Regulatory fees from April 2018

Final regulatory impact assessment

This final regulatory impact assessment has been published alongside *Regulatory fees from April 2018 under the Health and Social Care Act 2008 (as amended): Our response to the consultation.* We suggest that you read that document in full before reading this impact assessment.

This document sets out our final analysis of the impact of the proposed changes to our fees scheme from April 2018.

Introduction

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

2. Section 85 of the Health and Social Care Act 2008 (the 2008 Act) gives CQC powers to charge fees associated with its registration functions. Also, the Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016 give CQC powers to charge fees associated with our review and performance assessment functions and enable us to charge fees to include all our activities associated with rating services. Like many public regulatory bodies, CQC is required by government to set fees in order to cover the costs of our chargeable activities.

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

4. In line with guidance from HM Treasury, CQC is committed to publishing a two-stage impact assessment. This document is the final impact assessment of our

two-stage impact assessment approach. It contains an overview of our updated analysis of the impacts on stakeholders of the proposals in our consultation document. These stakeholders include regulated providers, HM Treasury (representing the interests of taxpayers), people who use services, commissioners, the public and other regulators in the health and social care sector.

5. The Secretary of State for Health and Social Care has consented to the fees scheme and it will take legal effect from 1 April 2018.

Financial position

6. Our budget is made up of a combination of income from fees paid by providers and a small amount of grant-in-aid from central government budgets. The funding of our revenue budget is set out here. This table is in line with the four year spending review as agreed with the Department of Health. It demonstrates that our budget is reducing over time and this directly impacts on fees. In order to be effective and efficient we have targeted our need to achieve and demonstrate value for money as a key priority in our strategy.

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**

7. Fees in this document are shown on an invoiced basis as this reflects the actual impact on the health and social care sectors. However, we report fees on an accruals basis to the Department of Health and within our financial accounts. This means that the estimated income for 2018/19 on an accruals basis is £4.2 million lower than the invoiced total. This accounting adjustment is covered by grant-in-aid. The total indicative budget shown represents the budget that we expect to be our total cost target.

8. Our budget for 2018/19 will be £228.0 million, which compares to £230.0 million for 2017/18.

9. £27.0 million of the total budget will be covered by grant-in-aid. Of this, £20 million will support the elements of our functions where we cannot recover costs by charging fees. These functions include: Healthwatch, Office of the National Guardian, Market Oversight, Mental Health Act duties (including provision of second-opinion appointed doctors), thematic reviews and enforcement. £2.8 million will fund the element of costs for community social care providers not yet funded via fees. The remaining £4.2 million represents the accounting adjustment we have to apply for the effect of deferred income.

10. The £201.0 million funded by fees from providers is used to resource our registration and review and assessment functions under the Health and Social Care Act 2008 (the 2008 Act). These functions include registering new providers and managers, making changes to existing registrations, and monitoring, inspecting and rating services. Note that the £201.0 million in addition to the £4.2 million deferred income represents the £205.2 million invoiced to providers.

11. **Appendix A** shows the cost and fee budgets by sector for 2017/18 and 2018/19.

12. All sectors are now at full chargeable cost recovery, except for community social care providers, whose trajectory was set over four years. 2018/19 will be year three of their four year trajectory.

Overall impact of changes as a result of the proposals

13. The proposals and decisions are listed at **Appendix B**. Only proposal two increases the amount of income received from providers. This related solely to community social care providers and is the third year of a four year trajectory for this sector in our move to full chargeable cost recovery, as required by HM Treasury policy. All other providers reached this position during 2017/18.

14. Our funding from the government will decrease by the same amount, because our overall costs of regulating the sector do not change.

15. Other changes will not affect the total fees collected from sectors, but will change fees for individual providers in the sectors affected by our proposals. Our move to a proportionate approach is based on the positive step of producing a fees scheme which is more fairly distributed among providers. It avoids the step changes seen between bandings, therefore allowing for a more sensitive response to small and large changes in the size of providers.

