Consultation

Regulatory fees – have your say

Proposals for fees from April 2019 for all providers that are registered under the Health and Social Care Act 2008

October 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 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

Published October 2018

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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.

We launched our strategy for 2016-2021 on the foundations of a 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.

In this consultation we complete our move towards full cost recovery. By this we mean that following HM Treasury policy, we are now in a position to recover all our costs for our chargeable activities through fees.

We are seeking views on proposals to maintain our aim of ensuring that the fees recovered are appropriately aligned to the cost of regulation. Our proposals will therefore change the fees for individual providers. We will continue to apply this approach to all the sectors that we regulate in future years. The final decision on fees rests with the Secretary of State for Health and Social Care, and we expect this to be made in March 2019.

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
Chair

Ian Trenholm
Chief Executive

Introduction

Summary of proposals

We are consulting on the fee amounts for the 2019/20 fee scheme, in line with the requirements of the Health and Social Care Act 2008 (the HSCA).

Proposal 1 reflects the fourth and final year of our four-year trajectory to full chargeable cost recovery (FCCR) for community social care providers.

Proposals 2 and 3 are designed to ensure that the cost of regulation in sectors and the fees recovered are properly aligned. As a result of this, dental providers will see their fees increase, and residential social care providers will see their fees decrease.

The net, overall increase for all sectors will be £3.1 million, largely due to the planned increase described in Proposal 1, and will be sufficient to ensure we cover our regulatory costs for the next financial year.

Proposal 1

We propose to increase fees for the community social care sector for 2019/20, as the final year of the four-year trajectory to full chargeable cost recovery (FCCR). This will be an increase of £1.5 million in invoiced fees to £24.5 million. This is less than the amount signalled last year.

Proposal 2

We propose to increase fees for the dental sector so that we collect £8 million. This will be an increase of £600,000 across the sector.

Proposal 3

We propose to decrease fees in the residential social care sector so that we collect £69 million. This will be a decrease of £800,000 across the sector.

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

Other changes

Last year, we changed the fees structure and the way fees were calculated for NHS trusts, NHS GPs and community social care providers.

The fee is calculated for each provider as a proportion of their size against the total size of the sector.

This approach means that we need to recalculate fees for individual providers each year. This is the first year this has happened. It does not form part of the proposals, but it will mean a change to individual fees for providers in these sectors.

In relation to NHS trusts and NHS GPs, this will not alter the total fees collected overall, but it will mean small adjustments for all providers within these sectors.

The same adjustment will be made for community social care providers, but they will also see their fees increase as a result of proposal 1.

We are monitoring the impact of the changes to the fees structure introduced last year and include an early assessment of them in the draft regulatory impact assessment. However, we do not intend to make any further structural changes to how we calculate fees until we have been able to fully assess the impact over a longer period.

Other relevant reports

The draft regulatory impact assessment, provides the analysis behind our proposals and full details of our budget.

A draft equality and human rights impact assessment (EQHRIA) of our proposals 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 EQHRIA, please include any feedback in your responses to question 1 of our consultation.

Responding to the consultation

We will consider and take into account all your responses to this consultation before we finalise our provision for fees for 2019/20.

Please see page 19-20 for how to send us your comments. Please make sure that you give us your feedback by midday on **17 January 2019.**

When we have analysed the feedback from this consultation in January 2019, we will prepare a response and a final fees scheme. CQC's Board will recommend the scheme to the Secretary of State for Health and Social Care, 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 2019, for implementation on 1 April 2019.

This timescale means that we will not be able to confirm exactly what fees providers will be paying in 2019/20 until relatively close to when the scheme takes effect. This is because the fees shown in this document may change following the responses given to this consultation. 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 2019 as a guide for setting budgets.

CQC's financial context for setting fees

Our budget and funding

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 and Social Care. Grant-in-aid has reduced consistently over recent years as we have had to move to FCCR. In 2015/16 our budget was agreed at £249 million. We spent £239 million and have continued to drive down our costs so that our planned expenditure for 2019/20 is £217 million. (Figures quoted here do not include depreciation.) This is as a result of the controls we have exercised over our spending and increasing efficiency in our inspections and other operational activity, while switching our source of funding.

