April 2016

- Updates from Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust

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Care Quality Commission

Regulatory fees from April 2016 under the Health and Social Care Act 2008 (as amended)

Our response to the consultation

April 2016

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Summary

This document is the Care Quality Commission's (CQC) response to comments we received on our recent consultation about regulatory fees from April 2016 under the Health and Social Care Act 2008 (as amended). It summarises the changes that will be made to the 2016/17 fees scheme following the consultation.

We have also published separate documents alongside this summary on our website:
- The legal scheme of fees from April 2016.
- An analysis report of the consultation responses.
- A regulatory impact assessment to assess the overall economic impact of the fees scheme.
- An equality and human rights duties impact assessment
- Fees guidance for providers.

The Health and Social Care Act 2008 includes powers for CQC to set regulatory fees, subject to consultation. Fees are a charge for providers to enter and remain in a regulated market. CQC is required by HM Treasury policy to recover our chargeable costs and we are committed to achieving that obligation. CQC is legally required to consult on proposals for making changes to our fees scheme but can implement a new scheme only if the Secretary of State consents to it.

As we set out in detail from page 6, we have set fees in 2016/17 in the context of the two year cost recovery trajectory for all providers except for community social care and dental providers. We acknowledge the strength of feeling expressed by providers about the amount and timing of fee increases, and the reasons they gave for their views. However, given the absolute requirement on us to achieve full chargeable cost recovery, the significant gap in funding that would result from adopting a different option in 2016/17, and the impact that would have on delivering our statutory responsibilities in regulating health and social care services, we intend to charge fees in 2016/17 as follows:
- For all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option,
- For community social care providers at the levels set out in our consultation under the four year timescale option, and
- For dental providers at the same level as those charged in the 2015/16 fees scheme.

We have set out the reasons for these decisions in the section on 'Responses to the proposals in our consultation'.

The Secretary of State has consented to the fees scheme as described above, and it will take legal effect from 1 April 2016. We will not make any further changes to the scheme in 2016/17 other than those outlined above. Our consultation on fee charges for 2017/18 will be published in the autumn of 2016.

We have sought to consult openly and comprehensively, with transparency about our costs and our income. We have read and analysed every response and are grateful to all who took part in the consultation.

The consultation proposals

Context

CQC is responsible for setting fees for registration under the Health and Social Care Act 2008 (as amended) (the '2008' Act). We consulted between 2 November 2015 and 15 January 2016 on our proposals for a fees scheme to take effect from 1 April 2016.

We are obliged by HM Treasury to recover the chargeable costs of our regulatory activities, and the purpose of this consultation was intended to inform how CQC can deliver to that requirement. We consulted on two proposals. The main proposal for 2016/17 was to achieve a path to full chargeable cost recovery by setting fee amounts in the context of a two or a four year trajectory for all sectors except for dentists. Our second proposal was to hold the current fee levels for the dental sector in 2016/17, which had already reached full cost recovery, and decrease them in 2017/18.

We set out our detailed proposals in the consultation document and sought respondents' views and preferences to the options and questions we posed.

We also set out our strategic approach to regulation and fees, and additional contextual information including reference to other consultations either planned or running in parallel with the fees one.

Changes from the previous (2015/16) fees scheme

Following our consultation, we have made adjustments to the current 2015/16 fees scheme as follows:

- We have decided to set fees in 2016/17 for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option. Tables showing the full details for all fee categories are set out in Appendix 1 on page 16.
- We have decided to set fees in 2016/17 for community social care providers at the levels set out in our consultation under the four year timescale option. A table showing the full details for all fee categories are set out in Appendix 1 on page 20.
- We have decided to continue to charge fees for dental providers in 2016/17 at the same level as those charged in the 2015/16 fees scheme. Tables showing the full details for dental fee categories are set out in Appendix 1 on page 18.

Details about why we have made these changes follow from page 6. Further information is also available in our regulatory impact assessment, and our analysis of responses report, which are available on our website.

Summary of responses to our consultation

We received 1,127 responses to the consultation out of a total provider base of 30,842. The majority of responses were from individuals or small providers, including NHS general practitioners (GPs) (51%), adult social care providers (26%) and dentists (5%). Responses were also received from 24 of the major representative organisations for each of the main sectors, as well as a number of corporate provider groups.

The responses were broadly grouped around three issues across all sectors:

- Serious concern at the scale of the increases, irrespective of the options for their implementation, and corresponding concern about their impact on quality of care and sustainability of services.
- The timing of the fee proposals against the consultation on our five year strategy and the Department of Health's parallel consultation to extend CQC's fee-setting powers through new regulations.
- Positive comments and criticism about CQC's effectiveness, efficiency and value for money.

The responses we received to the specific proposals in our consultation are reviewed in the section below and in more detail in our separate analysis report.

Overview of our response to the consultation

Our consultation document set out the requirement for CQC to recover the chargeable costs from the providers we regulate – this is HM Treasury policy, and one we are obliged to meet. Our previous fee consultation in 2014 started to address the gap between fee income and recovery of chargeable costs. It did this by increasing fee charges in 2015/16 by the equivalent of 9% for all providers, except the dental sector, which had already reached full recovery. That increase brought the overall cost recovery level for chargeable activities in 2015/16 to 50%, meaning that a significant gap still needed to be filled.

This year's consultation set out two options for continuing to address that gap, by proposing fees for 2016/17 in the context of a two year or a four year trajectory. At the time we published the consultation, the budget for 2016/17 was still under negotiation with the Department of Health so, for consultation purposes, we assumed the budget to be around the same as for 2015/16 (£249 million). Figures in the consultation document were appraised against this figure.

We consulted on our fee proposals before final discussions had taken place with regard to the government's Spending Review in November 2015 and our budget for 2016/17. The timing of our consultation was necessary for a revised fee scheme to be ready for April 2016. The outcome of the Spending Review is that we will be required to save approximately 13% on our 2015/16 total costs over the four years of the Spending Review. This will reduce our operating costs over that period to £217 million. The calculations we show in this document reflect the latest budget position following discussions that have taken place during the consultation period with the Department of Health, and are based on an indicative budget figure of £236 million in 2016/17. Further details are set out in our regulatory impact assessment document.

Setting fees for 2016/17, as proposed, in the context of a two year trajectory would mean that £166.4 million in fee income would be recovered, so our indicative budget of £236 million would be met. Setting fees in 2016/17, as proposed, against a four year trajectory would mean that £137.7 million in fee income would be recovered, resulting in a gap of £28.7 million against our indicative budget. We have estimated that the indicative costs of £236 million for 2016/17 is the figure needed to undertake our functions and to deliver our programme, and our budget has been negotiated with the Department of Health on this basis.

Responses to the consultation showed a strong preference for cost recovery over a period of four years. However, this was in the context of overall opposition to the principle of cost recovery, with this preference being selected on the basis of it being the 'least worse' option, and not an indication that respondents supported the proposals. We fully considered all the consultation responses and acknowledge the significant strength of feeling expressed in the consultation and from wider engagement with stakeholder organisations during this period.

We looked at options for whether we could reconsider the indicative budget figure of £236 million for 2016/17, including options for making further efficiency savings, but had to take account of the level of funding required for us to be able to discharge our statutory functions. We also considered other options for whether it would be possible to differentiate fees for individual sectors in 2016/17, including setting fees for some at the level of those proposed for two years and others against the four year figures.

Discussions with the Department of Health following the Chancellor of the Exchequer's autumn statement have confirmed that the grant-in-aid required to pursue the four year trajectory to full chargeable cost recovery for all providers, as proposed, will not be available. The funding gap if we opted for the four year rather than the two year trajectory for all sectors would be £28.7 million, and having explored options for addressing the shortfall, the conclusion was reached that this would not be a sustainable position for CQC, because of the inevitable impact on delivery of our programme of work in 2016/17.

The two sectors furthest from full chargeable cost recovery are NHS GPs and the community social care sector. Their fees in 2016/17 would see the steepest increase of all sectors under a two year trajectory. We had full and detailed discussions with the Department of Health about the totality of all the responses we received. The Government has recently announced additional funding to cover the expense of the required increase to fees for NHS GPs in 2016/17, and we have agreed that the impact of increases for the community social care sector should be mitigated by setting fees for 2016/17 in the context of those proposed under a four year trajectory.

Therefore, on this basis, we invited the consent of the Secretary of State to allow CQC to charge fees in 2016/17 based on the two year trajectory towards cost recovery for all providers except community social care and dental providers. Given the absolute requirement on us to achieve full chargeable cost recovery, the significant gap in funding that would result from adopting a different option for 2016/17, and the impact that would have on delivering our statutory responsibilities in regulating health and social care services, the outcome is that, from 1 April 2016, we will:

- Set fees for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option,
- Set fees for community social care providers at the levels set out in our consultation under the four year timescale option, and
- Hold the current fee levels for dental providers at those set out in the 2015/16 fee scheme.

Setting fees for 2016/17 as set out above will mean that £158.3 million in fee income will be recovered, our indicative budget of £236 million will be met, and overall cost recovery for 2016/17 will be 67%.

We did not propose making any other amendments to the scheme for 2016/17, so there will be no changes to the fee scheme structure or the fee charges in 2016/17 except those we have specified above.

There is more detail about our decisions below. Further information is also available in our regulatory impact assessment, which is available on our website.

Analysis of responses

We have prepared a detailed report of our analysis, the methods we used and the results we obtained. The report is available on our website. We have summarised the main areas of feedback from respondents in this consultation response document, but the detail, including direct quotes from specific responses, is contained in our report.

We asked three questions in our consultation. The first and second, regarding options for achieving full chargeable cost recovery, impacts on all providers except for the

dental sector. The third question impacts only on dental providers. When assessing the responses to the third question, we took into account whether respondents would be directly affected by it, as only 6% of responses were made by those categorised as dental sector respondents. Further detail about how we conducted this analysis is included in our separate report.

Responses to the proposals in our consultation

Question 1. In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt:

- **Option 1 – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or**
- **Option 2 – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?**

Your response to question 1

Of the 1,127 total responses to the consultation, 62% indicated a preference for option 2 (4 years), 5% for option 1 (2 years) and 33% did not give a preference. 30,843 providers are registered. Numerically this represents a small percentage of our provider base, but this includes responses from 24 organisations that represent a large number of providers from the different sectors, and a number of corporate providers responding on behalf of their organisations. The total number of responses was 34% greater than that received for last year's consultation, when we proposed an across-the-board fee increase. A small number of individual respondents attached the response sent to us by their representative organisation to emphasise the points being made on their behalf.

Summary of comments

The three main trends across all sectors were:

- Serious concern at the scale of the increases, irrespective of the timescale options for their implementation, and corresponding concern about their impact on quality of care and sustainability of services.
- The timing of the fee proposals against the forthcoming consultation on our five year strategy, and the Department of Health's parallel consultation to extend CQC's fee-setting powers through new regulations.
- Positive comments and criticism about CQC's effectiveness, efficiency and value for money.

The responses from the stakeholder organisations mirrored those from individuals but covered all the points in more detail, and these are described below.

We also received a number of comments about our draft regulatory impact assessment, which we have addressed in our final impact assessment document, available on our website. Comments were also received about the consultation itself, which fell into three broad categories – criticism of the consultation document and process, suggestions for further engagement and requests for further information.

General comments from all sectors

The sectors gave different accounts of the perceived impact of proposed fees increases, although all talked about the squeeze on their total costs and the consequential impact on the quality of care.

All sectors gave similar comments about the timing of our proposals. Several stakeholder organisations suggested that no fee increases should be implemented until a fully-costed strategy was in place and until the outcome of the Department of Health's parallel consultation had concluded on new regulations being laid.

All sectors made similar criticism of CQC's effectiveness, efficiency and value for money. They cited the recent Public Account Committee report to support the view that CQC needs to evidence clear progress in improving our efficiency, effectiveness and achieving significant cost reductions before increasing fees.

Several stakeholders commented that they did not believe CQC would take any notice of the consultation feedback, and that the current goodwill in support of the new approach could be jeopardised should CQC not take account of the negative impact of fee increases on the delivery of services.

Scale and impact of proposals

Most of the responses indicated serious concern at the scale of the increases, irrespective of the timescale options for their implementation, and corresponding concern about their impact on quality of care and sustainability of services.

Most of the stakeholder organisations commented in detail on the impact of any increase in fees at a time when most were experiencing reductions in their income or funding, alongside increased costs. This was very similar to the responses to last year's consultation regarding the 9% uplift in fees. Relevant contextual factors included the wider economic climate, increasing demand for services, increased complexity and changing social demographics.

Specific examples were given by the adult social care and NHS GP sectors to illustrate their experience of reductions in funding in recent years and the increased demand on their services, neither of which were anticipated to change in the foreseeable future. The adult social care sector's main reason for opposing fee increases was providers' inability to recover the full costs of their services in fees from local authorities or CCGs. They also cited increased costs associated with the introduction of the National Living Wage, employer pension contributions, and recruitment and retention of staff. The domiciliary care sector gave market instability as a specific additional factor. NHS stakeholders commented on the efficiency savings the NHS was expected to make, and about the impact of fee increases on front-line services. Representatives of NHS GPs gave future recruitment of GPs and potential closure of practices as some of their reasons for criticism of the increases.

Many respondents commented that increasing fees would have a detrimental impact on quality and/or sustainability and that CQC's proposals did not recognise the operating environment and operating margins that providers were working within. A number commented on providers' inability to pass on increased costs to the users of their services, and that the cost recovery requirement placed on CQC by government was not matched by a similar requirement of state funding of care services. Charitable organisations commented on their reliance on donations to meet the shortfall in funding for services they provide on behalf of the NHS, which they considered unfair. Others disagreed with the principle that fees should be based on full recovery of chargeable costs. They argued that CQC's regulatory activities are driven by public interest, and that while providers have a part to play in meeting chargeable costs, this should not be exclusively borne by them.

Timing of the fee proposals

Respondents were critical of the publication of the fee proposals in advance of CQC's consultation on our five year strategy, and the Department of Health's parallel consultation to clarify CQC's fee-setting powers through new regulations. Respondents argued that changes to fees should be postponed until both consultations had concluded and the implications had been fully understood and costed. Responses also suggested that fee increases should be delayed until CQC had completed the first full round of comprehensive inspections and we had demonstrated that clear progress had been made in our own effectiveness and efficiency. Representatives of adult social care residential homes also commented that, as that sector was closest to cost recovery, their fees should be frozen until such time as NHS trusts reached a similar level of recovery.

CQC's effectiveness, efficiency and value for money

Despite the critical nature of many of the responses to the consultation, a number of positive comments were received about CQC's value, particularly from representative organisations and community social care providers. Improvements to regulation were noted, and positive experiences were commented on. However, it was also clear that respondents thought CQC had not yet sufficiently demonstrated value for money, and that there were a number of areas where our efficiency and effectiveness were critically questioned, such as the timescale for reporting, consistency of judgements and aspects of our registration processes.

51% of responses had been made by NHS GPs. This sector was particularly critical of CQC to an extent that others weren't, arguing that regulation of the sector had been imposed on it by government, and that it was an unnecessary, unwelcome and costly burden.

Our response to your feedback on question 1

In reviewing all the feedback, we looked carefully at the trends and issues described in the paragraphs above. We acknowledge the clear views expressed by respondents from all sectors about the amount of the increase irrespective of the trajectory that would be implemented, and its impact set against rising provider costs, increased demand and decreased income that providers and stakeholders told us about. We also acknowledge the views about the timing of the increase given that our strategy for the next five years is still to be published and the precise costs of our regulatory approach are yet to be fully established. We noted the suggestions about differentiating the fee increase against current levels of cost recovery and the comments made about CQC's efficiency and effectiveness. We also took note of the constructive and positive support for CQC's work, set against reservations expressed about issues such as inconsistency and timeliness of reporting.

The proposal to set fees in 2016/17 against a context of a two or a four year trajectory for all providers except dentists was made as a further step towards increasing recovery of the chargeable costs of regulation, as required by HM Treasury of CQC and other fee-setting regulatory bodies. Our cost recovery rate would rise from 50% to 76%, based on 2015/16 figures, if we implemented the two year proposal, and 63% if we implemented the four year one. The associated increase in income would enable us to move closer to cost recovery, as we are obliged to do, and to secure the appropriate level of funding that would enable us to deliver our programme of work in 2016/17.

We have considered the non-negotiable requirement on us to achieve full chargeable cost recovery against the significant gap in funding that would result from adopting a different option than fees for 2016/17 set in the context of a two year trajectory for all providers except the dental sector, and the impact that would have on delivering our programme of work. We fully acknowledge the strength of feeling expressed by providers about the amount and timing of fee increases, and the reasons they gave for their views, and considered those in detail in discussions with the Department of Health about increasing the level of grant-in-aid funding in 2016/17. The outcome of those discussions is that the Secretary of State has consented to our recommendation that fee amounts will be set in 2016/17 in the context of those we proposed under the two year trajectory for most providers, and in the context of those we proposed under the four year trajectory for community social care providers.

We understand that the scheme that we have put forward is not the one the majority of those who took part in our consultation would have preferred. However, the public need to know that services provide safe, effective, compassionate and high-quality care. As the quality regulator, it is our role to monitor, inspect and regulate services to ensure they meet fundamental standards, to publish what we find to help people choose care, and to take action where necessary to protect people from poor care. In order to do this, and to achieve our commitment to the government and the taxpayer, we need to rapidly come to full chargeable cost recovery.

At the same time, we are acutely aware of the financial pressures that providers of health and social care continue to face in an economically challenging environment. The impact on the two sectors furthest from cost recovery, whose proposed fee increases were the highest, has been taken into account through the contract negotiations for NHS GPs and by introducing a lower fee increase for community social care providers by implementing fee amounts in the context of those we proposed under a four year trajectory. By examining the savings and efficiencies that we will make, CQC has already committed to a continuation of cost-savings over the next five financial years, resulting in a budget reduction of £32 million in this period.

In May, we will publish our 2016-21 strategy, which will set out how we will be an efficient and effective regulator with fewer resources. We fully recognise that our evolving approaches under our future strategy are yet to be implemented and that we still have work to do to evidence our value for money and demonstrate our effectiveness and efficiency. It is important that, while we make efficiency savings, we can continue to carry out our role effectively.

Impact on the fees scheme in 2016/17

All providers, except the community social care and dental sectors, will see fee charges set at the level we proposed in our consultation under the figures for a two year trajectory, while those for community social care providers will be set at the level we proposed in our consultation under the figures for a four year trajectory. There are no changes to the fees for dental providers.

These changes are shown in the tables on pages 16-20.

The effect of these changes is set out in our regulatory impact assessment document, which is available on our website.

Question 2. Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:

- **A different option for how and when CQC should achieve full chargeable cost recovery.**
- **A different option on how we divide fees between different types of provider.**

Please explain what option you recommend to CQC and your reasons for proposing this.

Your response to question 2

Of the 809 responses to this question, many repeated their comments in respect of question 1 above, using question 2 to reiterate their thoughts about the proposed options for cost recovery.

General comments

Respondents provided suggestions about alternative options, often expressing a preference for a slower or later introduction of fee increases. Some also commented on ways to promote equity between providers in the way the fees structure is developed, and made suggestions for directly linking fees to the amount of inspection time required by individual services.

Respondents also commented on CQC's operating costs, suggesting overhead costs should be reduced, the inspection process should be more efficient and targeted and that CQC should work more closely with other organisations to reduce regulatory burden, duplication and costs. While respondents made many suggestions about how CQC could increase efficiency, through, for example, greater use of data monitoring, they considered it counterintuitive to increase fees if there would be greater monitoring requirements on providers themselves.

Our response to your feedback on question 2

Respondents provided many useful and constructive views and observations in commenting on this question. We have not been able to take account of them in this year's fees scheme, but will commit to fully reviewing them in consultation with provider representative organisations in advance of our next fee consultation later in 2016. In addition, as we develop our final strategy for 2016-2021, we will be putting plans in place with other oversight bodies to streamline the overall monitoring requirements on providers, by reducing duplication and improving alignment, and will closely monitor the impact on our costs of implementing this approach.

Impact on fees scheme

There is no impact on the 2016/17 fees scheme.

Question 3. Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?

Your response to question 3

Of the 761 responses to this question, 51 were received from dental respondents. 84% of those respondents agreed with the proposal. Of the other categories of respondent who replied to this question, 76% indicated it was not applicable to them and 15% disagreed with the proposal.

Summary of comments

We proposed to hold fees at 2015/16 levels for the dental sector, as it is already at full chargeable cost recovery, and reduce them in 2017/18, when costs are expected to fall.

As the sector affected by this proposal, the dental respondents were in broad agreement with it, commenting that it was an appropriate approach. However, some argued that fees should be decreased further than those estimated for 2017/18 and implemented sooner than April 2017. Several individual respondents and the main representative organisation commented that the fee for single location dental practices was high in comparison to the 'per location' multi-site, corporate provider fees. They felt that this was inequitable, and asked for consideration that the fees for corporate providers should be increased in 2016/17.

