Care Quality Commission

Consultation

Regulatory fees – have your say

Proposals for fees from April 2018 for all providers that are registered under the Health and Social Care Act 2008

October 2017

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 register health and adult social care providers.

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

We use our legal powers to take action where we identify poor care.

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

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

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Foreword

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

We regulate over 30,000 health and adult social care providers with more than 40,000 locations and set clear expectations of what good care looks like and when improvements need to be made. In 2016/17 we completed our comprehensive inspections and ratings programme for health and social care services in England.

We launched our strategy for 2016-2021 on the foundations of this robust baseline of quality across health and social care. The strategy makes a clear link between the delivery of our purpose and the need to do so efficiently and effectively. Our financial resources must be sufficient to allow us to regulate properly, but we must do so in the most economical way possible.

Following HM Treasury policy we are now in a position where almost all of our costs for our chargeable activities are being recovered through fees. We have largely discharged this requirement. Our proposals will change the fees for individual providers. Generally larger providers will pay higher fees and smaller providers lower fees. However, apart from a required increase to community social care providers, no sector sees an increase in their total fees.

In this consultation we are undertaking a review of the fees scheme to ensure that we continue to charge fees in as equitable and fair a way as possible. We have focused on three sectors where most adjustment is required, working with provider groups within these sectors in developing our proposals. We will apply this approach to all sectors in the following years as part of our continuous improvement. The final decision on fees rests with the Secretary of State, and we expect this decision to be made in March 2018.

We do not underestimate the impact on providers of paying fees, and we will continue to look carefully at our costs relating to regulation. We have a responsibility to cover our costs by charging fees, but we are also accountable for demonstrating that we are fair, efficient, effective and proportionate.

Peter Wyman CBE DL
Chair

Sir David Behan CBE
Chief Executive

Introduction

Summary of proposals

We are consulting on the fee amounts for the 2018/19 fee scheme, in line with the requirements of the Health and Social Care Act 2008 (the HSCA). Last year, following consultation, and with the agreement of the Secretary of State, we completed the path to achieve full chargeable cost recovery, set over a two-year period for most providers in line with government requirement. The exception was for community social care providers (which include homecare agencies) whose trajectory was set over four years. We intend to continue that path for them.

Now that we have reached full chargeable cost recovery for most sectors, we are continuing our review of the fees scheme to ensure that fees continue to be in alignment with our use of resources, distributed proportionately, and that the distribution of fees across sectors captures current developments within each sector. The sectors most in need of this review are community social care, NHS trusts, NHS GPs and urgent care providers. We are making proposals for each of these.

Only proposal two will increase the income we receive from fees. In line with the trajectory to full chargeable cost recovery we will see fee income rise by £3 million with an equivalent decrease in our grant-in-aid.

None of the other proposals change the income we are receiving from each sector for 2017/18. Changes in the structure will result in changes to fees for individual providers. These are discussed in detail for each proposal.

Proposal 1

We propose to change the fees scheme structure for community social care providers by:

- replacing the current banding structure
- charging fees in proportion to the size of a provider in the sector (using a measure chosen through this consultation).

Proposal 2

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

Proposal 3

We propose to change the fees scheme structure for NHS GP providers by:

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

Proposal 4

We propose to change the fees scheme structure for urgent care providers by:

- removing the current banding structure for providers with one location
- removing the current banding structure based on the number of locations for providers with more than one location
- adopting a new method of calculating fees (using an option chosen through this consultation).

Proposal 5

We propose to change the fees scheme structure for NHS trusts by:

- removing the current banding structure
- charging fees in proportion to the size of a provider in the sector
- continuing to use annual turnover as the measure of this size for all NHS trusts (using an option chosen through this consultation).

Full details and descriptions of each of our proposals are given in this document.

Other relevant reports

Please read the *Draft regulatory impact assessment* on our website, which sets out how we will evaluate the impact of different options for fees. It also provides the analysis behind our proposals and details of our budget.

We carried out a draft *Equality and Human Rights impact assessment* of our proposals, which is also available on our website. Our assessment identified that our fee proposals would have no impact on how the organisations we regulate deliver their functions in terms of equality or human rights. If you wish to comment on our draft Equality and Human Rights impact assessment, please include any feedback in your responses to the questions on page 27.

Responding to the consultation

We will take your responses to this consultation into account to finalise our provision for fees for 2018/19.

Please see the section 'How to give us your views' for how to send us your comments. Please make sure that your comments reach us by midday on **18 January 2018.**

When we have analysed the feedback from this consultation in January 2018, we will prepare a response and a final fees scheme. CQC's Board will recommend the scheme to the Secretary of State, who is responsible for making the final decision about fees charges, and whose consent is required in order for the scheme to come into effect. We expect to publish our response and our final fees scheme in March 2018, for implementation on 1 April 2018.

This timescale means that we will not be able to confirm exactly what fees individual providers will be paying in 2018/19 until relatively close to when the scheme takes effect. Providers may therefore wish to take the fee levels set out in this document as being indicative of the amounts we propose to ask the Secretary of State to approve from 1 April 2018 as a guide for setting budgets.

CQC's strategic context for fees

This section considers our budget, our strategic approach to both regulation and fees, and the development of our fees scheme. It draws together how they interact with each other. It is important that we secure the right level of resource so that we are able to discharge our regulatory duties properly. It is equally important that we do so as efficiently and economically as possible. We need to be able to demonstrate both to our key stakeholders.

Our budget

Overall our budget is reducing year on year. The table below, which is in line with the four year spending review as agreed with the Department of Health, demonstrates this.

