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Health and social care fees

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

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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.

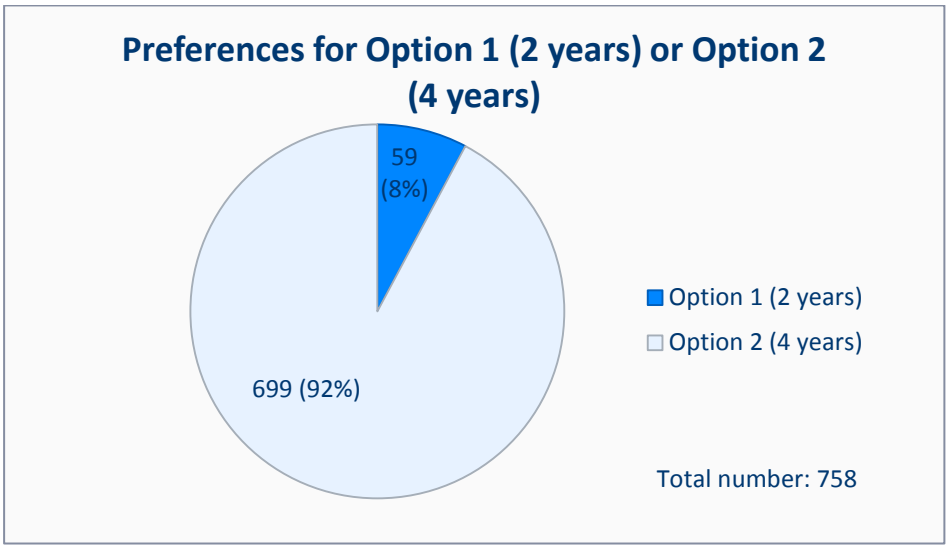

Figure 1. Preferences for Option 1 (2 years) or Option 2 (4 years)

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).

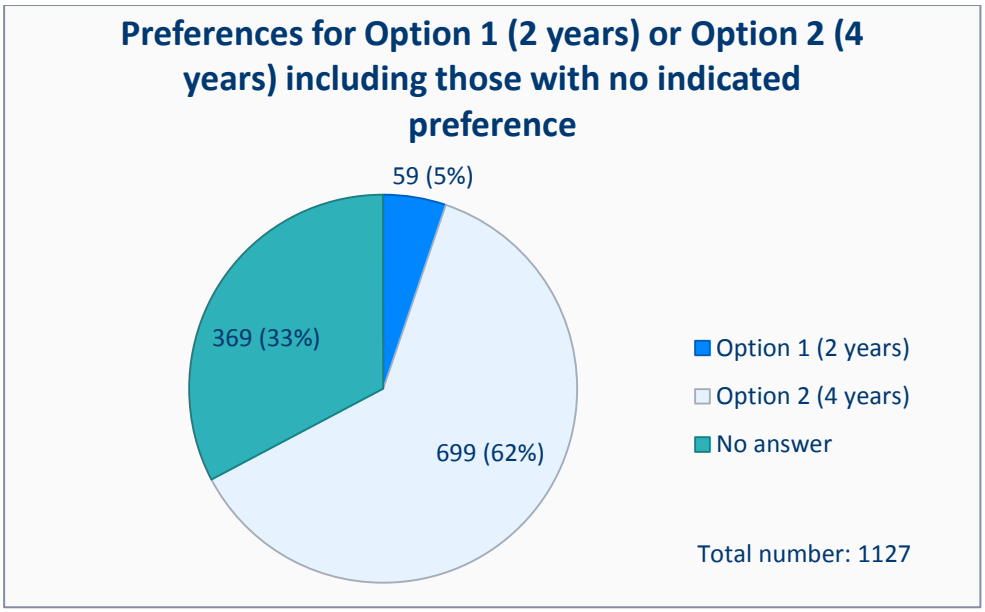

Figure 2. Preferences for Option 1 (2 years) or Option 2 (4 years) including those with no indicated preference

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%).