Of the 155 other respondent types who disagreed with this proposal, the reasons given included a challenge as to why the dental sector appeared to be receiving a more favourable approach, and that private dentists would be able to pass on costs to patients while other providers would not be able to do this.

Our response to your feedback on question 3

We will implement this proposal as set out in the consultation. We will commit to review the issues highlighted in the responses about the 'per location' fee for corporate dental providers over the summer and consider whether to make any proposals for change in our next consultation later in 2016.

Impact on fees scheme

Providers of dental services will see no change to their fees in 2016/17. These fee charges are set out in the tables on pages 18-19.

The effect of these changes is set out in our regulatory impact assessment document, which is available on our website.

Timetable for future fees strategy

We welcome the feedback this consultation has generated. It has identified a number of important areas we will actively consider in the next stages of planning our fees strategy, such as suggestions about the structure of the fees scheme.

We aim to consult again in the autumn of this year, following regular engagement with stakeholders including discussions about the feedback and suggestions set out in this consultation response. We will undertake a full assessment of the financial impact of our emerging strategy and ensure that assessment is fully shared and transparent. We will use information from our evaluation programme to inform this work.

The consultation will set out specific proposals that will come into effect on 1 April 2017, subject to the Secretary of State's consent to our fees scheme. We do not know yet precisely what those proposals will be. We anticipate that we will consult in the autumn, and publish our response and the fees scheme before the end of March 2017.

Appendix 1 – Table of fee charges in 2016/17 for all providers by fee category

NHS trusts (Part 1 of Schedule of existing fee scheme)

Amount of turnover	Fee charge 2016/17 2016/17
Up to £75,000,000	£78,208
From £75,000,001 to £125,000,000	£107,536
From £125,000,001 to £225,000,000	£136,864
From £225,000,001 to £325,000,000	£166,243
From £325,000,001 to £500,000,000	£195,519
More than £500,000,000	£224,847

Healthcare hospital services (Part 2, column 2 of Schedule of existing fee scheme)

Number of locations	Fee charge 2016/17 2016/17
1	£10,646
2 to 3	£21,272
4 to 6	£42,545
7 to 10	£85,090
11 to 15	£137,646
More than 15	£187,699

Community healthcare services (Part 2, column 3 of Schedule of existing fee scheme) – includes health service bodies (NHS Blood and Transplant) under paragraph 2(c)(i) of existing fee scheme

Number of locations	Fee charge 2016/17 2016/17
1	£1,763
2 to 3	£3,520
4 to 6	£7,039
7 to 10	£14,077
11 to 15	£28,155
More than 15	£56,309

Healthcare – Single specialty services
(Part 2, column 4 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of locations	2016/17
1	£1,679
2 to 3	£3,352
4 to 6	£6,704
7 to 10	£13,407
11 to 15	£26,814
More than 15	£53,628

Community healthcare services (independent ambulance services)
(Part 3 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of locations	2016/17
1	£939
2 to 3	£1,877
4 to 10	£4,692
11 to 50	£11,732
51 to 100	£28,155
More than 100	£56,309

Community healthcare services – Individual registered at one location providing only diagnostic and screening services (Paragraph 2(c)(ii) of existing fee scheme)

	Fee charge 2016/17
Number of locations	2016/17
1	£292

Primary care services (Medical) – One location
(Part 4 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of registered patients	2016/17
Up to 5,000	£2,187
5,001 to 10,000	£2,574
10,001 to 15,000	£2,978
More than 15,000	£3,365

Primary care services (Medical) – One location where walk-in-centre forms part or all of location (Paragraph 2(d)(i) of existing fee scheme)
and
Primary care services (Medical) – One location providing out-of-hours services (Paragraph 2(d)(iii) of existing fee scheme)

	Fee charge 2016/17
Location	2016/17
1	£3,365

Primary care services (Medical) – More than one location (Part 5 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of locations	2016/17
2	£4,761
3	£6,347
4	£7,934
5	£9,518
6 to 10	£11,900
11 to 40	£23,799
More than 40	£59,494

Primary care services (Dental) – One location (Part 6 of existing fee scheme) – includes domiciliary dental services under paragraph 2(d)(iv) of existing fee scheme where the fee charge is the same as for one dental chair

	Fee charge 2016/17
Number of dental chairs	2016/17
1	£600
2	£750
3	£850
4	£950
5	£1,100
6	£1,100
More than 6	£1,300

Primary care services (Dentists) – More than one location (Part 7 of existing fee scheme)

Number of locations	Fee charge 2016/17 2016/17
2	£1,600
3	£2,400
4	£3,200
5	£4,000
6 to 10	£4,800
11 to 40	£10,000
41 to 99	£30,000
More than 99	£60,000

Care services – Providers of care services who also provide accommodation (Part 8 of Schedule of existing fee scheme)

Maximum number of service users	Fee charge 2016/17 2016/17
Less than 4	£309
From 4 to 10	£805
From 11 to 15	£1,612
From 16 to 20	£2,356
From 21 to 25	£3,223
From 26 to 30	£4,212
From 31 to 35	£4,956
From 36 to 40	£5,701
From 41 to 45	£6,446
From 46 to 50	£7,190
From 51 to 55	£7,930
From 56 to 60	£8,673
From 61 to 65	£9,913
From 66 to 70	£10,902
From 71 to 75	£11,897
From 76 to 80	£12,886
From 81 to 90	£13,880
More than 90	£15,499

Care services – Hospices (Part 9 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of locations	**2016/17**
1	£1,861
2 to 3	£3,717
4 to 6	£7,435
7 to 10	£15,639
11 to 15	£29,738
More than 15	£59,478

Community social care services (Part 10 of Schedule of existing fee scheme)

	Fee charge 2016/17
Number of locations	**2016/17**
1	£1,369
2 to 3	£3,806
4 to 6	£7,611
7 to 12	£15,224
13 to 25	£30,447
More than 25	£60,893

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Health and social care fees

Analysis of responses to the CQC consultation on regulatory fees for 2016/17

February 2016

Client	**Care Quality Commission**
Company	OPM Group
Title	Health and social care fees
Subtitle	Analysis of responses to the CQC consultation on regulatory fees for 2016/17
Dates	last published 01/02/2016 last revised 23/03/2016
Status	Final
Classification	Released
Project Code	CQC3
Author(s)	Bethan Peach Remco van der Stoep Matthew Reynolds
Quality Assurance by	Isabelle Guyot
Main point of contact	Bethan Peach
Telephone	020 7042 8000
Email	info@dialoguebydesign.co.uk

If you would like a large text version of this document, please contact us.

OPM Group

252B Gray's Inn Road
London
WC1X 8XG

+44 (0)20 7042 8000
www.dialoguebydesign.co.uk
info@dialoguebydesign.co.uk

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1. Introduction

1.1 About OPM Group

OPM Group is an independent employee-owned research and consultancy organisation which supports and champions the delivery of social impact. The group consists of two divisions: OPM and Dialogue by Design. We work with public, private and third sector organisations and deliver: research and insight, evaluation and impact analysis, public engagement, and organisational development and change management services. Our commitment to social value runs through all of the work we do. Everything that we do as a business is to improve social outcomes.

We have been commissioned by the Care Quality Commission (CQC) to analyse and report on the responses to their consultation on regulatory fees for 2016/17. This report presents our findings.

1.2 About this consultation

The Health and Social Care Act 2008 includes powers for 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 two proposals for the health and social care regulatory fees for 2016/17:

Proposal 1

- The first proposal was to achieve full chargeable cost recovery over a defined timescale. This proposal applied to all registered providers, except for the dental sector. The consultation sought views on two options for the timetable to move to a position where CQC would recover full chargeable costs:
  - Option 1 – recovery over two years between 2016-2018
  - Option 2 – recovery over four years between 2016-2020

Proposal 2

- The second proposal related to fees for dental providers. The chargeable costs for this sector are fully recovered under the current fee levels, and CQC proposed that costs would remain the same during 2016/17, and would be expected to fall after that time. The consultation sought views on this proposal to hold fees at their 2015/16 levels and decrease them in 2017/18.

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

http://www.cqc.org.uk/content/health-and-social-care-fees-consultation

The consultation was live from 2 November 2015 until 15 January 2016 and responses could be submitted via an online form, email or post.

Following this consultation, CQC finalised the fees scheme for 2016/17, which was approved by the Secretary of State, and is published on CQC's website.

1.3 Responses received

A total of 1,127 responses were received. Table 1 shows the breakdown of responses by respondent category.

The analysis presented in this report should be read in the context of this breakdown of respondent types. Most notably, a high proportion of responses (51%) were received from those categorised as 'NHS GPs or NHS out-of-hours services'.

Table 1. Number of responses by respondent category

Category	Count
NHS GP or NHS Out-of-hours services	574
Community social care provider	152
Care home provider	140
Community healthcare provider	61
Dental provider	53
Other	37
Member of the public	30
NHS trust or Foundation trust	28
Representative of a national organisation or think tank	24
Independent healthcare single speciality service	14
Commissioner of services	6
Hospice provider	6
Independent healthcare hospital	2
Total	**1,127**

It should be noted that respondents were asked to choose which category they most closely represented from a drop-down list on the online form. Those that chose 'other' on the online form could also provide a description of their service, sector, or role. Of these, some were re-categorised by CQC prior to analysis. Those who responded via email were categorised by CQC before their responses were sent to OPM Group for analysis.

Although the number of responses from those categorised as 'Representatives of a national organisation or think tank' is relatively low as a proportion of the total number of responses (see Table 1), it should be noted that these organisations represent the interests of a large number of providers.

1.4 Reading this report

The purpose of this report is to provide an overview of respondents' comments on CQC's proposals on regulatory fees for 2016/17, allowing the reader to obtain an idea of their views. 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. The CQC response to the consultation feedback is provided in a separate document which can be obtained via the CQC website: www.cqc.org.uk

As with any consultation of this kind, it is important to remember that 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.

All responses were received by CQC and securely transferred to OPM Group for analysis. Upon receipt the responses were imported into OPM Group's analysis database, and each was read in its entirety. Using a coding framework, analysts applied codes to (parts of) the responses to each question, until every responses was coded in its entirety. This report draws on this analysis.

The structure of the report mirrors the consultation questionnaire, discussing comments to each consultation question in turn. A narrative summary of comments is interspersed with quotations from responses to further illustrate the issues highlighted. Tables and charts are included to provide an overview of responses to the closed consultation questions – questions 1 and 3a.

Where a specific theme or point was raised by a relatively large number of respondents, the report uses the phrase 'many respondents'. Where themes are analysed and divided out into sub-themes the phrases 'some' or 'a few respondents' is used instead of smaller numbers. Because of the qualitative nature of the data and variations in respondents' use of the consultation questionnaire, any numbers relating to the open questions are indicative. The focus of the analysis is on issues raised by respondents, and opinions are often shared across respondent categories. However, where appropriate the report specifies where views were expressed by a specific category of respondents or sector.

2. Responses to Proposal 1: Achieving full chargeable cost recovery

2.1 Options for achieving full chargeable cost recovery

Question 1 of the consultation asked:

In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

- *Option 1 – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or*
- *Option 2 – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?*

We received 741 responses to Question 1 via the online form or via email responses that followed the questionnaire format. In addition, 17 respondents stated their preference for Option 1 or Option 2 in email responses that did not follow the questionnaire format.

There was a strong preference overall for cost recovery over a period of four years, as indicated in the charts below. However, this finding should be considered in the context of the comments provided by many respondents which indicated overall opposition towards the proposals for cost recovery from service providers. As such, many respondents emphasised that they had indicated a preference based on the 'least worse' option and that this should not be taken to mean they supported the proposals. The following section of this chapter summarises these comments.

Of the total 758 responses that provided this information, 59 (8%) indicated a preference for Option 1 (cost recovery over two years) and 699 (92%) indicated a preference for Option 2 (cost recovery over four years). See Figure 1.

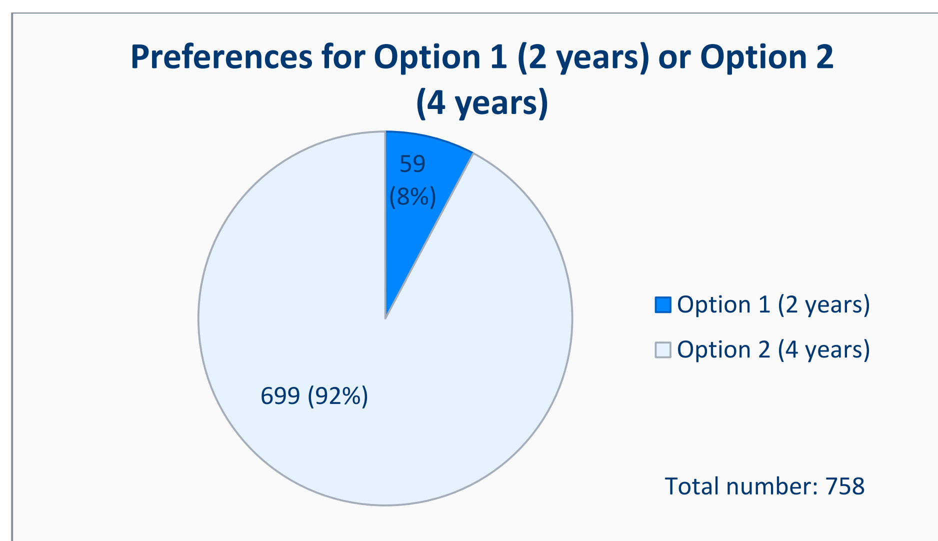

Figure 1. Preferences for Option 1 (2 years) or Option 2 (4 years)

Of the 1,127 total responses received to the consultation, 369 did not indicate a preference for either Option 1 or Option 2. That is, they neither responded to Question 1 via the online form nor did they explicitly indicate their preference via email. Taking these responses into account, 5% of all responses indicated a preference for Option 1, 62% indicated a preference for Option 2, and the remaining 33% did not provide an answer (see Figure 2).

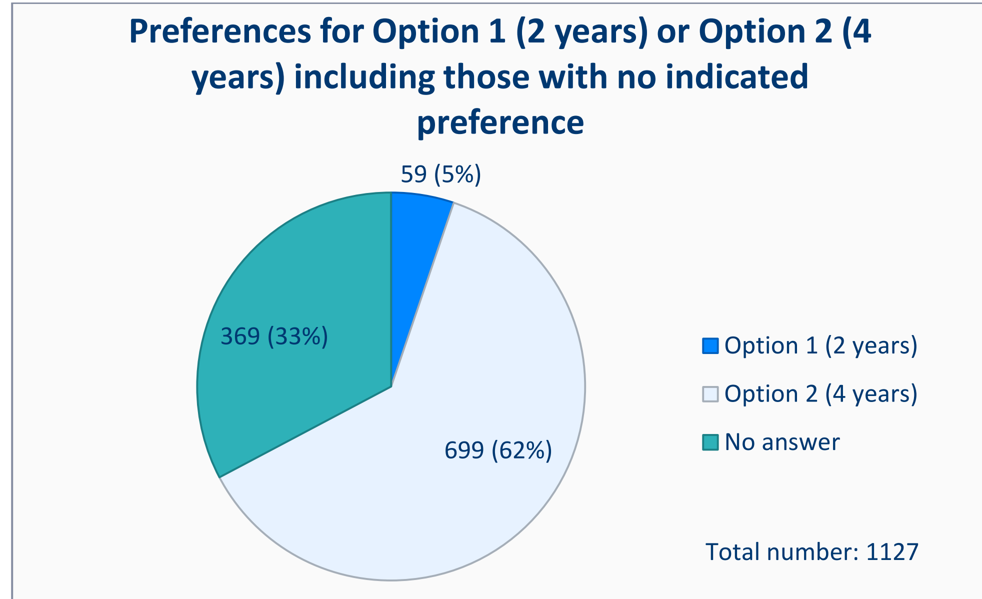

Figure 2. Preferences for Option 1 (2 years) or Option 2 (4 years) including those with no indicated preference

Of those who indicated a preference for either Option 1 or Option 2, the breakdown by respondent category can be found in Figure 3 (based on number of responses) and in Figure 4 (based on the percentage per respondent category).

When the preferences are broken down as percentages per respondent category (Figure 4) some notable patterns emerge:

- Among the commissioners of services, hospice providers, independent healthcare hospitals, and NHS trusts or Foundation trusts who indicated a preference, all (100%) responses indicated a preference for Option 2 (4 years).
- Among the NHS GPs or NHS Out-of-hours services who indicated a preference, 97% indicated a preference for Option 2.
- The proportion of responses that indicated a preference for Option 1 was highest among dental providers and members of the public (just under 30% of each respondent type preferred Option 1).
- A very large proportion of other respondent types indicated a preference for Option 2 (between 86% and 96%).

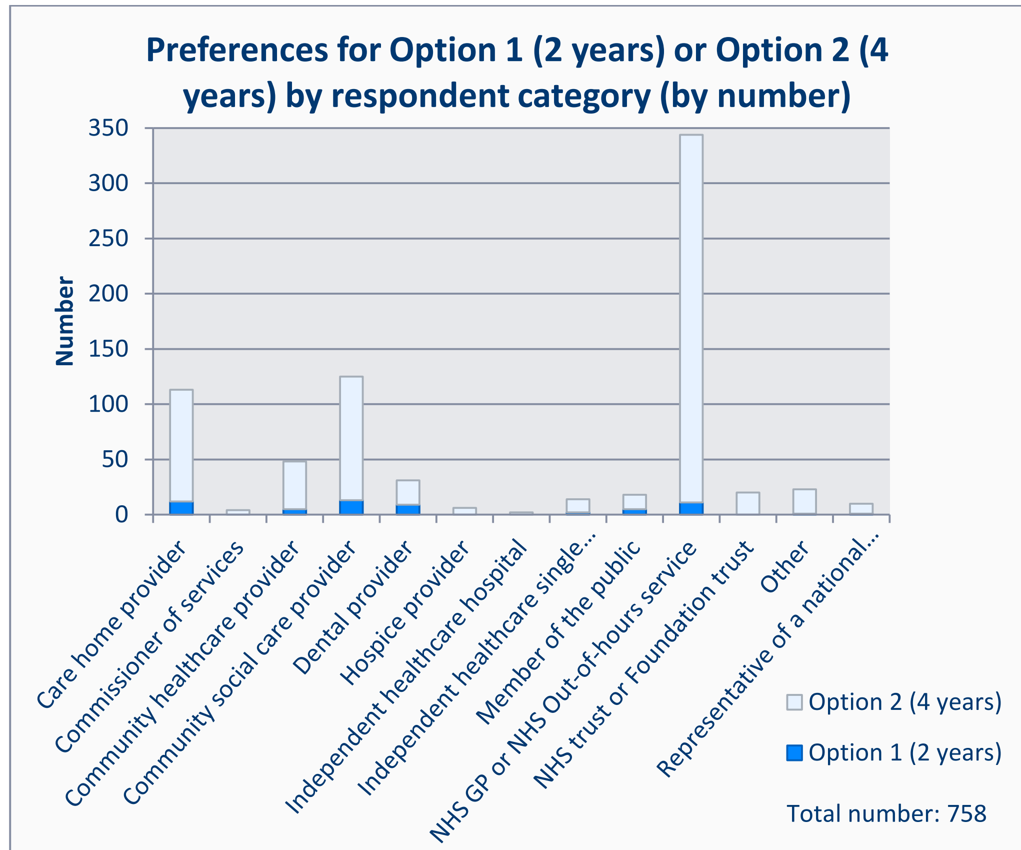

Figure 3. Preferences for Option 1 (2 years) or Option 2 (4 years) by respondent category (by number)

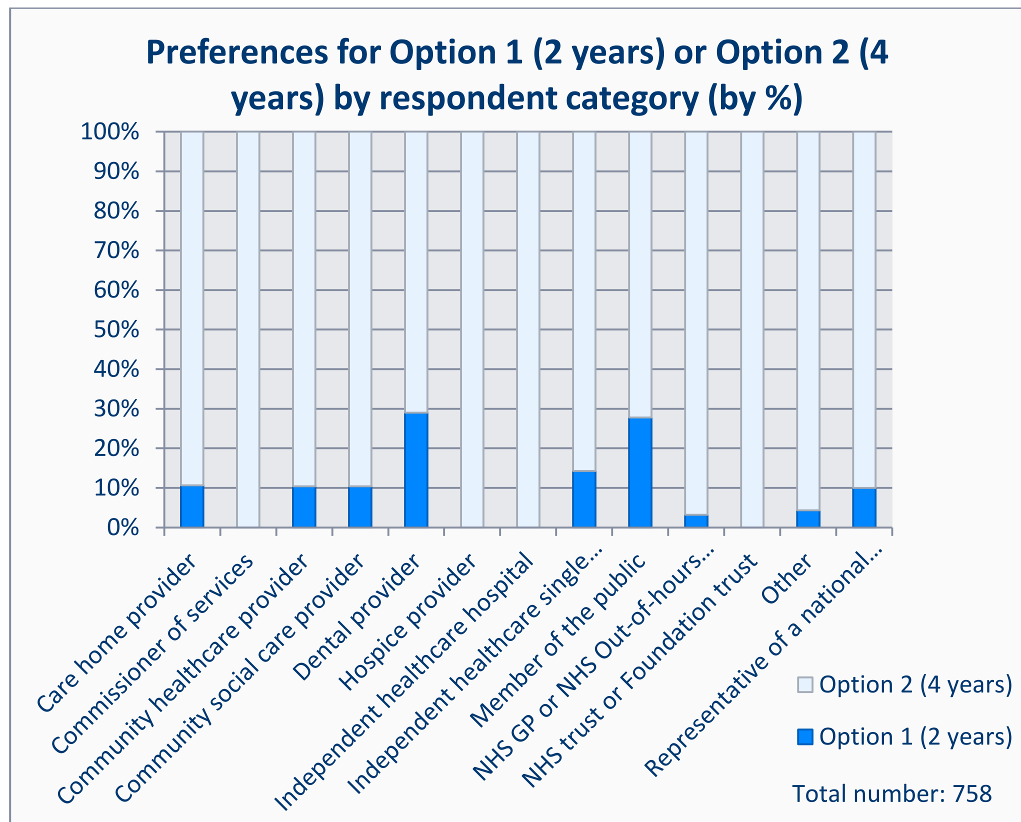

Figure 4. Preferences for Option 1 (2 years) or Option 2 (4 years) by respondent category (by %)

2.2 Comments about this proposal

Question 2 of the consultation asked:

Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:

- *A different option for how and when CQC should achieve full chargeable cost recovery.*
- *A different option on how we divide fees between different types of provider.*

Please explain what option you recommend to CQC and your reasons for proposing this.

