CareQuality Commission

Regulatory fees from April 2018 under the Health and Social Care Act 2008 (as amended)

Our response to the consultation

March 2018

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

Our purpose

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

Our role

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

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

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

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Summary

Legal setting

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

We consulted between 26 October 2017 and 18 January 2018 on our proposals for a fees scheme to take effect from 1 April 2018. We set out details of our proposals for this year's fee scheme in the consultation document and sought providers' views to the questions we posed. We invited respondents to comment on the fee proposals on their service, so that we could consider these views carefully in deciding our approach. We have set out those views to CQC's Board, the Department of Health and Social Care (DHSC) and HMT.

Fees response documents

This document is CQC's response to the comments we received on our recent consultation. It summarises the changes that will be made to the 2018/19 fees scheme.

We have also published separate documents alongside this summary on our website:

- The legal scheme of fees from April 2018.
- An analysis report of the consultation responses.
- A regulatory impact assessment to assess the overall economic impact of the fees scheme.
- An equality and human rights duties impact assessment.
- Fees guidance for providers.

Summary of responses to our consultation

We received 238 responses, which is low in terms of total number of providers and compared to the previous two consultations. This is not surprising given that in previous consultations, all providers were impacted by increasing fees. In this consultation, only half of providers will see any changes to their fees and, of those, only one sector, community social care, will see an overall increase.

The changes in other sectors will not change the fees that we collect overall, but they will see a readjustment so that generally, larger providers will see an increase in fees while smaller providers will see a reduction.

The themes of respondents' feedback to the specific proposals in our consultation are reviewed in this document, and are set out in more detail in our separate analysis report.

Our response to the consultation

In coming to our decisions on each of the proposals, we have taken account of the responses received and the voices of the national bodies, who represent a large number of members. Where there is no clear consensus we have acted in what we consider to be the best interests of the sector and people who use the services, and have given our reasons. We set this out in this document in each section.

Our decision on fee charges in 2018/19

We intend to charge fees in 2018/19 as proposed in our consultation, as follows:

Proposal one: Community social care providers

- We will replace the current banding structure.
- We will charge fees in proportion to the number of service users as the measure of size for all community social care providers.
- We will set a minimum and a maximum fee.

Proposal two: Community social care providers

- We will increase fees for this sector by £3 million, as it is the third year of a four year trajectory to full chargeable cost recovery.

Proposal three: NHS GPs

- We will remove the current banding structure based on patient list size for providers with one location.
- We will remove the current banding structure based on the number of locations for providers with more than one location.
- We will charge 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.
- We will set a minimum and a maximum fee.

Proposal four: Urgent care providers

- We will retain the current banding structure for providers with one location and with more than one location.

Proposal five: NHS trusts

- We will remove the current banding structure.
- We will charge 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.
- We will not set a minimum or a maximum fee.

Conclusion

The Secretary of State has consented to the fees scheme as described above, and it will take legal effect from 1 April 2018. We will not make any further changes to the scheme

in 2018/19 other than those outlined above. Our consultation on fee charges for 2019/20 will be published in the autumn of 2018.

Details about why we have made the changes to our fees scheme are given in the chapter 'Responses to the proposals in our consultation'. Further information is also available in our regulatory impact assessment, and our analysis of responses report, which are available on our website.

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

Overview of our response to the consultation

Background

Previous consultations have had to address the issue of a move to full chargeable cost recovery in line with HM Treasury policy. All but one sector is now in that position. This provides us with the opportunity to review the fees scheme and to ensure that fees are charged equitably and fairly, and that they respond to changing structures and conditions in the sectors we regulate.

With this in mind, our proposals focused on:

- NHS trusts
- NHS GPs
- Community social care providers

We considered these areas to be most in need of review as a result of significant developments within the sector that impact the fees scheme, or because we have a clear requirement to review how fees are distributed fairly and in line with our resources.

Feedback from respondents

Feedback was generally positive to the need to change and the proposals being made. We have responded to all comments in the individual sections relevant to each proposal. There were a number of comments that were about the fees scheme in general, which are considered in this section.

Consideration of CQC's fees scheme

Many providers commented on the size of CQC's fees, believing them to be too high. Other comments flowed from this and can be grouped around two areas:

- The impact of fees on providers.
- The need for CQC to reduce its costs.