Year	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
Grant-in-aid	85.0	34.0	27.0	18.0
Fees	151.0	196.0	201.0	199.0
Total budget	**236.0**	**230.0**	**228.0**	**217.0**

The fees funding shown here includes all the costs chargeable to our regulatory work and the depreciation from our assets that underpin that work. The reductions are a result of both strong management of our expenditure, and planning for the resources that we need to carry out our duties. This planning includes the investment that we need to make in areas such as our digital programme, to ensure that we continue to reduce our costs over the medium and long term. During this period we have changed our funding position, as a direct result of HM Treasury policy, such that funding from government has reduced and funding from providers has increased. Nearly 90% of our activities are now funded through fees. We therefore expect to see fees reduce for providers over time.

Our budget is funded by a combination of grant-in-aid from central government budgets and income from fees paid by providers. We are not consulting on our budget as it has been agreed by the Department of Health as outlined above. Grant-in-aid has been falling consistently as we have moved to full chargeable cost recovery, and we are now at full chargeable cost recovery for all sectors except community social care providers. A small amount of grant-in-aid funding remains to cover activities that cannot be recharged as fees. These are: enforcement, thematic reviews, Market Oversight, Healthwatch, National Guardian's Office and work performed under the Mental Health Act. All other costs form part of our regulatory activity.

The relationship between our strategic approach to regulation and fees

We published our strategy for the next five years from 2016 (see *Shaping the future: CQC's strategy for 2016 to 2021*).

Following on from this, during the last year we have published two of three consultation documents concerning our next phase of regulation. In terms of sectors, the first addressed new models of care and NHS trusts. The second focused on adult social care and primary medical services. The third will review independent health care. All documents highlight important changes to our methodologies in our regulation of services and providers. These changes are being embedded from 2017/18.

Our approach to setting fees

We have positioned fees as a charge for entering and remaining on our register. 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, such as a fee based on the exact resources used by each provider. We have taken a more nuanced approach, where we have characterised providers and grouped them into sectors that are of similar size and complexity and which are regulated in similar ways. We then charge according to their size, which is a good measure of the resource required for regulation. We believe that this balances fairness with simplicity.

Our assessment of the cost of regulating each sector is measured by the data we collect from our current methodology, modified by our understanding of future changes. Our new strategy will change some elements of how we approach our methodology, but others will remain unchanged. We have factored these in to the calculation of our proposed fees for 2018/19 and will continue to do so for future years.

Development of our fees scheme

We are reviewing our fees scheme to ensure that we continue to charge fees in as fair a way as possible and ensuring that the structure is fit for purpose. To do this, we need to make sure that it aligns as appropriately as possible to the changes in each sector, using available information. We also need to understand how we currently use our resources, and how the changes to our inspection methodologies are likely to affect this. We have developed our costing model to do this.

This review takes account of the resources we will require over the next period. We have reduced costs successfully over the past two years, initially as part of the spending review, but now under our own control. As a public body we have always been conscious of the need to spend wisely and demonstrate our value for money. We have consistently spent within our budget and are now reducing costs year on year. Our challenge in moving to a position where providers fund 90% of our work, is to secure an overall reduction in income, while continuing to invest to improve our efficiency and effectiveness in the future.

Overview of our fees proposals from April 2018

This consultation is inviting comments and opinions from providers and stakeholders on our proposals for the fee amounts and methodology for 2018/19. We are required to consult on our fees scheme (under section 85 (4) of the HSCA). The opinions and views we receive are important as they allow us to reflect the views of those directly affected by this consultation to our Board and the Secretary of State.

Our proposed changes below are subject to the outcome of this consultation and the final decision of the Secretary of State.

Now that we are close to full chargeable cost recovery on those areas of activity where we can charge fees, as required of us by HM Treasury policy, we are in a position to review our fees scheme to ensure that we continue to charge fees fairly and proportionately for each sector. We have focused on those sectors where changes in the sector suggest to us that they should be prioritised for adjustment. We have concentrated on the following sectors:

- community social care providers
- NHS GPs and urgent care services
- NHS trusts.

The reasons, issues and proposals are described in detail below. Other sectors will be included in this continuing review over the next few years.

The solutions offered will change the fees for individual providers. However, apart from the required increase for community social care providers that was signalled last year, no sector sees an overall increase in their total fees. The adjustments are intended to ensure that fees are charged to providers in the affected sectors equitably, and in line with the relative costs of regulation.

The changes that we are making are tailored for each area, but have two common themes discussed below.

1. Charging fees in proportion to their size within the sector

Since 2009, the fee scheme has been structured using bandings. As fees have increased this has produced 'cliff edges', where a provider moving to a higher band might incur a sudden increase in fees or a provider moving to a lower band can see a sudden decrease.

Charging fees in proportion to their size removes this problem. It is, in effect, a very granular form of banding and allows us to respond appropriately to small and large changes.

The mechanism for charging a fee is demonstrated using NHS trusts as an example. The first step is to collect the turnover for all trusts. Adding them all together provides the total turnover for all trusts in the sector. Then dividing a trust's own turnover by the total for the sector gives us the size of that provider as a proportion of the whole sector. We know the total fees that we have to recover from a sector, so multiplying the fee total by this proportion determines a provider's individual fee. We will apply this methodology to each sector.

We will determine the total measure of each sector at the start of the year. We will use this as the basis of fee calculations for the financial year. For NHS GPs and community social care providers, the total number of providers in the sectors is large compared to the numbers of those who newly register and de-register in the year. For NHS trusts, changes in the market are largely a result of mergers and service transfers, so again will have minimal impact on total budget in a particular year.

This means that we will calculate fees for providers who register in the year on the same basis as providers registered at the start of the year. It also means that we will calculate refunds for providers who leave registration completely in the year on the same basis as their original fee calculation. We will review the position each year and make adjustments to the calculation where there has been significant movement.

This means that we do not give a specific range of fees, as we did with the small number of bandings, but we do provide sufficient information for a provider to be able to calculate their likely fee.

2. Floors and ceilings

Introducing a floor sets a lower limit for fees. An argument in favour of this approach is that there is always an essential level of regulatory activity and associated cost, regardless of the size of the provider. An argument against this is the practical outcome that means smaller providers pay a little more and larger providers a little less as a result of redistributing fees as we need to obtain the same total income.