We received 809 comments in response to this question via the online form or emails that followed the questionnaire format. In addition, 113 other emails provided comments relevant to the proposal for full chargeable cost recovery. This section summarises these comments.

It should be noted that the comments summarised here may have been made in response to either of the two open questions on the online form, or via email responses. Any comments made in response to Question 2 that were relevant to the proposals for the dental sector have been summarised in the following chapter.

Many respondents used the space provided in Question 2 to outline their overall thoughts about the proposal rather than addressing the question directly by providing alternative suggestions. The body of this section of the report summarises these comments, which fall broadly into the following themes:

- Opposition and support.
- Contextual information about respondents' situations.
- Impact of the proposals on providers.
- Reasons for any preferences for Option 1 or Option 2.
- Alternative suggestions.

2.2.1 Opposition and support

Opposition to the proposal

A very large number of respondents signalled their opposition to the proposed options for achieving full chargeable cost recovery. They often did so in general terms, emphasising their outright opposition to the premise of passing these costs on to providers.

"We disagree with the premise that fees should be based on full cost recovery. The regulation and inspection of services is an activity which is primarily driven by public interest. Providers have a part to play in meeting these costs, but not exclusively. This basic premise has been overlooked by both the Treasury and CQC." - Representative of a national organisation or think tank

Many respondents used strong terms to highlight their opposition to the proposed fee increases, stating for instance that they thought the increases were ‘wrong’, ‘unfair’, ‘unreasonable’ or ‘ridiculous’. Similarly, others reflected that the proposed fee increases would be ‘unrealistic’, ‘unjustifiable’ or ‘unaffordable’.

There was widespread concern among respondents that the scale of the proposed fee increases was very substantial, irrespective of the implementation timescale. Many respondents emphasised how much they believed the fees would increase for them as individual providers, with cited figures ranging from 12% to a sevenfold increase.

Some respondents illustrated what the proposed fees equated to for particular providers, stating for example that they would represent a few percent of a practice’s overall income or a few weeks’ full-time earnings for a GP. A few respondents argued that providers could employ one or more care professionals with the increased charges they would have to pay to CQC. There were a few suggestions as to what a more reasonable fee would be (e.g. £200 for a small GP practice). A few respondents emphasised that the amount providers would be required to pay CQC far exceeded 0.16% of their turnover, the percentage of the budget for CQC in relation to the overall spending on health and adult social care in England.

> ***“It is outrageous to state that 0.16% of the NHS budget is going to go on CQC fees. The proposed £5000 fee for our small GP practice is actually 2.2% of our practice annual turnover.” - NHS GP or NHS Out-of-hours service***

Several respondents highlighted that the proposed increases were above the inflation rate, implying that fee increases would only be justified if they kept in line with inflation figures. Some respondents suggested that the current fees charged by CQC to providers were too high, or that they should be reduced in line with funding for care services, or in line with the government’s reductions to CQC funding.

Some respondents emphasised that they understood there was a need for CQC to recover its costs and noted that they would be willing to pay a lower rate of increase, but that the proposed scale of fee increase was unacceptable.

Respondents made reference to the Department of Health consultation on CQC’s fee raising powers and the CQC strategy consultation, suggesting that the proposed fee increases were inappropriate prior to their conclusion (see section 2.2.5 for further suggestions about the timing of the proposals).

A few respondents indicated that, as providers, they would refuse to pay an increased fee and opt to boycott CQC instead. Others thought the implementation of the proposals could trigger a GP strike. A few respondents argued that the implementation options proposed in the consultation were a tactic to divert attention from the scale of the proposed increases.

Support for the proposal

One representative of a national organisation indicated that they supported the proposed fee increase, stating that they believed it was a fair increase over a period of four years and that it

would lead to a more 'level playing field'. Another respondent (a care home provider) thought the gradation of fees based on resident numbers was a sensible approach. A few others made positive comments about the principle and mechanism of cost recovery.

General opposition to regulatory fees for providers

Some respondents not only opposed the proposed increases, but argued that the fees should be removed altogether, or reduced from their current levels. Respondents often asserted that CQC regulation was imposed upon providers by the government and that therefore CQC should be centrally funded instead of requiring providers to 'pay for the privilege'. Several respondents argued that CQC or NHS England should negotiate this with the government, sometimes implying that CQC's role includes representing the interests of the sector. Others thought that it would be preferable for CQC to be closed, thus removing the need for providers to pay fees.

> ***"Why on earth should we be charged for an inspection we have not asked for?" - NHS GP or NHS Out-of-hours service***

Respondents frequently emphasised that regulation, and inspections in particular, were diverting funds from frontline care, often questioning whether this was in the public interest and suggesting that health and social care provision should be prioritised over regulation.

A common argument in respondents' cases against CQC recovering their costs from providers was that such a mechanism does not apply to other industries. In particular, many respondents said that schools are not required to pay a fee for being inspected by Ofsted. In the case of primary care, several respondents thought the fees represented a 'tax on general practice'.

A small number of respondents suggested that a model where providers pay for their regulator could affect public perceptions of the regulator's independence and credibility.

Justification of fee increases

A large number of respondents reflected on how providers' fees compared to the services provided by CQC, generally concluding that providers were not receiving value for money. Where respondents expanded on this, many went on to argue that CQC's regulation regime had not proven to achieve improvements in the quality of care, or that providers had not asked for CQC or its inspections.

Often these comments were made by respondents identifying themselves as primary care professionals. A common theme among these comments was that GP practices are only infrequently inspected by CQC and that this is a fairly small operation, adding that the great majority of GP practices inspected by CQC received a 'good' or even 'outstanding' rating. They questioned the scale of the fees charged to GP practices in particular, saying the costs of inspections they have witnessed are unlikely to match that amount.

Some comments highlighted specific regulation and insurance mechanisms that GPs pay for, which they believed CQC's regulation duplicated, at least in part. These respondents argued

that CQC inspections are therefore unnecessary. Similarly, other respondents concluded that quality monitoring by other organisations was sufficient, saying CQC did not add value.

A few respondents thought that in return for higher fees, providers should obtain greater support from CQC. Some said that current levels of support were insufficient; others thought CQC could help providers to address their financial struggles or that CQC support could help providers to maintain a high level of public confidence. Some suggested that fee increases should be accompanied by greater influence for providers in shaping the regulatory model.

Some respondents referred to CQC's strategy proposals, which they thought indicated a move to greater self-regulation with fewer comprehensive inspections. Reflecting on this, respondents argued that it would be counterintuitive for fees to increase if a greater proportion of the monitoring requirements would sit with providers themselves.

Comments on CQC performance

Despite the overwhelmingly critical character of most responses to this consultation, several respondents made positive comments about CQC (particularly representatives of national organisations and community social care providers). These respondents felt CQC's work to be valuable and acknowledged improvements to regulation achieved in recent years. As such, some respondents welcomed the new inspections regime and the associated reporting system. A few respondents commended CQC's open and transparent approach and the insight it offers. Several said they had had a positive experience in their recent interactions with CQC.

However, many of the comments on CQC's performance were critical. As reported above, a common theme in respondents' objections to the proposed fee increases was that they did not think the increased fees represented value for money, saying that CQC's regulatory efforts had limited benefits for providers or those who use services.

> ***"I feel the fee increase is completely disproportionate to the service that CQC provide. There is no evidence that their involvement directly improves patient care." - NHS GP or NHS Out-of-hours service***

When reflecting on the value of regulation, many respondents perceived inspections to be burdensome for providers and thought that there was little evidence of quality improvement to justify the perceived burden. Respondents commonly referred to inspections as 'disproportionate', 'unnecessary' or 'a waste of time', sometimes providing examples of how an inspection they witnessed had failed to impress them. Several respondents said they regarded CQC inspections to be 'tick box exercises'.

Respondents also made a variety of critical comments about the competence and attitude of inspectors, or complained that inspection reports were not evidence-based. Indeed, CQC's reporting was the subject of various critical comments, with some respondents arguing that it took too long for inspection reports to be produced and published. Others thought that the quality and consistency of the reports could be improved, or asserted that they were too long in their current form and inappropriate for the general public. Some respondents thought the

accuracy of the ratings awarded by CQC was questionable, or that CQC had not succeeded in identifying poor services.

A few respondents commented on the registration process specifically, describing this as inefficient and prone to delays. Other specific criticisms were aimed at CQC's intelligent monitoring and the use of key lines of enquiry (KLOEs), which some respondents thought were ineffective. There were a few comments criticising CQC for making accounting errors that had resulted in additional charges for home care providers.

In the view of some respondents, CQC was not sufficiently responsive, for instance when providers requested information or challenged inspection findings. A few respondents remarked that information about providers on CQC's website was sometimes inaccurate. One respondent said CQC should be more consistent in engaging with commissioners during the inspection process.

Many respondents made comments about CQC's overall performance, usually as part of an argument against the proposed fee increases. A central thread in these comments was respondents' assertion that CQC is a bureaucratic and/or inefficient organisation. There were also various suggestions that CQC, as a monopoly regulator, did not have sufficient incentive to keep its costs down, and requests for improved financial transparency (see section 2.2.5).

Many respondents argued for a complete rethink of how health and social care are regulated. Commonly, this type of argument was accompanied with an implication that such an overhaul would see CQC closed in its current form, or given a much smaller remit. A common phrase in responses was that CQC was 'not fit for purpose'. Some respondents stated that CQC was not achieving its targets, and that a Select Committee report had confirmed this, adding to concerns about the organisation's cost-effectiveness.

Equity between providers

A number of respondents commented on CQC's aim to ensure that fees are more equitable between all types of providers they regulate. A few respondents commended this aim and indeed the potential of the new fee structure to reduce inequality between provider types. However, many others were concerned that the proposals would maintain or even exacerbate elements of inequality.

There were calls from respondents to exempt particular providers from fee increases, with suggestions that GPs or adult social care providers could qualify for exemption because of their performance or their financial circumstances. A few comments highlighted that charities, such as some hospices, would be in a difficult moral position of having to spend charitable donations on a government-instigated regulator.

Several comments suggested that adult social care providers are at a disadvantage compared to healthcare providers. Similar comments were made by respondents concerned about inequity between NHS providers and independent sector providers.

Some respondents argued that larger (corporate) providers would be more able to pay an increased fee than smaller providers, or said that larger providers are more likely to benefit

from other advantages, such as tax breaks. A few respondents expressed concern that smaller providers might respond to fee increases by making changes to their practices that would not be in the public's best interest, or that they would struggle to compete with larger providers.

While some respondents expressed satisfaction with the separate treatment of fees for dental care providers, others claimed that the distinction is divisive or unfair (see Chapter 3).

To some respondents, the proposed bands determining the level of providers' fees by the size of their organisation were a cause of concern. Several respondents thought that the bands were too wide or the fee increases from one band to the next too big. Respondents thought the boundaries were arbitrary or unfair, with some reasoning that practices would limit their patient numbers to remain in a more advantageous band.

Respondents put forward several alternative suggestions for how the implementation and allocation of fee increases could be approached to promote equity between providers. These suggestions are summarised in section 2.2.5.

2.2.2 Contextual information

In order to put their other comments in context, many respondents provided information about their existing situation.

Existing financial difficulties

Many respondents commented on the existing financial difficulties faced by the health and social care sector in general as a context for their views on the increased fees. They highlighted the current financial climate of austerity and emphasised how this was impacting upon providers.

> ***"Surgeries are already financially stretched having reduced income with increasing workload." - NHS GP or NHS Out-of-hours service***

Some respondents went further to suggest that their sector was close to collapse due to the financial pressures and the decreasing resources available to provide services. Other respondents remarked that the timing of the proposals was poor given the current financial climate and the precarious financial position of the health and social care sector.

Another key point was the issue of sustainability, with respondents suggesting that CQC's move to full cost recovery would not support a sustainable future for their sector. These comments were often followed with observations that providers were already struggling to pay the fees to CQC without further increases.

In terms of sentiment, respondents expressed their serious concern at the proposals given the current financial difficulties. Others thought that the proposals were unfair, or that CQC was unaware of the financial difficulties they were facing. Some respondents suggested that the CQC proposals should reflect the economic pressures that providers were under and that CQC should support providers during this difficult time.

Some respondents highlighted the efficiencies they had already made to their budgets in order to survive as well as in response to pressure from Local Authorities. As such, they believed that increased fees would further affect their financial situation.

Respondents listed various other costs that contributed to their existing financial difficulties:

- Insurance and indemnity costs.
- Cost of overheads including infrastructure and utilities.
- Fees for defence unions.
- Fees to other national bodies such as the General Medical Council.

Funding and income reductions

Many respondents felt it would be unfair to increase CQC fees while there was no corresponding increase in their funding. Respondents described a pressure to deliver more services for less resource and argued that these funding cuts had been reducing the quality of care for people who use services and made staff retention more difficult. They often emphasised that commissioners were not in a position to increase funding for care services, that providers had no options to recover the increased costs associated with higher fees, and that it was commonly known that the care sector was financially struggling.

Local authorities and commissioning groups featured heavily in the respondents' comments on funding and income reduction. They questioned how providers can afford increased fees for CQC when they do not receive sufficient funding from local authorities or commissioners:

> ***"Any increase in fees will be difficult for providers to absorb but the proposed increase will prove a step to far for many providers who are already struggling to maintain services due to local authority underfunding." - Community social care provider***

Experience was divergent on the extent of this perceived scarcity of funding. Some noted that there had been a decrease in fees received from local authorities and commissioners, while others indicated that those fees had been frozen for a period ranging from four to eight years. A few respondents noted that there had been an increase in some local authority fees but only by a nominal amount.

Some respondents highlighted that salaries for medical professionals have been decreasing, in addition to the income for services as a whole. Most often these comments were made in relation to GPs' salaries and contracts.

Increased staffing costs

Several respondents made comments with regard to increased staffing costs as a context for their concerns about the CQC fee proposals. Such issues were often raised alongside the comments on financial difficulties and funding reductions noted above.

The introduction of the National Living Wage (NLW) was a prominent issue across the comments, cited in terms of the additional pressure on service provider finances. Numerous

respondents argued that local authorities and commissioners were not increasing their fees to cover this increase and as such perceived this disparity as unjust:

> ***"We providers in the Domiciliary Care Sector do not get paid enough by Local Authorities / Government to cover our essential costs such as paying a living wage or even a minimum wage and running our businesses." - Community social care provider***

Some respondents also argued that CQC should have factored the new NLW into the consultation's impact assessment. A number of respondents mentioned the increased 'minimum wage' which may either refer to the NLW by another name or to the minimum wage update carried out by the government each year. This was unclear to the analysts.

Respondents referred to further recent legislation that would lead to increased costs of staffing. They highlighted that they will now have to pay employees for travel time, waiting time between visits, and 'sleep-in' time (where staff sleep on the premises in order to be available for duty if the need arises). They noted that paying for these additional hours in conjunction with the NLW would add financial burden to providers.

Another important issue brought up by respondents was pensions. As with the living wage, respondents were concerned that the increased cost of pensions as a result of the introduction of automatic enrolment was not being covered by funding from local authorities and commissioners and would force providers to absorb the costs.

Respondents also listed various other staffing costs that they have to absorb:

- Employee training such as the Care Certificate.
- Apprenticeships and the apprenticeship levy coming into effect in April 2017.
- Increases to National Insurance.
- Increases to VAT rate.

Existing staffing challenges

Several respondents highlighted existing staffing challenges faced by the health and social care sectors as background to their views about the CQC fee proposals. The two central issues raised were recruitment and retention difficulties, often raised by respondents in conjunction:

> ***"Recruitment is at an all-time low and doctor retention is at a critical state." - NHS GP or NHS Out-of-hours service***

Funding cuts leading to a drop in income and wages, as well as overwork and stress were suggested as the causes for challenges facing recruitment. Similar issues were linked to retention with some respondents referring to specific examples of early retirements, emigration and redundancies.

Outside of recruitment and retention, respondents also commented on a perceived atmosphere of low morale across the sector, due in part to high workloads and the pressure to deliver services with diminishing resources.

After outlining these existing challenges, respondents often proceeded to outline the potential detrimental impact that the increase in CQC fees could have in terms of compounding these issues. This is discussed later in this chapter.

Comparison with other fees

A few respondents compared the increase in CQC fees to other fees they are required to pay. Some highlighted that public sector costs had either remained static or increased by a nominal amount. One respondent stated that consideration should be given to section 117, duty to provide aftercare for those who have been detained under the Mental Health Act, as these fees have not moved for several years.

2.2.3 Potential impacts of the proposals

Many respondents described potential impacts that the increase in CQC fees could have on their service or on health and social care services in general.

Impact on ability to operate

Many respondents commented on the potential impact on providers' ability to operate following increased fees. By far the most prominent concerns were the risk of bankruptcy and closures as a result of fee increases:

> ***"How can an increase of 567% be justified? Practices will be driven to closure." - NHS GP or NHS Out-of-hours service***

These comments were often mentioned alongside the existing context, arguing that the increased fees in combination with existing financial hardship would be the breaking point for many providers. A few respondents went further to suggest that the proposals were part of a political attack on the health and social care sector.

Many respondents singled out primary care providers as particularly impacted by the proposed fee increases, while several respondents also commented on potential impacts upon care homes and domiciliary care. It is worth noting however that it was not provider type that was the key distinguishing factor, but provider size. Respondents highlighted particular concerns about the potential impact of the fee increases on small providers generally, and on rural surgeries, specialist clinics and multi-site providers. They argued that these types of providers had a more difficult financial situation, a dependence on state funding and a lower annual turnover, and as such the fee increases would be more damaging.

Respondents also highlighted other concerns regarding providers' ability to operate:

- NHS providers may decide to become private services in order to generate an income that would enable them to afford the fee increases.

- New social care organisations may be particularly at risk due to start-up costs.
- Providers may have to close certain offices or merge into one location to afford the fees.
- New providers may be dissuaded from establishing due to fee increases.
- The potential for people who use services to be left without a GP due to practices closing, downsizing, or relocating.

Impact on service quality

Many respondents commented on the potential impacts of fee increases upon service quality across the health and social care sectors. A large proportion of these respondents commented on the impacts on general practice in particular. These impacts were rarely mentioned in isolation but instead as an effect of providers' ability to operate, through the closure of practices or homes, or as an effect of problems surrounding staff morale, retention and recruitment (discussed below).

Respondents often made general comments with regard to how services would be affected by fee increases, mentioning potential decline in both service quality and service provision:

> ***"These unfunded increases in costs, if charged to providers, can only result in a reduction in service provision and quality." - NHS GP or NHS Out-of-hours service***

One potential impact that was highlighted in detail was upon vulnerable people. This included those depending on state support who may no longer be able to afford services if the costs of fee increases are passed on to those who use services (discussed further later in this chapter). It also included disabled people in rural areas who may have their access limited if smaller practices have to close.

A few respondents commented that there was a degree of counter-productivity in the proposed fee increases. They argued that as service quality may decrease as a result of the fees; this would be incongruous with CQC's intended purpose of improving service quality.