Providers felt that CQC's fees diverted resources away from the frontline, and that services would struggle to absorb any increases in fees so these increases would have to be passed on to people who use services.

Comments on CQC's fees also highlighted respondents' expectations of a reduction in fees, particularly since CQC was moving from a comprehensive inspection model to an intelligence-led, risk-based approach.

In our response, we do understand these concerns. Some providers have doubted that we do understand, but we have had to switch our funding from government to providers, which is why fees have risen. During this time our overall budget has reduced and will continue to do so through to 2019-2020. We have achieved these reductions in our budget through strong management of our expenditure. At the same time, our strategy will move us from the comprehensive inspection model to a more responsive, targeted and collaborative approach. To do this, we need to make the right decisions

with the right resources and the right investment. As we progress we are looking to keep our costs as low as possible and improve our efficiency and effectiveness. This will be reflected in our fees.

Our decision for fee charges in 2018/19

Taking into account all responses, we invited the consent of the Secretary of State to allow CQC to charge fees in 2018/19, based on the amounts we set out in our consultation. The outcome is that, from 1 April 2018, we will charge fees in 2018/19 as set out on page 4.

Proposals one, three and five, considered the same outline solution for each sector. Our individual responses are set out under each proposal. The overall approach is considered here.

General approach

Proportionate fees
Proposals one, three and five all suggested moving from a banded to a proportionate approach. A proportionate approach means charging a provider the same proportion of the total cost of regulating the sector as the size of that provider to the whole sector. As an example, consider a sector where the size of the provider is measured in widgets. The total size of all the providers in the sector is 2,000 widgets. This sector costs £1 million pounds to regulate. If a provider is 200 widgets in size, then the fee they will pay is 200/2,000 of £1 million, which is £100,000.

This removes the steps in the bandings where a small change in a provider's position might incur an inequitable increase or decrease in fees. Charging fees in proportion to their size removes this problem. It is, in effect, a very detailed form of banding and allows us to respond appropriately to small and large changes.

Calculating the fee for each provider means that we cannot charge more than it costs us to regulate the sector, as we distribute a portion of the total cost of regulation to each provider.

Floors and ceilings
Setting a floor and a ceiling, or a minimum and a maximum fee ensures that there is no distortion due to outliers. With no ceiling (maximum fee), very large providers would pay very high fees, which would probably be well in excess of the actual cost of regulation. With no floor (minimum fee) very small providers would pay well below the cost of regulating them. So a ceiling, limiting high fees, and a floor, preventing low fees, would guard against this. This becomes an issue when the range of the size of providers from smallest to largest is large. It is not an issue when the range is small, which is why we have not applied it to NHS trusts, but have applied it to NHS GPs and community social care providers. For NHS trusts the largest trust is only thirty times larger than the smallest trust, so there are no outliers. The scale is in the thousands for the other two sectors.

Throughout the paper we will use the terms 'floors' and 'ceilings', except in the more formalised statements on proposals, which will use the terms 'minimum' and 'maximum'.

Analysis of responses

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

We made five proposals in our consultation. We considered all responses to these questions. Where respondents had commented on sectors which were not their own, we considered those comments but decided to give less weight to them generally in reaching our decisions, because we felt that that it was important to ensure that the views of providers impacted by the proposals were given precedence.

Responses to the proposals in our consultation

Proposal 1

We proposed 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).**

There were three parts to this proposal and we take them in order in each section:

- The move to a proportionate approach
- The measure to use
- Whether to set a floor and a ceiling

For shorthand, the following terms are used:

- *Total hours of care* for 'the number of hours of regulated activities provided by the service at a specified period'; and
- *Number of service users* for 'the number of people receiving support with regulated activities from the service at a specified period'.

Your response and comments to proposal 1

Moving to a proportionate approach

Of the 92 community social care providers who responded to this proposal, 77 were in favour of replacing the current banding structure and moving to a proportionate approach and the remaining 15 against. Five of the six national bodies were also supportive of the move; the remaining one did not offer a view.

There were few comments around this part of the proposal as many have recognised that the current banded approach does not properly reflect the size or split of providers in this sector, leading to potential inequity in the way fees are charged.