Ceilings affect larger providers and restrict the highest fee paid. This protects particularly large outliers, where economies of scale effectively mean that overall costs of regulation tend to plateau rather than continue to rise. It requires redistributing fees so that smaller providers pay more in order to maintain the same total income.

The fairest result will differ from sector to sector depending on the size of providers relative to each other, their complexity and resources required to regulate them. With this in mind, we have included two options within each model as well as the proportionate fee described above. One option offers a model with both a floor and a ceiling and the other offers just a floor. Providers are able to

review and make comments specific to their sector. Further details are provided in the proposals section and the draft regulatory impact assessment.

Note on hospice providers

During 2017/18, the regulation of hospices transferred from our Adult Social Care Directorate to our Hospitals Directorate, involving a change of category definition in the fees scheme. This is a minor technical change and there is no immediate impact on the fee structure, so the fees charged will remain unchanged. A new methodology is being prepared for hospice providers, so we will monitor this to assess the impact on the cost of regulating the sector and any impact on fees.

Proposals 1 and 2 for community social care providers

There are two proposed changes to this sector.

Proposal 1: Changes in the structure of the fees scheme for community social care providers

We propose to change the fees scheme structure for community social care providers by:

- replacing the current banding structure
- charging fees in proportion to the size of a provider in the sector (using a measure chosen through this consultation).

Our own assessment and comments from the sector show that the number of locations used by a provider is not a satisfactory measure of size. This, coupled with increasing fees as the sector moves to full cost recovery, exacerbates two existing issues:

1. Providers of very different size but registered with one location all pay a fee in 2017/18 of £2,192.
2. The use of locations for bandings and the significant differences between those bandings results in large step increases between providers: for example (using 2017/18 figures), a provider with 12 locations will pay £24,370, while a provider with 13 locations will pay twice that, at £48,740.

The challenge is to find a replacement measure. We have discussed this with a number of different representatives from membership bodies of the sector and drawn up a list of possible options. The United Kingdom Homecare Association (UKHCA) offered to run a survey among its members and share its findings with us so that we would be able to concentrate on the most likely options. We were pleased to accept. UKHCA represents homecare providers of different sizes from the independent and voluntary sector and its members were asked which methods they favoured from the following list:

- The number of hours of regulated activities provided by the service at a specified period (abbreviated for the remainder of this document to 'Total hours of care').
- The number of people receiving support with regulated activities from the service at a specified period (abbreviated for the remainder of this document to 'Number of service users').
- Annual turnover of the provider that relates to its regulated activities.
- Whole time equivalent staff employed at a specified period (abbreviated to 'Number of staff employed').

The number of locations was also included as the base position, as well as 'other' to ensure that we did not miss any possible options. The draft regulatory impact assessment discusses how the options offered as part of this consultation were decided.

UKHCA received 216 responses to its survey, which is around 10% of its membership. There was a clear preference for either the total hours of care or the number of service users. We provide more detailed analysis in our draft regulatory impact assessment. We validated the proposed options with other membership organisations in the sector. These results do not predetermine the outcome of the consultation, but do help in shaping a set of options that are better aligned to expectations within the sector. We are inviting comments on the whole list, but on the basis of the results from the survey we have modelled the first two options.

As part of the survey, we also asked for views on moving to a calculation based on the size of the provider in proportion to the rest of the sector (rather than based on a banding structure, as currently). Respondents to UKHCA's survey were overwhelmingly in favour of this (85%), so we have modelled on this basis.

Each option is modified to produce two further options by providing a floor and ceiling, which are listed below. We have modelled four of these options. We offer options 1c and 2c for consideration, but have not modelled them. This is discussed further on pages 15 and 16.

1a. Total hours of care, distributed in proportion to the size of a provider's location in the sector.

1b. Total hours of care, distributed in proportion to the size of a provider's location in the sector with the inclusion of a floor.

1c. Total hours of care, distributed in proportion to the size of a provider's location in the sector with the inclusion of a floor and ceiling.

2a. Total number of service users, distributed in proportion to the size of a provider's location in the sector.

2b. Total number of service users, distributed in proportion to the size of a provider's location in the sector with the inclusion of a floor.

2c. Total number of service users, distributed in proportion to the size of a provider's location in the sector with the inclusion of a floor and ceiling.

The draft regulatory impact assessment provides an analysis of data from recently inspected providers who had completed Provider Information Returns (PIRs) and who had provided data for "People receiving support with regulated activities" or "Hours of regulated activities did you provide in the seven days before the start of the return".

We give initial calculations for the options below. It is important to note that these figures need to be regarded as indicative and will not necessarily reflect the final fees if this option is chosen. They are based on the information that we have from

recently inspected providers. While we believe that the sample is a relatively good representation of the population, there will inevitably be some variation when actual figures for the whole sector are collected.

More detail is provided in the draft regulatory impact assessment.

1. Total hours of care

a. Without a floor and ceiling

Based on the above calculations, a community social care provider with one location that currently pays a fee of £2,192 would pay the same fee with around 810 hours of care, using one week as the unit of measure. Providers with fewer care hours than this would pay less and those providing more care hours would pay more. The decrease or increase would be around £270 for every 100 hours of less or more care provided over the previous seven days if the sample data is representative of the sector overall.

b. With a floor but no ceiling

Based on the above calculations, applying a floor would mean that a community social care provider with one location that currently pays a fee of £2,192 would pay the same fee with around 760 hours, using one week as the unit of measure. The change would be around £400 for every 100 hours of care provided over the previous seven days, if the sample data is representative of the sector overall.

c. With a floor and a ceiling

It is not possible to model the ceiling from the sample as the ceiling needs to be set in relation to known outliers. This will be assessed when data is collected. If a ceiling is applied then it would increase fees for all providers below the ceiling. The large number of providers in this sector means that the increase would be relatively small.

