Fees from April 2016

Draft regulatory impact assessment

This initial regulatory impact assessment has been published alongside our consultation document, *Regulatory fees – have your say*. We suggest that stakeholders read that document in full before reading this impact assessment.

This document sets out our initial analysis of the costs and benefits of the proposed changes to our fee scheme from April 2016.

Introduction

1. The Care Quality Commission (CQC) is the independent statutory 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. Like many public regulatory bodies, CQC is required by government to set fees in order to cover the costs of its functions.

3. CQC can only use fee income for its registration functions under the 2008 Act and not for other functions such as monitoring the use of the Mental Health Act.

4. We have a duty to consult every time we want to make any changes to the fees scheme. We have published our regulatory fees consultation: *Regulatory fees – have your say*, which will run from 2 November 2015 to 15 January 2016.

5. In line with guidance from HM Treasury (HMT), CQC is committed to publishing a two-stage impact assessment. This document is an initial impact assessment which highlights our initial analysis of the costs and benefit impacts on stakeholders of the various proposals contained within the consultation document. These stakeholders include regulated providers, HMT (representing the interests of taxpayers), people who use services, commissioners, the public and CQC.

6. A final impact assessment will be published once CQC has analysed responses to the consultation and will be published on our website in due course.

Background and impetus for the proposed changes

Financial position

7. CQC's total revenue budget for 2015/16 is £249.3 million, of which £4.9 million is allocated to Healthwatch England, so we are operating with resources of £244.4 million. The budget is derived from a combination of grant-in-aid and income from fees paid by providers. Of our operational resources, £224.4 million relates to our registration functions under the 2008 Act and £20.0 million to other functions.

8. During the previous two years, the CQC budget relating to our registration functions has increased to underpin the transformation required in our inspection model that will ensure that providers can deliver safe, effective, compassionate and high-quality care, and to encourage them to make improvements. This increase has the effect of reducing the proportion of income recovered in fees compared to previous years. The budget relating to our other functions has decreased during the same period.

9. In 2015/16, fees paid by providers are estimated to generate £113.5 million. This is 50.6% of the budget relating to our registration functions (£224.4 million).

10. The elements that we are not able to recover from fee charges include our regulation under the Mental Health Act 1983, our enforcement and thematic review work and the activities we are undertaking on Market Oversight.

11. This increase in budget meant that the proportion of fees recovered in 2014/15 was much lower than it had been in previous years. This is not a sustainable position under HMT requirements. Last year CQC signaled its intent to move towards recovering the full chargeable costs of the new regulatory methodology. This meant increasing fees for all sectors, except the dental sector, by 9%.

12. This year we are in a position to publish our intended approach to achieving full chargeable cost recovery for all sectors. Two options are presented – a two year and a four year trajectory.

External context to increasing fees

13. Government policy states that the ability to recover costs of services underpinned by statute shows the real economic cost of the service. It promotes better control of costs and efficient and effective use of public money.

14. We can recover costs that relate to our chargeable regulatory work under the 2008 Act (see paragraph two). We have two sources of funding – grant-in-aid from the government and fees income from providers. We can never raise more than it costs to deliver our functions and so an increase in funding from one source will always mean a reduction from the other. As we move to a position of

full chargeable cost recovery, we need to find a balance in our funding that fulfils government policy and also allows us to safeguard our position as an independent regulator of the health and adult social care sectors.

15. We are fully aware that providers consistently raise concerns about any fee increases, particularly against a background that is economically challenging. We are sympathetic to that position, but we have to set that against the fact that ultimately we are constrained by the policy requirements of the Secretary of State for Health and HMT.

16. With this in mind, we consider the effect of our costs from both the macro perspective of the total health and adult social care economy and the micro perspective of individual fee increases for specific providers. This is not an attempt to explain away our increases, or to marginalise the effect of them, but to provide context for why changes are necessary.

17. The launch in 2015 of a payment by instalments scheme is also a practical way in which we are helping providers to be able to manage payment of fees so that it does not impact cash flow as severely as a one-off payment can.

Internal context to increasing fees

18. The trajectories for the two options are shown using the 2015/16 budget as our base. This is shown for simplicity and illustrative purposes only. We do not expect our budget to remain static during these timescales. There are a number of significant reasons for this.

19. Firstly, we are in the middle of a spending review where we are reviewing our cost base. This aligns with a drive which we are already undertaking to ensure the best value for money for the public purse. We intend to drive out efficiencies in the way in which we deliver inspection and are investigating ways in which we can realise significant non-pay savings through commercial strategies.

20. Secondly, we are developing a new strategy for 2016-2021, which aligns with our drive for finding efficiencies. Further information about our strategy is included in Section 4 of our consultation document. As our future strategic direction is yet to be confirmed and its full impact on fees assessed, this impact assessment focuses on two main options for achieving full chargeable cost recovery.

21. We have an increasing understanding of our costs and are able to analyse these for each sector, including the split between direct and indirect costs and overheads. We are still moving towards steady state and our allocation of indirect costs and overheads will continue to fluctuate until we have embedded our new methodology. Other initiatives, such as implementing our new five-year strategy, will also affect costings as we refine our models, improve our processes and drive efficiencies.

22. Despite these uncertainties, it is important that we map out what the future may look like, while acknowledging that the actual figures for future years will vary. This removes some uncertainty and provides the opportunity for forward planning.

Costing methodology

23. Our costs are divided into direct costs, indirect costs and overheads. Direct costs result from activity directly related to our inspection activity and can be allocated at provider level (though we rarely do that). Indirect costs result from activities that can be apportioned to a particular sector, but cannot be allocated to specific providers. Overheads cannot be allocated to specific sectors and so have to be apportioned using appropriate measures (as an example, human resource costs would be apportioned on headcount as these costs are generally "driven" by the activities of staff). The costs for all sectors are made up of these three costs.