The measure to use

Of those in favour, and who also went on to consider the measure that should be used for this proportionate approach, the position was much more mixed. In the consultation we offered several options listed below:

1. Total hours of care
2. Number of service users
3. Annual turnover
4. Number of staff employed
5. Number of locations.

Options three, four and five were supported by 13 providers between them. The majority were split between the first two, with 35 preferring total hours of care and 26 the number of service users. The remaining three providers suggested other alternatives which were variations or combinations of the above. National organisations were also split, with three favouring total hours of care, two the number of service users and one the number of locations.

Providers were open in saying that their 'vote' for either contact hours or service users generally depended on what was better for them. One national body raised the point that a provider could have a large number of clients all with packages with only a few hours of care each, or equally a small number of clients with large care packages. Therefore, some providers will be disadvantaged whichever option is chosen.

Even though these were the two most popular options, there were concerns about the practicality of using either measure. Those considering contact hours were concerned about separating out regulated and non-regulated hours, determining the period this would be measured over, and how adjustments would be made for variations. Those commenting on service users were concerned with how this measure was determined.

Providers raised concerns over disincentivisation, where both options could adversely influence the sort of care packages that providers would be prepared to take on.

The remaining options also received comment, but very little favour. Full details are recorded in the analysis document.

Floors and ceilings

There was also a split view over floors and ceilings: 32 wished to have both, while 29 wanted none and 15 wanted a floor but no ceiling. The national bodies were equally split with two favouring both, two favouring neither and one a floor but no ceiling.

There was less comment on this area. Those supporting floors said that providers should pay a minimum cost to have their services regulated and that it would act as a positive barrier against 'fly by night organisations'. Those against floors said that it would better support small providers against volatility and shrinkage.

Those who supported ceilings did so because of the view that there would be a cut-off point where costs of regulation would plateau regardless of the size of a provider.
One criticism of floors and ceilings was the view that the smallest and largest providers would not pay proportionate fees, leading to a disparity in the way that these providers would be charged as opposed to the rest of the sector.

Our decision on proposal 1

We have decided to:

- Move from a banded approach to a proportionate approach in charging fees
- To use number of service users as the measure of size for all community social care providers
- To set a minimum and a maximum fee

Our response to your feedback on proposal 1

Moving to a proportionate approach

A move to a proportionate approach is also our preferred approach and is in line with the responses, particularly the national bodies. We believe that this represents a very positive step in producing fairer fees within the sector.

The measure to use

It is clear that the two most popular measures are total hours of care and number of service users. Numerically the support was in favour of total hours of care, but this is a very small number and the national bodies, who represent significant numbers of providers, were divided. Arguments for and against both measures were clearly and cogently argued. It was also clear that providers would make the argument for the measure that was most favourable to them. A number did declare this.

This was not an easy decision. We currently collect both sets of information for a small number of providers as part of our Market Oversight work. We also collect both sets as part of the pre-inspection provider information return, as well as the provider information return, that we will be launching later this year. One of the key concerns in making the decision was to be able to calculate fees easily and accurately, and so the data collected, which enabled this, had to be easy to understand, collect and validate.

On weighing all the arguments and views, we opted for the number of service users, except for nursing agencies who will still be charged based on number of locations because they are structured differently. Our decision has been made on the basis that service user data is easier to define, understand and collect and meets most of the concerns raised by the sector. Our reasoning is set out below.

We believe that the number of service users is a more stable figure over a period of time as there is likely to be less variation in those numbers than in total hours of care. This means that fees are less likely to be affected overall by changes in the numbers. It is also easier to collect. Some concerns were raised over the inclusion of respite care in the definition of number of service users, but this is a relatively small problem compared to the wider range of issues affecting the definition of total hours of care. These arguments lean towards the view that there is greater certainty around collecting and verifying the figure for the number of service users.

The information that we possess as a result of preparatory work for the provider information returns also shows that the range between the highest and lowest number of service users is smaller than the equivalent range for total hours of care. The draft regulatory impact assessment contains more detail on this. This means that in charging providers proportionately, the range between the highest and lowest fees will be lower using service users as a measure and will reduce the issue around fees that are too small or excessively large. There is more on this in the section on floors and ceilings.