2. Total number of people receiving support

a. Without a floor and ceiling

Based on the above calculations, a community social care provider with one location that currently pays a fee of £2,192 would pay the same fee with around 55 people receiving support. Providers with fewer service users than this would pay around £400 less for every 10 people receiving support, if the sample data is representative of the sector overall. Those with more would pay correspondingly higher fees.

b. With a floor but no ceiling

Based on the above calculations, applying a floor means that a community social care provider with one location currently paying a fee of £2,192, would pay the same fee with around 50 people receiving support. Providers with more care hours than this would pay more. The change would be around £425 for every 10 people receiving support, if the sample data is representative of the sector overall.

c. With a floor and a ceiling

It is not possible to model the ceiling from a sample as the ceiling needs to be set in relation to known outliers. We will assess this when data is collected. If a ceiling is applied then it would increase fees for all providers below the ceiling. The large number of providers in this sector means that the increase would be relatively small.

Consideration of options

We have provided calculations for two from the list of options, but the principles of charging proportionally hold for all options. Providers will wish to weigh all options as there are several different measures of size. We invite providers to consider what would produce the fairest system for charging fees for the whole of the sector. We will seek to apply the one that the sector considers to be the most beneficial.

Interaction between proposals 1 and 2

In addition to this restructure, we will also be increasing the total fee income in this sector to progress further to full chargeable cost recovery. This is set out in proposal 2. To understand the actual fee paid, a provider will need to take account of both proposals.

Data collection

The data required to calculate this will be collected as part of our provider information collection. We have used the data currently available from this to estimate the fees payable above. As we receive more data it will become more accurate. We will need to collect the data once the consultation is closed and we know the measure favoured by the sector. Community social care providers should therefore be prepared to receive a data request in January or early February, which we will ask them to complete within four weeks. This will enable us to calculate fees from 1 April 2018.

Proposal 2: Changes to fee amounts in the fees scheme for community social care providers

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

The previous two years have seen all sectors, except community social care providers, progress to full chargeable cost recovery. Community social care was some way from this position, so their trajectory was extended by a further two years. 2018/19 is the third year of that trajectory and in line with this, fees for the sector as a whole will increase by 15%, which will take total recovery for the sector to £23.7 million (from £20.7 million in 2017/18), leaving a further increase of £2.8 million for 2019/20.

For a provider to understand their full fee, they will need to consider the combined effect of this proposal with proposal 1. Providers should not therefore assume that their individual increase will be 15%. Applying this to the fees from proposal one for both options with no floors or ceilings would mean:

Measure	**Size**	**Indicative fee under Proposal 1**	**Indicative fee including impact of Proposal 2 (+15%)**
Total hours of care	810 hours of care	£2,192	£2,521
	Change by 100 hours	Fee changes by £270	Fee changes by £311
Total number of people receiving support	55 people	£2,192	£2,521
	Change by 10 people	Fee changes by £425	Fee changes by £489

Further detail, including what this would mean for options with floors and ceilings is provided at Annex A1 for total hours of care and A2 for total number of people receiving support. Please note that these are **only** indicative figures.

In very broad terms and based on the above calculations, we expect around 60% of providers to see a reduction against their fee for 2017/18 and 40% to see an increase. The size of the increase/decrease will be dependent on the measure, the option chosen and the size of the provider.

Further details are provided in the draft regulatory impact assessment.

Consultation questions

1. We propose to change the fees scheme structure for community social care providers by charging fees in proportion to the size of a provider relative to the sector.

Do you agree?

Yes ❑ No ❑

1a. What do you think would be the best way to measure the size of community social care providers?:

- Total hours of care (number of hours of regulated activities provided over the last seven days at a location) ❑
- Number of service users (number of people receiving support with regulated activities at a location) ❑
- Annual turnover by location ❑

- Number of staff employed (whole time equivalent staff employed at a location) ❑
- Number of locations ❑
- Other ❑

1b. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

2. Do you want to give any additional feedback about proposals 1 and 2?

……
……..……..

Proposal 3 for NHS GPs

We propose to change the fees scheme structure for NHS GP providers by:

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

As stated in section on 'CQC's strategic context for fees', CQC charges fees on the principle for entering and remaining on our register. We set fees by accounting for the costs incurred by CQC's regulatory work in line with the underpinning principles of fairness and equality. We hold the view that the size of the provider is a suitable measure for complexity and the relative costs of regulation.

The current structure for charging NHS GPs was introduced when NHS GPs first came in to regulation by CQC. Increases in fees and developments in the sector mean that continued use of the current structure creates several issues, highlighted below.

1. Changes in the way primary care is organised
Many GP practices are collaborating in formal ways, such as joining super-partnerships, multi-site practice organisations or other new models of care. We refer to this as large-scale general practice. Some practices have retained their independent status while others are fully integrated within a larger organisation. These changes mean that using locations as a measure of the size of a GP practice appears to us to be increasingly inappropriate. Changes can result in larger organisations paying lower fees than the individual practices prior to reorganisation.

Using locations as a measure does not produce a fee that reflects the costs incurred by CQC for regulation or is commensurate with the complexity of the provider.

2. Changes in the way primary care is provided
Since we introduced our new approach to regulation three years ago, we have seen an increasing number of providers operating across multiple sectors, and we expect to see many more new and complex models of care emerging over the coming years. We have described these as 'complex providers'. The implication for the fees scheme is that we need to explore better ways of measuring the size of the provider, but we can only do this as it becomes clearer how these changes come in to effect.

3. Changes in the way CQC regulates providers

We have recently consulted on how we propose to develop our approach to regulating primary medical services in the context of a changing landscape of care and in line with the direction set out in our new five-year strategy. We have proposed a number of changes to how we will monitor, inspect and rate. There will be a greater role for monitoring, an increase in the number of focused rather than comprehensive inspections and a shorter reporting timetable.