The consultation for this year sees us move to a position where all our regulatory costs are being met through fees from providers. The final increase in fees for the community social care sector means that grant-in-aid is no longer set to fund any of this work. The grant-in-aid figure for 2019/20 solely covers activities that cannot be charged as fees. These are: enforcement, thematic reviews, Market Oversight, Healthwatch England, National Guardian's Office and work pursuant to our duties under the Mental Health Act.

We need to ensure that we maintain this funding position. This requires ongoing work as we must constantly assess our costs against a changing regulatory landscape, our changing models of regulation as we respond to this and our continuing understanding and assessment of our own costs. We consider the issues in understanding our costs in the section on "Assessing the cost of regulation".

As well as achieving cost recovery in total, we also need to ensure that we achieve cost recovery for each sector. Given the variables that we have described above, it is not possible to do this over a short period of time. With this in mind, we are working to align our fees better with our costs, so that we will achieve cost recovery for each sector. These proposals are our first steps along this path.

Fees fund all the costs chargeable to our regulatory work, including the depreciation of our assets. A key part of this is the delivery of our digital programme that will enable our development as a more targeted, responsive and collaborative regulator, so that more people receive high-quality care (see Shaping the future: CQC's strategy for 2016 to 2021).

Development of our fees scheme

We continue to review the scheme to ensure that fees are charged fairly. This involves reviewing both the level of fees and the ways in which we structure the charge to providers.

Last year we made structural changes to three areas. This has been in operation for just over six months at the time of this publication. We do not plan to make any further structural changes until we have been able to review the impact on these sectors for a full year, but we have provided an early assessment of the impact of these changes in the draft regulatory impact assessment.

We are now in a position to make changes to fees to ensure that the full costs of regulation are better aligned between sectors. We have been careful in how we approach this. The challenge of assessing the costs of regulation is discussed in the next section. We continue our aim of bringing costs and fees into balance for each sector so that we do not cross-subsidise across sectors, in line with the guidance in HM Treasury's Managing Public Money *(MPM)*. We will do this so that we do not cause fees to fluctuate unreasonably. We will continue to consider our data to identify and, where appropriate, address differences between costs and fees.

Assessing the cost of regulation

Our costing model was established in 2015/16. We produced it for a number of reasons, including informing the level of our fees. We now have three years' worth of data and have published the results in our annual accounts and reports for 2015/16, 2016/17 and 2017/18. We have used this information to assess the costs of regulation into the future and the fees required to cover them.

Because the costing model is now more established, we can consider to a greater extent whether we are recovering costs in line with the approach that HM Treasury's *MPM* recommends. MPM requires us to ensure that we recover all chargeable costs in fees and do not cross-subsidise.

We cannot simply take historical costs and extrapolate them into the future. The level and nature of our regulatory activity changes over time. This alters how our resources are used and complicates forecasting. In turn, this affects the measurement of what it takes to regulate a sector. Here are examples of these changes and how they affect our understanding of our costs:

1. Between 2015/16 and 2017/18, our approach to regulation has been changing from comprehensive inspections to an intelligence-driven approach, which sees more targeted, responsive and collaborative inspections with a greater reliance on monitoring. This changes the activities that occur and therefore the costs attributed to inspection. As an example, the new approach increases the amount of monitoring and decreases inspections.

2. We have been adopting the new approach by sector at different times and over different timescales.

3. The regulatory activity associated with small sectors fluctuates from month to month, much more markedly than for larger provider sectors. This means that the costs attributed to them will fluctuate in line with this activity. We may inspect 10 in one month, none in the next and 30 the month after that. The equivalent months for the following year may show a pattern of 20, 50 and five. If we had simply applied the pattern of the first year to the next year, then the costs would have looked very different to what actually happened and different to what we were planning for next year.

4. Activities funded by grant-in-aid need to be carefully separated out from fees-funded activity. Enforcement is an example of the former. It is a clear activity but it is rooted in the initial regulatory activity which is funded by fees. As well as making the actual costs difficult to measure, the frequency with which enforcement activity varies will also affect costings.