In terms of collection of data in relation to number of service users, we have had an excellent response from providers. Appendix 1 shows how to apply the formula. Full information on how we are calculating fees is contained in our 'Fees scheme 2018/19: Guidance for providers' document. The figures incorporate the increase as a result of proposal 2.

In terms of the comments made about disincentivisation, our view is that generally the relative change in value that would be produced in our fees will be too low to impact the overall decision that a provider will make. The smallest providers might feel some impact, but the employment of a floor will provide protection for this, as the fee will not increase up to a certain threshold. We will review this as part of the 'bedding-in' process.

The remaining options are commented on fully in the analysis report and, although very few were favourable in their use, we will briefly review the reasons for discounting them.

Turnover is a difficult figure to collect for all the various types of providers and is also difficult to define, particularly as we would also need to differentiate turnover generated from regulated activities from that generated from non-regulated activities.

Locations data is easy to collect, but does not remove the initial problem that the number of locations is a poor measure of size for a provider. It would simply produce a more granular structure for the fees scheme that we currently have.

Finally, the number of staff suffers from the triple problems of variability of numbers, the difficulty to define, and the further difficulty of disaggregating regulated and non-regulated activities.

Floors and ceilings

We believe that a floor and a ceiling is important for this sector as, even using the number of service users, the range will be relatively large between the largest and smallest providers. A ceiling will ensure that the largest providers will not pay a fee that is disproportionate to the costs of regulation. A floor will ensure that the smallest providers still make a reasonable contribution to the cost of regulation. Many respondents acknowledged that we are crucial to ensuring high-quality and safe care, so it is reasonable that our funding model ensures that all providers contribute fairly.

Impact on the fees scheme in 2018/19

As a result of this proposal there is no change to the total income recovered from the sector, but there will be a shift in the way that fees are charged. It needs to be read in conjunction with proposal two, which does increase the total amount of fees recovered.

During March, we are collecting the details required to calculate and charge fees. We will not be able to state what the actual fee is for an individual location until we have completed this work. This means that all the figures in this document related to this proposal are indicative. However, the analysis that we have done on the data that we do have, shows that the majority of providers operate from one location and that fees will fall for all small providers registered with one location; similarly fees will increase for all large providers registered with one location. This is simply because we have a much more sensitive scale on which to measure the size of providers. The size of the actual fall or increase will depend on the information submitted.

It is more difficult to predict how fees will change for providers with more than one location until we have finished collecting the details required.

Despite these caveats, it is clear that larger providers will pay higher fees. This is inevitable because the intention has been to distribute fees more fairly. Locations are a

poor measure of size and many small providers are paying a disproportionately high fee, considering what it costs to regulate them, against larger providers. We do acknowledge that this means sizeable increases for some providers, but we believe that this more fairly aligns our charges to our resources, making it fairer for the sector as a whole.

Proposal 2
We proposed 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.)

Your response and comments to proposal 2

Very few providers commented on this proposal, as most are aware of the requirement. The small number (six) who did, observed that it was high in relation to inflation and some commented that it would directly impact service provision. One national body did note that CQC had been tasked with this by government.

Our decision on proposal 2

We will increase fees for this sector by £3 million as the third year of a four year trajectory to full chargeable cost recovery.

Our response to your feedback on proposal 2

This proposal did not include any questions or options. It is a continuation of our move to full chargeable cost recovery, as required by HM Treasury policy. For community social care providers, this is the third year of a four year trajectory. All other providers reached this position during 2017/18.

Two specific comments were made about the implication of fee increases. Firstly, the increase does not relate to inflationary pressures. As funding increases from providers to achieve full chargeable cost recovery, our funding from government decreases by exactly the same amount. Secondly the concern around the effect that increased fees has on provider resources. As pointed out we do have to make this transition in funding. It is also worth remembering that, even with such increases, fees are a small part of all the expenses faced by a provider. That said, we do agree that the regulatory burden on providers should be appropriate to the work required, and to that end we have reduced our costs year on year and are achieving greater efficiencies, which has limited the increase seen by the sector.