16. Floors and ceilings were considered for each of the areas. Floors set a minimum fee to ensure that very small providers pay a fee that reasonably reflects the cost of regulation and means that very small providers will not pay a fee well below this level. Ceilings set a maximum fee to ensure that very large providers do not pay excessively high fees against the cost required to regulate them.

17. The issue of whether or not to set floors and ceilings and at what level depends on each sector and the range in size between the largest and smallest providers in the sectors.

18. Each sector is affected differently by the move to proportionality, by the introduction of floors and ceilings and whether or not fees increase for the sector as a whole. This is discussed in each individual section.

19. We did not consult on the following sectors: independent healthcare providers of any description, dental providers, residential care home providers and hospice providers. There is no change or impact to them for the 2018/19 fees scheme.

Impact of changes to the fees scheme on community social care providers

20. This sector is affected by the decisions from proposals one and two.

21. The decision for proposal one is to change the fees scheme structure by:
    - replacing the current banding structure
    - charging fees in proportion to the size of a provider in the sector using the number of service users (number of people receiving support with regulated activities at a location)
    - applying a minimum fee (floor) and a maximum fee (ceiling).

22. The decision for proposal two is to increase fees for community social care providers as the third year of the four year trajectory to reach full chargeable cost recovery (FCCR).

23. The measure of the number of service users is new for this sector and we have been collecting this information. We have used what we have collected to set the parameters with which to calculate the scheme. The following examples give some idea of the range of outcomes:
    - A provider with 1 location and 15 service users will see their fee fall from £2,192 to £926
    - A provider with 3 locations and 50, 100 and 45 service users respectively at each of the locations will see their fee increase from £6,093 to £9,643

    The detail of these examples are show in **Appendix C**.

24. Number of service users and total contact hours were the two most popular choices for measuring size. We chose the number of service users as the measure for a number of reasons. In terms of calculating the fee, the stability of the figure is important. It changes less frequently than that for contact hours and so is a better measure of overall stability. In addition, the range from smallest to largest is much lower, meaning that there are fewer outliers attracting either too high or too low a fee. The draft regulatory impact assessment showed that the largest submission for hours was 180,000 times larger than the smallest, while for numbers of service users, the differential was only 3,400. This makes it easier to set a floor and a ceiling.

25. We are currently transitioning from our fully comprehensive model to a more risk-based approach. This takes time to bed in and understand our costs fully, so we have estimated our base requirement and set the floor using a top-down approach and then validating by a bottom up view. We calculated that around 10% of the total cost represents our absolute baseline activity in regulation of the sector. We will set the actual fee and review once we have a complete set of data with which to do this.

26. We will set the ceiling at the same time as the floor, ensuring that outliers are not disadvantaged.

Impact of changes to the fees scheme on NHS GPs and urgent care providers

27. This sector is affected by the decisions from proposals three and four.

28. The decision for proposal three is to change the fees scheme structure 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 and applying a minimum fee (floor) and a maximum fee (ceiling).

29. The measure of patient list size has been expanded for this sector to include GPs with more than one location. We are in the process of verifying and reconciling this information. This means that the figures we use to show the impact are reasonably close to the final position, but are likely to change by the time that we send out our first invoices. The figures will be available on our website by then.

30. We have included a floor and a ceiling for this sector. The range from largest to smallest is around 70,000 with some lower outliers. Setting floors and ceilings for the first time requires some trial and error, and we will use this year to bed them in and review and adjust them as necessary next year.

31. Using the floor and ceiling, means that our fee calculation requires several stages:
    A) We calculate the floor (see paragraph 32) and every provider is charged this
    B) Then apply the equation:
    (Individual RPAL/total RPAL for sector) x (Cost to regulate the sector less the total cost of the floor in A)
    [RPAL – Registered Patients at that Location] where the list size is the lower of RPAL or the ceiling
    C) Repeat for each location
    D) Add together the floor plus the calculation for each location

32. We are using the same approach for determining the floor as for community social care providers, as described in paragraph 25.