These proposals impact directly and indirectly on our costs of regulation and how we charge fees. We have made significant changes in our approach to inspecting GP surgeries, which will be phased in from November 2017. We are developing our approach to inspecting large-scale general practice and will be testing this approach over the next 18 months with identified providers. This will take time to bed in and costs will be monitored during this period.

4. Measuring the size of NHS GP providers

The fee scheme employs two measures to assess the size of NHS GPs. NHS GPs with one location are banded by list size, while those with more than one location are banded by locations. Changes in the provider landscape and in how we regulate, as discussed above, show that this structure needs to be reviewed. The following two examples highlight why.

- Providers with two or three locations are charged significantly more than providers with one location (up to more than double for two locations and triple for three locations), even though they might look after a smaller number of patients overall.
- Over 90% of providers have one location and the current four bandings mean that the range of fees charged is small compared to the range in size of practices. The differentiation in fees charged does not adequately reflect the differentiation in size of providers.

What this means for fees

As demonstrated, the current fees structure does not fit the way the sector is structured, and it will become increasingly outmoded as the way services are organised and delivered develops further.

Bearing this in mind, we are proposing to adjust the structure of the fees scheme so that it measures size in what appears to us to be a fairer and more equitable way. The changes will benefit smaller providers and ensure a more equitable distribution of fees. This addresses the above point on the changes in the way primary care is organised.

We will follow this with a set of changes over the next few years, which will reflect:

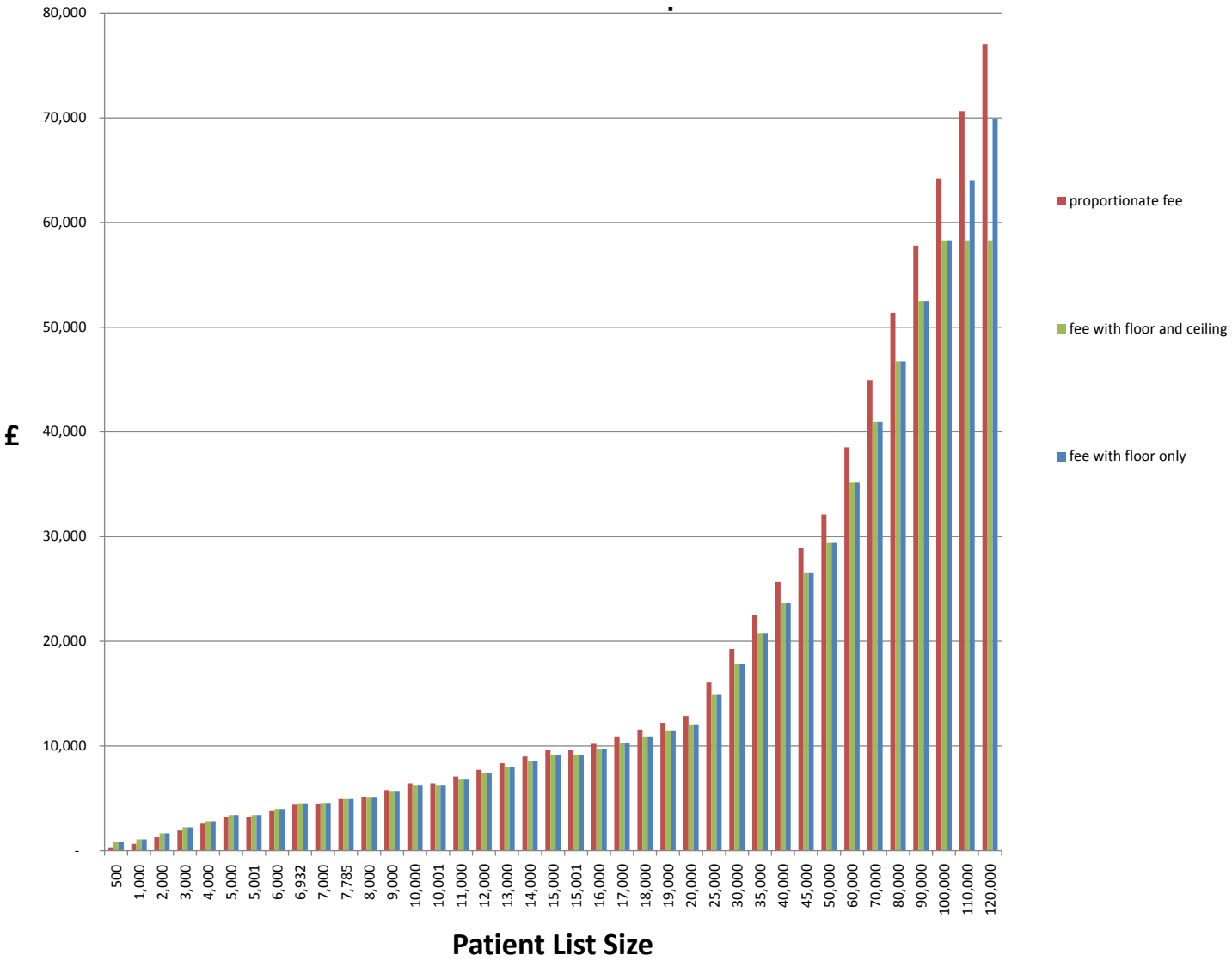
- Continuing restructuring in the sector
- The inclusion of services that are not solely dependent on list size as part of the measure of the complexity and size of a provider

- Changes to our own regulatory model and the impact that it has on the cost of regulating the sector, and consequently fees.

Options

There are three options – one with no floor or ceiling, one with a floor and ceiling, which means that there is a minimum fee for smaller providers and a limit to larger providers, and one with a floor but **no** ceiling. The options are shown in figure 1, using the information that we have for the sector as a whole.