Impact on the fees scheme in 2018/19

As a result of this proposal, we will collect a further £3 million from the sector as a whole. Our funding from the government will decrease by the same amount, because our overall costs of regulating the sector do not change. The effect on providers will vary as each will be individually affected by the results of proposal one. All fees charged will have the increase built in to the fee, but because of the redistribution of fees as a result of proposal one, many providers will still see their fees fall against the 2017/18 fee.

Proposal 3
We proposed 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).**

There were two parts to this proposal and we take them in order in each section:

- The move to a proportionate approach using patient list size
- Whether to set a floor and a ceilings

Your response and comments to proposal 3

Moving to a proportionate approach

Fifty-eight NHS GP providers responded to this proposal. Of these, 23 agreed with the move away from a banded approach while 35 opposed such a move. The three national bodies that responded all favoured the move to a proportionate approach.

Floors and ceilings

Of those who agreed to the move, 13 wanted both a floor and a ceiling, six wanted neither and three a floor but no ceiling. One national body was in favour of a floor and ceiling.

Other comments

The comments from this sector generally struck a cautious note. The use of patient list size was accepted, but one national body considered that it did not represent the complexity of providers. A number of providers were concerned about the method used to collect the patient list size and that it could deter collaborative working.

Provider performance was also suggested as a measure for fees with the view that it would act as an incentive to drive improvements.

Our decision on proposal 3

We have decided to:

- Move to a proportionate from a banded approach in charging fees using patient list size for all NHS GP providers
- To set minimum and maximum fees

Our response to your feedback on proposal 3

Moving to a proportionate approach

We have decided to move to a proportionate approach using patient list size as a measure for all providers, using the patient list size as published by NHS Digital. While the 'majority' view, in terms of straightforward count, opposed the change, all national bodies endorsed it and they represent a significant number of providers.

Our reasoning in the consultation showed that the current structure, with its two measures of patient list size and number of locations, does not adequately reflect the differentiation in size and range of practices. Changes to the way providers in this sector are organised and the provision of services exacerbate that. The move to a more proportionate method provides a better basis for aligning fees more closely with the cost of regulation. We agree that the provision of services, the way in which they are offered and the structure of providers, is becoming more complex. We will need to continue to review the structure of the fees scheme to keep pace with this.

Floors and ceilings

The views on a floor and ceiling were mixed, though there is a mild preference for both. We have decided to employ both a floor and a ceiling, given the range in size of providers. We believe that this maintains a reasonable alignment between our costs and fees as there is a minimum cost to being on the register regardless of the size of a provider. A ceiling reduces the possibility of larger providers paying a significantly larger fee than it costs to regulate them.

Other comments

The nature of a proportionate approach means that a provider will always pay in proportion to the size as measured by patient list size – so a provider with double the list size of another provider will broadly pay twice the fee. We are confident that this approach will not deter collaborative working. The proportionate nature of the fee means that it will be broadly cost neutral for any collaborative working that involves restructuring. The sum total of the fees of any number of organisations will be the same as the fee of the combined organisation, where the number of patients and the number of locations remains unchanged.

We have not considered using provider performance to incentivise improvement by charging lower fees to those rated as outstanding or good in this proposal. We can understand the popularity of this among providers, but it would complicate our charging system and the decrease offered would be small. We will continue to review this position, but it is more effective for us to concentrate on reducing our costs overall.

Impact on fees scheme 2018/19

Overall there is no change to total income recovered from the sector, but there will be a shift in the way that fees are charged. The change will depend on how the patient list size varies for each provider. Generally providers currently at one location with patient list sizes larger than the average will pay more while providers with one location and below average list sizes will pay less. The position for providers with more than one location will depend on the current number of locations registered and the patient list

size that will be recorded for each location. Further detail is provided in the regulatory impact assessment.

NHS GP providers have been reimbursed for their fees via their GMS contract for the last two years.

Proposal 4
We proposed 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 charging fees (using an option chosen through this consultation).**

Your response and comments to proposal 4

No responses were received from urgent care providers. Two national bodies did comment. One suggested adopting the Integrated Urgent Care (IUC) contract value as the measure. The other did not make any suggestions, but did agree with retaining the current approach if no agreed alternative approach was possible before the end of the consultation.

Our decision on proposal 4

We have decided to:

- Retain the current fee structure for urgent care providers until we can determine a better approach.