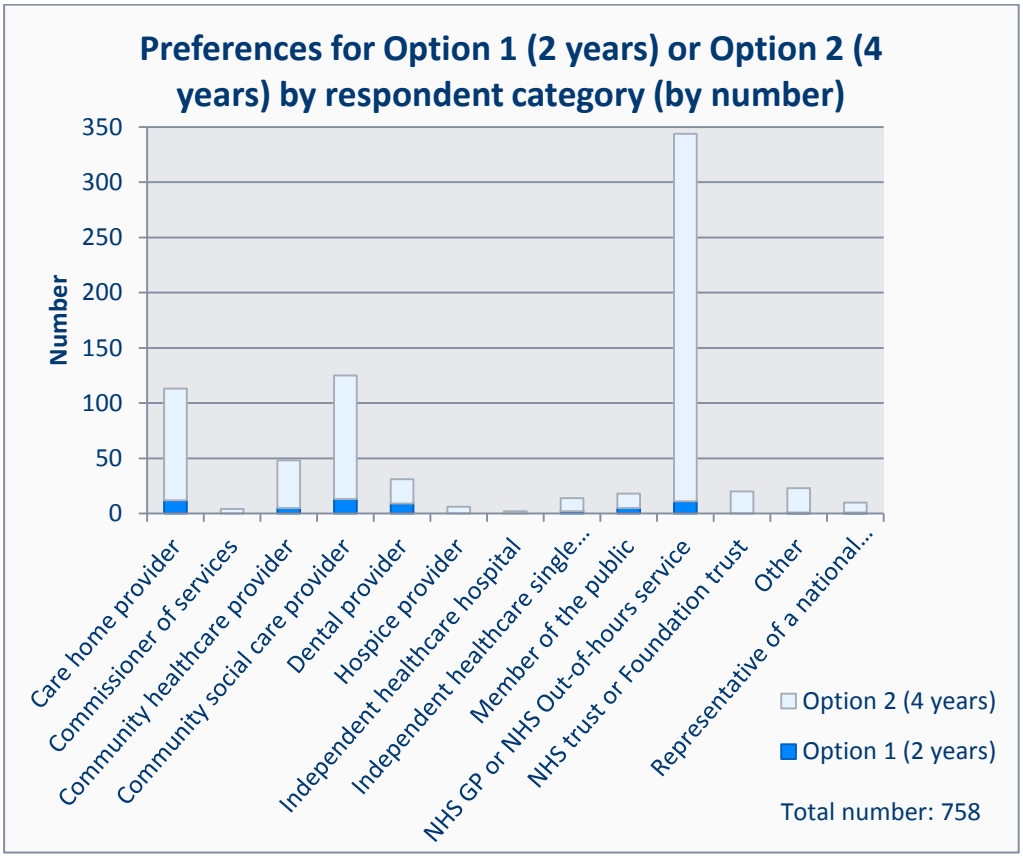

Figure 3. Preferences for Option 1 (2 years) or Option 2 (4 years) by respondent category (by number)

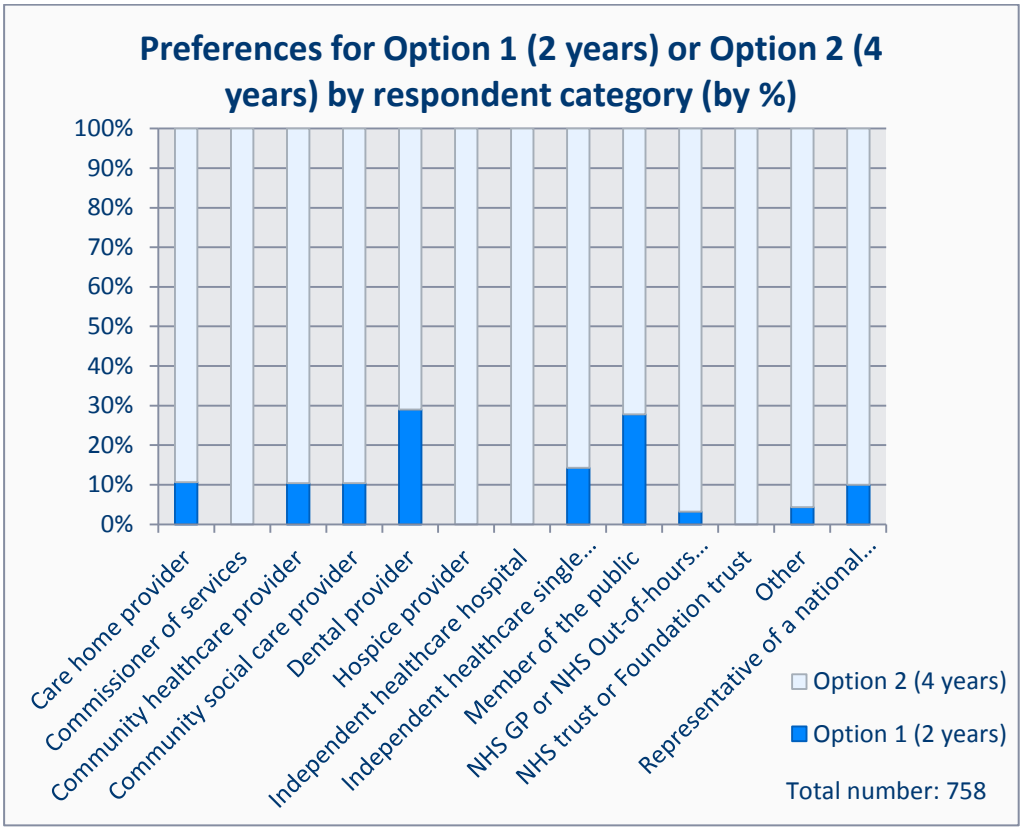

Figure 4. Preferences for Option 1 (2 years) or Option 2 (4 years) by respondent category (by %)

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.