Figure 1: Indicative fee based on GP list size per location



Under the option with no floor or ceiling, a GP provider with a patient list size of 7,000 and one location, will pay a fee of £4,495, which would rise to £4,545 under the option with floor and a ceiling. This compares to a current fee of £4,526. The option with a floor but no ceiling has no further impact on the majority of providers, but means that the largest providers with a patient list size of over

100,000 pay a fee somewhere between the other two options. Both Annex A3 and the draft regulatory impact assessment contains further details for all three options.

Broadly, providers with one location with a list size of less than the mean (estimated at 7,785) will pay a lower fee while those with a higher list size will pay a higher fee. We have estimated the effect of these changes using the data we have available. We believe that this means that around half of providers will pay a lower fee and around half will pay a higher fee.

Consultation questions

3. We propose to change the fees scheme structure for NHS GP providers to one using patient list size per location as the sole measure of size for all NHS GP providers.

Do you agree?

Yes ❑ No ❑

3a. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

4. Do you want to give any additional feedback about proposal 3?

……
……..……..

Proposal 4 for urgent care providers

For the purposes of the fees scheme we define urgent care providers as those providers who are charged fees under the GP fee scheme for the following services: walk in centres, minor injuries units, urgent care centres and out of hours services.

We propose to change the fees scheme structure for urgent care providers by:

- removing the current banding structure for providers with one location
- removing the current banding structure based on the number of locations for providers with more than one location
- adopting a new method of calculating fees (using an option chosen through this consultation).

Currently we charge urgent care providers with one location according to the highest banding for a single location, which is equivalent to the fee for NHS GPs with a patient list size that is greater than 15,000 and those with multiple locations according to the fees scheme for NHS GPs with multiple locations.

Moving NHS GPs to a measure based on patient list size (see proposal 3) means that this is no longer possible. We therefore need to determine an appropriate measure and charge this group according to that.

Options

Establishing an alternative measure for this group requires discussion with suitable providers. We propose to use the consultation period to engage with members and representatives, which consist of about 53 single location and 55 multiple location providers, to determine an equivalent measure to patient list size for them. We will then use the response to the consultation to develop a measure through discussion with the sector and its representatives.

If we are not able to agree on a measure in this timescale then we will retain the fee as it applies to each provider under the current fees scheme.

Consultation questions

5. What do you think would be the most appropriate measure of size for urgent care providers?

……...……
……...

6. Do you want to give any additional feedback about proposal 4?

…….....
.....…….....

Proposal 5 for NHS trusts

We propose to change the fees scheme structure for NHS trusts by:

- removing the current banding structure
- charging fees in proportion to the size of a provider in the sector
- continuing to use annual turnover as the measure of this size for all NHS trusts (using an option chosen through this consultation).

The fees scheme structure for NHS trusts has not changed since 2010, except for fee increases for each band. It is in six wide bands, set by turnover. The scheme needs some adjustment as the highest band is for trusts with a turnover of more than £500 million. Initially only a very small number of trusts fell in to this band. Since then the trend has been for trusts to merge into larger trusts, which means that about 20% of trusts are likely to fall into the top band for 2018/19. Some adjustment is therefore needed to reflect the complexity of the sector and the cost of regulation of individual trusts.

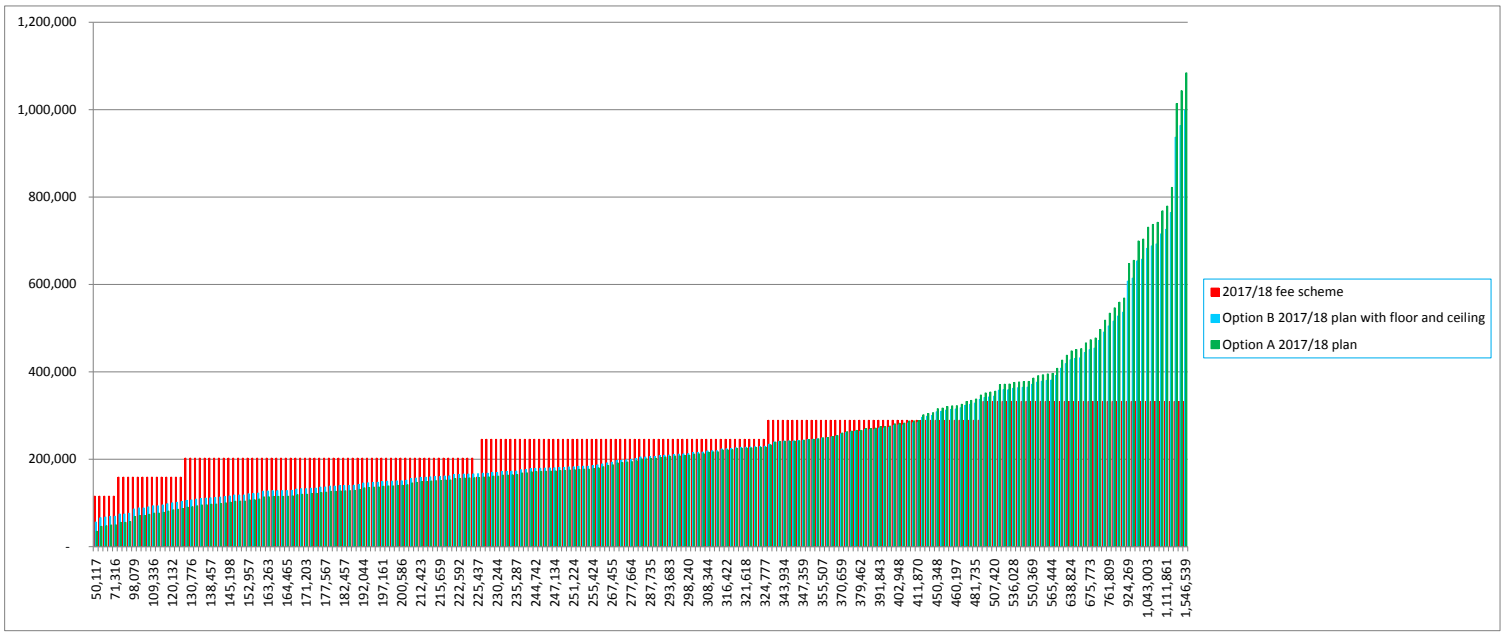
Removing the banding structure and charging fees in proportion to the size of the provider ensures that the fee is aligned more closely to the turnover of the provider and so the complexity and resource demands of each trust.