Our response to your feedback on proposal 4

We received one suggestion, but received no other representation from any of the providers from this small though important sector. We will explore the recommendation further during the coming year.

Impact on fees scheme 2018/19

There is no impact on this area as we are not changing the fee structure. However we do now show them separately in the fees scheme, as NHS GP fees will be calculated differently from 1 April 2018.

Providers should note that where a provider of NHS GP services also provides urgent care services (which can include out-of-hours services) from the same location, that a fee will be payable in respect of both the NHS GP services and also for the urgent care services. This reflects the different approaches to regulation of these services and also takes into account that urgent care services do not have a patient list size.

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).**

There were two parts to this proposal and we take them in order in each section:

- The move to a proportionate approach using turnover
- Whether to set a floor and a ceiling

Your response and comments to proposal 5

Twelve NHS trusts responded to this proposal and 10 agreed with the move to a proportionate approach, with two opposing it. The one national body that responded was also in favour of the move to a proportionate approach.

Of the 10 providers in favour of the change, four favoured both a floor and a ceiling, five neither and one a floor but no ceiling.

The only specific comment received, other than to express views on the proposals, concerned the view that 'NHS trust' as a category is too simple.

Our decision on proposal 5

We have decided to:

- Move to a proportionate from a banded approach in charging fees using turnover
- To have no minimum and maximum fees

Our response to your feedback on proposal 5

We have decided to move to a proportionate approach, using turnover as the measure. The responses are generally in line with this and we believe that it is the best approach for the sector as it ensures a better distribution of fees across the sector.

Views on a floor and a ceiling tended towards not having them. CQC's position is in agreement with this stance. The largest NHS trust is about thirty times larger than the smallest, which is a much lower range than in any other sector and so does not give rise to the same distortion in the size of fees. Because there is no floor or ceiling, all trusts pay about 0.07% of their total budget towards fees for CQC. We believe that this reasonably reflects the level of resource that we require for each trust, when factoring in their size.

We agree that the NHS trust category does need to be reviewed, and we will consider that as part of our future work.

Impact on fees scheme 2018/19

Overall there is no change to the total income recovered from the sector, but there will be a shift in the way that fees are charged. The largest 25% of providers will pay higher fees while the 75% below this will pay lower fees. Further detail is provided in the regulatory impact assessment.

Future fees developments

We also asked for feedback on future developments. There were no strong individual themes, but the comments did show that there was a clear desire to see all aspects of the scheme reviewed at some point. Full details can be found in the *Fees 2018-19 consultation analysis*.

We intend to consult again in the autumn of this year and will use the information that the feedback has given us to identify the areas that will be most in need of review for 2019/20. Where these are specific to a sector, we will engage with key stakeholders in each sector so that we can develop our proposals collaboratively. We will also review the changes we are implementing for 2018/19 to ensure that the proposals are working as we envisaged and are fit for the future. From that work we will set out specific proposals that will come into effect on 1 April 2019, subject to the Secretary of State's consent to our fees scheme. We will also set out our early thinking on areas that may potentially change over subsequent years, which we will consult on at the appropriate time.

During 2017/18, the regulation of hospices transferred from our adult social care directorate to our hospitals directorate. This was a minor technical change and there is no immediate impact on the fee structure, so the fees charged will remain unchanged. See Part 9 of the fees scheme.

Appendix 1 – Table of fee charges in 2018/19 for all providers by fee category

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

The fee payable under paragraph 2(1) in respect of providers who are NHS trusts (on 1st April 2018) is to be calculated as follows:

A. The calculation for Part 1:

$\frac{\textbf{Turnover}}{\textbf{Total turnover}}$	X	£ Cost	=	£ Fee payable

B. Definitions specific to Part 1:

1) **Turnover** is

   (a) the total operating revenue received by a NHS trust as shown in the latest audited accounts to be published for the trust as at the date the fee falls due, or

   (b) where no such accounts are available, or where the trust is a new NHS trust or has had services transferred to it from another NHS trust since the date of those accounts, the estimated operating revenue as shown in the trust's business plan for the year in which the fee falls due.

2) **Total turnover**: is the total annual turnover of all NHS trusts.