5. Overheads and indirect costs are apportioned using generally accepted costing principles, but they need to be tested constantly to ensure they continue to be applicable, as demonstrated by the changes in activity described above. Definitions of these cost types can be found at Annex C.

The changing nature of our work and the providers we regulate means that we must continue to be careful in assessing the level of cost recovery. In calculating the cost of regulation for each sector and in total, we need to take into account the changes in the regulatory model, our understanding of how our costs are allocated, and the effect of activity arising from non-chargeable activities.

Implications for the 2019/20 fees scheme

Our approach to the proposals has been shaped by the above issues. We have focused on sectors where we are confident that we can make a change that should not need to be reversed in future years.

The changes are targeted and made carefully, balanced with our need to ensure that we charge fees fairly with our best understanding of the data we have. The table below quantifies the individual effect on an average provider. Full details of changes are in Annex A and the draft regulatory impact assessment.

Fee Category	Provider Size	Unit of Measurement	Fee £	New Fee £
NHS trusts	£347 million	Turnover	245,734	247,807
Residential social care	26 - 30	Number of beds per location	4,375	4,311
Community social care	46	Service users supported with regulated activities	2,344	2,634
Dentists	4	Dental chairs for providers with one location	837	946

We are not proposing any changes this year to the fees structure for NHS trusts or NHS GPs. There are differences between their costs and fees collected for both these sectors, but we need to allow changes from last year to bed in and understand their impact before suggesting further changes.

Fees for NHS GPs are currently covered by NHS England. Furthermore, the health and social care sector as a whole is undergoing a period of significant change with the development of models of integration in health and social care and any future changes to the fees scheme must accommodate these developments.

We are not recommending changes to fees for the independent healthcare sector, though there are also differences between costs and fees. As outlined above, this sector comprises a small number of diverse providers, which means that they are particularly sensitive to cost allocations and changes in assumptions. We need to progress with care in understanding costs and fee-charging for these groups.

We will continue this process as part of our ongoing, annual development of the scheme. The end of the spending review in 2020 also gives us the opportunity to move to a longer-term forecast for our fees and expenditure. This will enable us to develop a five year forward plan which will provide a roadmap for our approach to charging fees.

QUESTION 1

The proposals in this consultation are part of our ongoing review to make sure that the full costs of regulation are broadly aligned between sectors.

We propose to balance fees between sectors carefully so fees do not fluctuate more than is necessary.

(Questions 2 to 4 relate specifically to the community social care, dental and residential social care sectors respectively)

1a. To what extent do you agree or disagree with our approach to assessing costs and fees for all sectors?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

1b. Please explain your answer

Proposals

Proposal 1 for community social care providers

We are proposing to increase fees for community social care providers as the fourth and final year of their transition to FCCR. This trajectory was set in 2016. Most sectors were set at two years, meaning that they progressed to FCCR by 2017/18. The trajectory for community social care was set at four years, as an acknowledgement of the fragility in the sector that was articulated in responses to our consultation. 2019/20 is the fourth and final year of that trajectory and, in line with this, invoiced income from fees for the sector as a whole will increase by £1.5 million, which will take total recovery for the sector to £24.5 million. This is a lower increase than indicated in last year's consultation. Given the challenge described in assessing costs, we have applied the same care as we have in other sectors in aligning our fees with our costs.

The cost breakdown for the sector under our operating model is shown in the table below. As with all areas we will continue to review and make further changes as we gather more data.

	Direct	Indirect	Overhead	Total
	£'M	£'M	£'M	£'M
Registration	2.0	0.4	0.8	**3.2**
Monitoring	6.9	0.9	2.1	**9.9**
Inspection	8.5	0.7	2.1	**11.3**
Independent Voice	0.1	0.4	0.2	**0.7**
Depreciation	0.0	0.0	1.2	**1.2**
Total	**17.5**	**2.4**	**6.4**	**26.3**

It should be noted that the fees for 2018/19 were set at £19.5 million. The £5 million increase to the total for £24.5 million is due to a combination of the proposed increase of £1.5 million and the effect of deferred income of £3.5 million. Deferred income is an accounting adjustment that is the difference between what we invoice in a year and what we show as our budgeted income. When fees do not change year on year then the invoiced amount and the income amount are the same. When the invoiced amount levels out after a period of increases, then the effect of deferred income is to increase the income from one year to the next, which is what we see happening here. It is not a result of invoicing higher fees.