24. These costs are distributed using a relatively simple approach. Overheads are first apportioned to indirect and direct costs using the drivers as discussed above. This includes those costs that relate to our non-regulatory functions. Some of these costs do not attract indirect costs.

25. The next step is to allocate the indirect costs, with their share of overheads, using specific indicators which allocate them to the relevant inspection directorates. As an example, a team that develops the strategy for hospital inspection will be allocated exclusively to the Hospital Directorate.

26. This then gives us a fully absorbed cost for each of the inspection directorates. Knowledge of the regulatory model, backed up with data collected from timesheets provides the detail that allows us to allocate costs to each category of fees. This provides a total cost for each sector.

27. These costs are then distributed among providers in the relevant sectors using the structure of the fees scheme to ensure that smaller providers are protected and that providers are charged appropriate to their size.

Summary of options

28. We are presenting two options for the fee scheme for April 2016. These are:

- Achieving full chargeable cost recovery over a period of two years for all providers
- Achieving full chargeable cost recovery over a period of four years for all providers

Under both options, we have presented fee increases that are differentiated by sector, dependent on how close to full chargeable cost recovery they are under current cost analysis.

Other possible options considered but not presented

29. Arriving at the two options has required considerable discussion within CQC and with government departments, as well with providers through the Fees Advisory Panel. There are two key variables for increasing fees: the percentage increase and the length of time over which the increase is applied.

30. In addressing the first variable, we were conscious that holding fees at the same level as this year was simply not an option given the requirement we have to move to full chargeable cost recovery. A similar increase to 2015/16 (9%) was also not considered a credible stance by HMT. Making an increase last year enabled us to make a statement of intent, but in this year we have to make that intention a reality, by introducing increases that move us substantially to our target recovery position.

31. We considered a number of options in varying the length of recovery period, particularly for those sectors at a lower level of full chargeable cost recovery that will face proportionately larger increases than others. Again we faced constraints around what was considered an acceptable maximum period of recovery. We came to the conclusion after advice from the Department of Health that this was four years.

32. Last year, we noted that the budget for CQC in relation to the overall health and adult social care sector spend is 16p in every £100 spent. We stated at the time that this does not remove our requirement to be as efficient as we possibly can or to constantly seek better ways of working. It does show, however, that our overall budget is set to regulate care in a very large area of the economy, which has over 30,000 providers with more than 40,000 locations.

33. At the individual provider level, it is also worth understanding that the final position of fees at full chargeable cost recovery will still represent no more than 1% of the turnover of an average provider and will be much less for many providers. This is also tax allowable, so the differential rate of taxation, whether for a sole trader, partnership or company, will reduce that proportion further.

34. To reiterate, we understand that this does not remove the need to explain our fee increases and to keep them to a minimum. It does add a note of caution when discussing fees in terms of a percentage increase which can imply more dramatic increases than is factually correct.

Option 1: Achieving full chargeable cost recovery over two years

35. This option shows a trajectory of recovery as follows:

- Increase fees for the next two years for all sectors with two exceptions:
  - Dental providers will see no increase in the first year, and a reduction in the second year
  - Fees for single specialty services will be held for the first year and increased only in the second year

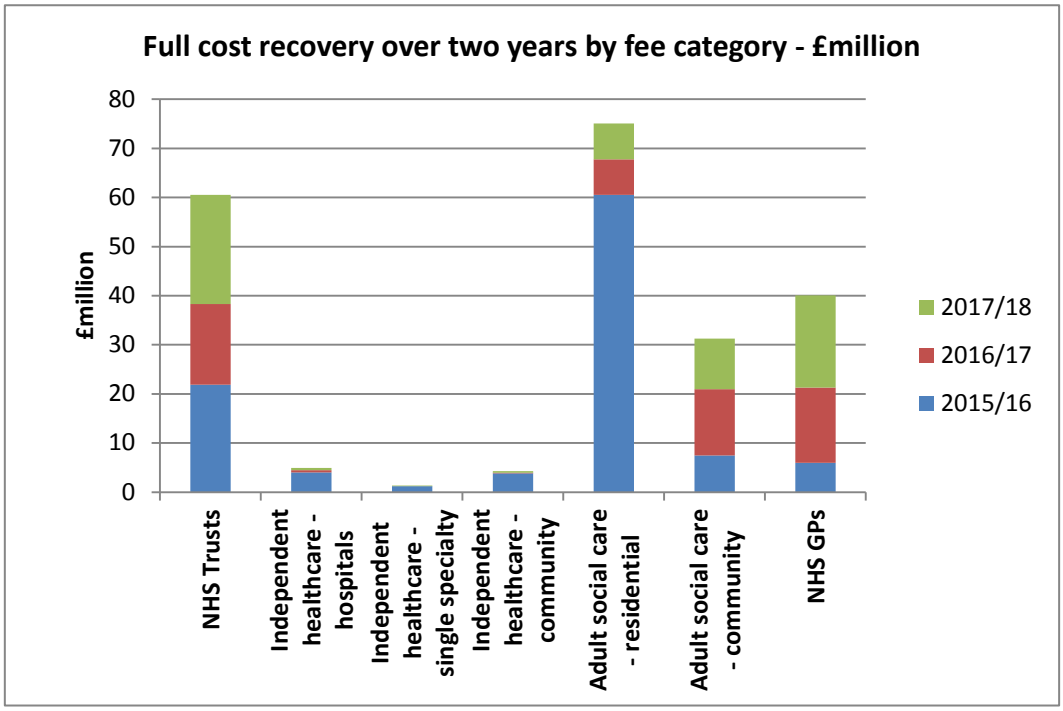
36. The table below shows the profile of the varying levels of increases, with all sectors at full chargeable cost recovery by 2017/18. This would result in a £53.3m increase in fees received by CQC for 2016/17 over 2015/16 and an extra £58.1 million for 2017/18 on top of the previous year.