33. We calculated that around 10% of the total cost represents our absolute baseline activity in regulation of the sector. This translates to around a fee for NHS GPs of £509. This approach means we are protecting smaller providers.

34. The ceiling has been set at a patient list size of 100,000, which equates to a fee of £57,505. This is high compared to current GP practice list sizes, but we have set this in anticipation of further restructuring in the sector.

35. Around 57% of providers will see their fees fall while the remainder will see increases, with about 40% of providers seeing increases of more than 5%. These are providers with patient list sizes generally larger than 8,000, irrespective of the number of locations.

36. The following examples give some idea of the range of outcomes:
    - A provider with 1 location and a patient list size of 5,200 will see their fee fall from £4,526 to £3,473
    - A provider with 2 locations and a patient list sizes of 10,000 and 8,300 at each of the locations will see their fee increase from £8,371 to £11,449

    The detail of these examples are show in A**ppendix D**.

37. The decision for proposal four is to retain the current approach to fees for urgent care providers by:
    - keeping the current banding structure for providers with one location
    - keeping the current banding structure based on the number of locations for providers with more than one location.

38. This means that fees will not change for providers in this group for 2018/19. Providers will be charged in line with the fee applicable to them in the 2017/18 fees scheme.

39. 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.

Impact of changes to the fees scheme on NHS trusts

40. This sector is affected by the decisions from proposal five.

41. The decision for proposal five is to change the fees scheme structure 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 and **not** applying either a minimum fee (floor) or a maximum fee (ceiling).

42. The measure of turnover is currently used for the banded approach and still a good measure of the size of providers in this sector. 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.

43. The budgeted cost for regulating the sector for 2018/19 is £56.5 million. The total turnover for the sector using turnover for 2016/17 from annual reports and business plans where appropriate is £80.57 billion. We use this information when we calculate the individual fee for an NHS trust.

44. Detailed examples of the calculations for NHS trusts can be found in **Appendix E**.

45. With the figures we have provided, we expect 76% of providers to see a decrease in fees and 24% to see an increase.

46. We have not opted for either a floor or a ceiling. The smallest provider has a turnover of £50 million and the largest a turnover of £1,546 million. So the largest provider is nearly 31 times larger than the smallest, which is a small range compared to other sectors, so the fee divergence is not unreasonable. Under the current scheme, the largest provider would only be paying a fee only three times greater than the smallest provider.

Appendix A: Grant-in-aid (GIA) and fees by sector for 2017/18 and 2018/19

	2017/18				2018/19		
	Per budget				Per budget		
	COSTS	**FEES**	**GIA**		**COSTS**	**FEES**	**GIA**
	£'M	**£'M**	**£'M**		**£'M**	**£'M**	**£'M**
NHS trusts	56.6	56.6	-		56.5	56.5	-
Independent healthcare - hospitals	4.6	4.6	-		4.5	4.5	-
Independent healthcare - single specialty	1.2	1.2	-		1.2	1.2	-
Independent healthcare - community	4.2	4.2	-		4.1	4.1	-
Adult social care - residential	70.3	70.3	-		70.3	70.3	-
Adult social care - community	26.5	20.7	5.9		26.5	23.7	2.8
NHS GPs	37.5	37.5	-		37.5	37.5	-
Dentists	7.4	7.4	-		7.4	7.4	-
Invoiced to providers as fees	**208.4**	**202.5**	**5.9**		**208.0**	**205.2**	**2.8**
Deferred income		(6.5)	6.5			(4.2)	4.2
Grant in Aid	*21.6*	*-*	*21.6*		*20.0*		*20.0*
TOTAL	***230.0***	***196.0***	***34.0***		***228.0***	***201.0***	***27.0***

Appendix B: Proposal Decisions

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.