QUESTION 2

This is the fourth and final year of our four-year trajectory to full chargeable cost recovery. This was addressed in previous consultations.

We propose to increase fees for community social care providers by £1.5 million overall for 2019/20. The proposed increase is lower than the amount we stated previously.

2a. To what extent do you agree or disagree with our reasons for increasing fees for community social care providers by £1.5 million overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

2b. Please explain your answer

Proposal 2 for dental providers

We are proposing to increase fees for dental providers by a total of £600,000, which means that total fees for the sector will be £8 million. The last increase that this sector saw was in 2014/15, having assessed that we had reached full cost recovery. We then decreased fees in 2017/18 on the basis that we were implementing a model based around risk assessment rather than a comprehensive inspection model. We anticipated that this would bear a lower cost than we had estimated for the comprehensive model.

The calculations for both regulatory models were made using earlier costing models. The costing model is now well-established and we have had three years to review and understand the costs better. Using our current costing model, we assess the costs of regulating the dental sector to be £9.5 million, which suggests that we are currently under-recovering

by over £2 million. The proposed increase is made in a measured way, because we have further work to do in reviewing the costs for this sector.

Our model shows that the costs of our model split as follows:

	Direct	Indirect	Overhead	Total
	£'M	£'M	£'M	£'M
Registration	2.8	0.3	0.7	**3.8**
Monitoring	1.3	0.4	0.5	**2.2**
Inspection	1.7	0.4	0.6	**2.7**
Independent Voice	0.0	0.2	0.1	**0.3**
Depreciation	0.0	0.0	0.5	**0.5**
Total	**5.8**	**1.3**	**2.4**	**9.5**

The most obvious question which may arise is why we propose to increase fees when we estimated that a change in the model would result in lower costs. There are two important responses to this. The first is that the assessment of costs up to 2016 represented our best understanding at the time. Since then we have built a much more detailed model, based on accurate timesheet data and from all areas of CQC that contribute to the various aspects of our operating model. This allows us to map our total use of resources much more accurately, especially in newer areas of our operating model such as our increased focus on the use of intelligence in monitoring. The second is that our results show that this model is cost-effective. The costs represent 4.5% of our resources, while dental providers account for about 20% of our total number of providers.

We are confident that raising fees in this sector is the correct approach. The gap between fees collected and costs incurred in regulating the sector needs to be reduced. The model of regulation is well-established, has been in place for three years and the activity is constant over a reasonable period of time. This, coupled with the data collected from our costing model, provides us with a higher level of understanding of the costs of this sector. We have tested our assumptions and this demonstrates that stability.

We need to continue to refine all areas of the operating model for dental providers, both in terms of how we are allocating costs and how we carry out our work. We will particularly review the costs of the registration and monitoring components of the operating model, so that we can ensure they properly reflect the costs of the activities that are undertaken in this sector.

This proposal takes a first step in the direction of reducing the gap between fees and costs. It addresses both the fact that we are sure that

fees need to increase to align better with costs and also that we need to monitor and review those costs.

We propose raising fees by the same percentage increase for all providers. We considered applying different percentages according to the size of providers. However, 90% of providers have only one location and a further 9% have two or three locations. These pay proportionately the same fee. Any differentiation for much larger providers would have had a minimal effect on most providers. We will assess and review the structure of the dental sector as part of a wider review of the sector.

QUESTION 3

We propose to increase fees for dental providers by £600,000 overall for 2019/20. This better aligns the amount of fees collected with the costs of regulating this sector.

3a. To what extent do you agree or disagree with our reasons for increasing fees for dental providers by £600,000 overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

3b. Please explain your answer

Proposal 3 for residential social care providers

We are proposing to decrease fees for the residential social care sector so that we collect £69 million, an overall decrease of £800,000 compared with 2018/19.