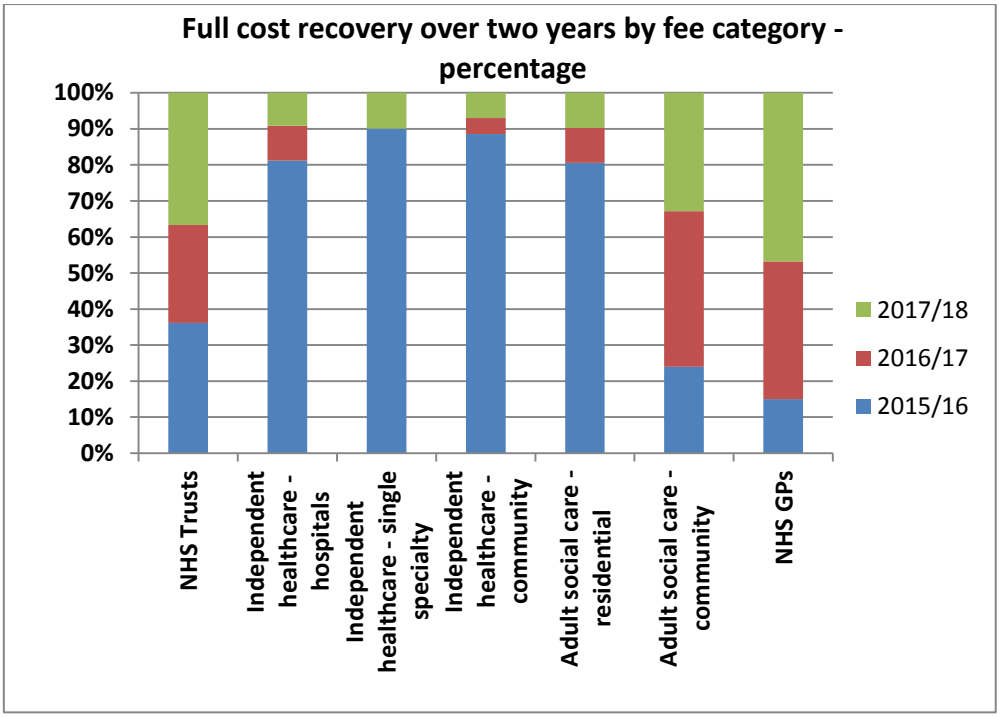
		2016-17				2017-18		
		GIA	Fees	Total		GIA	Fees	Total
		£'M	£'M	£'M		£'M	£'M	£'M
NHS Trusts		22.2	38.3	60.5		0.0	60.5	60.5
Independent healthcare - hospitals		0.5	4.4	4.9		0.0	4.9	4.9
Independent healthcare - single specialty		0.1	1.2	1.3		0.0	1.3	1.3
Independent healthcare - community		0.3	4.0	4.3		0.0	4.3	4.3
Adult social care- residential		7.3	67.8	75.1		0.0	75.1	75.1
Adult social care- community		10.3	21.0	31.3		0.0	31.3	31.3
NHS GPs		18.7	21.3	40.0		0.0	40.0	40.0
Dentists		-1.3	8.3	7.0		0.0	7.0	7.0
Non-Chargeable Work		24.9	0.0	24.9		24.9	0.0	24.9
		83.0	**166.3**	**249.3**		**24.9**	**224.4**	**249.3**

37. The profile in the table also shows the relationship between fees and government funding (grant-in-aid). This is demonstrated more fully in appendix two.

Costs

38. All providers would see their fees increase to achieve full chargeable cost recovery over a period of two years (subject to paragraphs 39 and 40). This is shown graphically below in financial and percentage terms.





39. The fees for dental providers will be held at their current rate, but they are expected to fall in year two as their full regulatory model will have embedded by then and will be delivering savings through the improved methodology.

40. The fees for single specialty services are being held in the first year because they are close to full chargeable cost recovery now under the latest analysis. A new methodology for these services is currently being piloted, so it is feasible that as we embed the new approach, refine our cost base overall and make efficiencies, the costs allocated to this sector could change. If we increased their fees in the first year then we may have to alter their costs in the second year.

41. Examples of some of the individual increases that a two-year trajectory will produce are:

    - A mid-banded NHS trust would see their fee rise by £58,656 in year one and by £78,971 in year two.
    - A single location GP with a patient list size between 5,001 and 10,000 would see their fee rise by £1,849 in year one and by £2,265 in year two.
    - A 28 bed care home would see their fee rise by £451 in year one and by £449 in year two.
    - A single location community social care provider would see their fee rise by £1,433 in year one and by £1,058 in year two.

    For a full breakdown on how this affects individual fees, please refer to appendix three.

Benefits

42. CQC will achieve the position of full chargeable cost recovery in line with expectations from the government in two years. This would also mean a

reduction on the reliance in grant-in-aid and an equivalent increase in fee income to CQC.

43. It helps to secure the aim for us to be a stronger independent regulator not overly reliant on government funds. Raising fees directly from providers is a key method by which we can achieve this goal.

Feasibility

44. This would be simple to implement administratively.

Risks

45. A trajectory of two years means that significant increases will take place in parallel with a growing understanding of our cost base and as we are making efficiencies. This raises the possibility that some sectors will be overcharged in the second year and the likelihood that there will need to be adjustments to fees in the following years as a result of this implementation.

46. We have set out above that the overall increases are not large in the context of the sector as a whole and that the same holds true at the level of the individual provider (see paragraphs 32 to 34). However an increase of this nature would provoke considerable debate and there is a risk that the level of concern outweighs the actual effect of the increases, particularly over such a short period.

Option 2: Achieving full chargeable cost recovery over four years

47. This option shows a trajectory of recovery as follows:

- Increase in fees for the next four years for all sectors with two exceptions:
  - Dental providers will see no increase in the first year, a reduction in the second year and then will be held at that lower level for the remaining two years.
  - Fees for single specialty services will be held for the first year, increased in the second year and then held for the remaining two years.