Certain points were made with reference to specific provider types:

- Social care / care homes:
  - Personal care services may be withdrawn in order to make efficiencies.
  - Those who use services who should be in social care or care homes may be forced to stay in hospitals as a result of closures.
- Domiciliary care:
  - Providers may move their focus to clients who pay for services, putting those dependent on state-funding at risk.
- General practice:
  - Decrease in consistent care following losses of full time GPs and an increase in temporary locums and part-time GPs.

Impact on staff morale, retention and recruitment

Several respondents commented on the perceived impact of the fee increases on staff morale, retention and recruitment, which was identified as an existing challenge (as discussed earlier). A large proportion of these respondents commented specifically on the impact on primary care staff. Some comments emphasised that low staff morale and staffing challenges can have subsequent detrimental impacts upon service quality.

One of the concerns regarding recruitment was that the increased fees would reduce the amount of money available to providers, and as such finding space in the budget for new employees would become difficult. Another issue raised was that the fee increases may add to the perceived public image of declining wages and workplace stress, and as a result potential employees may be dissuaded from entering the health or social care sectors.

In terms of retention, respondents highlighted two broad issues. The first was the concern that staff would choose to leave their providers voluntarily following fee increases due to potential wage decreases, increased workloads and stress. They argued that older staff may choose to retire earlier than expected and that younger staff may choose to emigrate. The second concern surrounding retention was that budget cuts caused by the increased fees may force providers to downsize and make employees redundant:

A few respondents detailed the specific number of staff they may need to let go in their own situation, or the equivalent number of front-line posts the proposed increases could fund. A few other respondents argued that the increased fees may dissuade salaried staff from becoming partners in practices as there would be little economic incentive to do so.

Impact on staff pay

A few respondents made comments about potential impacts on staff pay. A large proportion of these responses focused on GP salaries 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, 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, staff salaries would be the most likely target.

Costs for people who use services

A few respondents noted that they may have to pass some of the additional costs on to people who use their services. They raised concerns about this, highlighting that some people who use services are already struggling to pay for their care. Respondents talked generally about the health and social care sectors, arguing that it was unfair to pass costs onto those who use services. Others talked particularly about domiciliary care and care homes. Specific concerns focused on the increased hourly rates that providers may need to charge, potentially

dissuading new clients or forcing them to only take private clients who could afford the higher rates. They also argued that it would be unjust to make self-funding residents or clients supplement council funding cuts for non-fee-paying residents or clients.

Other impacts on specific provider types

Respondents noted specific concerns about the potential impact of the proposed fee increases on certain types of provider:

- Charities:
  - Moral issues of paying for regulation using charitable funds raised from the public.
  - Concern that it was unjust for charity providers to have similar fee increases to for-profit providers when they work within smaller margins.
- Domiciliary care:
  - Perceived discrepancies between the fee increases for domiciliary care and care homes.
- General practice:
  - Perceived victimisation and attack on this provider type.
  - Disproportionate impact of the fee increases upon rural practices which operate across multiple sites in order to increase access for the sparsely populated area.
  - Issue with paying for regulation that GPs argued adds bureaucracy.
- Social care / care homes:
  - Disproportionate burden on care providers when they argued they required no more inspection time or regulatory resource from CQC than other provider types.
  - Concern that it was unjust to target what are often small family-run businesses.
- NHS trusts
  - Concern that it was unfair to base NHS trust fee levels on turnover while the fees for other provider types are determined by number of locations.

2.2.4 Reasons for preferences in Question 1

Preference for Option 1

One respondent made a comment to explain their preference for Option 1 in Question 1 (cost recovery over a period of two years). They argued that increasing the CQC fees over two years would be expedient; implying that speeding up the process could be to the advantage of some providers.

Preference for Option 2

Reflecting the overall preference for Option 2 in Question 1 (cost recovery over a period of four years), several respondents made comments to explain this preference. A common reason given was that this would give providers additional time to adjust to the increased costs:

> ***"Option two - gives longer for sector to adjust to full costings. Spreads the increased fee burden over a longer period" - NHS Trust or Foundation Trust***

Respondents often stated that this 'phased' approach was preferable to the 'front-loading' of costs which would take place if Option 1 was chosen. Four years was perceived as a more reasonable amount of time to plan budget forecasts and make necessary efficiencies to adjust to the fee increases. Respondents noted that this phased approach would be particularly preferable for their own type of service such as small businesses or care homes.

Financial security was another reason given for the preference of Option 2. The background of the economic climate was often highlighted at this point, with the pressures of funding cuts and the introduction of the NLW as described in the above sections. Some respondents went further to suggest that the second option was essential as if the costs were to be spread over two years, they argued that service quality would be at risk and many practices or services would have to close.

Respondents often clarified that they did not necessarily support this option, but recognised it as the 'least worse option'. Some argued that the proposed increase over four years was still too great an increment, while others wished for as long a period as could be justified. A few were cynical of the viability of full cost recovery while a few argued the contrary, that four years would make full cost recovery a more achievable aim.

Some respondents made alternative suggestions regarding the timescale for implementation. These suggestions are summarised in section 2.2.5.

Reasons for not choosing an option

Several respondents emphasised that they did not choose an option in Question 1 because they oppose the proposals overall, and Question 1 did not provide an option to indicate this opposition.

2.2.5 Alternative suggestions

Respondents made many suggestions about alternative options for cost recovery. Many of these comments were about different ways of implementing and allocating fee increases, although there were also a substantial number of suggestions relating to how CQC operates. This section discusses each of these themes in turn.

Fees: suggestions for the timescale for increases

Several respondents commented on the proposed timescales for the implementation of fee increases, often suggesting options beyond those proposed in the consultation document.

Respondents' comments about timescales usually expressed a preference for a slower or later introduction of the proposed fee increases in order to give providers more time to adjust. Some respondents emphasised that providers should be given as long as possible or argued that the implementation of fee increases should be a gradual process over many years. A few

respondents suggested specific extensions to the proposed timescales, saying it would be more appropriate for the fee increases to be spread over six, eight or ten years. Others suggested that smaller providers in particular should be given more time. One respondent thought it was inappropriate for CQC to introduce the greatest increase in the first financial year.

In contrast, one respondent argued that the implementation of the fee increases should be done as rapidly as possible.

Various suggestions were made for postponing the introduction of CQC fee increases. They included calls to delay the increases until:

- CQC had completed its first round of comprehensive inspections.
- CQC had demonstrated it had made progress on effectiveness and efficiency.
- The Department of Health consultation on CQC's fee raising powers had concluded.
- CQC's strategy consultation had concluded.
- The year 2017.

> ***"The timing of this fees consultation is out of alignment with two other consultations, both of which are of direct relevance to the level of fees that should be levied on our members. Given the potential far-reaching impact of these consultations, we would argue that a fee increase next year should be postponed, until the implications are more fully understood." - Representative of a national organisation or think tank***

Fees: suggestions to promote equity between providers

Respondents made a range of suggestions about CQC's proposed allocation of fees according to provider type and setup. Many of these comments questioned the fairness of the proposals, often accompanied by an example of how the proposed fee structure could disproportionately affect a particular provider or type of provider, as summarised previously in section 2.2.1.

A common concern among respondents was about CQC's current method of charging according to a provider's number of locations. These respondents thought that this is an arbitrary measure and emphasised that number of locations was not synonymous to size. They often argued that it would be fairer if charges reflected providers' size measured in numbers of clients, numbers of beds or hours of care delivered. Others thought the most appropriate measure would be providers' number of employees, turnover or profit.

Several respondents thought that CQC could introduce more gradual scales for establishing the appropriate fee for individual providers, with specific criteria for GPs, care homes and domiciliary care providers. There were a few calls for a fixed, basic fee for small providers, which could be accompanied by additional fee bands for medium-sized and large providers. A few respondents suggested a cap on the total fee based on a (small) percentage of a provider's turnover.

Reflecting concerns about the distribution of CQC fees between types of providers (see section 2.2.1), there were calls to restore equity between social care and healthcare providers, independent providers and NHS trusts, commercial and charitable providers, and care homes and GPs. There were also calls to introduce bespoke measures for specialist clinics, hospices and extra care.

> ***"Hospices are unique among health and social care providers. Most of the care that they provide is charitably funded, and they are not funded on a cost recovery basis for the NHS services that they provide." - Representative of a national organisation or think tank***

Some respondents suggested that CQC should base its fees on the level of involvement required with a particular provider or type of provider. Some of these suggestions specified respondents' preference for a direct mechanism linking fees to inspections, with providers paying per inspection, or a rate that reflects CQC's use of time and resources to monitor a provider.

Similarly, several respondents thought that CQC should take into account each provider's performance in setting their fees, with higher fees charged to providers with weaker ratings. Respondents argued that this would be fair to those providers whose rating is 'good' or 'outstanding' and who therefore require very little monitoring from the regulator. Some also thought that a system that linked fees to performance might work as an incentive to providers that perform poorly. Suggestions for the implementation of such a system included the introduction of fines or supplementary charges for providers requiring additional inspection visits, a rebate system for providers with high ratings, or a scheme reflecting that of the NHS Litigation Authority. One respondent recommended fee charges based on risk and type of provider but emphasised that a risk assessment of all sites would need to take place as soon as possible to ensure a consistent approach.

A few respondents thought CQC should take into consideration other specific factors when establishing the fee levels charged to providers. In particular, there were calls for location differences to be recognised, with one representative organisation making a comment about the potential equality impact of the proposed fee-setting mechanism:

> ***"The equality impact assessment should analyse the providers - in both health and social care - most adversely affected by these proposals and the demographic make-up of the populations they serve to determine whether, for example, many of those practices serve an elderly population against whom these proposals may discriminate." - Representative of a national organisation or think tank***

Several respondents made general remarks suggesting there could be no justification for an increase in fees above inflation levels and called on CQC to keep increases within those levels.

CQC: suggestions for CQC operating costs

As touched upon in the sections above, many respondents linked their serious concern about the proposed fee increases to criticisms of how CQC performs. Respondents often made specific observations or suggestions as to measures they believed CQC should take in order to mitigate the need for increased fees. The most commonly made suggestions are discussed below.

Respondents emphasised what they perceived as a large corporate overhead in CQC's organisational model and thought CQC should seek to cut its costs. Several respondents argued that all organisations within the care sector were forced to make efficiency savings and that it would be appropriate for CQC to do the same and, as some respondents put it, 'live within its means'.

"CQC costs need to reflect the straightened circumstances of health providers and, as all providers need to do, reassess their work and make it more efficient rather than add so significantly to the financial burden that reduces the availability of cash to invest in direct patient care." - NHS trust or Foundation trust

Reflecting the views about CQC performance (in section 2.2.1), many respondents argued that CQC could save on costs by making the inspection process more efficient, suggesting that CQC should inspect providers less frequently or with fewer inspectors, and that it should produce shorter reports. Common suggestions included a move to light-touch regulation and a greater focus on poorly rated or at-risk services. Various respondents suggested specific changes to the regulatory process, such as more self-assessment and self-reporting by providers and greater use of technology and data to support the monitoring of providers.

A few respondents reflected on the evolution of the care sector and CQC's progress in regulating it, mentioning new models of care and the imminent completion of the first round of comprehensive inspections, saying that these factors could help CQC bring down costs (and fees) in the near future.

Other commonly made observations focussed on CQC's organisational model, which respondents thought should be slimmed down. Many believed that CQC should scale back and reduce its operating cost by cuts to staff, management and overhead, such as their office costs and salaries. Respondents also frequently mentioned the perceived high expenditure on meals and accommodation associated with inspections.

Respondents argued that in order to justify its proposed fee increases, CQC should provide greater detail and transparency in relation to its operating costs as well as its efforts and achievements in reducing their cost in line with the rest of the care sector (see Chapter 4 for further detail). Related to this, there were some requests for CQC to model 25% and 40% savings on all chargeable activity, alongside references to a Treasury requirement for CQC to "*model savings on activity which is funded through grant-in-aid*". Some respondents quoted the recent Public Accounts Committee report which includes criticism on CQC's effectiveness, using this to challenge CQC's justification for increasing fees. A few respondents raised

concerns about CQC's reputation and emphasised the need to reassure the public that CQC uses public funds well.

A few respondents emphasised the costs incurred by providers that resulted from requirements imposed on providers by CQC. One respondent argued that CQC should avoid introducing any new activities of which the cost would fall onto providers; another respondent thought that providers should be compensated for extra workload generated as part of regulatory requirements.

There were also some calls for CQC to work more closely with other regulators so that unnecessary overlap could be removed, for instance through a national regulation framework.

CQC: Other funding suggestions

As outlined in section 2.2.1, many respondents emphasised that, since regulation was required by the government, all of the associated costs should be centrally funded. Alongside these comments calling for the government to fully cover the costs of care regulation, some respondents argued that the government should partially cover the increased costs. Their suggestions included:

- Providers to continue to pay the current fee rates; Government to cover CQC's remaining costs.
- Providers only to pay for costs directly associated with the inspection of their practices.
- Government to pay the fees of 'outstanding' and 'good' providers.
- Government to subsidise small providers to cover CQC fees.
- Government to pay a set proportion of CQC costs, e.g. 70 or 75 percent.

Some respondents said that Clinical Commissioning Groups (CCGs) should have a role in funding CQC, either by paying into CQC directly or by reimbursing providers for the fees.

A few respondents suggested that if providers were to be (partly) reimbursed for their expense on CQC fees, it would be more efficient for the government to allocate those funds to CQC directly, rather than maintaining an inefficient indirect funding stream.

A number of respondents made suggestions for fundamental changes to the inspection regime. A suggestion made by a few respondents was to introduce peer-to-peer inspections or a buddy system for primary care. Similarly, a few others suggested that CQC could ask local specialists which GP practices would need inspecting, or that CQC works with CCGs to benefit from their local knowledge. Other suggestions included:

- Local authorities to take responsibility for regulation and inspections.
- Government to create one body for the regulation of the care sector.
- CQC to become an independent body solely focussing on improving care.

3. Responses to Proposal 2: Fee charges for dental providers

3.1 Decreasing fees for the dental sector

Question 3a of the consultation asked:

Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?

Participants could choose from the following options: Yes / No / Not applicable

We received a total of 761 responses to Question 3a.

3.1.1 Responses from the dental sector

Of these 761 responses to Question 3a, 51 were from those categorised as dental sector respondents. The breakdown of their responses can be found in Figure 5.

There was a high level of support for the dental sector fee proposals from dental sector providers who responded to the consultation.

A total of 43 out of the 51 responses (84%) indicated their support for the proposal for dental sector fees, seven (14%) indicated that they disagreed with this proposal, and one (2%) dental sector respondent indicated that the question was not applicable to them.

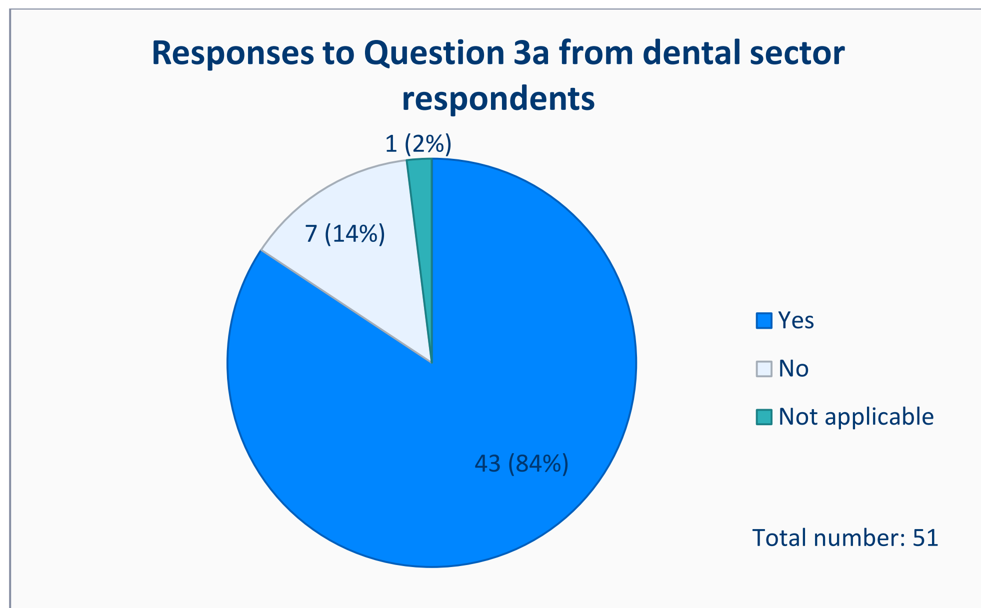

Figure 5. Responses to Question 3a from dental sector respondents

3.1.2 All other responses

We received 710 responses to Question 3a from those not categorised as dental sector respondents. Of these, 104 responses (15%) disagreed with the proposals for the dental sector, 66 responses (9%) indicated their agreement with the proposals, while 540 (76%) indicated that the question was not applicable to them (see Figure 6).

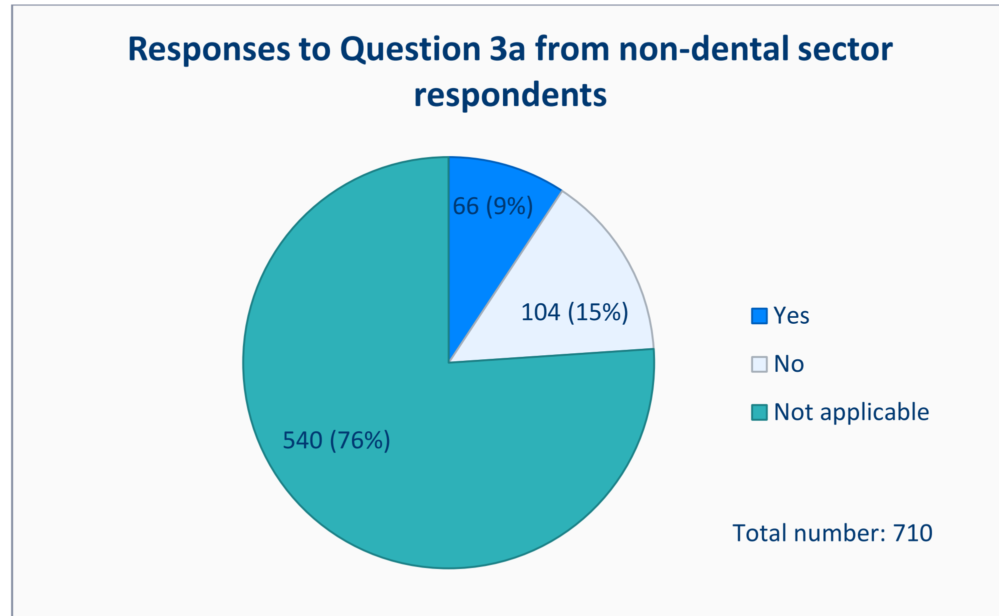

Figure 6. Responses to Question 3a from non-dental sector respondents

3.2 Comments about this proposal

Question 3b of the consultation asked:

If there are aspects of this proposal that you do not agree with, please explain why.

We received 180 comments in response to this question via the online form or emails that followed the questionnaire format. In addition, 16 emails that did not follow the questionnaire format provided comments relevant to this proposal.

Not all of the comments made in response to Question 3b were related to the dental sector proposal, but reflected respondent's opposition to the fee increase proposed in Question 1. This section summarises the comments relating to the proposal for the dental sector only, taking in turn the comments made by those categorised as dental sector respondents and then the comments made by other respondent types.

Any comments made in response to Question 3b that were not specific to the proposal for the dental sector have been included in the preceding chapter.

3.2.1 Comments from dental sector respondents

Support and opposition

Several respondents expanded on their answers to Question 3a with statements of support for the decreased fee charges for the dental sector. They thought that as only 10% of dental locations would be physically inspected each year, the reduced rate was appropriate:

> ***"Fully agree as you are only visiting 10% of practices." - Dental provider***

Respondents also thought that it made sense to have reduced inspections, and therefore reduced fees, as they perceived the sector to have existing high standards and regulation by other bodies.

One respondent noted that dentists had already been achieving full chargeable cost recovery for several years, unlike GPs, and that therefore a reduction was appropriate. In relation to this, another respondent emphasised that dentist's fees should be reduced until other sectors have achieved balance.

Some respondents supported the proposal to decrease the fees for the dental sector but argued that they should be decreased further than the proposed increment. A few calculated that if 10% of locations were to be inspected then the fees should be decreased by 90%.

Some argued that the fees for dental providers are still very high for small practices and single location practices in comparison to large and multi-site practices, and thought that this was inequitable.

Others stated their opposition towards paying fees at all, arguing that CQC inspections do not offer sufficient value for money and generate excess bureaucracy. These comments have been summarised in Chapter 2.