Options

There are three options: one with no floor or ceiling, one with a floor and a ceiling and one with only a floor. The latter two options are currently the same for this small population as there are no real outliers. However it is important to offer three options as the size of NHS trusts may increase beyond the largest provider that we anticipate for 2018/19. When no floor or ceiling is applied then smaller trusts pay a lower amount and this is rebalanced by larger trusts paying more. The effect is not large and under both options around 75% of trusts will see some form of reduction while the remaining 25% will see an increase.

With no floor or ceiling, NHS trusts will pay a fee that is around 0.07% of their income. With the introduction of a floor and ceiling, smaller trusts will see this rise to around 0.11% and larger trusts will see a fall to around 0.06%. Details on what individual trusts are likely to pay can be found at Annex A4 with more details in our draft regulatory impact assessment.

Figure 2: Indicative fee distribution for NHS trusts



Consultation questions

7. We propose to change the fees scheme structure for NHS trusts by charging fees in proportion to the size of a provider in the sector measured using annual turnover. Do you agree?

Yes ❑ No ❑

7a. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

8. Do you want to give any additional feedback about proposal 5?

……
……

General comments for all providers

The proposals in this consultation are part of our continuing review of the fees scheme to ensure that fees are charged and distributed proportionately, and to ensure it captures developments within each sector now and in the future. If you are in a sector that has not been affected by these proposals, we invite you to comment generally on our approach and also on what areas we should consider in the future. Please provide your reasoning and any comments that you believe will help us to decide the most appropriate approach to your sector.

Consultation questions

9. What sectors do you think we should review in future fee consultations?

……

9a. Do you have any suggestions for how we might charge fees for these services……

……

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

……

How to give us your views

The questions we have asked about fees from April 2018 for providers that are registered under the Health and Social Care Act 2008 are:

1. We propose to change the fees scheme structure for community social care providers by charging fees in proportion to the size of a provider relative to the sector.
Do you agree?
Yes ❑ No ❑

1a. What do you think would be the best way to measure the size of community social care providers?:

- Total hours of care (number of hours of regulated activities provided over the last seven days at a location) ❑
- Number of service users (number of people receiving support with regulated activities at a location) ❑
- Annual turnover by location ❑
- Number of staff employed (whole time equivalent staff employed at a location) ❑
- Number of locations ❑
- Other ❑

1b. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

2. Do you want to give any additional feedback about proposals 1 and 2?
……
……..,……..

3. We propose to change the fees scheme structure for NHS GP providers to one using patient list size per location as the sole measure of size for all NHS GP providers.
Do you agree?
Yes ❑ No ❑

3a. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

4. Do you want to give any additional feedback about proposals 1 and 2?
……
……..……..

5. What do you think would be the most appropriate measure of size for urgent care providers?

……..……
……...

6. Do you want to give any additional feedback about proposal 4?

…….....
.....…….....

7. We propose to change the fees scheme structure for NHS trusts by charging fees in proportion to the size of a provider in the sector measured using annual turnover. Do you agree?
Yes ❑ No ❑

7a. If fees are based on the size of the provider, would you prefer:

- No minimum fee (floor) and no maximum fee (ceiling) ❑
- A minimum fee (floor) and a maximum fee (ceiling) ❑
- A minimum fee (floor) but **no** maximum fee (ceiling) ❑

8. Do you want to give any additional feedback about proposal 5?

…….....
...……

9. What sectors do you think we should review in future fee consultations?

…….....
...……

9a. Do you have any suggestions for how we might charge fees for these services…….....
.....……

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

…….....
...……

Please send us your response by midday on 18 January 2018

You can respond to our consultation in two ways:

Online
Use our online form at **www.cqc.org.uk/FeesConsultation2017**

By email
Email your response to **feesconsultation@cqc.org.uk**

Annex A – Indicative fees for 2018/19

A1 – Community Social Care: Total hours of care

All figures are indicative. The option for ceilings has not been included as it can only be assessed properly once data is collected. Further detail on the calculation is contained within the regulatory impact assessment.

	Option 1a		Option 1b	
	Proposal 1	Including 15% Uplift from Proposal 2	Proposal 1	Including 15% Uplift from Proposal 2
Total hours of care	Indicative fees with no floor	Indicative fees with floor	Indicative fees with no floor	Indicative fee with floor
	£	£	£	£
100	268	308	576	662
Median 500	1,339	1,540	1,540	1,771
1,000	2,672	3,073	2,740	3,151
2,000	5,356	6,160	5,155	5,928
3,000	8,007	9,208	7,541	8,672
5,000	13,394	15,403	12,390	14,249
32,000	85,398	98,208	77,193	88,772
42,200	113,081	130,043	102,108	117,424

A2 – Community Social Care: Total number of people receiving support

All figures are indicative. The option for ceilings has not been included as it can only be assessed properly once data is collected. Further detail on the calculation is contained within the regulatory impact assessment.

	Option 2a		Option 2b	
	Proposal 1	Including15% Uplift from Proposal 2	Proposal 1	Including 15% Uplift from Proposal 2
Total no. of people receiving support	Indicative fees with no floor £	Indicative fees with floor £	Indicative fees with no floor £	Indicative fee with floor £
5	197	227	499	574
10	394	453	676	777
15	591	680	853	981
Median 30	1,182	1,359	1,385	1,593
50	1,970	2,266	2,094	2,408
100	3,939	4,530	3,867	4,447

500	19,697	22,652	18,048	20,755
2,000	81,939	94,230	74,066	85,176

A3 – NHS GPs: Indicative proposed fees

Further detail on the calculation is contained within the regulatory impact assessment.