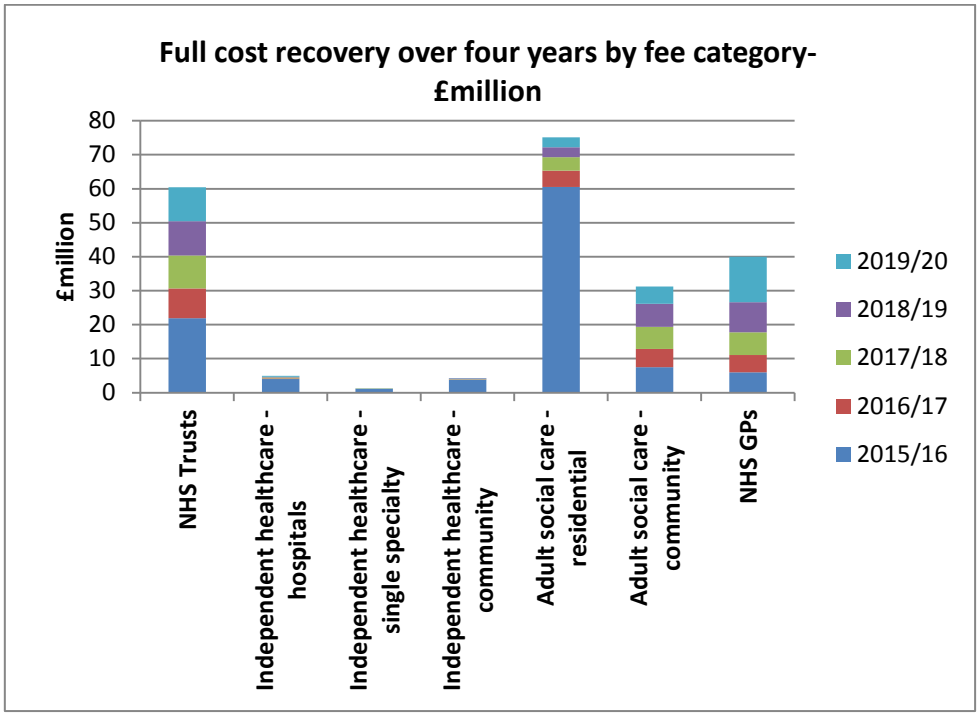
48. The table below shows the profile of the varying levels of increases, with all sectors at full chargeable cost recovery by 2019/20. This would result in a £24.6m increase in fees received by CQC for 2016/17, an extra £25.9 million for 2017/18, £29.1m for 2018/19 and £31.8m for 2019/20.

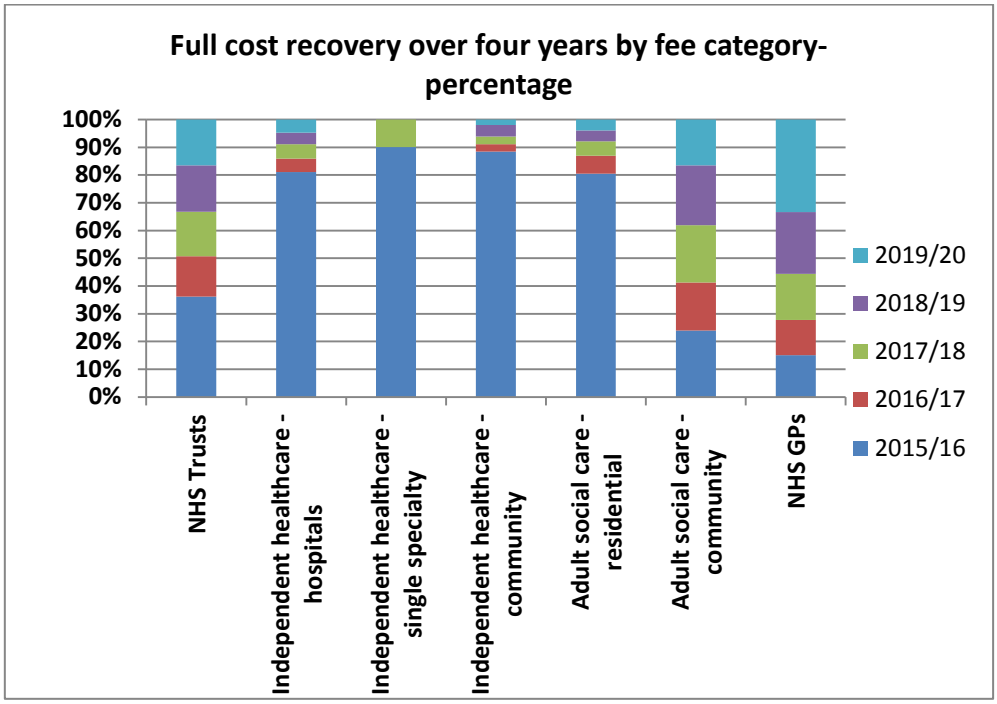
	2016-17			2017-18			2018-19			2019-20		
	GIA	Fees	Total	GIA	Fees	Total	GIA	Fees	Total	GIA	Fees	Total
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
NHS Trusts	29.8	30.7	60.5	20.1	40.4	60.5	10.0	50.5	60.5	0.0	60.5	60.5
Independent healthcare - hospitals	0.7	4.2	4.9	0.4	4.5	4.9	0.2	4.7	4.9	0.0	4.9	4.9
Independent healthcare - single specialty	0.1	1.2	1.3	0.0	1.3	1.3	0.0	1.3	1.3	0.0	1.3	1.3
Independent healthcare - community	0.4	3.9	4.3	0.3	4.0	4.3	0.1	4.2	4.3	0.0	4.3	4.3
Adult social care- residential	9.7	65.3	75.1	5.9	69.2	75.1	2.9	72.2	75.1	0.0	75.1	75.1
Adult social care- community	18.4	12.9	31.3	12.0	19.4	31.3	5.2	26.1	31.3	0.0	31.3	31.3
NHS GPs	28.9	11.1	40.0	22.2	17.8	40.0	13.4	26.6	40.0	0.0	40.0	40.0
Dentists	-1.3	8.3	7.0	0.0	7.0	7.0	0.0	7.0	7.0	0.0	7.0	7.0
Non-Chargeable Work	24.9	0.0	24.9	24.9	0.0	24.9	24.9	0.0	24.9	24.9	0.0	24.9
	111.7	**137.6**	**249.3**	**85.8**	**163.5**	**249.3**	**56.7**	**192.6**	**249.3**	**24.9**	**224.4**	**249.3**