3) **£ Cost**: is the current full chargeable budgeted cost of regulating NHS trusts.

4) **£ Fee payable**: is the amount to be paid by providers who are NHS trusts.

C. And subject to the following:

1) For any new NHS trust created after 1 April 2018 the calculation (with the definitions and amounts being identical to those used in the calculation in Paragraph **A** of **Part 1**) will be as follows:

£ Cost / Total Turnover	=	0.071%			
	Turnover	**X**	**0.071%**	**=**	**£ Fee payable**

Turnover in this calculation is the estimated operating revenue as shown in the trust's business plan for the year in which the fee falls due.

Any recalculation of fees for NHS trusts (and guidance in relation to that) which may be necessary as a result of, for example, changes in their composition/structure will be published on the CQC website (www.cqc.org.uk/fees)

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

	Fee charge
Number of locations	**2018/19**
1	£10,968
2 to 3	£21,917
4 to 6	£43,836
7 to 10	£87,670
11 to 15	£141,820
More than 15	£193,390

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

	Fee charge
Number of locations	**2018/19**
1	£1,867
2 to 3	£3,728
4 to 6	£7,456
7 to 10	£14,910
11 to 15	£29,820
More than 15	£59,640

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

	Fee charge
Number of locations	2018/19
1	£1,743
2 to 3	£3,479
4 to 6	£6,958
7 to 10	£13,915
11 to 15	£27,831
More than 15	£55,662

Community healthcare services (independent ambulance services) (Part 3 column 2 of Schedule of fee scheme)

	Fee charge
Number of locations	2018/19
1	£994
2 to 3	£1,988
4 to 10	£4,970
11 to 50	£12,425
51 to 100	£29,820
More than 100	£59,640

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

	Fee charge
Number of locations	2018/19
1	£309

NHS primary medical services (Part 4 of Schedule of existing fee scheme)

The fee payable under paragraph 2(2)(d)(i) in respect of the number of registered patients at each location will be calculated as follows in relation to providers of NHS primary medical services –

A. **The calculation for Part 4:**

One location:

Step 1 - work out the chargeable fee for that single location based on the number of **registered patients at that location ('RPAL')**

£ Floor	+	(	RPAL / Total RPALs	X	£ Cost	)	=	£ Fee payable

More than one location:

Step 2 - repeat Step 1 for each *additional* location and then add together the **£ Fee payable** for Step 1 and each of the locations in Step 2 to give the total **£ Fee payable** by the provider.

B. **Definitions specific to Part 4:**

1) **RPAL / registered patients at that location)**: is those -

   (a) who are recorded by the Board as being on the provider's list of patients at that location, or

   (b) whom the provider has accepted for inclusion on its list of patients (whether or not notification has been received by the Board) and who has not been notified by the Board to the provider as having ceased to be on that list;

2) **Total RPALs**: is the total number of registered patients across all NHS primary medical services providers in Part 4.

3) **£ Cost**: is the current full chargeable budgeted cost of regulating providers of NHS primary medical services.

4) **£ Fee payable**: is the amount to be paid by providers with single locations (calculated using Step 1) or those with more than one location (calculated using Step 1 and Step 2).

5) **£ Floor**: is the minimum fee applicable to each provider (at location level) and represents the standing cost for regulatory activity regardless of the size of the provider.

6) **Ceiling**: the Ceiling for a location will be a registered patient list size of 100,000. The maximum fee for a location will be calculated using that list size where the registered patient list size exceeds 100,000.

C. **And subject always to the following**

7) Each location will pay the **£ Floor** of £509 and a fee calculated by reference to registered patient list size, which will be the registered patient list size divided by 1.7545.

8) For any new locations created after collation of the reference data the calculation (with the definitions and amounts being identical to those used in the calculation in Paragraph **A** of **Part 4**) will be as follows:

£ Cost / Total RPALs	**=**	**1.7545**				
(	**RPAL / 1.7545**	)	**+**	**£ Floor (£509)**	**=**	**£ Fee payable**

9) Any recalculation of fees for NHS primary medical services providers (and guidance in relation to that) which may be necessary as a result of, for example, changes registered patient list size will be published on the CQC website (www.cqc.org.uk/fees).