List size	Indicative fee based on list size per location £	Indicative fee based on list size per location with floor and ceiling £	Indicative fee based on list size per location with floor only £
500	321	789	789
1,000	642	1,078	1,078
2,000	1,284	1,656	1,656
5,000	3,211	3,390	3,390
Median 7,785	4,999	4,999	4,999
10,000	6,421	6,279	6,279
15,000	9,632	9,169	9,169
20,000	12,842	12,058	12,058
40,000	25,685	23,616	23,616
60,000	38,527	35,174	35,174
80,000	51,369	46,732	46,732
100,000	64,211	58,290	58,290
120,000	77,054	58,290	69,848

A4 – NHS trusts: Indicative proposed fees

Further detail on the calculation is contained within the regulatory impact assessment.

Indicative size of provider	Turnover £000	Indicative proportional fee with no floor or ceiling £	Indicative proportional fee with floor and ceiling £	Indicative proportional fee with floor only £
mean	352,044	245,464	245,482	245,482
median	286,335	194,597	199,702	199,702
smallest	50,117	35,124	56,176	56,176
largest	1,546,539	1,083,870	1,000,048	1,000,048
maximum fee (example)	1,600,000	1,121,337	1,033,769	1,033,769
example	1,800,000	1,261,504	1,033,769	1,159,919
example	2,000,000	1,401,672	1,033,769	1,286,069

Annex B – Key principles for setting fees

We work to key principles to guide how we set fees. These reflect the principles for managing public resources and the standards expected of public service bodies, set out in HM Treasury's guide to Managing Public Money.

	Guiding principles	Key actions
1	**Demonstrate fairness and proportionality**	• Involve stakeholders in advising on how to distribute charges and grant-in-aid, and on reasonableness of charges. • Balance providers' different situations, including their size, complexity and inherent risk, with our income requirements and the government requirement for full recovery of chargeable costs.
2	**Reflect costs**	• Ensure we use an evidence-based approach that is derived from a better monitoring of costs, so that our charges increasingly reflect in more detail the costs of our activity.
3	**Make fees simple**	• Make the structure of fees as intuitive as possible, so they are seen to relate to costs.
4	**Be transparent**	• Build the approach from an open discussion about CQC's actual costs. • Involve stakeholders openly and on an ongoing basis.

Annex C – Our fee-setting powers

Our powers for setting fees[1] are flexible, to enable a proportionate approach. For example, they allow us discretion to set:

- Different fees for different types of services.
- Different fees for different types of providers.
- Different fees, based on other criteria that we may specify.
- Flexibility for us to determine when payments fall due.

Our powers for setting fees extend to our registration functions under chapter 2 of the 2008 Act. These functions cover all our activities associated with registering providers, making changes to their registration and carrying out inspections. Other existing responsibilities, such as our work under the Mental Health Act, are not included within our registration functions, and their costs are covered instead by grant-in-aid from the Department of Health.

In addition, our powers to set fees extend to our review and performance assessment functions under chapter 3 of the 2008 Act by virtue of the Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016, which came into force on 1 April 2016. These functions cover all our activities associated with rating services.

[1] See Annex C.

Annex D – Section 85 of the Health and Social Care Act 2008

85 Fees

(1) The Commission may with the consent of the Secretary of State from time to time make and publish provision—

(a) requiring a fee to be paid in respect of—
i. an application for registration as a service provider or manager under Chapter 2,
ii. the grant or subsistence of any such registration, or
iii. an application under section 19(1);
(b) requiring English NHS bodies, English local authorities, persons registered under Chapter 2 and such other persons as may be prescribed to pay a fee in respect of the exercise by the Commission of such of its other functions under this Part as may be prescribed.

(2) The amount of a fee payable under provision under subsection (1) is to be such as may be specified in, or calculated or determined under, the provision.

(3) Provision under subsection (1) may include provision—
(a) for different fees to be paid in different cases,
(b) for different fees to be paid by persons of different descriptions,
(c) for the amount of a fee to be determined by the Commission in accordance with specified factors, and
(d) for determining the time by which a fee is to be payable.

(4) Before making provision under subsection (1) the Commission must consult such persons as it thinks appropriate.

(5) If the Secretary of State considers it necessary or desirable to do so, the Secretary of State may by regulations make provision determining the amount of a fee payable to the Commission by virtue of this section, and the time at which it is payable, instead of those matters being determined in accordance with provision made under subsection (1).

(6) Before making any regulations under this section, the Secretary of State must consult the Commission and such other persons as the Secretary of State thinks appropriate.

(7) For the purpose of determining the fee payable by a person by virtue of this section, the person must provide the Commission with such information, in such form, as the Commission may require.

(8) A fee payable by virtue of this section may, without prejudice to any other method of recovery, be recovered summarily as a civil debt.

Annex E – Protecting your rights

Following the Code of Practice

This consultation follows the Cabinet Office Consultation Principles. In particular we aim to:

- Be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses.
- Ensure that our consultation is clear, concise and widely accessible.
- Ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- Monitor our effectiveness at consultation, including through the use of a designated consultation coordinator.
- Ensure our consultation follows better regulation best practice, including carrying out a regulatory impact assessment if appropriate.

Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding.

We will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Further information

If you have any comments or concerns relating to the consultation process that you would like to put to us, please write to:

Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

How to respond to this consultation

Online

Use our online form at:
www.cqc.org.uk/FeesConsultation2017

By email

Email your response to:
feesconsultation@cqc.org.uk

Please send us your response by midday on 18 January 2018

Please contact us if you would like a summary of this document in another language or format.

If you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

www.cqc.org.uk

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