49. The profile in the table also shows the relationship between fees and government funding. This is demonstrated more fully in appendix two.

Costs

50. All providers would see their fees increase to full chargeable cost recovery over a period of four years (subject to paragraphs 51 and 52). This is shown graphically below in financial and percentage terms.





51. The fees for dental providers will be held at their current rate, but they are expected to fall in year two as their full regulatory model will have embedded by then and will be delivering savings through the improved methodology and this will remain the steady state position for the remaining two years.

52. The fees for single specialty hospitals are being held in the first year because they are close to full chargeable cost recovery now under the latest analysis. A new methodology for these services is currently being piloted, so it is feasible that as we embed the new approach, refine our cost base overall and make efficiencies the costs allocated to this sector could change. If we increased their fees in the first year then we may have to alter their costs in the second year and subsequent years.

53. Examples of some of the individual increases that a four-year trajectory will produce are:

    - A mid-banded NHS trust would see four increases of £31,283, £34,709, £36,050 and £35,585 respectively over each of the next four years.
    - A GP with a patient list size between 5,001 and 10,000 would see four increases of £616, £805, £1,073 and £1,620 respectively.
    - A 28 bed care home would see four increases of £301, £244, £180 and £175 respectively.
    - A single location community social care provider would see four increases of £573, £685, £718 and £515 respectively.

    For a full breakdown on how this affects individual fees please refer to appendix three.

Benefits

54. Generally, the benefits are the same as those for the two year option. However, CQC will move to full chargeable cost recovery more slowly as this will take four years rather than two. This will still mean a reduction on the reliance in grant-in-aid and an equivalent increase in fee income to CQC. It mitigates the risk of charging more than costs as we will have two extra years in which to refine the trajectory to full chargeable cost recovery.

55. It helps to secure the aim for us to be a stronger independent regulator not overly reliant on government funds. Raising fees directly from providers is a key method by which we can achieve this goal.

Feasibility

56. This would be simple to implement administratively.

Risks

57. The discussion about the overall context of the increases described in paragraph 46 still hold true. The fact that the increases take place over four years reduces each individual increase, but probably will not decrease the force of the reaction among providers.

58. A trajectory of four years still means that significant increases will take place in parallel with a growing understanding of our cost base and as we are making efficiencies.

59. Key government stakeholders may consider the lengthening of the period to be too long.

Comments on costs for adult social care community providers

60. The costs relating to adult social care community providers are higher than have been set out in previous analysis, showing that the sector is at a lower rate of cost recovery than previously understood. The implication is that the final fees under both trajectory options will be higher than set out in last year's fees scheme.

61. This has happened as a result of a flaw in the previous model we were using. When we started reviewing costs by sector in the first years of CQC, we had very little data that allowed us to differentiate costs for adult social care providers between residential care homes and agencies. In the absence of this, we used the amount of fees paid by each part of the adult social care sector. In 2010, the care home sector was paying about nine times more in fees than the community sector. This was the split that was then used to allocate the costs between the two areas.

62. This error was carried through to later models and it is only in rebuilding it for this year that it has come to light. Under the new model, costs for each sector are driven by the number of locations, the frequency of inspections, the length of inspections and the size of the teams. On this basis adult social care agencies absorb about one-third of the total costs for the adult social care sector. This, and the increase in budget over the last two years, has increased the actual costs of regulation by four times the previous estimate, with the correction of the error responsible for about 75% of the increase.

63. We are monitoring this closely to ensure that we maintain an accurate analysis of the costs. We considered loading charges towards the end of the trajectory to cushion the effect of the increase. We have been able to do this for the four year trajectory, but it is more difficult and less effective for the two year option.

Appendix 1: Methodology for assessing options in Impact Assessment

What criteria are used to assess the options?

65. Options for each proposal are assessed according to the following criteria:

    a. Feasibility of implementing each option.

    b. Comparative costs and benefits for regulated providers.

    c. Overall costs and benefits.

    d. Management of risks.

66. Please note that in setting out the costs and benefits of the various scenarios in this document, we compare these to a ‘continue as is’ scenario. This allows us to see what the marginal impacts of the proposed scenarios would be over and above the current status quo (current fee scheme).

What is the feasibility of implementing each option?