Suggestions

Respondents brought up a variety of other suggestions regarding dental fee charges:

- Reduce dental fee charges with immediate effect, or sooner than proposed.
- Implement variable changes in fee amounts based on practice size.
- Consider commitments made by the Regulation of Dental Services Programme Board.
- Source funding from the government because that is where the requirement for CQC to inspect dental practices comes from.
- Do not charge NHS contracted practices.

A further suggestion was that CQC should make efficiencies in order to further reduce dental fee charges, reflecting some of the wider comments made in relation to the CQC proposals overall (see Chapter 2).

3.2.2 Comments from other respondents

Opposition and support

Many respondents commented on their opposition to the proposals for reduced dental fee charges. These statements were often phrased as challenges, questioning why one provider type was being treated differently from others. Some respondents went on to explain that they perceived the proposals were unjust as private dentists were able to pass costs on to those who use services while others, such as GPs, cannot. They also argued that the dentistry sector was more profitable than other health and social care sectors, and as such they should be able to afford higher fees:

> ***"The dental sector is one of the most lucrative and profitable. How can it be fair to decrease their fees?" - Community social care provider***

A few respondents expressed support for the proposals for reduced dental fee charges. They echoed the points raised by dental providers (discussed above); their views that as the dentistry sector has higher safety standards and other forms of regulation, less inspection is needed and as such a lower fee is appropriate.

Alternative suggestions

Several respondents made alternative suggestions in relation to the dental fee proposals. Unlike the suggestions made by dental providers above, these were not suggestions of how to change the dental fee proposals but how to change other proposals in comparison to the dental fee proposals. A few of these respondents suggested that single location specialities (dermatology, IVF clinics, cosmetic clinics etc.) should be charged at the same rate as dentists due to their similar size and setup. Other respondents argued that the fee charges should be uniform across all provider types. One respondent suggested that the proposal for inspecting 10% of dental locations should be duplicated in the adult social care sector in order to reduce this sector's fee charges.

4. Comments about this consultation

This section summarises the comments respondents made about the consultation process. These comments fell broadly into three categories: criticism of the consultation; suggestions for further engagement; and requests for further information.

Criticism of the consultation

Many respondents argued that Question 1 of the consultation was flawed or biased. They thought that there should have been an option to express their opposition to the overall proposals, instead of only being presented with two options for their implementation, particularly in light of the scale of the proposed fee increases.

> ***"To force a choice of option 1 or option 2 is a fudge of consultation as it will allow statements saying x% support option 1 when in reality the vast majority of providers will fundamentally disagree with both options." – Community social care provider***

Respondents thought the consultation should have asked for views on the scale of the increase as well as the timescale for the increase. Several respondents suggested that a consultation on fees should also seek views on whether CQC provides value for money.

Others thought the consultation was a 'tick box exercise', suggesting that responses would not influence CQC proposals. A representative organisation commented that their feedback on the proposals prior to the consultation had not been taken into account, and therefore they were not confident that the consultation responses would have any influence either. The same organisation also questioned whether the consultation might be open to legal challenge, if the proposals are not subsequently influenced by respondents' feedback. Other representative organisations also echoed these concerns about a lack of genuine influence over the proposals, with one such respondent describing the consultation as 'meaningless'.

Several respondents, including representative organisations, commented on the timing of the consultation, suggesting that it should have been postponed until after the Department of Health consultation on CQC's fee raising powers had concluded and/or until CQC's strategy consultation had concluded. Some emphasised that the regulatory regime should have been scrutinised and remodelled before any further increases to fees were consulted upon. Please see section 2.2.5 for further suggestions regarding the timing of the proposals.

There were some criticisms of the online form, where several respondents noticed spelling errors. A few respondents also commented on the choice of words in the consultation document. One respondent suggested that in describing their role in terms of 'protecting the public', CQC had used emotive language implying that the public needed to be protected from providers. It was also suggested that the pressures which providers are under were not adequately reflected in CQC's consultation documentation, although it was not clear whether this referred to the consultation document or the impact assessment document.

Suggestions for further engagement

Several respondents thought that members of the public should be consulted more widely, since the proposals mean that the fees are paid by tax payers. While some acknowledged that members of the public were able to respond, they thought the consultation should have been more widely advertised in order to encourage responses. There was also a suggestion that the public should be consulted on CQC operations more widely, for example by providing feedback about the style and length of inspection reports.

While there was some acknowledgement of CQC's efforts to engage with providers, several respondents reiterated their perception that this consultation was a 'tick-box exercise' and thought that meaningful engagement was lacking. Several representative organisations echoed these views. Respondents reiterated that they thought there should be consultation and engagement on wider issues related to the regulatory system and different options for addressing the financial pressures collectively. One representative organisation made specific reference to the CQC Fees Advisory Panel. They thought this panel was not an effective engagement forum.

One representative organisation referred to a statement in the consultation document that CQC would continue to '*identify the provider characteristics that are the major drivers of cost, in order to apportion fees fairly among providers*'. They requested that CQC carry out this work in advance of making decisions about the proposed fee increases.

Requests for further information

There were many requests for additional information, including:

- Evidence of CQC cost-effectiveness and value for money.
- Evidence of CQC effectiveness in improving quality of care.
- Evidence of CQC making internal efficiencies to address some of the costs.
- A breakdown of how the fees are, and will be, spent.
- Clarity about how providers would be categorised, including specific requests from individual providers as to what they would be charged.
- Transparency over CQC operating costs overall and per type of inspection.
- More detailed rationale for the proposed fees for different provider types.
- Clarity over the fee structure per year, including the calculations behind the proposed fee increases.
- Rationale for the removal of the 'grant subsidy'.
- Whether the Department of Health or NHS England is planning any mechanism for reimbursement of the fees.

Appendix A: List of consultation questions

Question 1

In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

- *Option 1 – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or*
- *Option 2 – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?*

Question 2

Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:

- *A different option for how and when CQC should achieve full chargeable cost recovery.*
- *A different option on how we divide fees between different types of provider.*

Please explain what option you recommend to CQC and your reasons for proposing this.

Question 3a

Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18? [Yes / No / Not applicable]

Question 3b

If there are aspects of this proposal that you do not agree with, please explain why.

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Care Quality Commission

Regulatory fees from April 2016

Final regulatory impact assessment

This final regulatory impact assessment has been published alongside *Regulatory fees from April 2016 under the Health and Social Care Act 2008 (as amended): Our response to the consultation.* We suggest that stakeholders read that document in full before reading this impact assessment.

This document sets out our final analysis of the impact of the proposed changes to our fee scheme from April 2016.

Introduction

1. The Care Quality Commission (CQC) is the independent regulator for health and adult social care in England. The fees it charges to registered providers make up a significant proportion of the income CQC needs to carry out its statutory duties.

2. Section 85 of the Health and Social Care Act 2008 (the 2008 Act) gives CQC powers to charge fees associated with its registration functions. Like many public regulatory bodies, CQC is required by government to set fees in order to cover the costs of its functions.

3. CQC consulted on proposals to modify the current fee scheme in the consultation: *Regulatory fees – have your say*. We published an initial regulatory impact assessment alongside this consultation which provided stakeholders with our initial analysis of the likely impacts of our proposals.

4. In line with guidance from HM Treasury, CQC is committed to publishing a two-stage impact assessment. This document is the final impact assessment of our two-stage impact assessment approach. It contains an overview of our updated analysis of the impacts on stakeholders of the proposals in our consultation document. These stakeholders include regulated providers, HM Treasury

(representing the interests of taxpayers), people who use services, commissioners, the public and other regulators in the health and social care sector.

5. The Secretary of State has consented to the fees scheme and it will take legal effect from 1 April 2016.

Background

Financial position

6. Government policy states that the ability to recover costs of services underpinned by statute shows the real economic cost of the service. It promotes better control of costs and efficient and effective use of public money.

7. We can recover costs that relate to our chargeable regulatory work under the 2008 Act. We have two sources of funding – grant-in-aid from the government and fees income from providers. We can never raise more than it costs to deliver our functions and so an increase in funding from one source will always mean a reduction from the other. Providers consistently raise concerns about any fee increases, particularly when this is against an economically challenging background. We understand that position but we have to set that against the fact that ultimately we are constrained by the policy requirements of the Secretary of State for Health and HM Treasury, which expect us to recover chargeable costs of the services we provide through fees over a reasonable time period.

8. CQC's total revenue budget for 2015/16 was £249.3 million, of which £4.9 million was allocated to Healthwatch England, so we were operating with resources of £244.4 million. The budget is derived from a combination of grant-in-aid and income from fees paid by providers (£113.5 million or 50.6% of the total). Of our operational resources, £224.4 million related to our registration functions under the 2008 Act and £20.0 million to other functions.

9. The £20.0 million covered activities that we are not able to recharge as fees and include our regulation under the Mental Health Act 1983, the Office of the National Freedom to Speak Up Guardian, our enforcement and thematic review work, and the work we are undertaking on Market Oversight. These are all funded by grant-in-aid.

10. We increased fees for 2015/16 by 9% from the previous year for all sectors, except the dental sector. This signified our intent of moving to full chargeable cost recovery within a reasonable time frame as required by HM Treasury. It was also a pragmatic decision while we were developing the methodology to identify the costs of the new regulatory approach for each sector. Appendix 3 outlines our costing methodology and the development of the costing model.

11. The increase in fees for 2016/17 builds on that foundation. The sectors vary on how close they are to full chargeable cost recovery and so the increase in

2016/17 is differentiated by sector to ensure that all sectors will reach this position at the same time. This is detailed in Appendix 1.

12. The fee increases are a reflection of the move to full chargeable cost recovery and not due to inflationary increases. The overall fee increase is matched by a corresponding reduction in grant-in-aid. In future CQC's overall budget will reduce as a result of the savings required by the Department of Health under the Spending Review. Table 1 shows CQC's total indicative budget broken down by grant-in-aid for non-recoverable services and provider fees over the four years of the Spending Review (2016/17 to 2019/20). This is in line with the indicative budget negotiated with the Department of Health. The indicative budget is further broken down by sector in Appendix 1 with actual figures shown for 2015/16 and indicative figures for 2016/17 to 2019/20.

13. Further details of the impact of the Spending Review on CQC are provided in paragraphs 23-25.

Response to increasing fees

14. We asked three questions in our consultation. The first and second, regarding options for achieving full chargeable cost recovery over two or four years respectively, impact on all providers except for the dental sector. The third question impacts only on dental providers which had already reached full chargeable cost recovery. The overwhelming majority of responses to the first two questions confined their views to these two proposals and expressed a preference for the second of these two options.

15. The responses were broadly grouped around three issues:
    - Serious concern at the scale of the increases, irrespective of the options for their implementation, and corresponding concern about their impact on quality of care and sustainability of services.
    - The timing of our fee proposals against the consultation on our five year strategy and the Department of Health's parallel consultation to extend our fee-setting powers through new regulations.
    - Positive comments and criticism about CQC's effectiveness, efficiency and value for money.

16. Greater detail is provided in the consultation response document and the detailed report analysing responses, which are available on our website.

17. The two sectors furthest from full chargeable cost recovery are NHS GPs and the community social care sector. Their fees in 20161/7 would see the steepest increase of all sectors under a two year trajectory. We had full and detailed discussions with the Department of Health about the totality of all the responses we received. The Government has recently announced additional funding to cover the expense of the required increase to fees for NHS GPs in 2016/17, and we have agreed that the impact of increases for the community social care sector

should be mitigated by setting fees for 2016/17 in the context of those proposed under a four year trajectory.

18. Therefore, on this basis, we invited the consent of the Secretary of State to allow CQC to charge fees in 2016/17 based on the two year trajectory towards cost recovery for all providers except for community social care and dental providers. Given the absolute requirement on us to achieve full chargeable cost recovery, the significant gap in funding that would result from adopting a different option for 2016/17, and the impact that would have on delivering our statutory responsibilities in regulating health and social care services, the outcome is that, from 1 April 2016, we will:
    - Set fees for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option,
    - Set fees for community social care providers at the levels set out in our consultation under the four year timescale option, and
    - Hold the current fee levels for dental providers at those set out in the 2015/16 fee scheme.

19. Looking at CQC's costs within the wider context of health and social care costs more generally, the overall indicative CQC budget is around 0.19% of the total amount spent on Health and Social Care in England. While this figure is not intended to diminish the importance with which any rises in fees are regarded by individual providers, it does demonstrate that the total amount spent on regulation is proportionately small. Individual fees are, for the majority, no more than 1% of a provider's turnover and in instances where a provider pays tax, then fees are tax allowable, so the differential rate of taxation, whether for a sole trader, partnership or company, will reduce that proportion further.

20. The launch in 2015 of a payment by instalments scheme has helped providers to manage the payment of fees in a way that does not impact cash flow as severely as a one-off payment does.

Strategy, Spending Review and cost improvement

A) Introduction

21. We are required by government to move to full chargeable cost recovery and have previously avoided such significant changes to fees while we embedded our approach to regulation. A number of providers have argued that we should wait until this is embedded before looking at how we move to full cost recovery for our regulation.

    We believe that identifying the budgetary constraints at an early stage helped focus and inform the strategy.

B) Strategy

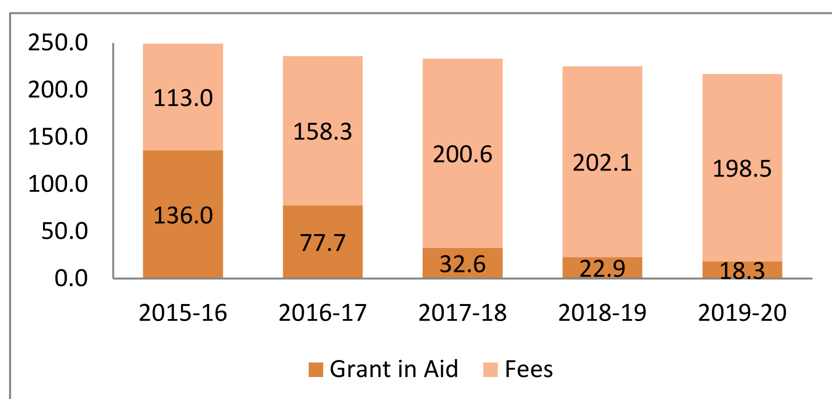
22. *CQC's strategy 2016 to 2021 shaping the future: consultation document* describes how we intend to deliver our vision with reduced resources by being more efficient and effective. We intend to improve the efficiency of our inspections and registration approach as we improve our use of intelligence, and our underlying systems and processes. As we develop our plans, we will set out what this means for the costs of inspection.

C) Spending Review

23. During 2015 the government's Spending Review resulted in significant reductions in funding to the public sector and CQC is no exception in having to make savings. CQC is required to achieve at least £32 million in savings over the four years of the Spending Review. This equates to about 13% of the indicative CQC budget over the next four years. We have modelled the impact of this and identified indicative budget levels for the remaining four years reducing the overall indicative budget to £217 million in 2019/20.

24. Table 1 shows graphically the impact of the Spending Review on CQC's indicative budget as submitted to the Department of Health. It also estimates the ratio of grant-in-aid and fees over each of the next four years with fees achieving full chargeable cost recovery by 2017/18 and overall indicative budgets going down to £217 million by 2019/20. Appendix 1 shows the estimated impact of the Spending Review on the sectors for the years 2015/16 to 2016/17.

Table 1: Graph showing ratio of grant-in-aid and fees for the period 2015/16 to 2019/20. Fees achieve full chargeable cost recovery by 2017/18 for all sectors and overall budgets go down to £217 million by 2019/20. Note the figures for 2016/17 and beyond are indicative only



25. The fees for 2016/17 are the same as those presented in the draft consultation document and they are in line with the indicative Spending Review budget provided to the Department of Health. 2017/18 to 2019/20 figures are lower than presented in the draft consultation document as they now reflect the settlement submitted following the Spending Review set out in table 1.

D) Cost improvement

26. The strategy identifies that although we have introduced fundamental changes to our model of regulation over the past three years, many of the supporting processes and systems we use need to be more efficient. We believe we can make significant savings over the next five years by improving these processes and systems, including greater use of new technologies to help us identify and reduce waste and duplication, and to standardise our core activities. The strategy document provides examples of these technologies such as the CQC provider portal, national resource planning tool, CQC website developments, IT infrastructure, and data analysis tools.

27. A cost improvement programme is also being introduced to CQC. This will ensure that both recurrent and non-recurrent savings are identified. The programme will focus on realising significant savings through commercial strategies, and then moving into efficiencies in the way in which we deliver inspection in years two to four of the Spending Review. Work has already begun in some areas of the organisation to modernise ways of working and, as we do so, there will be structural changes to help release costs from the organisation. We expect that we will be doing much more of this in the next period covered by the strategy.

28. Fees for years beyond 2016/17 are indicative and are based on our current understanding of costs. They will change as a result of the implementation of the CQC strategy with the various initiatives and system improvements described, as well as our improved understanding of costs. Despite this, it is important that we map out what the future is likely to look like, while acknowledging that the actual figures for future years may vary either because of changes to costs or as a result of any changes made to the fees scheme in future years.

Impact on providers

29. The consultation responses highlighted the financial difficulties that providers face, ranging from frozen or reducing income to increasing staff costs (such as the impact of the introduction of the Living Wage and increases in national insurance). The consultation response document and analysis report provides detail on this. These are available on our website.

30. Table 2 shows the actual fees for 2015/16 and the indicative increases for 2016/17.

Table 2: Indicative fees increases for 2016/17

	2015/16 actual fee (£m)	**2016/17 indicative increase (£m)**
NHS trusts	21.9	16.4
Independent healthcare - hospitals	4.0	0.5
Independent healthcare - single specialty	1.2	0.0

Independent healthcare - community	3.8	0.2
Adult social care - residential	60.5	7.3
Adult social care - community	7.5	5.4
NHS GPs	6.0	15.3
Dentists	8.3	0.0
	113.2	**45.1**

We considered our proposed fees against the estimated value of each market sector (Table 3). As we have stated before, our fees will represent 0.12% of overall indicative turnover of the health and social care market although this varies between sectors. We will review the impact on each sector in turn.

31. The proposed fees for the NHS trust sector corresponds to a very small part (0.04%) of typical turnover and such small comparative increases do not impact the sector disproportionately. The cost of regulation for this sector is the lowest percentage of indicative turnover but, as described in Appendix 3, fees are based on the underlying costs of regulation.

32. The independent sector is a small and varied one consisting of hospitals, community and single specialty providers, and we are conscious that because of this our modelled costs could be more sensitive to change than larger sectors. We are implementing a small overall increase for this sector and an average fee of 0.18% of turnover. Within this, we feel that 'independent healthcare - single specialty' is particularly vulnerable to the apportionment of indirect costs and overheads, as this group consists of a few smaller providers and so we have decided to leave their fees at 2015/16 values.

33. The fees for dental providers will be held at their current rate as under the current model the chargeable costs for this sector are at full cost recovery. Those costs will remain the same during 2016/17 and the costs of regulating this sector are expected to fall after that.

34. The fee for 'adult social care – residential' providers will be 0.45% of average indicative turnover. This sector has been at a higher level of recovery than all other sectors for a period of time, so the increases are in line with this position.

35. The fee for 'adult social care - community' providers will represent 0.29% of average indicative turnover of their sector. As noted in the draft regulatory impact assessment, 'adult social care - community' costs are higher than previously identified due to a flaw in the former costing model, so the sector is at a lower rate of cost recovery than previously understood. Because of this, providers asked us to consider recommending a longer trajectory than other sectors. We have introduced a lower fee increase for community social care providers by implementing fee amounts in the context of those we proposed in our consultation under a four year trajectory.

36. The NHS GPs sector fee increase represents 0.23% of average turnover of their sector and they are furthest from full chargeable cost recovery.

Table 3: Impact of 2016/17 fees on provider sectors	**Value of market £m**	**% of FCCR**	**2016/17 fee**	**% of turnover**
NHS trusts	90,300	67%	38.3	0.04%
Independent healthcare - hospitals				
Independent healthcare - single specialty				
Independent healthcare - community	5,308	98%	9.7	0.18%
Adult social care - residential	14,901	96%	67.8	0.45%
Adult social care - community	4,500	44%	12.9	0.29%
NHS GPs	9,100	56%	21.3	0.23%
Dentists	5,730		8.3	0.14%
Total indicative value of market (£m)	**129,839**		**158.3**	**0.12%**

FCCR: full chargeable cost recovery

See Appendix 2 for reference data

37. The decision is to charge fees in 2016/17 fees in the context of those we proposed under the two year trajectory towards full chargeable cost recovery for all providers except for community social care and dental providers. This option provides a balance in our funding that fulfils government policy and also allows us to safeguard our position as an independent regulator of the health and adult social care sectors by allowing us to implement our strategy and our new model of regulation in full in a timely way. This would mean greater responsiveness to providers and continued assurance to users, their carers and the general public of the quality of services provided by regulated providers.