We are proposing decreases to fees for this sector for two reasons. With about 7,700 providers, they represent about 30% of the total number of registered providers and the regulatory activity is consistent over a period. This stability gives us a level of confidence in the data which allows us to

start to reduce fees. As with the other sectors, we also need to monitor and review all costs. This is how costs breakdown for this sector:

	Direct	Indirect	Overhead	Total
	£'M	£'M	£'M	£'M
Registration	3.8	0.7	1.5	**6.0**
Monitoring	17.7	2.3	5.9	**25.9**
Inspection	22.1	1.8	5.1	**29.0**
Independent Voice	0.2	1.2	0.4	**1.8**
Depreciation	0.0	0.0	3.4	**3.4**
Total	**43.8**	**6.0**	**16.3**	**66.1**

As with all our changes, it is our first step in ensuring that we align fees better with the costs, but that we do not cause fees to fluctuate unnecessarily. We will continue to assess and make changes to fees as we evaluate the position of this sector and all others.

QUESTION 4

We propose to decrease fees for residential social care providers by £800,000 overall for 2019/20. This better aligns the amount of fees collected with the costs of regulating this sector.

4a. To what extent do you agree or disagree with our reasons for decreasing fees for residential social care providers by £800,000 overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

4b. Please explain your answer

Adjustments to other sectors

The changes we made last year to how we calculate fees for NHS trusts and NHS GPs means that individual fees may change slightly for these providers, though the total amount of fees collected from these sectors will not.

We will reassess the fees on the basis of the updated information that we use to calculate their fees (i.e. turnover and patient list size respectively).

Fees will increase for community social care providers as a result of proposal 1. However, they may also change as a consequence of a change in the measure we use to calculate fees (i.e. the number of service users they support).

It is not possible to say what these changes will be, until we have reviewed all the information closer to the end of the year. However, none of them are expected to be significant. More detailed information can be found in the draft regulatory impact assessment.

How to give us your views

The questions we have asked about fees from April 2019 for providers that are registered under the Health and Social Care Act 2008 are:

QUESTION 1
The proposals in this consultation are part of our ongoing review to make sure that the full costs of regulation are broadly aligned between sectors. We propose to balance fees between sectors carefully so fees do not fluctuate more than is necessary.

(Questions 2 to 4 relate specifically to the community social care, dental and residential social care sectors)

1a. To what extent do you agree or disagree with our approach to assessing costs and fees for all sectors?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

1b. Please explain your answer

QUESTION 2
This is the fourth and final year of our four-year trajectory to full chargeable cost recovery. This was addressed in previous consultations.

We propose to increase fees for community social care providers by £1.5 million overall for 2019/20. The proposed increase is lower than the amount we stated previously.

2a. To what extent do you agree or disagree with our reasons for increasing fees for community social care providers by £1.5 million overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

2b. Please explain your answer

QUESTION 3
We propose to increase fees for dental providers by £600,000 overall for 2019/20. This better aligns the amount of fees collected with the costs of regulating this sector.

3a. To what extent do you agree or disagree with our reasons for increasing fees for dental providers by £600,000 overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

3b. Please explain your answer

QUESTION 4
We propose to decrease fees for residential social care providers by £800,000 overall for 2019/20. This better aligns the amount of fees collected with the costs of regulating this sector.

4a. To what extent do you agree or disagree with our reasons for decreasing fees for residential social care providers by £800,000 overall for 2019/20?

- strongly agree
- agree
- neither agree or disagree
- disagree
- strongly disagree
- no opinion

4b. Please explain your answer

Please send us your response by midday on **17 January 2019**.

You can respond to our consultation in two ways:

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

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

Annex A – Indicative income and fees for 2019/20

Proposal 1 – Community social care providers

This is an example of how fees will change for proposal 1. To calculate the fee for a location, a provider in this sector needs to multiply the number of service users at each location by the "variable element" and then add the floor to obtain the whole sum.

Providers need to note that this calculation is based on current information which is expected to change slightly when it is recalculated for the new year.

Fee elements		2018/19	Proposed 2019/20	Mean proposed fee increase
Floor		239	249	
Ceiling number of service users		1,700	1,700	
Variable element multiplied by number of service users up to ceiling		45.770	51.852	
Maximum fee		78,047	88,397	
Mean number of service users per location	46	£2,344	£2,634	£290

Proposal 2 – Dental providers

This is how fees will change for proposal 2.