67. The key test of feasibility of each option is whether it is:

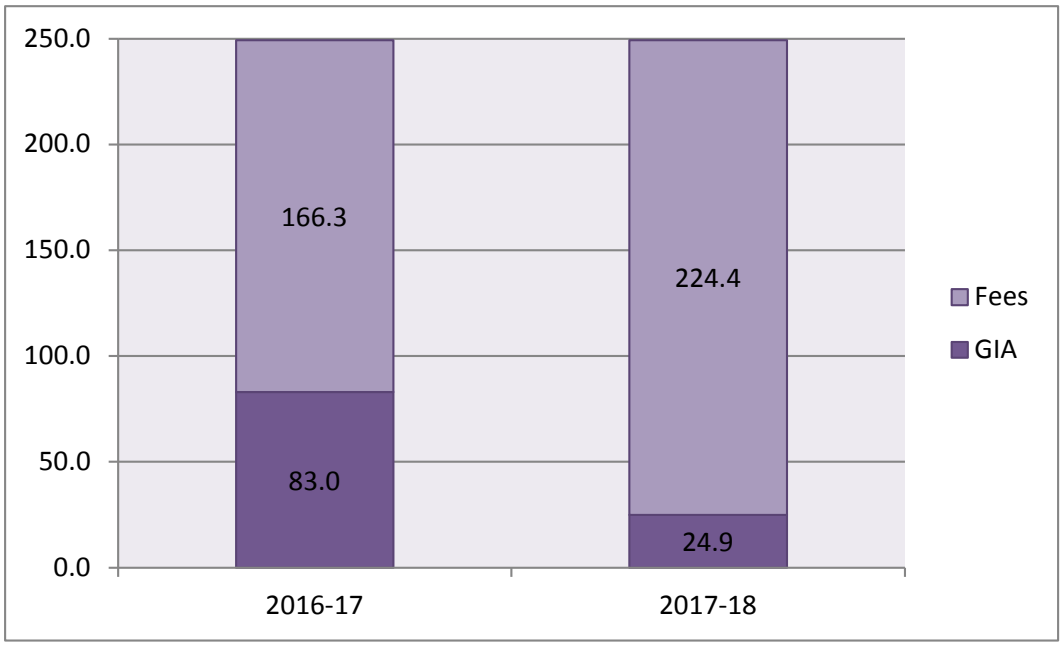
    • Simple and straightforward to implement by April 2016.

    • Achievable within CQC’s existing capabilities.

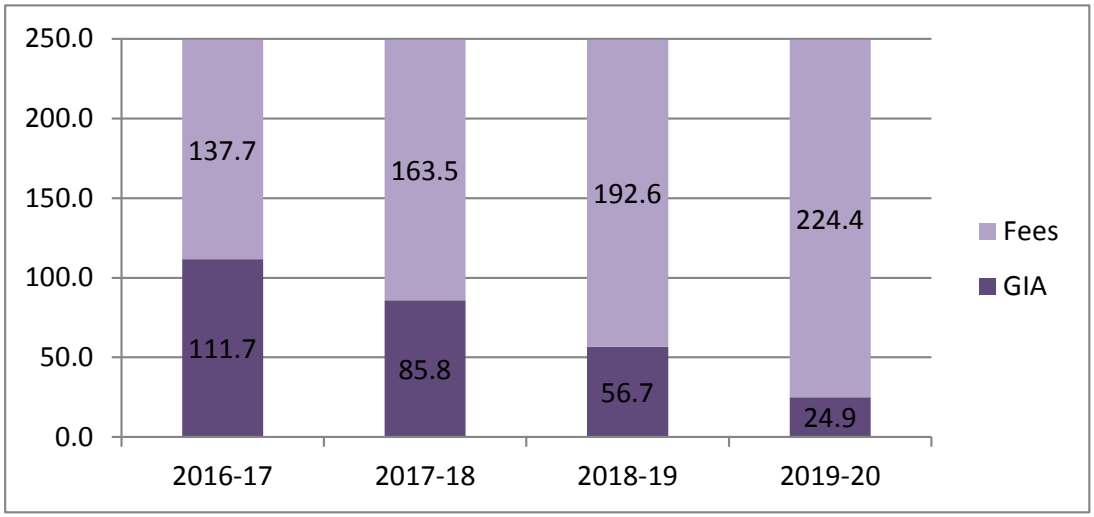
    • Cost efficient to collect fee income.

Appendix 2: Proposed fee increases by sector

Proportionate change in grant-in-aid (GIA) and fees for two year trajectory:



Proportionate change in grant-in-aid (GIA) and fees for four year trajectory:



Appendix 3: Proposed new fee band tables – two year trajectory

The tables below show the effect of increasing fees at an individual level as proposed in option 1.

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

	Actual fee	Proposed fee	Estimated fee
Amount of turnover	2015/16	2016/17	2017/18
Up to £75,000,000	£44,690	£78,208	£123,333
From £75,000,001 to £125,000,000	£61,449	£107,536	£169,584
From £125,000,001 to £225,000,000	£78,208	£136,864	£215,835
From £225,000,001 to £325,000,000	£94,996	£166,243	£262,165
From £325,000,001 to £500,000,000	£111,725	£195,519	£308,333
More than £500,000,000	£128,484	£224,847	£354,584

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

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£9,505	£10,646	£11,710
2 to 3	£18,993	£21,272	£23,399
4 to 6	£37,987	£42,545	£46,800
7 to 10	£75,973	£85,090	£93,599
11 to 15	£122,898	£137,646	£151,410
More than 15	£167,588	£187,699	£206,468

Healthcare – Single specialty services
(Part 2, column 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,679	£1,679	£1,864
2 to 3	£3,352	£3,352	£3,721
4 to 6	£6,704	£6,704	£7,441
7 to 10	£13,407	£13,407	£14,882
11 to 15	£26,814	£26,814	£29,764
More than 15	£53,628	£53,628	£59,527

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

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,679	£1,763	£1,851
2 to 3	£3,352	£3,520	£3,696
4 to 6	£6,704	£7,039	£7,391
7 to 10	£13,407	£14,077	£14,781
11 to 15	£26,814	£28,155	£29,562
More than 15	£53,628	£56,309	£59,125

Community healthcare services (independent ambulance services)
(Part 3 of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£894	£939	£986
2 to 3	£1,788	£1,877	£1,971
4 to 10	£4,469	£4,692	£4,927
11 to 50	£11,173	£11,732	£12,318
51 to 100	£26,814	£28,155	£29,562
More than 100	£53,628	£56,309	£59,125