Providers of out-of-hours services and/or providers of walk-in centres (Part 5 of Schedule of existing fee scheme)

Location	Fee charge 2018/19
1	£5,918
2	£8,371
3	£11,161
4	£13,951
5	£16,736
6 to 10	£20,924
11 to 40	£41,848
More than 40	£104,614

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

Number of dental chairs	Fee charge 2018/19
1	£529
2	£661

3	£749
4	£837
5	£969
6	£969
More than 6	£1,145

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

	Fee charge
Number of locations	**2018/19**
2	£1,410
3	£2,114
4	£2,819
5	£3,524
6 to 10	£4,229
11 to 40	£8,810
41 to 99	£26,429
More than 99	£52,857

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

	Fee charge
Maximum number of service users	**2018/19**
Less than 4	£321
From 4 to 10	£836
From 11 to 15	£1,674
From 16 to 20	£2,447
From 21 to 25	£3,348
From 26 to 30	£4,375
From 31 to 35	£5,147
From 36 to 40	£5,921
From 41 to 45	£6,694
From 46 to 50	£7,468
From 51 to 55	£8,235
From 56 to 60	£9,008
From 61 to 65	£10,295
From 66 to 70	£11,322

From 71 to 75	£12,355
From 76 to 80	£13,383
From 81 to 90	£14,415
More than 90	£16,096

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

	Fee charge
Number of locations	**2018/19**
1	£1,933
2 to 3	£3,861
4 to 6	£7,721
7 to 10	£16,242
11 to 15	£30,885
More than 15	£61,771

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

The fee payable under sub-paragraph 2(2)(f) in respect of the number of service users (SUs) at each location will be calculated as follows in relation to providers of community social care services:

A. The calculation for Part 10:

One location:

Step 1 - work out the chargeable fee for that single location based on **Location SUs:**

£ Floor	+	(	Location SUs / Total SUs	X	£ Cost	)	=	£ Fee payable

More than one location:

Step 2 - repeat Step 1 for each *additional* location and then add together the **£ Fee payable** for Step 1 and each of the locations in Step 2 to give the total **£ Fee payable** by the provider.

B. Definitions specific to Part 10:

1) **Location SUs**: is the number of service users who received regulated activities from and/or were supported in their use of regulated activities

from a single location by a provider of community social care services over a 7 day period.

2) **Total SUs**: is the total number of service users who received regulated activities and/or were supported in their use of regulated activities from providers of community social care services.

3) **£ Cost**: is the current full chargeable budgeted cost of regulating providers of community social care services

4) **£ Fee payable**: is the amount to be paid by providers with single locations (calculated using Step 1) or those with more than one location (calculated using Step 1 and Step 2).

5) **£ Floor**: is the minimum fee applicable to each provider (at location level) and represents the standing cost for regulatory activity regardless of the size of the provider.

6) **Ceiling**: the Ceiling for a location will be a **Location SUs** figure of 1,700. Namely, the maximum fee for a location will be calculated using that **Location SUs** figure where the total **Location SUs** figure exceeds 1,700.

C. And subject always to the following

7) Each location will pay the **£ Floor** of £239 and a fee calculated by reference to **Location SUs**, which will be the **Location SUs** multiplied by **45.770**.

8) For any new Locations created after collation of the reference data the calculation (with the definitions and amounts being identical to those used in the calculation in Paragraph **A** of **Part 10**) will be as follows:

£ Cost / Total SUs	**=**	**45.770**				
	(Location SUs X 45.770)		**+**	**£ Floor (£239)**	**=**	**£ Fee payable**

9) Any recalculation of fees for Community Social Care providers (and guidance in relation to that) which may be necessary as a result of, for example, changes in the number of locations/Location SUs will be published on the CQC website (www.cqc.org.uk/fees).

Community social care services providing nursing care (Part 11 of Schedule of existing fee scheme)

The fee payable under sub-paragraph 2(2)(f)(i) in respect of the number of locations will be calculated as follows in relation to providers of community social care services providing nursing care

	Fee charge
Number of locations	**2018/19**
1	£2,192
2 to 3	£6,093
4 to 6	£12,184
7 to 12	£24,370
13 to 25	£48,740
More than 25	£97,476