Primary care services (Dental) – One location

Number of dental chairs	2018/19	2019/20	increase 18/19 to 19/20
1	£529	£598	£69
2	£661	£747	£86
3	£749	£846	£97
4	£837	£946	£109
5	£969	£1,095	£126
6	£969	£1,095	£126
More than 6	£1,145	£1,294	£149

Primary care services (Dental) – More than one location

Number of locations	2018/19	2019/20		increase 18/19 to 19/20
2	£1,410	£1,593		£183
3	£2,114	£2,389		£275
4	£2,819	£3,185		£366
5	£3,524	£3,982		£458
6 to 10	£4,229	£4,779		£550
11 to 40	£8,810	£9,955		£1,145
41 to 99	£26,429	£29,865		£3,436
More than 99	£52,857	£59,728		£6,871

Proposal 3 – Residential social care providers

This is how fees will change for proposal 3.

Maximum number of service users per location	2018/19	2019/20 Proposed		Proposed fee reduction 18/19 to 19/20
Less than 4	£321	£316		-£5
From 4 to 10	£836	£824		-£12
From 11 to 15	£1,674	£1,649		-£25
From 16 to 20	£2,447	£2,411		-£36
From 21 to 25	£3,348	£3,299		-£49
From 26 to 30	£4,375	£4,311		-£64
From 31 to 35	£5,147	£5,071		-£76
From 36 to 40	£5,921	£5,834		-£87
From 41 to 45	£6,694	£6,595		-£99
From 46 to 50	£7,468	£7,358		-£110
From 51 to 55	£8,235	£8,114		-£121
From 56 to 60	£9,008	£8,875		-£133
From 61 to 65	£10,295	£10,143		-£152
From 66 to 70	£11,322	£11,155		-£167
From 71 to 75	£12,355	£12,173		-£182
From 76 to 80	£13,383	£13,186		-£197
From 81 to 90	£14,415	£14,203		-£212
More than 90	£16,096	£15,859		-£237

Fee paid by an average provider	*£4,369*	*£4,305*		*-£64*

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 – Definition of costs

1. Our costs are divided into direct costs, indirect costs and overheads.

2. Direct costs result from activity directly related to our inspection activity and can be allocated at provider level (though we rarely do that). An example would be inspection staff costs.

3. Indirect costs result from activities that can be apportioned to a particular sector, but cannot be allocated to specific providers. For example, strategy and intelligence may make an amendment to a policy which impacts a specific sector.

4. Overheads cannot be allocated to specific sectors and so have to be apportioned using appropriate measures (as an example, IT costs would be apportioned on headcount as these costs are generally “driven” by the activities of staff).

5. The costs for all sectors are made up of these three costs.

Annex D – 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, section 85 of the HSCA. 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 and Social Care.

In addition, our powers to set fees extend to our review and performance assessment functions under, section 46 of the HSCA by virtue of the Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016. These functions cover all our activities associated with rating services.

[1] See Annex E.

Annex E – 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 F – 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) and the Environmental Information Regulations 2004). You would also have a right of access to any information you have submitted to CQC under the General Data Protection Regulation (GDPR).

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.

Processing of personal data

We will process your personal data in accordance with GDPR and, in most circumstances, this will mean that your personal data will not be disclosed to third parties. CQC is collecting responses in order to fulfil the requirements of section 85(4) of the Health and Social Care Act 2008. Under the General Data Protection Regulation, CQC has a lawful basis to process the personal data as processing is necessary for meeting CQC's legal obligations and for exercise of CQC's official authority.

CQC will use your responses to conduct an analysis of the proposed fees structure and in some cases use a specialist company to analyse results. Any information you give will be stored securely and only be used strictly for the analysis purposes. Once the consultation is completed your responses will be retained by CQC according to our Retention and Destruction Schedule. You can read more about how CQC processes personal data in our full Privacy statement.

If you have submitted responses and no longer wish for your responses to be considered for analysis please email feesconsultation@cqc.org.uk

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/feesconsultation

By email

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

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

Corporate member of
Plain English Campaign
Committed to clearer communication.
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