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

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£278	£292	£306

Primary care services (Medical) – One location (Part 4 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of registered patients	2015/16	2016/17	2017/18
Up to 5,000	£616	£2,187	£4,111
5,001 to 10,000	£725	£2,574	£4,839
10,001 to 15,000	£839	£2,978	£5,599
More than 15,000	£948	£3,365	£6,327

Primary care services (Medical) – One location where walk-in-centre forms part or all of location (Paragraph 2(d)(i) of existing fee scheme); and

Primary care services (Medical) – One location providing out-of-hours services (Paragraph 2(d)(iii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Location	2015/16	2016/17	2017/18
1	£948	£3,365	£6,327

Primary care services (Medical) – More than one location (Part 5 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
2	£1,341	£4,761	£8,950
3	£1,788	£6,347	£11,933
4	£2,235	£7,934	£14,916
5	£2,681	£9,518	£17,893
6 to 10	£3,352	£11,900	£22,371
11 to 40	£6,704	£23,799	£44,742
More than 40	£16,759	£59,494	£111,850

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

	Actual fee		Estimated fee
Number of dental chairs	2015/16	2016/17	2017/18
1	£600	£600	£510
2	£750	£750	£638
3	£850	£850	£723
4	£950	£950	£808
5	£1,100	£1,100	£935
6	£1,100	£1,100	£935
More than 6	£1,300	£1,300	£1,105

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

	Actual fee		Estimated fee
Number of locations	2015/16	2016/17	2017/18
2	£1,600	£1,600	£1,360
3	£2,400	£2,400	£2,040
4	£3,200	£3,200	£2,720
5	£4,000	£4,000	£3,400
6 to 10	£4,800	£4,800	£4,080
11 to 40	£10,000	£10,000	£8,500
41 to 99	£30,000	£30,000	£25,500
More than 99	£60,000	£60,000	£51,000

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

	Actual fee	Proposed fee	Estimated fee
Maximum number of service users	2015/16	2016/17	2017/18
Less than 4	£276	£309	£342
From 4 to 10	£719	£805	£891
From 11 to 15	£1,439	£1,612	£1,783
From 16 to 20	£2,104	£2,356	£2,607
From 21 to 25	£2,878	£3,223	£3,567
From 26 to 30	£3,761	£4,212	£4,661
From 31 to 35	£4,425	£4,956	£5,484
From 36 to 40	£5,090	£5,701	£6,308
From 41 to 45	£5,755	£6,446	£7,132
From 46 to 50	£6,420	£7,190	£7,956
From 51 to 55	£7,080	£7,930	£8,774
From 56 to 60	£7,744	£8,673	£9,597
From 61 to 65	£8,851	£9,913	£10,969
From 66 to 70	£9,734	£10,902	£12,063
From 70 to 75	£10,622	£11,897	£13,164
From 76 to 80	£11,505	£12,886	£14,258
From 81 to 90	£12,393	£13,880	£15,358
More than 90	£13,838	£15,499	£17,149

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

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,662	£1,861	£2,060
2 to 3	£3,319	£3,717	£4,113
4 to 6	£6,638	£7,435	£8,226
7 to 10	£13,963	£15,639	£17,304
11 to 15	£26,552	£29,738	£32,905
More than 15	£53,105	£59,478	£65,812

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

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£796	£2,229	£3,287
2 to 3	£2,213	£6,196	£9,140
4 to 6	£4,425	£12,390	£18,275
7 to 12	£8,851	£24,783	£36,555
13 to 25	£17,702	£49,566	£73,109
More than 25	£35,403	£99,128	£146,214

Note: Should regulations be made requiring independent midwives to register from April 2016, their fee for 2016/17 will be £872 for each location under paragraph 2 (c)(iii) of the existing fee scheme. We intend to review that fee charge once those providers have registered and a costed methodology is in place, so that we can move to a position of full chargeable cost recovery at an appropriate time.

Annex 4: Proposed new fee band tables – four year trajectory

The tables below show the effect of increasing fees at an individual level as proposed in option 2.

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

	Actual fee	Proposed fee	Estimated fee		
Amount of turnover	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Up to £75,000,000	£44,690	£62,566	£82,399	£102,999	£123,333
From £75,000,001 to £125,000,000	£61,449	£86,029	£113,300	£141,625	£169,584
From £125,000,001 to £225,000,000	£78,208	£109,491	£144,200	£180,250	£215,835
From £225,000,001 to £325,000,000	£94,996	£132,994	£175,154	£218,942	£262,165
From £325,000,001 to £500,000,000	£111,725	£156,415	£205,999	£257,498	£308,333
More than £500,000,000	£128,484	£179,878	£236,899	£296,123	£354,584

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
1	£9,505	£10,075	£10,680	£11,160	£11,710
2 to 3	£18,993	£20,133	£21,341	£22,301	£23,399
4 to 6	£37,987	£40,266	£42,682	£44,603	£46,800
7 to 10	£75,973	£80,531	£85,363	£89,205	£93,599
11 to 15	£122,898	£130,272	£138,088	£144,302	£151,410
More than 15	£167,588	£177,643	£188,302	£196,775	£206,468

Healthcare – Single specialty services
(Part 2, column 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,679	£1,679	£1,864	£1,864	£1,864
2 to 3	£3,352	£3,352	£3,721	£3,721	£3,721
4 to 6	£6,704	£6,704	£7,441	£7,441	£7,441
7 to 10	£13,407	£13,407	£14,882	£14,882	£14,882
11 to 15	£26,814	£26,814	£29,764	£29,764	£29,764
More than 15	£53,628	£53,628	£59,527	£59,527	£59,527

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,679	£1,729	£1,781	£1,817	£1,851
2 to 3	£3,352	£3,453	£3,556	£3,627	£3,696
4 to 6	£6,704	£6,905	£7,112	£7,255	£7,391
7 to 10	£13,407	£13,809	£14,223	£14,508	£14,781
11 to 15	£26,814	£27,618	£28,447	£29,016	£29,562
More than 15	£53,628	£55,237	£56,894	£58,032	£59,125