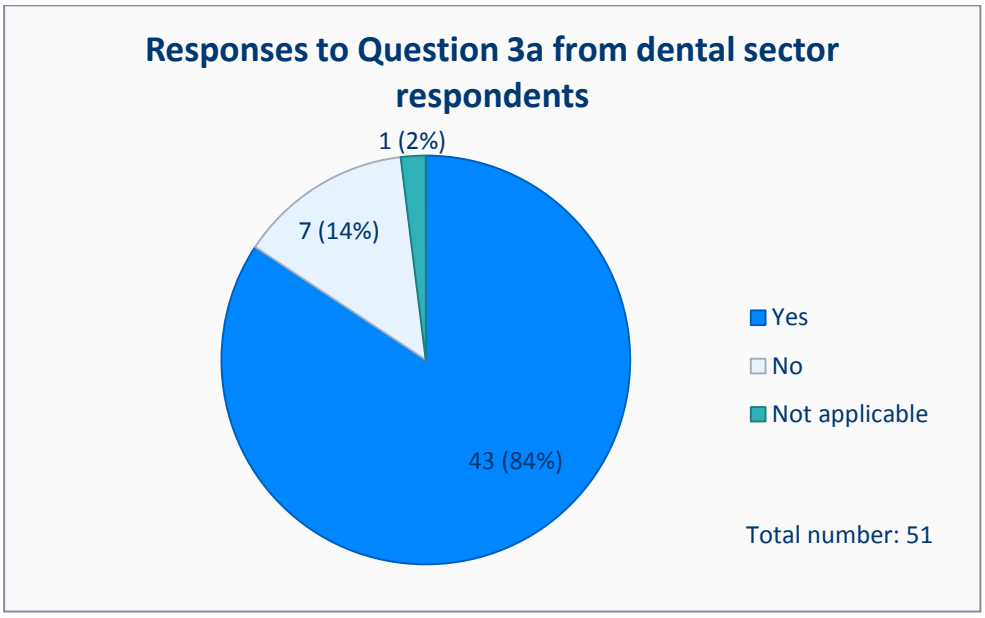

Figure 5. Responses to Question 3a from dental sector respondents

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).

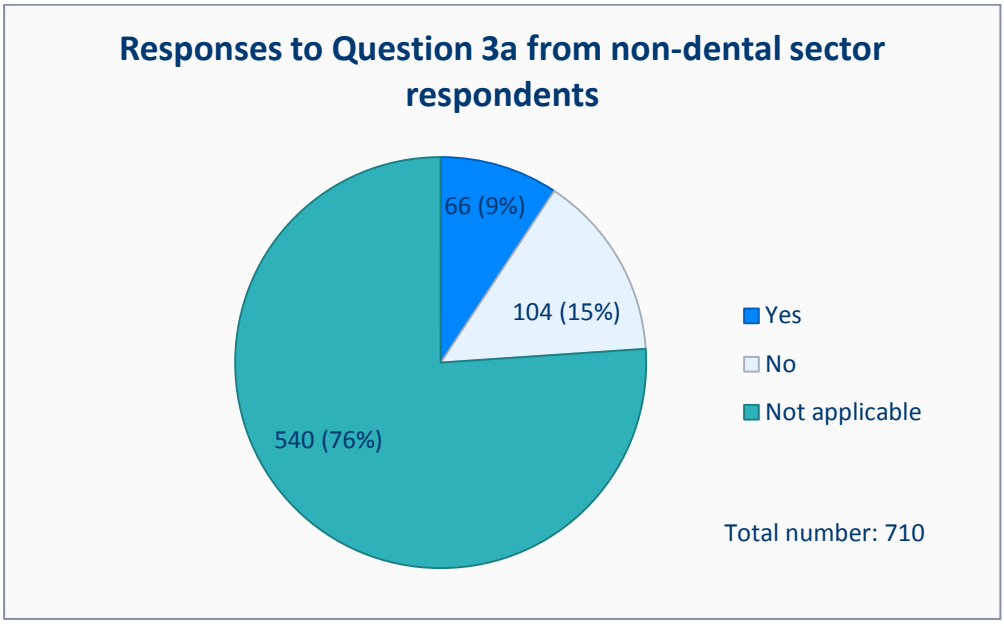

Figure 6. Responses to Question 3a from non-dental sector respondents

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.