38. We will ensure that we remain accountable to providers and the public for how we use our income, and demonstrate that our judgements are independent and we are fair, efficient, effective and proportionate. In this context we estimate that the current indicative budget for CQC is approximately 0.19% of the overall spending on health and social care in England and we estimate it will reduce to 0.17% by 2021 using the current market valuation.

Developing the fees scheme

39. Over the last few years the fees scheme has, by necessity, concentrated on two key areas: accommodating sectors new to regulation into the scheme and addressing the requirement to move to full chargeable cost recovery. During this time we have obtained a growing understanding of how sectors are structured and the factors that contribute towards determining the size of individual providers.

40. We need to undertake a review of our fees structure for each area so that our bandings and measures better reflect each sector. Providers have made comments about this and we have responded in some areas where the structure has been particularly unreasonable.

41. Feedback from the consultation suggested that some of the bands were too wide or the fee increases from one band to the next too large. It was suggested that the boundaries were arbitrary or unfair, with some reasoning that practices would limit their patient numbers to remain in a more advantageous band. Fees based on a provider's number of locations were questioned as some felt that the number of locations was not synonymous to size. Some felt that it would be fairer if charges reflected providers' size measured in numbers of clients, numbers of beds or hours of care delivered. Others thought the most appropriate measure would be providers' number of employees, turnover or profit. There were a few calls for a fixed, basic fee for small providers, which could be accompanied by additional fee bands for medium-sized and large providers. A few respondents suggested a cap on the total fee based on a (small) percentage of a provider's turnover.

42. From next year we will undertake a systematic review taking into account the above points and provider comments.

Final decision

43. Set fees for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option.

44. Set fees for community social care providers at the levels set out in our consultation under the four year timescale option.

45. Hold the current fee levels for dental providers at those set out in the 2015/16 fee scheme. The 2016/17 fee band tables can be found in the published fee scheme.

Appendix 1: Grant-in-aid and Fees by sector for 2015/16 and 2016/17

	2015-16					2016-17			
	GIA	Fees	Total	% FCCR		GIA	Fees	Total	% FCCR
	£'M	£'M	£'M			£'M	£'M	£'M	
NHS Trusts	38.1	21.9	60.0	36%		18.3	38.3	56.6	67%
Independent healthcare - hospitals	0.9	4.0	4.9	81%		0.2	4.5	4.7	96%
Independent healthcare - single specialty	0.1	1.2	1.3	90%		0.1	1.2	1.3	96%
Independent healthcare - community	0.5	3.8	4.3	88%		0.1	4.0	4.1	98%
Adult social care-residential	14.1	60.5	74.6	81%		2.6	67.8	70.3	96%
Adult social care-community	23.7	7.5	31.2	24%		16.5	12.9	29.4	44%
NHS GPs	33.8	6.0	39.8	15%		16.3	21.3	37.6	56%
Dentists	0.0	8.3	7.0	119%		0.0	8.3	8.3	119%
Total indicative budget for chargeable work	**111.2**	**113.2**	**224.4**	50%		**54.0**	**158.3**	**212.2**	75%
Non-Chargeable Work	24.9	0.0	24.9			23.8		23.8	
Total indicative budget	**136.1**	**113.2**	**249.3**	**45%**		**77.7**	**158.3**	**236.0**	**67%**

Key:
FCCR = Full chargeable cost recovery
GIA = Grant-in-aid

Note on accounting treatment of figures:
Fees in this document are shown on an invoiced basis as this reflects the actual impact on the health and social care sectors. We report fees on an accruals basis to the Department of Health. This means that we estimate reported income for next year will be £7 million lower than the invoiced total. The total indicative budget shown represents the budget that we expect to be our total cost target. Therefore grant-in-aid represents the balancing figure and will be £7 million higher than shown through the impact assessment.

Appendix 2: References

	Value of market £m	Information source
NHS trusts	90,300	http://www.health.org.uk/sites/default/files/APerfectStorm.pdf page 9: Figure 1.1: Resource spending in real terms in England, 2014/15
Independent healthcare - hospitals		Commission on the Future of Health and Social Care in England The UK private health market and https://www.laingbuisson.co.uk/MediaCentre/PressReleases/PrivateAcute.aspx
Independent healthcare - single specialty		
Independent healthcare - community	5,308	
Adult social care - residential	14,901	Laing and Buisson Care of Older People 27th Ed. (2014/15).
Adult social care-community	4,500	Laing and Buisson Domiciliary Care UK market report 2013
NHS GPs	9,100	http://www.health.org.uk/sites/default/files/APerfectStorm.pdf page 9: Figure 1.1: Resource spending in real terms in England, 2014/15
Dentists	5,730	Dentistry An OFT market study 01/05/2012
Total indicative value of market (£m)	**129,839**	

Appendix 3: Costing methodology and development of the costing model

1. Our costs are divided into direct costs, indirect costs and overheads. Direct costs result from activity directly related to our inspection activity and can be allocated at provider level (though we rarely do that). Indirect costs result from activities that can be apportioned to a particular sector, but cannot be allocated to specific providers. Overheads cannot be allocated to specific sectors and so have to be apportioned using appropriate measures (as an example, IT costs would be apportioned on headcount as these costs are generally "driven" by the activities of staff). The costs for all sectors are made up of these three costs.

2. These costs are distributed using a relatively simple approach. Overheads are first apportioned to indirect and direct costs using the drivers as discussed above. This includes those costs that relate to our non-regulatory functions. Some of these costs do not attract indirect costs.

3. The next step is to allocate the indirect costs, with their share of overheads, using specific indicators which allocate them to the relevant inspection directorates. As an example, a team that develops policy for hospital regulation will be allocated exclusively to the Hospital Directorate.

4. This gives us a fully absorbed cost for each of the inspection directorates. Knowledge of our model of regulation, backed up with data collected from timesheets (or the national resource planning tool, once it is implemented) provides the detail that allows us to allocate costs to each category of fees. This provides the total chargeable cost for each sector, as well as the cost of non-regulatory and non-chargeable activity.

5. The model began as a relatively simple model which provided high level sector costs and this has been used as the basis for the fees consultation. Significant further work and development has been undertaken in the last six months and a more detailed granular model has evolved. The assumptions and outputs from the model have been rigorously tested, and continue to be reviewed by directorates on a quarterly basis in line with the refreshing of the data and the approach refined in order to ensure that the model is as accurate a representation of the underlying costs as possible. This process ensures we have a good model that is able to monitor both our performance and value for money. With improved efficiencies and predicted changes in CQC strategy, future years' budgets and forecasts will be used in a version of the model to monitor expected activity costs for future years. This will assist in modelling future years' fee projections as well as business planning. Additional development will include reporting costs regionally, allowing Directorates to identify high performing regions and benchmark performance within other regions.

6. There are various methods that could be have been used to calculate fees using these fully absorbed costs. We have positioned fees as a charge for entering and remaining in a regulated market. There is a range of ways we could have charged providers, from the simplest where every provider pays the same fee, to the most complicated and bureaucratic approach which could be a fee based on

the exact resources utilised by each provider. We have taken a more nuanced approach where we have characterised providers and grouped them into sectors which are of similar size and complexity and which are regulated in similar ways. Within these sectors we have tried to band providers for fee charging purposes in ways that reflect the characteristics of that particular market combined with ease of collecting the required data. We have tried to charge appropriately to their size. We believe that this balances fairness with ease of implementation. It recognises that different methodologies, and hence different costs, do apply to different sectors.

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Care Quality Commission

Care Quality Commission: Equality and human rights duties impact analysis (decision making and policies)

Equality Act 2010
Human Rights Act 1998

1.

Identifying Name (name of project, policy, work, or decision)	2016/17 Provider fees consultation
Intended outcomes (include outline of objectives or aims)	Enables CQC to recover fees to meet the costs of its regulatory activity and functions that are not covered through grant in aid from the Department of Health. A revised scheme of fees will take legal effect from 1 April 2016.
Who will be affected? (People who use services, CQC staff, the wider community)	All registered providers.

2.

• Does the work affect people who use services, employees or the wider community? (This is not only refers to the number of those affected but also by the significance of the impact on them)	Possibly, but unquantifiably
• Is it a major piece of work, significantly affecting how functions are delivered?	No
• Will it have a significant effect on how other organisations deliver their functions in terms of equality or human rights?	No
• Does it relate to functions that previous engagement has identified as being important to particular protected groups or human rights?	No
• Does or could it affect different protected groups differently?	No
• Does it relate to an area with known inequalities or breaches of human rights?	No
• Does it relate to an area where equality objectives have been set by CQC?	No
• Does or could it impact upon personal privacy? For example by: • Using personal data (information about identifiable individuals) in new or significantly changed ways, or for new purposes. • Collecting new identifiers (i.e. information which identifies people, such as name, D.O.B., NHS number, postcode etc). • Combining anonymised data sources in such a way as to risk identifying individuals? • Disclosure or publication of personal data or identifiers. • New or additional information technologies with substantial potential for privacy intrusion (e.g. surveillance, image or video recording of individuals, tracking or monitoring of individual). • Observing or monitoring with potential for privacy intrusion (e.g. observing intimate personal care).	No

If the work does or could impact upon personal privacy, explain how (for example: what additional information is being collected, used or shared?) If there is no anticipated impact upon personal privacy, skip this box and continue below.

3.

Do the answers above indicate that this work is relevant to equality or human rights? If yes skip this box and continue below. If no, document the reasons below and forward this EHRDIA to the EDHR team for sign-off
Government policy requires fee-setting bodies to recover the costs of their chargeable regulatory activity from fees from providers rather than from grant-in-aid from the Department of Health. CQC's fees scheme for 2016/17 is designed to further CQC's progress in achieving that requirement. The changes to the scheme affect all sectors except for dental providers who are already at cost recovery and whose fees will remain at 2015/16 levels in 2016/17. A response to the consultation questioned our draft equality and human rights duties impact analysis, published alongside our consultation in November 2015. Our assessment set out that the fees consultation and its proposals had no direct impact on equality or human rights. A representative organisation suggested in its consultation response that the equality impact assessment should have analysed the providers most adversely affected by the proposals and the demographic make-up of the populations they serve to determine whether the proposals might discriminate against any of the people who use those services. The comment above was made in the context of an increase in fees having the potential to force services to close. The complexity of provider cost structures, and the relatively small impact of CQC fees (typically no more than 1% of turnover), means this is unquantifiable as a direct causative factor. Having reviewed the EHRDIA, we consider that the fees scheme does not directly affect any of the characteristics protected in the Equality Act (age, disability, gender, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion and belief, and sexual orientation), or privacy. This policy has the potential to interfere with the right to possession of property under article 1 of protocol 1 because it makes changes to the fees that providers are obligated to pay. In changing the fee providers are required to pay, there is the potential for the loss of property to result. However, CQC has concluded that the changes to the fees are necessary, proportionate and justified under the ECHR and HRA. In particular, a key government policy is for government arms-length bodies to recover the costs of their chargeable regulatory activities from fees from providers rather than from grant in aid. CQC is therefore justified in taking steps to make changes to the fees it charges providers to offset its reliance on grant in aid.

4.

Analysis Considering the evidence and engagement activity, set out below the actual or likely effect of the policy, project or work under the Human Rights Act or each of the general duties of the Equality Act. CQC must have due regard to the general duties in the exercise of all of its functions	
Effect on compliance with Human Rights Act 1998	This policy has the potential to interfere with the right to possession of property under article 1 of protocol 1 because it makes changes to the fees that providers are obligated to pay. In changing the fee providers are required to pay, there is the potential for the loss of property to result. However, CQC has concluded that the changes to the fees are necessary, proportionate and justified under the ECHR and HRA. In particular, a key government policy is for government arms length bodies to recover the costs of their chargeable regulatory activities from fees from providers rather than from grant in aid. CQC is therefore justified in taking steps to make changes to the fees it charges providers to offset its reliance on grant in aid.

Signed off by:
Executive Director of Strategy and Intelligence, 23 March 2016
Equality, Diversity and Human Rights Manager, 23 March 2016

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Leeds Community Healthcare NHS Trust

AGENDA ITEM
2015-16
(117)

Report to: Trust Board
Date of meeting: 31 March 2016
Report title: Chief Executive's Report
Responsible Director: Chief Executive
Report author: Chief Executive
Previously considered by: n/a

EXECUTIVE SUMMARY

This report sets out the context in which the Trust works and helps to frame the Board papers. In particular, this month's report focuses on a number of developments covered in more depth by Board discussions on later items, namely:

- Service and business developments
- Winter pressures and the impact on services
- Patient safety and 'learning from mistakes'
- Staffing matters including junior doctors industrial action and actions to support equality and diversity in the workforce
- Non-executive director appointments

A further verbal update will be provided at the Board meeting.

RECOMMENDATION

The Board is recommended to:

- Note the contents of this report

Links to Strategic Objectives:	This report supports the following strategic objectives: • To provide high quality, safe services, continuously improving patient experience and measuring our success in outcomes • To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home • To engage and empower our workforce, ensuring we recruit, retain and develop the best staff • To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money
Links to Principal Risks:	This report sets out a context that is relevant to each of the principal risks.
NHS Constitution:	The values of the NHS Constitution underpin service provision within the organisation: • Working together for patients • Respect and dignity • Commitment to quality of care • Compassion • Improving Lives • Everyone counts
CQC Outcomes:	Outcome 4: Care and welfare of people who use services • People should get safe and appropriate care that meets their needs and supports their rights. Outcome 6: Cooperating with other providers • People should get safe and coordinated care when they move between different services. Outcome 13: Staffing • There should be enough members of staff to keep people safe and meet their health and welfare needs.
Equality and Diversity:	An equality analysis screening form has not been completed because the report does not relate to a new or revised policy, strategy, project or service.
Sustainability Implications:	N/A
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act

1

1. Purpose of this report

1.1. This report sets out the context in which the Trust works and helps frame the Board papers. The paper describes a number of local developments and, in addition, refers to a small number of external or national announcements that have the potential to impact on the Trust.

2. Patient and public engagement in service re-locations

2.1. At its December 2015 meeting, the Board approved a paper which summarised the outcomes of patient and public engagement in proposals related to the disposition of a range of community services across the city. The proposals contained a number of changes and adjustments which together aimed to ensure a planned approach to the location of services. Furthermore, the changes involved the reduction to the number of locations from which some services are provided and a proposal to cease providing services in Garforth Clinic. A further update on implementation of the proposals was noted at the Board meeting held on 5 February 2016.

2.2. The City Council's Scrutiny Board (adult social services, public health and NHS) has been keen to engage with the consultation on the changes. On 16 October 2015, the proposed changes were presented to a working group of the Scrutiny Board; contributions were hears from the Trust, CCGs, Healthwatch, ward councillors and members of the working group. Notes from this meeting were shared with the Trust but no formal response from the Scrutiny Board was received by the Trust before the end of the public engagement period.

2.3. As part of ongoing engagement with the Scrutiny Board, the Trust had been invited to comment on a report produced by the Scrutiny Board in relation to the service changes. This has included a number of recommendations, including: presentation of a further report to the Scrutiny Board on actions relating to the outcome of the Trust's December 2015 conclusions on service changes; greater consideration of the potential implications of proposed changes during subsequent public engagement exercises and identification of a longer term vision for the future of community health services.

2.4. The Scrutiny Board's report is attached for Board members to view.

2.5. The Board should also note that, having approved the proposals in December 2015, the Trust has moved to implement the agreed changes.

2.6. To support the changes, a programme of communication with those patients and their families who may be affected by the changes is well underway and is a combination of direct communication with patients, notices within health centre locations and coverage within the media

3. Leeds Health and Care Partnership Executive Group

3.1. A group has been established, under the chairmanship of Tom Riordan, Chief Executive, Leeds City Council, which brings together the chief officers of all NHS organisations (providers and commissioners) and the key directors from the City Council. This group is now acting as the steering group and governance for the development of the city's sustainability and transformation plan which sits within the wider West Yorkshire sustainability and transformation plan.

3.2. The group has a simple aim to seek ways to work together in the most integrated way possible. All partner organisations as members of the group recognise the very real gap between resources available and the growing demands places on services and so the focus is on considering how to achieve maximum efficiency and effectiveness from the 'Leeds pound'. There are There are partnership successes on which to build: the single patient care record, the city as a national leader for children's safeguarding and management of waiting times in accident and emergency care.

3.3. Success will be tested against the key superordinate goals for the Leeds care system including: providing care closer to home and making the best use of the Leeds pound.

4. Health and social care across Leeds: winter pressures

4.1. The Trust has continued to play an active role in the system resilience arrangements to ensure the continuity of services across the winter period. As spring approaches it is worth noting that:

- The Trust had secured funding for a number of schemes aimed at assisting services to be more resilient through the difficult winter months; the funding for most of these schemes however is not to be continued in 2016/17. Due to the non-recurrent nature of the funding, agency staff had been employed into these services and as a result schemes can be closed without legacy costs; however the impact to the system has been clearly articulated. Exit plans are now in train. The funding for additional therapy in care homes has been continued but is dependent on demonstration of activity over and above that detailed in the core contract – this will create a challenge for the service as the scheme has been in place for a number of years and the associated activity has therefore been included in the baseline. Work with the service is ongoing.

- In 2015/16 a number of "resilience" schemes were also funded through the Better Care Fund; again notice has been given on these schemes and exit strategies are now being prepared. The cessation of these three schemes will have a significant impact on system flow.

- At the end of February 2016, there had been a steady but significant decrease in delayed transfers of care.

- Leeds Teaching Hospitals NHS Trust has continued to experience higher than average levels of activity over recent weeks including accident and emergency attendances and emergency medical admissions. The Trust's approach to partnership working is assisting in mitigating the impact of potential unnecessary admissions and delayed discharges from hospital care.

5. **Patient safety: avoiding clinical risk**

5.1. NHS Improvement has published its first Learning from Mistakes League Table in March 2016. The table ranks each trust alongside other providers based on scores from three key findings in the staff survey relevant to reporting and learning, namely:

- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Staff confidence and security in reporting unsafe clinical practice
- Staff ability to contribute to improvements at work

5.2. The ranking was then adjusted for other negative indicators and then categorised as follows:

- Outstanding levels of openness and transparency
- Good levels of openness and transparency
- Significant concerns about openness and transparency
- Poor reporting culture

5.3. The Trust is ranked 150 (out of a total of 230) and has been located in the third category as having significant concerns.

5.4. The Trust is very concerned to see the Trust's ranking in this league table as the Trust is fully committed to open, transparent and safe clinical practice across all the Trust's services. The Trust had already noted the relatively low ranking in the staff survey on these key questions and had started a process to understand why this might be the case. The Executive Director of Nursing and Executive Medical Director will be leading this work and the process of understanding, action planning and change will be overseen by the Quality Committee.

5.5. In further developments, there is an indication that NHS Improvement will ask trusts to publish a *Charter on Openness and Transparency*. And, in a further step, on 7 March 2016, the CQC published a guide for trusts on establishing a *Freedom to Speak Up Guardian* to facilitate arrangements for people to feel able to raise concerns. The Trust is working through a process for appointing a *Freedom to Speak Up Guardian*.

6. **Reductions in public health spending**

6.1. At previous meetings, the Board has been advised of the reduction in public health spending by public health commissioners. As a community provider, this Trust has provided a range of services funded in this way for example

smoking cessation or healthy schools initiatives. The reduction in funding will reduce the Trust's ability to provide these services and to tackle these important healthcare issues.

6.2. Community providers across the country are similarly affected and the community chief executives' network has recently written to Simon Stevens, Chief Executive, NHS England and Jim Mackey, Chief Executive, NHS Improvement to express the concern felt across the community healthcare sector. The letter, which articulates the consequences for the sector and for local populations will be shared with Board members.

7. Junior doctors' industrial action

7.1. As reported previously, following a ballot of its members, the British Medical Association (BMA) announced that its junior doctor members would engage in industrial action in January and February 2016.

7.2. The BMA has now indicated three further periods of industrial action each lasting 48 hours as follows:

- 9 March 2016 to 11 March 2016
- 6 April 2016 to 8 April 2016
- 26 April 2016 to 28 April 2016

7.3. The planned action is in response to a trade dispute in respect of the proposed imposition of new terms and conditions of employment for doctors in training.

7.4. The Trust has only nine doctors in training who have been contacted to determine their intentions in order to facilitate business continuity planning. The Executive Medical Director and clinical leads coordinated business continuity plans to manage the potential for impact on services with the aim of safeguarding services to patients. Locally, discussions are held with local BMA representatives through the Joint Negotiating Committee. Luckily, the action has and will continue to have very limited impact on the provision of services.

8. Equality and diversity

8.1. At its December 2015 meeting, the Board agreed a refreshed strategic approach to matters of equality and diversity. One aspect of this related to the national workforce race equality standard. This challenges trusts to move towards a more comprehensive race equality strategy which would include an expectation to build a more diverse Board and representative senior leadership. There is under-representation of minority groups at the most senior levels in the Trust.