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£894	£921	£948	£967	£986
2 to 3	£1,788	£1,842	£1,897	£1,935	£1,971
4 to 10	£4,469	£4,603	£4,741	£4,836	£4,927
11 to 50	£11,173	£11,508	£11,853	£12,091	£12,318
51 to 100	£26,814	£27,618	£28,447	£29,016	£29,562
More than 100	£53,628	£55,237	£56,894	£58,032	£59,125

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£278	£286	£295	£301	£306

Primary care services (Medical) – One location (Part 4 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of registered patients	2015/16	2016/17	2017/18	2018/19	2019/20
Up to 5,000	£616	£1,140	£1,823	£2,735	£4,111
5,001 to 10,000	£725	£1,341	£2,146	£3,219	£4,839
10,001 to 15,000	£839	£1,552	£2,483	£3,725	£5,599
More than 15,000	£948	£1,754	£2,806	£4,209	£6,327

Primary care services (Medical) – One location where walk-in-centre forms part or all of location (Paragraph 2(d)(i) of existing fee scheme); and

Primary care services (Medical) – One location providing out-of-hours services (Paragraph 2(d)(iii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Location	2015/16	2016/17	2017/18	2018/19	2019/20
1	£948	£1,754	£2,806	£4,209	£6,327

Primary care services (Medical) – More than one location
(Part 5 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
2	£1,341	£2,481	£3,969	£5,954	£8,950
3	£1,788	£3,308	£5,292	£7,939	£11,933
4	£2,235	£4,135	£6,616	£9,923	£14,916
5	£2,681	£4,960	£7,936	£11,904	£17,893
6 to 10	£3,352	£6,201	£9,922	£14,883	£22,371
11 to 40	£6,704	£12,402	£19,844	£29,766	£44,742
More than 40	£16,759	£31,004	£49,607	£74,410	£111,850

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

	Actual fee		Estimated fee		
Number of dental chairs	2015/16	2016/17	2017/18	2018/19	2019/20
1	£600	£600	£510	£510	£510
2	£750	£750	£638	£638	£638
3	£850	£850	£723	£723	£723
4	£950	£950	£808	£808	£808
5	£1,100	£1,100	£935	£935	£935
6	£1,100	£1,100	£935	£935	£935
More than 6	£1,300	£1,300	£1,105	£1,105	£1,105

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

	Actual fee		Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
2	£1,600	£1,600	£1,360	£1,360	£1,360
3	£2,400	£2,400	£2,040	£2,040	£2,040
4	£3,200	£3,200	£2,720	£2,720	£2,720
5	£4,000	£4,000	£3,400	£3,400	£3,400
6 to 10	£4,800	£4,800	£4,080	£4,080	£4,080
11 to 40	£10,000	£10,000	£8,500	£8,500	£8,500
41 to 99	£30,000	£30,000	£25,500	£25,500	£25,500
More than 99	£60,000	£60,000	£51,000	£51,000	£51,000

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

	Actual fee	Proposed fee	Estimated fee		
Maximum number of service users	2015/16	2016/17	2017/18	2018/19	2019/20
Less than 4	£276	£298	£316	£329	£342
From 4 to 10	£719	£777	£823	£858	£891
From 11 to 15	£1,439	£1,554	£1,647	£1,717	£1,783
From 16 to 20	£2,104	£2,272	£2,409	£2,510	£2,607
From 21 to 25	£2,878	£3,108	£3,295	£3,433	£3,567
From 26 to 30	£3,761	£4,062	£4,306	£4,486	£4,661
From 31 to 35	£4,425	£4,779	£5,066	£5,279	£5,484
From 36 to 40	£5,090	£5,497	£5,827	£6,072	£6,308
From 41 to 45	£5,755	£6,215	£6,588	£6,865	£7,132
From 46 to 50	£6,420	£6,934	£7,350	£7,658	£7,956
From 51 to 55	£7,080	£7,646	£8,105	£8,446	£8,774
From 56 to 60	£7,744	£8,364	£8,865	£9,238	£9,597
From 61 to 65	£8,851	£9,559	£10,133	£10,558	£10,969
From 66 to 70	£9,734	£10,513	£11,143	£11,612	£12,063
From 70 to 75	£10,622	£11,472	£12,160	£12,671	£13,164
From 76 to 80	£11,505	£12,425	£13,171	£13,724	£14,258
From 81 to 90	£12,393	£13,384	£14,188	£14,783	£15,358
More than 90	£13,838	£14,945	£15,842	£16,507	£17,149

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,662	£1,795	£1,903	£1,983	£2,060
2 to 3	£3,319	£3,585	£3,800	£3,959	£4,113
4 to 6	£6,638	£7,169	£7,599	£7,918	£8,226
7 to 10	£13,963	£15,080	£15,985	£16,656	£17,304
11 to 15	£26,552	£28,676	£30,397	£31,673	£32,905
More than 15	£53,105	£57,353	£60,795	£63,348	£65,812

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

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£796	£1,369	£2,054	£2,772	£3,287
2 to 3	£2,213	£3,806	£5,710	£7,708	£9,140
4 to 6	£4,425	£7,611	£11,417	£15,412	£18,275
7 to 12	£8,851	£15,224	£22,836	£30,828	£36,555
13 to 25	£17,702	£30,447	£45,671	£61,656	£73,109
More than 25	£35,403	£60,893	£91,340	£123,309	£146,214

Note: Should regulations be made requiring independent midwives to register from April 2016, their fee for 2016/17 will be £872 for each location under paragraph 2 (c)(iii) of the existing fee scheme. We intend to review that fee charge once those providers have registered and a costed methodology is in place, so that we can move to a position of full chargeable cost recovery at an appropriate time.