Appendix C: Fees calculation for community social care providers

The calculation for each location is:

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

The essential parameters are:

£ Floor = £239

Variable calculation:

$$\frac{\text{£ Cost}}{\text{Total SUs}} = 45.770$$

(Location SUs X 45.770) + £239 = £ Fee payable

Example one

A provider with one location and 15 service users (SUs) currently pays a fee of £2,192.

In 2018/19 they will pay a fee of £926, a decrease of £1,266. This is calculated using the following details:

The calculation is:
1) Floor = £239
2) Location = 15 x 45.770 = £687

1 and 2 together total £926

Example two

A provider with three locations, A, B and C, where A has 50 recorded service users, B has 100 recorded service users and C has 45 recorded service users currently pays a fee of £6,093.

In 2018/19 they will pay a fee of £9,626, an increase of £3,533. This is calculated using the following details:

The calculation is:
1) Floor = £239 x 3 = £717
2) Location A = 50 x 45.770, which comes to £2,289
3) Location B = 100 x 45.770, which comes to £4,816
4) Location C = 45 x 45.770, which comes to £2,060

1, 2, 3 and 4 add to a total fee of £9,643

Appendix D: Fees calculation for NHS GP providers

The calculation for each location is:

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

The essential parameters are:

£Floor = £509
Variable calculation

$$\frac{\text{£ Cost}}{\text{Total RPALs}} = 1.7545$$

$$\left(\frac{\text{RPAL}}{1.7545}\right) + \text{£509} = \text{£ Fee payable}$$

Example one

A provider with one location and a list size of 5,200 currently pays a fee of £4,526.

In 2018/19 they will pay a fee of £3,473, a decrease of £1,053. This is calculated using the following details:

The calculation is:

1) Floor = £509
2) Location = 5,200/1.7545, which comes to £2,964

1 and 2 add together to £3,473

Example two

A provider with two locations, A and B, where A has a list size of 10,000 and B has a list size of 8,300 currently pays a fee of £8,371.

In 2018/19 they will pay a fee of £11,449, an increase of £3,078. This is calculated using the following details:

The calculation is:

X) Floor = £509 x 2 = £1,018
Y) Location A = (10,000/1.7545, which comes to £5,700
Z) Location B = (8,300//1.7545, which comes to £4,731

X, Y and Z added together comes to £11,449

Appendix E: Fees calculation for NHS trusts

The calculation for each location is:

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

The essential parameters are:

$\frac{\text{£ Cost}}{\text{Total Turnover}}$	=	0.071%

Turnover	X	0.071%	=	£ Fee payable

Example one

A trust with a turnover of £681,000,000 currently pays a fee of £322,249.

In 2018/19, they will pay a fee of £483,510, an increase of £151,261. This is calculated as follows:

681,000 x 0.071%, which comes to £483,510

Example two

A trust with a turnover of £120,000,000 currently pays a fee of £158,902.

In 2018/19, they will pay a fee of £85,200, a decrease of £73,702. This is calculated as follows:

120,000,000 x 0.071%, which comes to £85,200

Appendix F: Impact of fees on provider sectors

Sector	Value of market £m	Fee £m	% of turnover	Information source
NHS trusts	76,336	56.5	0.07%	https://www.gov.uk/government/publications/nhs-foundation-trust-accounts-consolidation-ftc-files-201516 https://www.gov.uk/government/publications/nhs-trusts-accounts-data-for-2015-to-2016
Independent healthcare - hospitals				Laing Buisson UK Healthcare Market Review – 28th edition
Independent healthcare - single specialty	9,100	5.7	0.06%	
Independent healthcare - community	3,900	4.1	0.11%	
Adult social care - residential	17,100	70.3	0.41%	
Adult social care - community	6,600	23.7	0.31%	
NHS GPs	7,764	37.5	0.48%	G/PMS, APMS and PCTMS expenditure from DH annual report 2015/16
Dentists	5,900	7.4	0.13%	Laing Buisson Dentistry UK Market report 2014
Total fees	**126,700**	**2052**	**0.16%**	
Total CQC budget	**126,700**	**228.0**	**0.18%**	