8.2. To broaden the engagement on this important issue, a workshop was held on 10 March 2016. The workshop was open to any member of staff from a black or minority ethnic (BME) background at pay band six or above; over 30 individuals attended the event which was facilitated by the Chief Executive

and the Patient Experience and Inclusion Manager. The Chair attended.

8.3. A number of action areas emerged from the workshop, including:

- Promoting the profile of positive role models by highlighting stories and images of success
- Establishing a supportive network of and for people from BME backgrounds
- Bespoke support and development for staff from BME backgrounds who want to develop their careers
- Creating a culture that is open and welcoming so that staff feel able to ask for support that they need
- Training and support on diversity issues and unconscious bias to front line managers
- Intervening as necessary; going out and seeing patients and clients who are racist or who harass staff.

8.4. A second meeting has been arranged for October to follow up actions.

8.5. Two workshops have been convened for staff who identify as having a disability so that views from those staff, based on experience of working for the Trust, can be heard and factored into future actions. These meetings are in May.

9. Board membership: non-executive director recruitment

9.1. At its last meeting, the Board noted that, with regret, two non-executive directors were stepping down from the Board as at 31 March 2016. Robert Lloyd and Ieuan Ellis have made considerable contributions to the Trust and will be greatly missed.

9.2. A national recruitment campaign was run in January 2016. The campaign engendered a large number of candidates from whom a strong shortlist was drawn. The Chair, Neil Franklin, led an interview process from which two impressive candidates were identified as preferred candidates.

9.3. The NHS Trust Development Authority, as the body with the role of appointing non-executive directors to NHS trusts, has now confirmed the two appointments. The successful candidates are:

- ***Richard Gladman.*** Richard works for Deloitte as a director in their consulting health leadership team. He has specialised in defining and delivering complex IT enabled change programmes within large government organisations As a leader in the Deloitte Health Technology group he has worked with several large NHS trusts. He is a CIMA qualified accountant.

- ***Elaine Taylor-Whilde.*** Elaine is an experienced clinician (physiotherapist) and senior manager with health sector experience gained over 30 years in the public, private and third sector. Elaine is currently the Chief Executive Officer of Nine Health Community Interest

Company (CIC), set up to accelerate technology uptake within health and related sectors for public and patient benefit.

9.4. Both appointees take up their roles on 1 April 2016.

10. NHS Trust Development Authority (TDA): Board compliance statements and Monitor's licence conditions

10.1. It was noted at the 5 February 2016 Board meeting that boards are no longer required to review and sign a statement about compliance in relation to Monitor's licence conditions and TDA board statements.

10.2. For completeness, the Board should note that there was one outstanding action which related to improving information about services on NHS Choices, a key website for accessing information about local health services. The information about some services provided in many sites across the city, was limited and therefore misleading. The Trust has now agreed a process with a third party provider for updating service information. Following the launch of the refreshed Trust website in April 2016, for all services provided by the Trust, the NHS Choices website will signpost back to the Trust's website. This will ensure consistency and control of information relating to services. IT is anticipated that this will be completed by the end of June 2016.

11. Establishment of NHS Improvement

11.1. This body, responsible for overseeing NHS trusts, foundation trusts and independent providers replaces the former regulatory bodies NHS Trust Development Authority and Monitor was launched in February 2016. Key priorities are around the financial and operational challenges and returning the sector to stability. Clinical expertise is at the heart of the work of the organisation.

11.2. Over the coming months NHS Improvement will publish a series of 'roadmaps' to take forward the *Five Year Forward View.*

11.3. In February 2016, *The Five Year Forward View for Mental Health* was published and sets out a new five year strategy for mental health. The five year forward look at maternity services has also been published by the National Maternity Review.

11.4. The newly-formed Board of NHS Improvement met for the first time at the end of February 2016. As part of its agenda it reviewed the performance of the provider sector and noted sustained operational and financial challenges in quarter three of 2015/16. Collectively, providers were £2.26 billion in deficit but had achieved £741 million in efficiency savings. Rising demand, especially for urgent and emergency care coupled with an increase in agency costs had adversely impacted on the sector.

11.5. In looking forward to 2016/17, the Board noted the role for providers to develop affordable patient activity plans, quality improvement plans and

workforce plans as means to returning the system to aggregate financial balance, achieving access and referral to treatment standards and sustaining quality.

11.6. Sustainability and transformation plans (STPs) are to be developed by local health and social care communities for the period 2016/17 to 2020/21. NHS Improvement is looking for these to move substantially towards the introduction of new care models. The Trust will be utilising its Board workshop in July 2016 to consider the Leeds plan.

12. EU referendum

12.1. There will be an extended purdah in the run up to the EU referendum on Thursday 23 June 2016. Purdah will begin on Friday 15 April 2016 and end once the results have been announced, which in effect means late on Friday 24 June 2016. Local council elections on 6 May 2016 will also be affected. Clearly it is not appropriate to alter Board business for the period, nor is much that concerns the Board likely to have any bearing on the outcome of the referendum or local elections

12.2. The general principles that apply in a pre-election period are:

- the NHS should remain politically impartial at all times; staff should not engage in activities which are likely to call into question the political impartiality of their organisation, or which could give rise to criticism that public resources are being used for party political purposes
- NHS business should proceed as normal with no disruption to patient services; but as issues relating to the NHS tend to be high profile, and may attract far greater scrutiny in a pre-election period than would otherwise be the case, special care is needed to avoid issues of propriety or party political controversy.

13. Recommendation

13.1. The Board is recommended to note this report.

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Leeds Community Healthcare NHS
NHS Trust

REPORT TO SCRUTINY BOARD (ADULT SOCIAL SERVICE, PUBLIC HEALTH, NHS)

PURPOSE OF THIS REPORT

The purpose of the report is to provide Scrutiny Board with an update from Leeds Community Healthcare NHS Trust on progress made against actions identified by the Care Quality Commission during an inspection of the Trust in November 2014. This includes progress against compliance and improvement actions.

CQC RATINGS

The following table outlines the conclusions of the Care Quality Commission (CQC) inspection team in November 2014. Progress against the action plan written in response is tracked on a monthly basis by the Trust's Senior Management Team and Quality Committee.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Adults – long term conditions	Requires improvement	Good	Good	Good	Good	**Good**
Children's and Family services	Good	Good	Good	Good	Good	**Good**
Inpatient services	Requires improvement	Requires improvement	Good	Requires improvement	Good	**Requires improvement**
CAMHS - IP	Requires improvement	Good	Good	Good	Good	**Good**
CAMHS - OP	Requires improvement	Good	Good	Requires improvement	Good	**Requires improvement**
Dental	Good	Good	Good	Good	Good	**Good**
Overall	**Requires improvement**	**Good**	**Good**	**Requires improvement**	**Good**	***Requires improvement***

CQC COMPLIANCE ACTIONS

The CQC set out two compliance actions (must-do's) which both relate to the safe domain:

- CAMHS - *ensuring risk assessments are recorded on electronic records*. This was promptly actioned and is monitored on an ongoing basis

- CAMHS in-patient service - *ensuring effective risk assessment of the physical environment, having a clear timescale for moving to new premises and improving the present premises pending whilst waiting for the move*. Risk assessment processes on the Unit have been strengthened and ligature risks minimised. The Trust is actively working up proposals for alternative premises in Leeds for this service and has two favoured options at present, both utilising existing buildings owned or leased by the public sector. NHS England, as the commissioner of the service, is fully aware of the position. At the time of writing this report the Trust is still awaiting the invitation to tender documentation for service provision effective from 1 April 2017.

CQC IMPROVEMENT ACTIONS

Progress in addressing improvement actions / recommendations (should-do's) is as follows:

Adult services

- *Ensuring safe staffing levels in community teams*. Staffing levels in the Neighbourhood Teams have improved significantly as a result of a highly successful recruitment campaign in the summer. Another key focus is the re-organisation of the Twilight service to ensure appropriate, safe staffing levels 6-10pm: this will be complete by the end of May 2016. Systems for monitoring daily capacity and demand and escalation based on recognised Resource Escalation Action Plan (REAP) levels have been strengthened. The Trust is investing in an e-rostering system which will improve efficiency of staff allocation

- *Ensuring safe medicines transcribing processes in place.* The Trust has recruited pharmacy technicians to transcribe so that nurses only need to do so in exceptional circumstances. This will be consistent with national guidance.

South Leeds Independence Centre (SLIC)

- *Ensuring staffing levels and skill mix are suitable for staff to effectively provide the necessary support to patients.* The service model has been agreed with commissioners and is being adhered to. The service has developed a patient dependency tool to inform admission decisions and ensure the service is able to meet the needs of patients. Service leadership has been strengthened and agency usage reduced

- *Strengthening assessment and care planning processes.* Care planning, including discharge planning, and evaluation have been strengthened and are now timely. The combined effect of this since December 2015 has been a significant reduction in the average length of stay

- Other improvement actions have been addressed relating to management of equipment, ensuring access to emergency drugs, maintaining drug fridge temperatures; and completion of DNA CPR forms

CAMHS

- *Reducing waiting times*. The Trust and commissioners are assured that high risk patients are accessing the service quickly. Waiting times for consultation clinics have been reduced to 12 weeks and we are now focussing on reducing waiting times for internal onward referrals, starting with autism assessments

The Trust does not yet have a date for a re-inspection by the CQC. The CQC has advised that this will be dependent on any change in approach and prioritisation emerging from the CQC's recent consultation about its inspection approach. The Trust is working towards being ready for an inspection from early summer and is putting in place a programme of staff engagement, building on lessons learned from the initial inspection.

Thea Stein
Chief Executive
Leeds Community Healthcare NHS Trust
April 2016

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Scrutiny Board (Adult Social Services, Public Health, NHS)

19 April 2016

Leeds Teaching Hospitals NHS Trust Chief Executive's Report

Presented for:	Information and discussion
Presented by:	Suzanne Hinchliffe, Deputy Chief Executive and Chief Nurse
Author:	Julian Hartley, Chief Executive
Previous Committees:	NONE

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	✓
Seamless integrated care across organisational boundaries	✓
Financial sustainability	✓

Key points	
1. To provide an update on the actions and activity of the Chief Executive since the last Board meeting	Discussion and information

1. Reviewing 2015/16

The end of the 2015/16 financial year has been a good opportunity to reflect on Trust's achievements over the past 12 months, and to look forward to the year ahead.

The Trust begins 2016/17 with real cause for optimism. We are confident that we will meet the targets set out in our 2015/16 financial plan and at the same time, will continue to build on the improvements we are making to the quality of our services and the results of our staff survey to be the best for patient care.

From the outset, we must set any achievements in the context of an increasingly difficult period for the NHS. The last year has been one of the most challenging in its history and the pressures on the health and social care system have been felt across Leeds. At the Trust, our Emergency Care Standard (ECS) reflects the reality of these pressures, both for our staff and the patients who need our care. In 2014/15, we were one of few Trusts to meet the standard but this year we and other Trusts around the UK are finding it a challenge. We are currently seeing 93.3% of patients within four hours against a standard of 95%. Meeting the ECS is both a national and system-wide issue, and we are working across the Trust and with partners in Leeds to improve patient flow and resolve the challenges we are facing.

Despite this, the overall picture throughout the Trust is one of real improvement. Thanks to the dedication of our staff, we begin the next financial year with a plan to be marginally in surplus. We have also made huge strides in meeting our service targets and obligations to our patients. Since summer 2015 for example, we have consistently delivered on our 62 day cancer waiting times, have almost halved the number of cancelled operations not rebooked within 28 days from 132 to 69, are meeting the Referral to Treatment incomplete standard and have been successful in delivering the diagnostic target required for endoscopy JAG accreditation. All of this means faster, more efficient and better care for our patients.

The quality of our care continues to be our main priority. We have attracted national interest in our new patient safety huddles. These ward-based, short meetings identify patients at risk of deterioration and the appropriate actions to take. Other initiatives have resulted in a 30% reduction in 222 calls for urgent medical assistance on pilot wards, and again on pilot wards, a 20% decrease in falls. Our ward healthcheck has gone from strength to strength, achieving significant improvements in how we care for patients at ward level.

Our staff are undoubtedly the drivers of this strong and steady improvement. Across the Trust, they have embraced the theme of 'Knowing Our Business'; that is, providing excellent care in a way that gives the best value and experience for our patients.

This was ably demonstrated during the 10-week Going for Gold campaign at the end of the financial year. Trust-wide, staff shared examples of good practice, looking at areas where they could refine the way they work to make our services more efficient and cost-effective, delivering more for our patients. These included initiatives to make clinics run more smoothly, cutting down on waste in theatres and improvements to patient pathways in the CDU at LGI. These contributed not only to better patient care but also to a saving of £7 million by the end of March, the impact of which will be felt throughout our hospitals.

This culture of improvement is reflected in the NHS Trust Development Authority's decision to choose LTHT to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known at the Trust as the Leeds Improvement Method.
Launched in elected orthopaedics in Chapel Allerton, it has brought together staff with a range of skills and experience to review and adjust how they work to increase their efficiency and improve patients' experience of our care. It is already paying huge dividends, reducing waiting and theatre turnaround times. As we begin 2016, we will begin new workstreams in abdominal

medicine and surgery, critical care and outpatient services. Complementing this, we are one of the founding Trusts to be working with Lord Carter of Coles as part of his review of NHS productivity to spread the learning from this work.

It is rewarding to see the impact of our improvements becoming embedded in patient care, and the difference this is making to their perception of our service. The 2015/16 NHS Friends and Family Test gathered 87,500 views from patients, and of these 93% said they would recommend the Trust to their friends and family, an increase of 1.67% from the year before. The impact of our work to improve discharge processes has also started to make a difference and has resulted in a significant decrease in the numbers of patients reporting delays. In addition in 2015/16, new complaints have gone down by 23%.

The Trust's achievements around better patient care and commitment to positive change are increasingly attracting staff who want to be part of our team. Last year, we recruited more nurses, midwives and support staff. Overall, the number of colleagues increased from 15,840 in March 2015 to 16,532 in March 2016. We have substantially reduced the amount we spend on agency administrative staff, from £188,000 a week in 2014-15 to a weekly £31,000 in March 2016. These are savings that can be reinvested in patient care.

We are also delighted that we are the most improved Trust in the UK in the 2015 NHS Staff Survey. Findings have significantly improved in 13 key areas, including motivation at work, support from line managers and the number who feel able to contribute to improvements at work, showing that our staff are living the values of the Leeds Way. Ninety-five percent of our staff reported that they had an appraisal in the last 12 months, making the Trust the top performer nationally.

We value the opinion of all our staff, so we asked all Trust employees to share their views in the staff survey - more than half responded. We worked hard to ensure the voice of all our staff was heard and our success at reaching everyone can be seen in the completion rate of groups who are thought hard to reach, with more than 950 Estates and Facilities staff completing the survey. This, and the changes we have made to improve our appraisal system mean we have a reliable way to gauge staff opinion and can confidently build on their input to make the Trust an even better place to work. We know that a good working environment for staff means better care for patients.

Having colleagues around us with the drive and commitment to achieve the best for patients is of course, fundamental to the Trust's continuing success. Nowhere is the quality of our staff, and their commitment to excellence more evident than in the innovations and successes we report each year. Last year, among many other achievements, the Trust became a key partner in the Genomic Medical Centre for Yorkshire and Humber and one of only six centres in the UK to develop precision medicine. We are the only NHS-funded centre for hand and upper arm transplants following a UK-first operation in 2012. Our staff have also won numerous awards.

As the new financial year begins, we should be under no illusions that it will be a challenge. The Trust will need to embody the values of the Leeds Way in everything it does and continue to develop our organisation as a great place to work, delivering better quality care, excellent patient access and financial sustainability across every service.

We are in a good position to do this. We have the potential to be one of the best performing Trusts in the UK.

2. Junior Doctors' industrial action

In March and April, junior doctors across the NHS took industrial action in response to the on-going national dispute with Government about contract changes. This period of industrial action ran from 8am on Wednesday 9 March to 8am on Friday 11 March 2016 and from 8am on Wednesday 6 April to 8am Friday 8 April.

On the days of action, our emergency and urgent services continued as normal however, we were required to rearrange around 600 outpatient appointments and approximately 55 operations or day cases during each period of industrial action. I would like to thank everyone who helped the Trust to maintain the highest levels of care for our patients during this period.

A further period of industrial action is planned for Tuesday 26 to Thursday 28 April 2016 and during this action, emergency care will be withdrawn between 8am and 5pm on each day. This has not happened in any of the previous industrial action. This will obviously put additional pressure on services and impact on planned care. We are currently planning for this so we can ensure we maintain the safety of our patients during this period.

3. New planning guidance STP

We have continued to work closely with our partners in the development of a five year Sustainability and Transformation Plan (STP), driving the national Five Year Forward View; and a one year Operational Plan for 2016/17.

Arrangements for the development of our Trust one year operational plan are already in progress and our planning team is working closely with clinical service units, workforce and finance teams to produce this, a first draft has been submitted to the TDA with the final version due on 11th April.

The aim of STP is to bring about better health, transformed quality of care delivery, and sustainable finances. Every health and care system is being asked to come together, to create its own ambitious local blueprint for accelerating its implementation of the Five Year Forward View. These STPs will cover the period between October 2016 and March 2021. Since my last update, it has been agreed that we will also participate in the production of a complementary STP for West Yorkshire which will allow any regional issues to be addressed. It is felt that this approach will offer the greatest opportunity for transformational change.

4. CQC update

I updated in my last Board report that the Care Quality Commission (CQC) will be returning to the Trust to carry out an inspection of our services on 10 - 13 May.

We have been busy collating a range of background information for the CQC to enable them to complete their inspection and we are keen to take the opportunity of the visit to show them the wide range of improvements we have made across the Trust.

The CQC will make its inspection based on a number of criteria and give the Trust one of four ratings: outstanding, good, requires improvement or inadequate. Following our last inspection, the CQC rated us as 'requiring improvement', the rating given to the majority of hospitals inspected up until the end of May 2015.

Over the past 18 months, our staff have worked hard to make real improvements to the quality of patient care, safety and experience at the Trust and this year, we are aiming for 'good' to reflect the high standard of our staff, services and care. I am very proud of the work we do and have real faith in our staff. I'm looking forward to sharing the significant progress we have made with the CQC.

5. National Centre for Hand transplants

I am delighted to be able to announce that from April 2016 we have been selected by NHS England as the national centre for hand and upper arm transplants. This builds on the work of Professor Simon Kay and his team who successfully performed the UK's first hand transplant in 2012.

The team will work closely with NHS England and NHS Blood and Transplant to ensure the service can get fully up and running as soon as possible. NHS Blood and Transplant will identify possible donors for patients accepted for surgery. For the next five years, the Trust will also work in partnership with experts at Oxford University NHS Foundation Trust who will undertake assessments and the non-surgical elements of follow-up care for patients.

6. GS1 inventory management

I'm delighted that our Trust has been chosen as one of six sites across the country to be a demonstrator site for a 24-month programme to introduce new standards, called GS1 and PEPPOL, for inventory management and procurement within the NHS.

Every year, the NHS wastes an estimated £150 million by over-stocking on products that go out of date or perish. This is a huge sum and this new project will mean that every location, medicine, medical device and even patient will be identified using a unique barcode. This will make it easier to track the patient journey through our hospitals and ensure we only order the stock we need and which gives the best value. By 2020/21, all hospitals in the UK will be expected to use the system, so our early involvement is testament to the commitment of the e-Procurement team within Supplies.

7. Peer Review of Neonatal and Transitional Care

The Yorkshire & Humber Neonatal Operational Delivery Network carried out a peer review of our Neonatal and Transitional care services at the Leeds Children's Hospital in March. The initial feedback from the review panel on the day was extremely positive, with particular emphasis on the fact that we are one of the busiest services in the country with excellent standards of care and high levels of service innovation. The panel were particularly interested in our pioneering service developments around family integrated care and organ donation, as well as our award-winning outreach team.

No date has been confirmed for feedback, but it is likely in the next two months.

8. Listening and learning

- I visited the End of Life Care and Bereavement teams on Ward J28 at St James's. The team has developed the new Care after Death and Bereavement Policy and is explaining to staff across the Trust the changes which have been made and answering their questions. It was very interesting finding out about the sensitive work they do each day.
- I attended the Leeds Health and Wellbeing Board in February and, as the Chair of the Citywide Directors of Finance Group, presented a paper on the scale of the financial challenge facing health and social care partners across the city over the next few years. There's no doubt this challenge is significant, but as a group we are committed to taking collective responsibility for how we work together to create a health and social care system for Leeds that is fit for current and future generations.
- I visited the Risk Management team to meet the staff and learn more about the excellent work they have been doing to support CSUs and other departments in the management of incidents, investigations, claims and coroner's inquests. I was really interested to learn

more about their achievements, which include work on sharing learning from incidents to help us improve quality and safety and the care we provide to patients.

- Over the last couple of months I have been visiting a number of our support services in Estates and Facilities to understand more about what they do behind the scenes to keep out hospitals running. I had the opportunity to pack a meal for patients on J7 at the Receipt and Distribution Unit (RADU) at Seacroft Hospital, visited the porters and housekeeping staff at Chapel Allerton Hospital, visited our Transport Team who perform a vital service transporting food, medicines and samples, and met Children from the Trust's nurseries which are wonderful environments offering fantastic care.
- I welcomed Hilary Benn MP, Shadow Foreign Secretary and MP for Leeds Central to the Trust and took him to visit the teams working in the Emergency Department and CDU, the Acute Medical Assessment Area and the Primary Care Access Line at St James's. The Winter period has been particularly demanding for staff and Hilary was keen to hear more about what we are doing to meet these challenges and improve the experience for our patients. He was extremely impressed with the way staff are committed to finding ways of improving patient pathways and providing excellent care in difficult circumstances.
- I had the opportunity to spend some fascinating time with two teams in our Yorkshire Heart Centre, which showed quite different sides of the amazing care we provide for our patients. In the morning I shadowed Consultant Cardiothoracic Surgeon David O'Regan and his colleagues in theatre and then met with the Inherited Cardiovascular Conditions (ICC) team on a visit led by Consultant Cardiac Electrophysiologist Stephen Page.
- I am pleased to be one of the Chief Executives selected to be on the NHS Improvement CEO Advisory Group. At the first meeting last month, NHS Improvement's (NHSI) Chief Executive Jim Mackey took the opportunity to find out from a selected group of NHS CEOs what support the Trust and other NHS providers need from NHSI as we work towards achieving quality care for patients that is also financially sustainable. This was a really interesting meeting and a chance to discuss a range of issues, including performance and winter pressures.
- I accompanied Stuart Andrew, MP for Pudsey, Horsforth and Aireborough on a visit to our congenital heart team on Ward L51 and PICU in the Leeds Children's Hospital to hear about recent developments and our progress in meeting the service specifications set out in the NHS England congenital heart review. He was impressed by the progress made since his last visit. All our MPs in Leeds have been extremely supportive of the Trust over this issue and I am confident we are well on the way to ensuring our excellent service fully meets the new national requirements.
- I met some of the clinical and support teams involved in our response to the electrical supply difficulties in Clarendon Wing last month. Managing this incident required a great deal of commitment and cooperation from all staff involved and it is testament to our teamwork and robust systems that patient safety was not compromised and we continued to provide the highest quality care.
- I visited the brand new, state-of-the-art automated Pathology and WASP labs based in the Old Medical School at the LGI. It was a fantastic opportunity for the CSU to showcase some of the UK's leading technology which is only available here at LTHT. It was a real glimpse into the future of healthcare.
- I visited the new Leeds Sexual Health hub in the Merrion Centre, our most recent development in our city-wide partnership with Leeds Community Healthcare (LCH) and charity, Yorkshire MESMAC. Dr Amy Evans, Matron Robin Darby and Lead Nurse Peter Davis showed me around the hub, which is a fantastic purpose-built facility and combines many of the services formally provided in the Sunnybank wing at the LGI and by LCH's sexual health team.

9. Celebrating success

- I was delighted to hear that Research Sister, Sue Hartup, one of the breast care team based in Bexley Wing has been awarded an NIHR Integrated Clinical Academic Training fellowship for doctoral study.
- I was really pleased to receive an email from a member of staff praising the care their grandmother had received in the Trust prior to sadly passing away earlier this month. Ward J46 at St James's was especially marked out for their "patient, friendly and reassuring" approach towards the care of the lady in her final hours.
- I'd like to congratulate Alistair Hall and Paul Emery, Consultants at the Trust and researchers at Leeds University who have been listed among the 'World's Most Influential Scientific Minds' in a citation analysis released by the Intellectual Property and Science business of Thomson Reuters.
- I was very happy to hear about the success of our Finance team at the recent Healthcare Financial Management Association (HFMA) Yorkshire and Humber awards. The Trust as a whole was recognised for efficiency while Payroll did incredibly well in the *Finance Team of the Year* category, both being highly commended. I'd also like to pass on special congratulations to Mark Songhurst, from Internal Audit, who was named *Finance Professional of the Year.*
- The team on J26 has become the first ward on the acute medical and elderly admissions floor to reach over 30 days without a fall. This fantastic achievement has been a real team effort.
- Congratulations to everyone working on the flu vaccination campaign for reaching the national target of over 75% frontline care workers being vaccinated against flu. Thank you to everyone who has come forward to be vaccinated, and to the Occupational Health team and peer vaccinators for working so hard during a really busy period.
- Congratulations to the Urogynaecology unit, which has become one of only 16 units in the UK to secure accreditation from the British Society of Urogynaecology in recognition of the high quality of practice and patient care delivered by their multidisciplinary team.
- I was also really pleased to hear that the Trust has been selected as one of only 10 trusts in the country to take part in the 'Building on the best' programme, run by the National Council for Palliative Care.
- Congratulations to Anthony Higgins, Clinical Scientist in Radiological Physics who has been named the Rising Star in the Medical Physics and Clinical Engineering category of the Chief Scientific Officer's Healthcare Science Awards, which are supported by the Health Service Journal.
- I was pleased to hear that the team from Leeds Children's Hospital has been shortlisted in the Student Nursing Times Awards in the Partnership of the Year category for their work with the University of Leeds on children's nursing placements.
- Well done to all the staff on ward J43 for the caring and compassionate support they gave to a patient with learning disabilities and challenging behaviours recently. The patient's support worker described the staff as 'absolutely amazing' and said they had 'all gone that extra mile and shown a genuine interest' in the patient and his care.
- I'm delighted that the Trust has received the bronze award from the Armed Forces Covenant Employer Recognition Scheme. The award acknowledges the Trust's pledge to support members of the armed forces, including those who are employees or prospective employees.
- Congratulations to the Diabetes in Pregnancy team for being shortlisted for the British Medical Journal's Diabetes Team of the Year award.
- We had amazing success at the Health Education Yorkshire and the Humber Talent for Care Awards in March where we scooped three awards. Abigail Arnett, Apprentice Clinical Support Worker, was highly commended as Intermediate Apprentice of the Year. Our functional skills programme with the Workers Education Association was highly commended in Partnership of the Year. To top if all off, in recognition of our work with Healthcare Career Ambassadors, internships and apprenticeships we won the ultimate award and were named Employer of the Year!

- Finally, I'd like to highlight an email I received last week praising the fantastic care one of our patients received at the LGI from the multidisciplinary team on ward L25. The patient described the consultants as 'top notch', the ward staff as 'wonderful', giving 'first-class care' and the physiotherapists as being 'well-focussed', setting 'appropriate targets to get me mobile'.

Julian Hartley
Chief Executive
March/April 2016

Scrutiny Board (Adult Social Services, Public Health, NHS)

19th April 2016

Update on Care Quality Commission (CQC) Compliance with Fundamental Standards and Preparations for Follow-Up Inspection 10-12 May 2016

Presented for:	Information and Assurance
Presented by:	Suzanne Hinchliffe, Chief Nurse/Deputy Chief Executive
Author:	Craig Brigg, Director of Quality
Previous Committees:	None

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	✓
Seamless integrated care across organisational boundaries	✓
Financial sustainability	✓

Key point/Purpose	
1. To update Scrutiny Board on the Trust's compliance with the Fundamental Standards of Care and Care Quality Commission Registration.	For information
2. To provide an update on the actions the Trust has taken following the comprehensive inspection in March 2014.	For information

1. Background

The Care Quality Commission set out a new vision and direction in their strategy for 2013 -16, proposing radical changes to the way they monitor, inspect and regulate health and social care services. In 2014, the Department of Health consulted on new regulations that set out the fundamental standards of quality and safety that all providers must meet. The Care Quality Commission subsequently issued guidance for providers to help them to meet the new regulations, and on how the CQC will use their enforcement powers to take action when they fail to do so.

The new health and social care regulations came into force on1 April 2015 setting out new Fundamental Standards for all care providers, to replace the previous standards and outcomes.

Two new regulations came into place on 27 November 2014; a fit and proper person requirement for directors, and duty of candour for NHS bodies.

A regulation has also been introduced requiring providers to display their CQC ratings, which came into force on 1 April 2015, to let the public know how care services are performing.

2. New Regulations and Fundamental Standards

There are now 11 new regulations setting out the fundamental standards of quality and safety:

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse
- Meeting nutritional needs
- Cleanliness, safety and suitability of premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed

The Trust has implemented the duty of candour regulations and provided support to clinical teams and managers in this process; the Trust introduced the fit and proper person requirement for directors and has been displaying its CQC ratings following inspection in March 2014 at its main hospital locations since May 2015.

3. Enforcement Powers

The Care Act 2014 gave the CQC strengthened enforcement powers to:

- protect people who use regulated services from harm and the risk from harm, and
- hold providers and individuals to account for failures in how the service is provided.

The changes now allow them to take swifter action and use the most appropriate tool to target poor performing providers. Importantly, the CQC are able to prosecute providers for certain breaches of regulation without first issuing them a warning notice.

The CQC have not taken enforcement action against the Trust during this period.

4. CQC Inspections/Visits

There have been no planned or unannounced CQC inspections of the Trust since their visit in March 2014. There have therefore been no changes to the Trust's registration during 2014/15.

5. Preparation for Follow up Inspection, May 10-12 2016

The action plan that was developed relating to the actions the Trust must take to comply with the fundamental standards of quality and safety. The actions (17 in total) were set out under key headings:

- Staffing
- Training
- Risk and Safety
- Governance
- Communication
- Human Resources
- Mental Health
- Equipment

The actions have been reviewed and the plans discussed at the Public Board.

Report on progress against the action plans following the 2014 visit were reported to the Quality Assurance Committee and outstanding actions mainstreamed into other Trust work programmes following discussion and agreement with commissioners at NHS West Leeds CCG and the TDA.

The CQC also made a number of recommendations; actions the Trust should take to improve quality and safety (39 in total) under the headings above and also the additional headings:

- Information Technology
- Facilities
- Children's Services
- Care
- Clinical Support

Preparation for the follow-up inspection continued in 2014/15 before the Trust was notified of the date for the inspection, which will take place 10-12 May 2016.

The Trust appointed 4 Patient Safety & Quality Managers in 2014/15. These appointments were made following the comprehensive CQC inspection to work with designated CSUs and provide support to them in developing their governance arrangements. These post holders have also supported trust wide improvement programmes, including falls prevention, deteriorating patient, sepsis, pressure ulcers and acute kidney injury. They have also worked with the Clinical Leadership Fellows appointed by the Deanery on a number of quality and safety programmes, including the establishment of a Doctors in Training forum. The Patient Safety & Quality

Managers have attended a number of governance and performance meetings and they are supporting CSUs to collect evidence for inspection, including reviewing minutes of governance meetings, Terms of Reference and action plans to ensure these are robust and fit for sharing with the CQC. Support has also been provided to CSUs with incident reporting, investigation reports and complaint responses.

A programme of work was established specifically to prepare for the follow-up inspection, building on the experience of the comprehensive inspection in March 2014. This included review of evidence that was posted on the shared drive, mapping this against the 5 key lines of enquiry, refreshing the information that was provided to staff and a further review of the actions the Trust were required to take following the previous inspection. A series of engagement meetings have taken place with Clinical Directors, Heads of Nursing and General Managers and their teams and key messages included in Trust briefings relating to the fundamental standards and improvements that have been implemented. The Trust has continued to publish Quality and Safety briefings that are sent out to all staff fortnightly and also included in the Chief Executive's Start the Week bulletin, supported by the communications team.

The core services identified in the inspection framework have reviewed and focused improvement work has been undertaken to support these areas:

Core service	**Judgement March 2014**	**Rating**
Urgent Care		Good
Medical Care		Requires Improvement
Maternity		Good
Children		Requires Improvement
Critical Care		Requires Improvement
Surgery		Requires Improvement
End of Life Care		Good
Outpatient		Good

The programme of work to prepare for inspection has been set against the 5 key lines of enquiry, to improve on the judgements that were made following the inspection in March 2014, as follows:

Overall rating for this Trust	Requires Improvement	
Are services at this Trust safe?	Requires improvement	
Are services at this Trust effective?	Good	
Are services at this Trust caring?	Good	
Are services at this Trust responsive?	Requires improvement	
Are services at this Trust well-led?	Requires improvement	

Progress was discussed at a Trust Board time-out and the Executive Directors have met fortnightly to monitor progress.

6. Engagement with the Care Quality Commission

The Trust continues to meet with the local Compliance Inspector to engage with them on the inspection process and changes to regulation. A planning meeting will be held with the CQC on 4 May 2016 in advance of the inspection visit the following week.

7. Routine CQC Enquiries

The Trust has continued to receive routine enquiries from the CQC when they have been contacted by patients or their families, or members of staff to raise concerns about treatment and care. In total there have been 8 enquiries from the CQC during 2014/15. These have been resolved in conjunction with CSUs. These enquiries continue to be monitored and tracked by the Trust's Quality Team.

8. Intelligent Monitoring Report (IMR)

The most recent CQC Intelligent Monitoring Report for the Trust was published in May 2015. The Trust's overall rating has remained in band 3.

9. Recommendations

Scrutiny Board is asked to:

i) Note this report and the assurance provided relating to the actions taken following the comprehensive inspection in March 2014 and the preparations for the follow-up inspection in May 2016.

Craig Brigg
Director of Quality
April 2016

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Leeds and York Partnership NHS
NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust
Update for Scrutiny Board 19 April 2016

1. Introduction

This paper provides a brief overview of key issues and developments within LYPFT over the last two months with a particular emphasis on the Trust's Operational Plan and preparation for an upcoming planned CQC inspection.

2. Operational Plan Priorities 2016/17

The NHS planning guidance 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' was published in December 2015 and set out expectations and submission requirements for all NHS organisations. Unlike previous years, all trusts have been required to submit a one year, as opposed to two year, Operational Plan, to allow much more detailed work on the citywide Sustainability and Transformation Plan to happen.

To ensure that we improve the quality of our services in 2016/17 and have a longer-term plan in pace, we have agreed three priorities for the year:

a) **Support and engage staff to improve people's health and lives:** Our Trust exists to provide treatment, care and support to people that helps them improve their health and lives. All of our staff are committed to improving the quality of care we provide, while improving the outcomes we deliver for service users. To do this well, our clinical and professional staff need time to develop trusting relationships with service users and carers. This means quickly recruiting more staff, particularly nurses, to fill vacancies, and in doing so helping all of our staff do their jobs effectively and efficiently. We want to make sure the Trust is a good place to work with opportunities for career progression. We will be significantly improving our clinical information system; and we will be implementing further time-saving technological solutions. We know that providing staff with good information and time will help improve outcomes for service users and carers.

b) **Meet CQC fundamental standards and improve quality through learning:** The CQC inspection of our services just over a year ago showed that we have lots of good practice across the Trust, but there are some areas where our performance does not meet essential quality standards. Since then, we have made significant improvements on mental health legislation, record keeping and compulsory training. We are also focusing attention on delivering much-needed improvements to the physical environment, by improving our processes now so that estates and facilities issues get dealt with quickly and efficiently, for the benefit of service users and staff. We will continue to improve performance reporting information to teams to help them manage performance against the essential quality standards.

c) **Work with partners to develop a clear plan for the Trust's future direction**: Broadly, we provide two kinds of care: local mental health, learning disability and addictions services for the people of Leeds; and specialist services across the region and even further afield, with large bases in Leeds and York, and smaller ones in Manchester and

Newcastle. We remain fully committed to maintaining and developing services at both these levels. We will be refreshing our Trust Strategy over the next few months, using Crowdsourcing so that service users, carers, staff and partners have the opportunity to have their say on our future direction. This strategy will set out how we are responding to the Leeds Mental Health Framework, the Five Year Forward View and what part we will play in the design and development of the local Sustainability and Transformation Plan.

Our operational plan includes a number of service developments for 2016/17 as set out below:

- Continue development of recovery-focused services, including: improvements to care planning; psychological thinking/interventions; new Recovery College with Converge, Leeds Mind and Leeds universities; access to support for financial advice and benefits; and Triangle of Care to support carers.
- Implement new community model agreed with commissioners.
- Develop and implement single point of access and assessment, to include IAPT services currently provided by LCH and 3rd sector.
- Implement integrated, system-wide model for older people's services.
- Implement plans for longer-term rehab out of area placements.
- Implement new urgent/emergency/crisis care model in line with commissioner plans and Mental Health Urgent Care Vanguard.
- Complete review of learning disability services and implement changes agreed with commissioners (includes community services; assessment and treatment; respite and local response to Transforming Care).
- Implement new models of care prototypes (integrated mental and physical health and social care) with Leeds West CCG, Leeds South & East CCG and Leeds North CCG.

3. THE STP and New Models of Care

The Leeds health and social care economy is working together to develop a place-based plan as part of a West Yorkshire-wide Sustainability and Transformation Plan (STP) for submission in June 2016. LYPFT is a member of the Partnership Executive overseeing the development of the Plan, and is participating in many of the supporting workstreams. We are continuing to highlight the need to better integrate mental and physical healthcare at all levels of the health and social care system and we believe the STP should ensure this is a priority.

LYPFT is continuing to participate in the development of new models of care across each of the CCG areas. The principle of better integrating physical and mental healthcare, and the benefits of preventative early interventions to the wider health system are a foundation of prototypes we are beginning to see develop. Supporting the development of different prototypes across the three CCG areas presents challenges to a citywide organisation. We are in the process of establishing an internal programme structure which will support these developments and help us focus on: identifying any initial learning; and ensuring that information is available across the Trust on developments, effective participation of clinicians, and that staff engagement is in place.

4. Quality and Performance

The Trust's 2014 CQC full inspection action plan has previously been shared with the Scrutiny Board and is now almost concluded. The action plan is currently 94% complete for Leeds based services. Four actions are classified as overdue and relate to achievement of our targets for compulsory training and appraisal. This is being further supported by a new action plan and monitoring process to support services to better meet these targets.

Four items are classed as partially complete due to two actions still requiring resolution:

- Provision of a long term solution for the location of the Yorkshire Centre for Psychological Medicine that is currently based at the Leeds General Infirmary. This is part of wider work on the Trust's clinical strategy review (due in the autumn of 2016) which will also identify the accommodation requirements of the entire Trust.

- All forensic patients at the Newsam Centre to be registered with a GP to ensure their physical healthcare needs are being met. This issue is being progressed and the Trust is seeking Leeds CCG support to identify GP provision for these patients.

The Trust met the vast majority of our national and local quality and performance standards for 2015/16. However, we continue to have too many people being placed out of area for inpatient care. We have a comprehensive action plan in place to address this issue, but much of the cause is due to significant pressures on mental health services (which was also highlighted in the recent Mental Health Taskforce Report's Five Year Forward View for Mental Health).

LYPFT's financial position remains stable, although, given the increasing demand for mental health services, achieving cost improvement plans is extremely challenging. NHS Improvement has required the Trust to plan for a surplus of £3.2m in 2016/17. After careful consideration, our Board of Directors agreed to reject this requirement on the grounds that it would have an adverse impact on quality of care. We are therefore planning to achieve a £1m surplus this year. We note that the Five Year Forward View for Mental Health recommends investment of £1 billion in mental health services by 2020.

5. CQC inspection 2016

The Trust received a responsive unannounced inspection on 4 and 5 April at two Leeds locations, the Becklin Centre and Parkside Lodge. These inspections looked at Mental Health Act compliance, patient safety themes and staffing. Verbal feedback from the visit was positive; however we must wait to consider the written report from the CQC when this becomes available.

Work continues at the Trust in preparation for the full comprehensive CQC inspection week commencing the 11 July 2016. This full inspection presents us with an opportunity to demonstrate the high quality of our services to the people we serve. We hope this will give our staff the recognition and the ratings they deserve and enable the Trust to illustrate our journey from 'requires improvement' to 'good', and in some areas 'outstanding', which we should all be aspiring to. A project group, and central project team have been set up and all services have carried out a self-assessment against CQC standards.

6. Board of Directors Public Meeting 31 March 2016

The link below provides the agenda and papers of the most recent public meeting of the Board of Directors. The link provides a comprehensive overview of strategic, governance, and information items. The next public meeting of the Board of Directors will be held on Thursday 28 April 2016 in Meeting Room 1&2, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB, and Scrutiny Board members are welcome to attend.
http://www.leedsandyorkpft.nhs.uk/_documentbank/1_Agenda_and_Papers___Board_of_Directors___PUBLIC___31_March_2016___WITH_BOOKMARKS.pdf

Jill Copeland
Interim Chief Executive

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